Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8215335	Nursing	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.10	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
7990256	Family Practice	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	DX41.1	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) The drug is not being used for Obstructive Sleep Apnea / Hypopnea Syndrome. This involves shallow breathing or pauses in breathing during sleep. 3) 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
7954496	Family Practice	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.419	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
7471371	Dermatology	ENBREL SURECLICK	*ANALGESICS - ANTI-INFLAMMATORY*	L40.9	Our prior authorization criteria for Enbrel have not been met. From the records that we have received, the following caused the denial of Enbrel. 1) Records of improvement within the past year were not 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 Enbrel have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Enbrel. 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 demonstrate significant improvement in his/her psoriatic condition; AND 3) Improvement within the past year must be documented. 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
8181028	Dermatology	HUMIRA	*ANALGESICS - ANTI-INFLAMMATORY*	I40.0	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) Significant improvement in condition has not been indicated. 2) 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 2 and 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
8129811	Dermatology	HUMIRA	*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) Significant improvement in condition has not been indicated. 2) 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 2 and 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
8081526	Dermatology	HUMIRA	*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
8289823	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. 1) Significant improvement in condition has not been indicated. 2) 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 2, 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
7763507	Internal Medicine	HUMIRA PEN	*ANALGESICS - ANTI-INFLAMMATORY*	K51.211	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) Significant improvement was not indicated. 2) Documentation of improvement within the past year was not 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 2 and 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 Gastroenterology Specialist; AND 2) Member must demonstrate a significant improvement in condition; AND 3) Documentation must be provided to show improvement within the past year. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7669552	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. 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
8325999	Family Practice	SPIRIVA HANDIHALER	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J44.9	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
8127719	Family Practice	TRINTELLIX	*ANTIDEPRESSANTS*	Major Depressive Disorder	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) The drug is not prescribed by or together with a Psychiatrist. 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 4 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) Prescribed by, or in consultation with, a Psychiatrist, AND 3) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND 4) 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
8345951	Family Practice	TRINTELLIX	*ANTIDEPRESSANTS*	dx.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, or paroxetine, have 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 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
7573983	Family Practice	TRINTELLIX	*ANTIDEPRESSANTS*	I47.9 Paroxysmal atrial tachycardia, I50.1 Left heart failure, I10 Essential hypertension, E78.2 Hypercholesterolemia, J44.9 COPD, E29.1 Testosterone deficiency, F32.1 Depression	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) The drug is not prescribed by or together with a Psychiatrist. 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 1 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) Prescribed by, or in consultation with, a Psychiatrist, 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
8030774	Family Practice	TRINTELLIX	*ANTIDEPRESSANTS*	F33.1	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) The drug is not prescribed by or together with a Psychiatrist. 2) Two selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine (tried), or paroxetine, have 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, 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) Prescribed by, or in consultation with, a Psychiatrist, AND 3) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND 4) 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
7987676	Internal Medicine	TRINTELLIX	*ANTIDEPRESSANTS*	F33.1	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) The drug is not prescribed by or together with a Psychiatrist. 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 4 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) Prescribed by, or in consultation with, a Psychiatrist, AND 3) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND 4) 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
7824051	Family Practice	TRINTELLIX	*ANTIDEPRESSANTS*	F33.1	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) The drug is not prescribed by or together with a Psychiatrist. 2) Two selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram, fluoxetine (tried), or paroxetine, have not been tried and failed. 3) 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, 3, 4 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) Prescribed by, or in consultation with, a Psychiatrist, AND 3) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND 4) 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
7791272	Family Practice	TRINTELLIX	*ANTIDEPRESSANTS*	F32.1 Major depressive disorder, single episode, moderate	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) The drug is not prescribed by or together with a Psychiatrist. 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 1 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Psychiatrist, AND 2) Member has a diagnosis of Major Depressive Disorder (MDD), AND 3) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND 4) 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
7737162	Family Practice	TRINTELLIX	*ANTIDEPRESSANTS*	F33.42	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) The drug is not prescribed by or together with a Psychiatrist. 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 1 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Psychiatrist, AND 2) Patient 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
7505444	Physician Assistant	TRINTELLIX	*ANTIDEPRESSANTS*	F33.1	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) 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 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Psychiatrist, 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
8317993	Family Practice	INVOKANA	*ANTIDIABETICS*	No Diagnosis Provided	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 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 Invokana 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 Invokana tablets. 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
8138023	Family Practice	INVOKANA	*ANTIDIABETICS*	E11.9	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 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 Invokana 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 Invokana tablets. 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

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8017727	ology, Diabetes & Me	INVOKANA	*ANTIDIABETICS*	E11.42	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) Farxiga or Xigduo/Xigduo XR 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 Invokana have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Invokana tablets. 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 or Xigduo/Xigduo XR). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Document: _INVOKANA_INVOKAMET_NHS_V4	No	No
8003580	ology, Diabetes & Me	INVOKANA	*ANTIDIABETICS*	E11.42	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) Farxiga or Xigduo/Xigduo XR 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 Invokana have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Invokana tablets. 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 or Xigduo/Xigduo XR). Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7885410	ology, Diabetes & Me	INVOKANA	*ANTIDIABETICS*	E11.42 SEE FAX	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) Farxiga or Xigduo/Xigduo XR 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 Invokana have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Invokana tablets. 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 or Xigduo/Xigduo XR). Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7753598	Internal Medicine	INVOKANA	*ANTIDIABETICS*	E11.65 TYPE 2 DIABETES W/ HYPERGLYCEMIA	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) Farxiga or Xigduo/Xigduo XR 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 Invokana have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Invokana tablets. 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 or Xigduo/Xigduo XR). 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
7751272	Family Practice	INVOKANA	*ANTIDIABETICS*	E11.29 TYPE 2 DIABETES	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) Jardiance, Synjardy, or Glyxambi 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 Invokana have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Invokana tablets. 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
7589731	dvanced Practice Nurs	NOVOLIN R RELION	*ANTIDIABETICS*	Type 1 DM, sliding scale	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, the following caused the denial. 1) All formulary drugs used for your condition have not been tried and failed. Other drugs that can be used are Novolin R (not including the ReliOn brand from Walmart) and other formulary alternatives. Please look at the formulary for a list of covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered.	No	No
7669004	Internal Medicine	ITRACONAZOLE	*ANTIFUNGALS*	No Diagnosis Provided	Based on the information we have received, you do not meet number 2 and 3 of our prior authorization criteria because we could not confirm you have one of the secondary diagnoses listed below and you have not failed terbinafine. Based on our Pharmacy and Therapeutics Committee prior authorization criteria for Itraconazole for the treatment of Onychomycosis, this drug is covered for members who meet the following criteria: 1) Prescribed by a dermatologist or podiatrist OR have a diagnosis confirmed by positive KOH stain, positive PAS stain or positive fungal culture AND 2) patient is a diabetic OR is immunocompromised OR has a systemic dermatosis with impaired skin integrity OR has a significant peripheral vascular compromise OR fingernail infection OR is experiencing significant pain due to infected toenail(s) AND 3) failed or was unable to tolerate terbinafine. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7849088	Internal Medicine	ITRACONAZOLE	*ANTIFUNGALS*	B35.1	Based on the information we have received, you do not meet number 2 of our prior authorization criteria because we could not confirm you have one of the secondary diagnoses listed below. Based on our Pharmacy and Therapeutics Committee prior authorization criteria for Itraconazole for the treatment of Onychomycosis, this drug is covered for members who meet the following criteria: 1) Prescribed by a dermatologist or podiatrist OR have a diagnosis confirmed by positive KOH stain, positive PAS stain or positive fungal culture AND 2) patient is a diabetic OR is immunocompromised OR has a systemic dermatosis with impaired skin integrity OR has a significant peripheral vascular compromise OR fingernail infection OR is experiencing significant pain due to infected toenail(s) AND 3) failed or was unable to tolerate terbinafine. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7772891	Dermatology	ITRACONAZOLE	*ANTIFUNGALS*	B35.1 Tinea unguium	Based on the information we have received, you do not meet number 3 of our prior authorization criteria because more information is needed to determine if you have tried and failed terbinafine. Based on our Pharmacy and Therapeutics Committee prior authorization criteria for Itraconazole for the treatment of Onychomycosis, this drug is covered for members who meet the following criteria: 1) Prescribed by a dermatologist or podiatrist OR have a diagnosis confirmed by positive KOH stain, positive PAS stain or positive fungal culture AND 2) patient is a diabetic OR is immunocompromised OR has a systemic dermatosis with impaired skin integrity OR has a significant peripheral vascular compromise OR fingernail infection OR is experiencing significant pain due to infected toenail(s) AND 3) failed or was unable to tolerate terbinafine. 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
7762585	Family Practice	ITRACONAZOLE	*ANTIFUNGALS*	L21.9 - Seborrheic dermatitis, unspecified	Based on the information we have received, you do not meet number 1, 2, and 3 of our prior authorization criteria because this was not prescribed by a dermatologist or podiatrist OR have a diagnosis confirmed by positive KOH stain, positive PAS stain or positive fungal culture, a topical antifungal was not documented as tried and failed, AND one of the diagnoses detailed below was not provided. Based on our Pharmacy and Therapeutics Committee prior authorization criteria for Itraconazole for the treatment of Dermatologic Fungal Infections, this drug is covered for members who meet the following criteria: 1) Prescribed by a dermatologist or podiatrist OR have a diagnosis confirmed by positive KOH stain, positive PAS stain or positive fungal culture AND 2) patient is a diabetic OR is immunocompromised OR has a systemic dermatosis with impaired skin integrity OR has a significant peripheral vascular compromise OR fingernail infection OR is experiencing significant pain due to infected toenail(s) AND 3) failed to respond to topical antifungals. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7653903	Internal Medicine	ITRACONAZOLE	*ANTIFUNGALS*	TINEA UNGUIUM (B35.1)	Based on the information we have received, you do not meet number 1, 2, and 3 of our prior authorization criteria because more information is needed. Based on our Pharmacy and Therapeutics Committee prior authorization criteria for Itraconazole for the treatment of Onychomycosis, this drug is covered for members who meet the following criteria: 1) Prescribed by a dermatologist or podiatrist OR have a diagnosis confirmed by positive KOH stain, positive PAS stain or positive fungal culture AND 2) patient is a diabetic OR is immunocompromised OR has a systemic dermatosis with impaired skin integrity OR has a significant peripheral vascular compromise OR fingernail infection OR is experiencing significant pain due to infected toenail(s) AND 3) failed or was unable to tolerate terbinafine. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8058415	dvanced Practice Nurs	DESLORATADINE	*ANTIHISTAMINES*	H65.93	This request has not been approved because this medication requires STEP THERAPY based on the formulary requirements for desloratadine (Clarinex). Before this medication may be covered, you must first try or be unable to try the following medication(s): cetirizine, loratadine, and fexofenadine. The information we received and our records do not indicate you could not tolerate or experienced medication safety issues with the medication(s) listed above.	No	No
8281515	Cardiology	REPATHA PUSHTRONEX SYSTEM	*ANTIHYPERLIPIDEMICS*	Pure hypercholesterol emia	Based on the information we have received, you do not meet number 1 of our prior authorization criteria because documentation did not show a diagnosis of ASCVD as defined below. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Repatha for Primary Hyperlipidemia-Clinical Atherosclerotic Cardiovascular Disease (ASCVD), this drug is covered for members who meet the following criteria: 1) Member has ASCVD defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin, AND 2) Member is unable to tolerate statin therapy, AND 3) Member has failed TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin, AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on high-intensity statin therapy (or member is taking statin in combination with ezetimibe and LDL level remains greater than or equal to 70 mg/dL). Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8124590	ology, Diabetes & Me	REPATHA SURECLICK	*ANTIHYPERLIPIDEMICS*	E78.5	Based on the information we have received, you do not meet number 1, 3, 4 of our prior authorization criteria because you do not have ASCVD as defined below and more information is needed on your previous statin trials and LDL levels after these trials. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Repatha for Primary Hyperlipidemia-Clinical Atherosclerotic Cardiovascular Disease (ASCVD), this drug is covered for members who meet the following criteria: 1) Member has ASCVD defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin, AND 2) Member is unable to tolerate statin therapy, AND 3) Member has failed TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin, AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on high-intensity statin therapy (or member is taking statin in combination with ezetimibe and LDL level remains greater than or equal to 70 mg/dL). Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8129504	Family Practice	VASCEPA	*ANTIHYPERLIPIDEMICS*	E78.2	Our prior authorization criteria for Vascepa for Hypertriglyceridemia have not been met. From the records that we have received, the following caused the denial of Vascepa. 1) Records do not show you continue to have triglyceride levels greater than or equal to 500 mg/dL on blood tests for cholesterol. Triglycerides are a type of fat found in the blood. 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 Vascepa for Hypertriglyceridemia have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Vascepa. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has persistent triglycerides greater than or equal to 500 mg/dL; AND 2) A trial of omega-3 acid ethyl esters (LOVAZA equivalent) 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

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8108537	Family Practice	VASCEPA	*ANTIHYPERLIPIDEMICS*	Mixed Hyperlipidemia Hypertriglyceridemia	Our prior authorization criteria for Vascepa for Hypertriglyceridemia have not been met. From the records that we have received, the following caused the denial of Vascepa. 1) Records do not show you continue to have triglyceride levels greater than or equal to 500 mg/dL on blood tests for cholesterol. Triglycerides are a type of fat found in the blood. AND 2) Omega-3 acid ethyl esters capsules (LOVAZA equivalent) 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 Vascepa for Hypertriglyceridemia 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 Vascepa. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has persistent triglycerides greater than or equal to 500 mg/dL; AND 2) A trial of omega-3 acid ethyl esters (LOVAZA equivalent) 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
7848927	Family Practice	VASCEPA	*ANTIHYPERLIPIDEMICS*	E78.1	Our prior authorization criteria for Vascepa for Hypertriglyceridemia have not been met. From the records that we have received, the following caused the denial of Vascepa. 1) Records do not show you continue to have triglyceride levels greater than or equal to 500 mg/dL on blood tests for cholesterol. Triglycerides are a type of fat found in the blood. AND 2) Omega-3 acid ethyl esters capsules (LOVAZA equivalent) 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 Vascepa for Hypertriglyceridemia 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 Vascepa. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has persistent triglycerides greater than or equal to 500 mg/dL; AND 2) A trial of omega-3 acid ethyl esters (LOVAZA equivalent) 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
7821881	ardiology, Intervention	VASCEPA	*ANTIHYPERLIPIDEMICS*	E78.2	Our prior authorization criteria for Vascepa for Secondary Prevention of Heart Disease have not been met. From the records that we have received, the following caused the denial of Vascepa. 1) Records do not show you continue to have triglyceride levels greater than or equal to 500 mg/dL on blood tests for cholesterol. 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 Vascepa for Secondary Prevention have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Vascepa. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of clinical Atherosclerotic Cardiovascular Disease (ASCVD). AND 2) Member is receiving concurrent treatment with moderate to high intensity statin. AND 3) Member has persistent triglycerides greater than or equal to 500 mg/dL. 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

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
7477870	epatology/Liver Medici	HARVONI	*ANTIVIRALS*	B18.2	Our prior authorization criteria for Harvoni have not been met. From the records that we have received, the following caused the denial of Harvoni. 1) Greater than 8 weeks of treatment with Harvoni is being requested. This plan only covers Harvoni for members who have not been treated for Hepatitis C before, who do not have severe liver damage (cirrhosis), and who have low Hepatitis C viral levels (less than 6 million units per milliliter). 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 Harvoni have not been met. From the information we have received, the member does not meet number 7 of our prior authorization criteria for Harvoni. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 2) Diagnosis of chronic Hepatitis C viral infection (HCV) genotype 1; AND 3) Current viral level (HCV-RNA titer and date) has been provided and must be from within the past 3 months and less than 6 million; AND 4) Member does not have cirrhosis; AND 5) Member is treatment naïve; AND 6) Member is HIV-uninfected; AND 7) Duration of therapy will be 8 weeks. Other products (Mavyret, Vosevi, and Epclusa) are covered with prior authorization for members for whom 8 weeks of treatment with Harvoni is not appropriate. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7477716	epatology/Liver Medici	HARVONI	*ANTIVIRALS*	B18.2	Our prior authorization criteria for Harvoni have not been met. From the records that we have received, the following caused the denial of Harvoni. 1) Records show Hepatitis C viral level is greater than 6 million. 2) Greater than 8 weeks of treatment with Harvoni is being requested. This plan only covers Harvoni for members who have not been treated for Hepatitis C before, who do not have severe liver damage (cirrhosis), and who have low Hepatitis C viral levels (less than 6 million units per milliliter). Our preferred treatments for members who have been previously treated, who have cirrhosis, or who have high viral levels are Mavyret, Vosevi or Epclusa (all require prior authorization). Based on the information submitted, criteria would be met for Mavyret for 8 weeks or Epclusa for 12 weeks. If treatment with Mavyret or Epclusa is acceptable, please submit prior authorization request for that drug. 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 Harvoni have not been met. From the information we have received, the member does not meet number 3 adn 7 of our prior authorization criteria for Harvoni. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 2) Diagnosis of chronic Hepatitis C viral infection (HCV) genotype 1; AND 3) Current viral level (HCV-RNA titer and date) has been provided and must be from within the past 3 months and less than 6 million; AND 4) Member does not have cirrhosis; AND 5) Member is treatment naïve; AND 6) Member is HIV-uninfected; AND 7) Duration of therapy will be 8 weeks. Other products (Mavyret, Vosevi, and Epclusa) are covered with prior authorization for members for whom 8 weeks of treatment with Harvoni is not appropriate. 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
7600991	epatology/Liver Medici	MAVYRET	*ANTIVIRALS*	CHRONIC VIRAL HEP C (B18.2)	Our prior authorization criteria for Mavyret have not been met. From the records that we have received, the following caused the denial of Mavyret. 1) The requested length of treatment is not appropriate. For members with genotype 1 infection, who do not have cirrhosis, and have not been previously treated [with NS3/4A protease inhibitor, the preferred regimen is 8 weeks of Mavyret. 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 Mavyret have not been met. From the information we have received, the member does not meet number 7 of our prior authorization criteria for Mavyret. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 2) Diagnosis of chronic Hepatitis C viral infection (HCV) and genotype is provided; AND 3) Current viral level (HCV-RNA titer and date) is provided and must be from within the past 3 months; AND 4) Member does or does not have cirrhosis (must be indicated); AND 5) Member is treatment naïve or if previously treated, documentation of prior therapies used is provided; AND 6) If 8 weeks treatment duration is requested: a) Member does not have cirrhosis, and b) Member has not been previously treated with an NS5a inhibitor or NS3/4a protease inhibitor, and c) If genotype 3, member is treatment naïve; OR 7) If 12 weeks treatment duration is requested: a) Member has not been previously treated with an NS5a inhibitor, and b) If genotype 3, member is treatment naïve, and c) Member has either compensated cirrhosis OR if genotype 1, member has failed prior treatment with an NS3/4a protease inhibitor; OR 8) If 16 weeks treatment duration is requested: a) Member has genotype 1 and has failed prior treatment with an NS5a inhibitor (without an NS3/4a protease inhibitor), or b) Member has genotype 3 and has failed prior treatment with an interferon, ribavirin, and/or sofosbuvir. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8349576	Internal Medicine	TRUVADA	*ANTIVIRALS*	Z72.52	Our prior authorization criteria for Truvada have not been met. From the records that we have received, the following caused the denial of Truvada. 1) Provider did not confirm testing will be continued every 3 months. 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 Truvada for Pre-Exposure Prophylaxis (continuing coverage) have not been met. From the information we have received, the member does not meet 2 of our prior authorization criteria for Truvada. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is Human Immunodeficiency Virus (HIV) negative; AND 2) Member continues to be tested every three (3) months. 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
8045310	Family Practice	TRUVADA	*ANTIVIRALS*	Pre-Exposure Prophylaxis	Our prior authorization criteria for Truvada have not been met. From the records that we have received, the following caused the denial of Truvada. 1) You do not weigh at least 35 kilograms (kg). 2) Prescriber has not completed the REMS Prescriber Checklist. 3) Member and prescriber have not signed the REMS Agreement Form. 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 Truvada for Pre-Exposure Prophylaxis (initial coverage) have not been met. From the information we have received, the member does not meet number 2, 4, 5 of our prior authorization criteria for Truvada. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is at high risk for contracting human immunodeficiency virus (HIV) due to sexual transmission and is receiving Truvada for pre-exposure prophylaxis. If not due to sexual transmission, another reason must be indicated; AND 2) Member is an adult or adolescent weighing greater than or equal to 35 kilograms (kg); AND 3) Member is HIV negative with the last test occurring within the previous three (3) months; AND 4) Prescriber has completed the REMS Prescriber Checklist; AND 5) Member and prescriber have signed the REMS Agreement Form and it is saved in the member's medical chart. 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

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
7742297	Allergy & Immunology	ODACTRA	*BIOLOGICALS MISC*	J45.901 Allergic Asthma	Our prior authorization criteria for Odactra have not been met. From the records that we have received, the following caused the denial of Odactra. 1) The drug is being used in combination with another drug that works on the immune system. 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 Odactra (initial coverage) have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Odactra. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by an Allergist, Immunologist, or Ears Nose and Throat (ENT) Physician; AND 2) Member will NOT use in combination with another sublingual or subcutaneous immunotherapy regimen. 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
7707152	Cardiology	ENTRESTO	*CARDIOVASCULAR AGENTS - MISC.*	I50.22	Our prior authorization criteria for Entresto have not been met. From the records that we have received, the following caused the denial of Entresto. 1) The drug is not being used for symptomatic chronic heart failure defined as New York Heart Association (NYHA) Class II-IV. Heart failure is a condition when the heart does not pump blood well. 3) The records do not indicate systolic dysfunction defined as left ventricular ejection fraction less than or equal to 40%. Ejection fraction is a measurement to determine how well the heart is pumping blood. 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 Entresto 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 Entresto. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Cardiology Specialist, AND 2) Prescribed for the treatment of symptomatic chronic heart failure (New York Heart Association NYHA class II-IV), AND 3) Left ventricular ejection fraction is less than or equal to 40%, indicating systolic dysfunction. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7988817	Internal Medicine	SILDENAFIL CITRATE	*CARDIOVASCULAR AGENTS - MISC.*	No Diagnosis Provided	Based on the information we have received, you do not meet number 1 and 2 of our prior authorization criteria because you do not have a diagnosis of pulmonary arterial hypertension confirmed by a right heart catheterization. Based on our Pharmacy and Therapeutics Committee prior authorization criteria for Pulmonary Arterial Hypertension (PAH) Agents, including SILDENAFIL tab 20MG, 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
7619891	Family Practice	SILDENAFIL CITRATE	*CARDIOVASCULAR AGENTS - MISC.*	N52.37 ED secondary to prostate removal	This request has not been approved because this medication is being used for erectile dysfunction. Medications used for this purpose are excluded from coverage as indicated in your benefit summary. Please refer to the formulary for specific information on what is covered. Your doctor or health care provider may be able to suggest other treatment options for your condition.	No	No
8200170	Family Practice	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	F52.21 I10. HTN	Our prior authorization criteria for tadalafil (Cialis) have not been met. From the records that we have received, the following caused the denial of tadalafil (Cialis). 1) Records do not show a diagnosis of benign prostatic hyperplasia (BPH). 2) Cialis was not prescribed by, or in consultation with, a Urologist. 3) A medication, in a class of drugs called alpha blockers, has not been tried and failed for a minimum of 30 days. 4) 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 tadalafil (Cialis) have not been met. From the information we have received, the member does not meet number 1, 2, 3 ,4 of our prior authorization criteria for tadalafil (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
8038108	Family Practice	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	n52.9	This request has not been approved because this medication is being used for erectile dysfunction. Medications used for this purpose are excluded from coverage as indicated in your benefit summary. Please refer to the formulary for specific information on what is covered. Your doctor or health care provider may be able to suggest other treatment options for your condition.	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
7651142	Family Practice	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	N40.1	Our prior authorization criteria for TADALAFIL have not been met. From the records that we have received, the following caused the denial of TADALAFIL. 1) More information is needed to determine if a medication, in a class of drugs called alpha blockers, has not been tried and failed for a minimum of 30 days. 2) More information is needed to determine if 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 TADALAFIL have not been met. From the information we have received, the member does not meet number 3 and 4 of our prior authorization criteria for TADALAFIL. 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
7643579	Family Practice	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	N40.1--BPH with lower urinary tract symptoms	Our prior authorization criteria for TADALAFIL have not been met. From the records that we have received, the following caused the denial of TADALAFIL. 1) Cialis was not prescribed by, or in consultation with, a Urologist. 2) A medication, in a class of drugs called alpha blockers, has not been tried and failed for a minimum of 30 days. 3) 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 TADALAFIL have not been met. From the information we have received, the member does not meet number 2, 3, and 4 of our prior authorization criteria for TADALAFIL. 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
7638910	Gastroenterology	BUDESONIDE	*CORTICOSTEROIDS*	CROHN'S DZ	BUDESONIDE capsule requires step therapy. Step therapy means that another drug will need to be tried and failed first. This other drug is mesalamine. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered.	No	No
7627843	Gastroenterology	BUDESONIDE	*CORTICOSTEROIDS*	CROHNS	BUDESONIDE capsule requires step therapy. Step therapy means that another drug will need to be tried and failed first. This other drug is mesalamine. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered.	No	No
7582023	Gastroenterology	BUDESONIDE ER	*CORTICOSTEROIDS*	No Diagnosis Provided	Based on the information we have received, you do not meet number 1 and 2 of our prior authorization criteria because we could not confirm you have a diagnosis active mild to moderate ulcerative colitis and have failed mesalamine. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Uceris, this drug is covered for members who meet the following criteria: 1) Diagnosis of active mild to moderate ulcerative colitis (TABLETS) OR patient has active mild to moderate distal ulcerative colitis extending up to 40 cm from the anal verge (RECTAL FOAM) AND 2) Trial and failure of mesalamine. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7623230	Gastroenterology	BUDESONIDE ER	*CORTICOSTEROIDS*	K50.813	Based on the information we have received, you do not meet number 1 and 2 of our prior authorization criteria because we could not confirm you have a diagnosis active mild to moderate ulcerative colitis and have failed mesalamine. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Uceris, this drug is covered for members who meet the following criteria: 1) Diagnosis of active mild to moderate ulcerative colitis (TABLETS) OR patient has active mild to moderate distal ulcerative colitis extending up to 40 cm from the anal verge (RECTAL FOAM) AND 2) Trial and failure of mesalamine. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7492387	Gastroenterology	BUDESONIDE ER	*CORTICOSTEROIDS*	K51.00	Based on the information we have received, you do not meet number 2 of our prior authorization criteria because you have not had a trial of mesalamine. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Uceris, this drug is covered for members who meet the following criteria: 1) Diagnosis of active mild to moderate ulcerative colitis (TABLETS) OR patient has active mild to moderate distal ulcerative colitis extending up to 40 cm from the anal verge (RECTAL FOAM) AND 2) Trial and failure of mesalamine. 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
7845556	Dermatology	CLOBETASOL PROPIONATE	*DERMATOLOGICALS*	L21.9	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 not tried and failed. 2) Augmented betamethasone dipropionate or clobetasol solution have not been not 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 number 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
7758950	Physician Assistant	CLOBETASOL PROPIONATE	*DERMATOLOGICALS*	(L40.0) Psoriasis Vulgaris	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) Augmented betamethasone dipropionate or clobetasol solution have not been not 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 number 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
7586679	Family Practice	CLOBETASOL PROPIONATE	*DERMATOLOGICALS*	I40.9	Our prior authorization criteria for Topical Steroids have not been met. From the records that we have received, the following caused the denial of clobetasol. 1) 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. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Topical Steroids have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for clobetasol. The reason for denial is explained to the member above. The criteria are listed here. 1) Trial and failure of one (1) medium or high potency formulary alternative topical steroid such as betamethasone valerate, triamcinolone, mometasone furoate(tried); AND 2) Trial and failure of one very high potency topical steroid such as augmented betamethasone dipropionate or clobetasol solution. 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
8248561	Dermatology	COSENTYX SENSOREADY PEN	*DERMATOLOGICALS*	L40.0	Our prior authorization criteria for Cosentyx have not been met. From the records that we have received, the following caused the denial of Cosentyx. 1) Chart notes showing disease improvement with treatment 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 Cosentyx have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Cosentyx for the treatment of Plaque Psoriasis (continuing coverage). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has demonstrated a significant improvement in their condition; AND 3) Documented (written explanation accepted) improvement within the past year was submitted with this request (Documentation is required for approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7714091	Dermatology	COSENTYX SENSOREADY PEN	*DERMATOLOGICALS*	L40.0	Our prior authorization criteria for Cosentyx have not been met. From the records that we have received, the following caused the denial of Cosentyx. 1) At least 15 sessions of phototherapy have not been tried and failed. 2) Methotrexate or soriatane has not been tried and failed. 3) Chart notes with details of the disease and treatments used 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 Cosentyx have not been met. From the information we have received, the member does not meet number 3, 4, and 5 of our prior authorization criteria for Cosentyx for the treatment of Plaque Psoriasis (initial coverage). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has either moderate to severe plaque psoriasis (at least 10% body surface involved) and significant functional disability OR debilitating palmoplantar psoriasis; AND 3) Failed a minimum of 15 sessions of phototherapy or phototherapy is contraindicated; AND 4) Failed methotrexate (minimum dose of 15 mg/week) OR failed soriatane; AND 5) Supporting chart notes or documentation submitted with this request (documentation required), such as: documentation of disease severity and progression, medication dose, duration, response, adverse reactions or contraindications, and/or phototherapy type, duration, response, adverse reactions or contraindications. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	Yes	No
8348244	Family Practice	DICLOFENAC SODIUM	*DERMATOLOGICALS*	M25.562	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
8159439	dvanced Practice Nurs	DICLOFENAC SODIUM	*DERMATOLOGICALS*	M47.896	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
7779122	Nursing	SKLICE	*DERMATOLOGICALS*	B85.2	Based on the information we have received, you do not meet number 1 of our prior authorization criteria because you have not tried an over-the-counter lice treatment recently. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Sklice lotion, this drug is covered for members who meet the following criteria: 1) Patient has tried and failed or was intolerant to an over-the-counter lice treatment for the current infestation. Name of medication tried and date it was tried must be provided for approval. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8049225	Dermatology	TRETINOIN	*DERMATOLOGICALS*	i78.1	Based on the information we have received, you do not meet the prior authorization criteria because your provider did not submit a diagnosis of acne vulgaris, acne rosacea, or actinic keratosis. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Preferred Acne Agents, this drug is covered for members who meet the following criteria: 1) A diagnosis of acne vulgaris, acne rosacea, or actinic keratosis. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7943853	Physician Assistant	TRETINOIN	*DERMATOLOGICALS*	L81.1	Based on the information we have received, you do not meet the prior authorization criteria because your provider did not submit a diagnosis of acne vulgaris, acne rosacea, or actinic keratosis. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Preferred Acne Agents, this drug is covered for members who meet the following criteria: 1) A diagnosis of acne vulgaris, acne rosacea, or actinic keratosis. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8298126	Physician Assistant	TRETINOIN	*DERMATOLOGICALS*	(L81.1) Chloasma	Based on the information we have received, you do not meet the prior authorization criteria because your provider did not submit a diagnosis of acne vulgaris, acne rosacea, or actinic keratosis. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Preferred Acne Agents, this drug is covered for members who meet the following criteria: 1) A diagnosis of acne vulgaris, acne rosacea, or actinic keratosis. 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
7662836	Internal Medicine	ONETOUCH ULTRA BLUE	*DIAGNOSTIC PRODUCTS*	No Diagnosis Provided	This product is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered product can be approved. The conditions in this policy have not been met. From the records that we have received, the following caused the denial. 1) All formulary products used for your condition have not been tried and failed. Other products that can be used are Accu-chek meters and supplies. Please look at the formulary for a list of covered products. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this product is not on formulary. An exception to allow coverage of a non-formulary product may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The product is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered products cannot be tried. 3) Records have been received showing the requested product is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered products are likely to be ineffective or unsafe for the member. 4) Prescription samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this product at this time. Please refer to the formulary for specific information on what is covered.	No	No
8337448	Gastroenterology	AMITIZA	*GASTROINTESTINAL AGENTS - MISC.*	K59.00	Our prior authorization criteria for Amitiza have not been met. From the records that we have received, the following caused the denial of Amitiza. 1) Linzess 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 Amitiza have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Amitiza. The reason for denial is explained to the member above. The criteria are listed here. 1) Diagnosis of chronic idiopathic constipation (CIC) OR irritable bowel syndrome with constipation (IBS-C) AND member has tried and failed Linzess; OR 2) Diagnosis of opioid-induced constipation (OIC) AND member has tried and failed Movantik. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8241866	Nurse Practitioner	AMITIZA	*GASTROINTESTINAL AGENTS - MISC.*	K59.03 - Drug induced constipation	Our prior authorization criteria for Amitiza have not been met. From the records that we have received, the following caused the denial of Amitiza. 1) Symproic 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 Amitiza have not been met. From the information we have received, the member does not meet number [INSERT #] of our prior authorization criteria for Amitiza. The reason for denial is explained to the member above. The criteria are listed here. 1) Diagnosis of chronic idiopathic constipation (CIC) OR irritable bowel syndrome with constipation (IBS-C) AND member has tried and failed Linzess; OR 2) Diagnosis of opioid-induced constipation (OIC) AND member has tried and failed Symproic. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7766286	Gastroenterology	AMITIZA	*GASTROINTESTINAL AGENTS - MISC.*	K58.1	Our prior authorization criteria for Amitiza have not been met. From the records that we have received, the following caused the denial of Amitiza. 1) Linzess 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 Amitiza have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Amitiza. The reason for denial is explained to the member above. The criteria are listed here. 1) Diagnosis of chronic idiopathic constipation (CIC) OR irritable bowel syndrome with constipation (IBS-C) AND member has tried and failed Linzess; OR 2) Diagnosis of opioid-induced constipation (OIC) AND member has tried and failed Movantik. 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
7765951	Gastroenterology	AMITIZA	*GASTROINTESTINAL AGENTS - MISC.*	K59.04	Our prior authorization criteria for Amitiza have not been met. From the records that we have received, the following caused the denial of Amitiza. 1) Linzess 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 Amitiza have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Amitiza. The reason for denial is explained to the member above. The criteria are listed here. 1) Diagnosis of chronic idiopathic constipation (CIC) OR irritable bowel syndrome with constipation (IBS-C) AND member has tried and failed Linzess; OR 2) Diagnosis of opioid-induced constipation (OIC) AND member has tried and failed Movantik. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
7857208	Internal Medicine	FREESTYLE LIBRE 14 DAY/RE	*MEDICAL DEVICES*	Type 2 Diabetes Mellitus with Hyperglycemia E11.65	Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of Freestyle libre. 1) The requested product is not being used for Type 1 or Type 2 Diabetes in a member using insulin. 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 Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Freestyle libre. The reason for denial is explained to the member above. The criteria are listed here. 1) Member with Type 1 or Type 2 Diabetes using insulin; AND 2) Member meets one of the following: (a) Member has demonstrated hypoglycemia unawareness, OR (b) undetected hypoglycemia poses an occupational safety risk, OR (c) Member has suboptimal diabetes control (and is unable to test capillary glucose readings due to physical or cognitive limitation, OR has widely fluctuating glucose levels, OR fails to test with sufficient frequency), OR (d) Member is expected to benefit from ongoing CGM use based upon a professional CGM trial, OR (e) Member is pregnant; AND 3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabetes; AND 4) Member will be instructed in use of the CGM products; AND 5) Provider has assessed the member's motivation and willingness to properly utilize CGM; AND 6) Provider believes that CGM may lead to considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia; AND 7) If above criteria are not met, rationale and/or documentation of any extenuating circumstance requiring use of CGM is provided. 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

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
7746547	Internal Medicine	FREESTYLE LIBRE 14 DAY/SE	*MEDICAL DEVICES*	E11.65	Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of Freestyle Libre. 1) The requested product is not being used for Type 1 or Type 2 Diabetes in a member using insulin. 2) Records did not show that: (a) You have trouble feeling when your blood sugar is low, OR (b) Low blood sugar may put your safety at risk when working, OR (c) Your blood sugar is not currently controlled, OR (d) You are expected to benefit from CGM based on a professional trial, OR (e) You are pregnant. 3) You are not under the care of a Diabetes specialist. 4) Records did not show that you have been instructed on how to use the CGM, that you are motivated and willing to properly use the CGM, and that your provider believes the CGM will help improve the control of your blood sugar. 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 Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 1, 2, 3, 4, 5, 6 of our prior authorization criteria for Freestyle Libre. The reason for denial is explained to the member above. The criteria are listed here. 1) Member with Type 1 or Type 2 Diabetes using insulin; AND 2) Member meets one of the following: (a) Member has demonstrated hypoglycemia unawareness, OR (b) undetected hypoglycemia poses an occupational safety risk, OR (c) Member has suboptimal diabetes control (and is unable to test capillary glucose readings due to physical or cognitive limitation, OR has widely fluctuating glucose levels, OR fails to test with sufficient frequency), OR (d) Member is expected to benefit from ongoing CGM use based upon a professional CGM trial, OR (e) Member is pregnant; AND 3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabetes; AND 4) Member will be instructed in use of the CGM products; AND 5) Provider has assessed the member's motivation and willingness to properly utilize CGM; AND 6) Provider believes that CGM may lead to considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia; AND 7) If above criteria are not met, rationale and/or documentation of any extenuating circumstance requiring use of CGM is provided. 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
8099069	Neurology	AIMOVIG	*MIGRAINE PRODUCTS*	g43.411	Our prior authorization criteria for Aimovig have not been met. From the records that we have received, the following caused the denial of Aimovig. 1) A minimum of a 3 month trial from TWO of the following drug classes: anticonvulsants (such as topiramate (TRIED), sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), antidepressants (such as amitriptyline, venlafaxine, etc.) 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 Aimovig (initial coverage) have not been met. From the information we have received, the member does not meet number [INSERT #] of our prior authorization criteria for Aimovig. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the prevention of migraine; AND 2) Prescriber meets any one of the following: Prescriber is, or has consulted, a Neurologist; OR United Council for Neurologic Subspecialties (UCNS)-certified headache medicine specialist; OR Member of the American Headache Society; Or Member of the National Headache Foundation; OR Member of the International Headache Society; OR Has a Certificate of Added Qualification in Headache Medicine; OR American Board of Headache Management Certified; AND 3) Member has four or more migraine days per month for at least the previous three months; AND 4) Member has tried and failed, is intolerant to, or is contraindicated from trying a minimum three month trial from TWO of the following drug classes: anticonvulsants (such as topiramate, sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), or antidepressants (such as amitriptyline, venlafaxine, etc.); AND 5) Member will NOT continue to receive Botox injections for migraine. 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

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
7492865	dvanced Practice Nurs	AIMOVIG	*MIGRAINE PRODUCTS*	G43	Our prior authorization criteria for Aimovig have not been met. From the records that we have received, the following caused the denial of Aimovig. 1) Records showing a history of headaches for at least 4 days per month for 3 months or more have not been received. 2) Botox injections for the treatment of migraine will continue. 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 Aimovig (initial coverage) have not been met. From the information we have received, the member does not meet number 3 and 5 of our prior authorization criteria for Aimovig. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the prevention of migraine; AND 2) Prescriber meets any one of the following: Prescriber is, or has consulted, a Neurologist; OR United Council for Neurologic Subspecialties (UCNS)-certified headache medicine specialist; OR Member of the American Headache Society; Or Member of the National Headache Foundation; OR Member of the International Headache Society; OR Has a Certificate of Added Qualification in Headache Medicine; OR American Board of Headache Management Certified; AND 3) Member has four or more migraine days per month for at least the previous three months; AND 4) Member has tried and failed, is intolerant to, or is contraindicated from trying a minimum three month trial from TWO of the following drug classes: anticonvulsants (such as topiramate, sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), or antidepressants (such as amitriptyline, venlafaxine, etc.); AND 5) Member will NOT continue to receive Botox injections for migraine. 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
8142650	Neurology	EMGALITY	*MIGRAINE PRODUCTS*	G43.709	Our prior authorization criteria for Emgality have not been met. From the records that we have received, the following caused the denial of Emgality. 1) Records do not show four or more migraine days per month for at least the previous three months. 2) Records received do not show a minimum three (3) month trial from TWO (2) of the following drug classes has not been tried and failed: Anticonvulsants (such as topiramate, sodium valproate, etc.) AND/OR Vasoactive agents (such as propranolol, metoprolol, etc.) AND/OR Antidepressants (such as amitriptyline, venlafaxine, etc.) (tried). 3) It is unknown if the drug is being used with Botox injections. 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 Emgality (initial coverage) have not been met. From the information we have received, the member does not meet number 3, 4, 5 of our prior authorization criteria for Emgality. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the prevention of migraine; AND 2) Prescriber meets any one (1) of the following: prescriber is, or has consulted, a Neurologist, OR United Council for Neurologic Subspecialties (UCNS)-certified headache medicine specialist OR member of the American Headache Society OR member of the National Headache Foundation OR member of the International Headache Society OR has a Certificate of Added Qualification in Headache Medicine OR American Board of Headache Management Certified; AND 3) Member has four or more migraine days per month for at least the previous three months; AND 4) Member has tried and failed, is intolerant to, or is contraindicated from trying a minimum three month trial from TWO of the following drug classes: Anticonvulsants (such as topiramate, sodium valproate, etc.) AND/OR Vasoactive agents (such as propranolol, metoprolol, etc.) AND/OR Antidepressants (such as amitriptyline, venlafaxine, etc.); AND 5) Member will NOT continue to receive Botox injections for migraine. 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

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
7800098	Pediatrics	DYMISTA	*NASAL AGENTS - SYSTEMIC AND TOPICAL*	(J30.9) Allergic Rhinitis, unspecified	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
8074821	Family Practice	RESTASIS	*OPHTHALMIC AGENTS*	(H04.129) Dry eye syndrome of unspecified lacrimal gland	Our prior authorization criterion for Restasis has not been met. From the records that we have received, the following caused the denial. 1) The drug is not prescribed by an Ophthalmology or Optometry specialist. For all other specialties, the drug is not approved. Since the criterion has not been met, we are not able to approve.	No	No
8633915	Family Practice	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	sleep apnea	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. AND Results of a sleep test have not been received. 2) The drug is not being used for Obstructive Sleep Apnea / Hypopnea Syndrome. This involves shallow breathing or pauses in breathing during sleep. AND Positive Airway Pressure (CPAP) therapy has not been tried. 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 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
8609949	Obstetrics & Gynecology	SOLOSEC	*AMEBICIDES*	N76.0 B96.89	Based on the information we have received, you do not meet number 1, 2 or 3 of our prior authorization criteria because more information is needed on your symptoms, it is unknown if you have had three episodes of this infection in the past year and it is unknown if you have also tried clindamycin or tinidazole. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Solosec, this drug is covered for members who meet the following criteria: 1) The drug is prescribed for the treatment of a woman with Bacterial Vaginosis as determined by THREE (3) of the FOUR (4) Amsel's Criteria: a) Homogeneous, thin, white discharge that smoothly coats the vaginal walls, b) Clue cells (e.g., vaginal epithelial cells studded with adherent coccobacilli) on microscopic examination, c) pH of vaginal fluid greater than 4.5, d) A fishy odor of vaginal discharge before or after addition of 10% potassium hydroxide (KOH) (i.e., the whiff test), AND 2) Member has experienced greater than or equal to 3 episodes in past year, AND 3) Trials of TWO (2) of the following were ineffective, contraindicated, or not tolerated: metronidazole, clindamycin, tinidazole. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No

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8532966	Dermatology	OTEZLA	*ANALGESICS - ANTI-INFLAMMATORY*	L40.0 Psoriasis vulgaris	Our prior authorization criteria for Otezla have not been met. From the records that we have received, the following caused the denial of Otezla. 1) The drug is not being used for moderate to severe Plaque Psoriasis with significant functional disability. Plaque Psoriasis is a condition in which skin cells build up and form itchy, dry patches. 2) Methotrexate at a dose of 15mg per week or soriatane 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 Otezla 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 Otezla for the treatment of Plaque Psoriasis (initial coverage). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has either moderate to severe plaque psoriasis (at least 10% body surface involved) and significant functional disability OR debilitating palmoplantar psoriasis; AND 3) Failed a minimum of 15 sessions of phototherapy or phototherapy is contraindicated; AND 4) Failed methotrexate (minimum dose of 15 mg/week) OR failed soriatane; AND 5) Supporting chart notes or documentation submitted with this request (documentation required), such as: documentation of disease severity and progression, medication dose, duration, response, adverse reactions or contraindications, and/or phototherapy type, duration, response, adverse reactions or contraindications; AND 6) Otezla will NOT be used in combination with biologic therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8579102	Family Practice	TESTOSTERONE	*ANDROGENS-ANABOLIC*	E34.9	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, the following caused the denial of TESTOSTERONE GEL 1%(50MG). 1) Two morning levels showing low testosterone 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for TESTOSTERONE GEL 1%(50MG). The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of primary or secondary hypogonadism and does not have age-related hypogonadism; AND 2) Member has symptoms of hypogonadism; AND 3) Two documented morning (time required) testosterone levels fall below normal range on separate days. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8618477	Family Practice	LEVALBUTEROL TARTRATE HFA	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	Asthma - allergy induced	Levalbuterol requires step therapy. Step therapy means that another drug will need to be tried and failed first. This other drug is Ventolin HFA. Quantity limits apply. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered.	No	No
8466900	Family Practice	SPIRIVA HANDIHALER	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J44.9	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

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8633267	Internal Medicine	SPIRIVA HANDIHALER	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J44.9	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
8470785	Family Practice	TRINTELLIX	*ANTIDEPRESSANTS*	F41.1	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) The drug is not being used for Major Depressive Disorder (MDD). 2) Two selective serotonin reuptake inhibitor (SSRI) antidepressants, such as sertraline, citalopram, escitalopram-tried, fluoxetine, or paroxetine, have not been tried and failed. 3) 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 1, 2, 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
8497494	Family Practice	TRINTELLIX	*ANTIDEPRESSANTS*	F41.1	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) The drug is not being used for Major Depressive Disorder (MDD). 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 1 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
8572820	Psychiatry	TRINTELLIX	*ANTIDEPRESSANTS*	F33.1 Major depressive disorder, recurrent, moderate	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) 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 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
8406907	Internal Medicine	INVOKANA	*ANTIDIABETICS*	E11.65	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) 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 Invokana have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Invokana tablets. 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
8646344	Family Practice	INVOKANA	*ANTIDIABETICS*	E11.9	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 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 Invokana 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 Invokana tablets. 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
8444777	Advanced Practice Nurse	REPATHA SURECLICK	*ANTIHYPERLIPIDEMICS*	Clinical Atherosclerotic Cardiovascular Disease	Based on the information we have received, you do not meet number 1 of our prior authorization criteria because you do not have Clinical Atherosclerotic Cardiovascular Disease (ASCVD) defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Repatha for Primary Hyperlipidemia-Clinical Atherosclerotic Cardiovascular Disease (ASCVD), this drug is covered for members who meet the following criteria: 1) Member has ASCVD defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin, AND 2) Member is unable to tolerate statin therapy, AND 3) Member has failed TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin, AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on high-intensity statin therapy (or member is taking statin in combination with ezetimibe and LDL level remains greater than or equal to 70 mg/dL). Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8496387	Advanced Practice Nurse	REPATHA SURECLICK	*ANTIHYPERLIPIDEMICS*	Clinical Atherosclerotic Cardiovascular Disease	Based on the information we have received, you do not meet number 1 of our prior authorization criteria because documentation does not show acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Repatha for Primary Hyperlipidemia-Clinical Atherosclerotic Cardiovascular Disease (ASCVD), this drug is covered for members who meet the following criteria: 1) Member has ASCVD defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin, AND 2) Member is unable to tolerate statin therapy, AND 3) Member has failed TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin, AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on high-intensity statin therapy (or member is taking statin in combination with ezetimibe and LDL level remains greater than or equal to 70 mg/dL). 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
8374301	Gastroenterology	ALINIA	*ANTI-INFECTIVE AGENTS - MISC.*	R10.13	Our prior authorization criteria for Alinia have not been met. From the records that we have received, the following caused the denial of Alinia. 1) Alinia was not prescribed for Giardiasis. 2) Metronidazole was not tried and failed. 3) Alinia was not prescribed for Cryptosporidiosis. 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 Alinia 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 Alinia. The reason for denial is explained to the member above. The criteria are listed here. 1) Alinia is prescribed for the treatment of Cryptosporidiosis; OR 2) Alinia is prescribed for the treatment of Giardiasis; AND 3) Metronidazole is ineffective, contraindicated or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8385422	Gastroenterology	ALINIA	*ANTI-INFECTIVE AGENTS - MISC.*	R10.13	Our prior authorization criteria for Alinia have not been met. From the records that we have received, the following caused the denial of Alinia. 1) Alinia was not prescribed for Giardiasis. 2) Alinia was not prescribed for Cryptosporidiosis. 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 Alinia have not been met. From the information we have received, the member does not meet number 1 or 2 of our prior authorization criteria for Alinia. The reason for denial is explained to the member above. The criteria are listed here. 1) Alinia is prescribed for the treatment of Cryptosporidiosis; OR 2) Alinia is prescribed for the treatment of Giardiasis; AND 3) Metronidazole is ineffective, contraindicated or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8486548	Advanced Practice Nurse	DESCOVY	*ANTIVIRALS*	HIV-Prep	Based on the information we have received, you do not meet number 1 of our prior authorization criteria because this medication is not being prescribed for the treatment of HIV infection. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Descovy, this drug is covered for members who meet the following criteria: 1) Prescribed for the treatment of HIV infection. Since criteria have not been met, we are unable to approve coverage for this drug at this time. PLEASE NOTE: TRUVADA is covered on formulary for the requested indication. More information is needed to determine if you have had documented intolerance with TRUVADA.	No	No
8375360	Advanced Practice Nurse	HARVONI	*ANTIVIRALS*	B18.2	Our prior authorization criteria for Harvoni have not been met. From the records that we have received, the following caused the denial of Harvoni. 1) The drug is not prescribed by a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist. 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 Harvoni have not been met. From the information we have received, the member does not meet number 1 of the prior authorization criteria for Harvoni. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 2) Diagnosis of chronic Hepatitis C viral infection (HCV) genotype 1; AND 3) Current viral level (HCV-RNA titer and date) has been provided and must be from within the past 3 months and less than 6 million; AND 4) Member does not have cirrhosis; AND 5) Member is treatment naïve; AND 6) Member is HIV-uninfected; AND 7) Duration of therapy will be 8 weeks. Other products (Mavyret, Vosevi, and Epclusa) are covered with prior authorization for members for whom 8 weeks of treatment with Harvoni is not appropriate. Since criteria have not been met, we are unable to approve coverage for this drug at this time.	No	No
8423097	Clinical Nurse Specialist	SILDENAFIL CITRATE	*CARDIOVASCULAR AGENTS - MISC.*	(N52.9) Male erectile dysfunction, unspecified	Based on the information we have received, you do not meet number 1 and 2 of our prior authorization criteria because you are using the medication for erectile dysfunction. Based on our Pharmacy and Therapeutics Committee prior authorization criteria for Pulmonary Arterial Hypertension (PAH) Agents, including sildenafil 20 mg, 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
8405112	Internal Medicine	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	F52.21	Our prior authorization criteria for tadalafil (Cialis) have not been met. From the records that we have received, the following caused the denial of tadalafil (Cialis). 1) Records do not show a diagnosis of benign prostatic hyperplasia (BPH). 2) Cialis was not prescribed by, or in consultation with, a Urologist. 3) A medication, in a class of drugs called alpha blockers, has not been tried and failed for a minimum of 30 days. 4) 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 tadalafil (Cialis) have not been met. From the information we have received, the member does not meet number 1, 2, 3, and 4 of our prior authorization criteria for tadalafil (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
8440505	Internal Medicine	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	R03.0	Our prior authorization criteria for tadalafil (Cialis) have not been met. From the records that we have received, the following caused the denial of tadalafil (Cialis). 1) Records do not show a diagnosis of benign prostatic hyperplasia (BPH). 2) Tadalafil was not prescribed by, or in consultation with, a Urologist. 3) A medication, in a class of drugs called alpha blockers, has not been tried and failed for a minimum of 30 days. 4) 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 tadalafil (Cialis) have not been met. From the information we have received, the member does not meet numbers 1, 2, 3 and 4 of our prior authorization criteria for tadalafil (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
8529068	Advanced Practice Nurse	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	Erectile dysfunction	Our prior authorization criteria for tadalafil (Cialis) have not been met. From the records that we have received, the following caused the denial of tadalafil (Cialis). 1) Records do not show a diagnosis of benign prostatic hyperplasia (BPH). 2) Cialis was not prescribed by, or in consultation with, a Urologist. 3) A medication, in a class of drugs called alpha blockers, has not been tried and failed for a minimum of 30 days. 4) 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 tadalafil (Cialis) have not been met. From the information we have received, the member does not meet number 1, 2, 3, 4 of our prior authorization criteria for tadalafil (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

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8597228	-	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	n52.01	Our prior authorization criteria for tadalafil (Cialis) have not been met. From the records that we have received, the following caused the denial of tadalafil (Cialis). 1) Records do not show a diagnosis of benign prostatic hyperplasia (BPH). 2) More information is needed to determine if tadalafil (Cialis) was prescribed by, or in consultation with, a Urologist. 3) A medication, in a class of drugs called alpha blockers, has not been tried and failed for a minimum of 30 days. 4) 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 tadalafil (Cialis) have not been met. From the information we have received, the member does not meet numbers 1, 2, 3 and 4 of our prior authorization criteria for tadalafil (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
8552267	Dermatology	CLOBETASOL PROPIONATE	*DERMATOLOGICALS*	L21.8	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) 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 number 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
8576160	Physician Assistant	BAXDELA	*FLUOROQUINOLONES*	Confirmed or suspected methicillin-resistant Staphylococcus aureus (MRSA) infection	Our prior authorization criterion for BAXDELA TAB 450MG has not been met. From the records that we have received, the following caused the denial. 1) The drug is not prescribed by Infectious Disease. For all other specialties, the drug is not approved. Since the criterion has not been met, we are not able to approve.	No	No
8537788	Family Practice	AMITIZA	*GASTROINTESTINAL AGENTS - MISC.*	K58.9	Our prior authorization criteria for Amitiza have not been met. From the records that we have received, the following caused the denial of Amitiza. 1) Linzess 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 Amitiza have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Amitiza. The reason for denial is explained to the member above. The criteria are listed here. 1) Diagnosis of chronic idiopathic constipation (CIC) OR irritable bowel syndrome with constipation (IBS-C) AND member has tried and failed Linzess; OR 2) Diagnosis of opioid-induced constipation (OIC) AND member has tried and failed Movantik. 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
8430498	Gastroenterology	DIFICID	*MACROLIDES*	(A04.72) Enterocolitis due to Clostridium difficile, not specified as recurrent	Dificid tab requires step therapy. Step therapy means that other drugs will need to be tried and failed first. These other drugs are vancomycin cap, vancomycin soln, or Firvanq (vancomycin) solution. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered.	No	No
8518514	Family Practice	FREESTYLE LIBRE 14 DAY/RE	*MEDICAL DEVICES*	E11.9	Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of FREESTYLE MIS READER. 1) The requested product is not being used for Type 1 or Type 2 Diabetes in a member using insulin. 2) Records did not show that: (a) You have trouble feeling when your blood sugar is low, OR (b) Low blood sugar may put your safety at risk when working, OR (c) Your blood sugar is not currently controlled, OR (d) You are expected to benefit from CGM based on a professional trial, OR (e) You are pregnant. 3) Records received do not show you are under the care of a Diabetes specialist. 4) Records did not show that you have been instructed on how to use the CGM, that you are motivated and willing to properly use the CGM, and that your provider believes the CGM will help improve the control of your blood sugar. 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 Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 1 through 7 of our prior authorization criteria for FREESTYLE MIS READER. The reason for denial is explained to the member above. The criteria are listed here. 1) Member with Type 1 or Type 2 Diabetes using insulin; AND 2) Member meets one of the following: (a) Member has demonstrated hypoglycemia unawareness, OR (b) undetected hypoglycemia poses an occupational safety risk, OR (c) Member has suboptimal diabetes control (and is unable to test capillary glucose readings due to physical or cognitive limitation, OR has widely fluctuating glucose levels, OR fails to test with sufficient frequency), OR (d) Member is expected to benefit from ongoing CGM use based upon a professional CGM trial, OR (e) Member is pregnant; AND 3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabetes; AND 4) Member will be instructed in use of the CGM products; AND 5) Provider has assessed the member's motivation and willingness to properly utilize CGM; AND 6) Provider believes that CGM may lead to considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia; AND 7) If above criteria are not met, rationale and/or documentation of any extenuating circumstance requiring use of CGM is provided. 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

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8469445	Advanced Practice Nurse	FREESTYLE LIBRE 14 DAY/SE	*MEDICAL DEVICES*	diabetes mellitus	Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of FREESTYLE LIBRE. 1) The requested product is not being used for Type 1 or Type 2 Diabetes in a member using insulin. 2) Records did not show that: (a) You have trouble feeling when your blood sugar is low, OR (b) Low blood sugar may put your safety at risk when working, OR (c) Your blood sugar is not currently controlled, OR (d) You are expected to benefit from CGM based on a professional trial, OR (e) You are pregnant. 3) Records received do not show you are under the care of a Diabetes specialist. 4) Records did not show that you have been instructed on how to use the CGM, that you are motivated and willing to properly use the CGM, and that your provider believes the CGM will help improve the control of your blood sugar. 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 Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 1, 2, 3, 4, 5, 6 of our prior authorization criteria for FREESTYLE LIBRE. The reason for denial is explained to the member above. The criteria are listed here. 1) Member with Type 1 or Type 2 Diabetes using insulin; AND 2) Member meets one of the following: (a) Member has demonstrated hypoglycemia unawareness, OR (b) undetected hypoglycemia poses an occupational safety risk, OR (c) Member has suboptimal diabetes control (and is unable to test capillary glucose readings due to physical or cognitive limitation, OR has widely fluctuating glucose levels, OR fails to test with sufficient frequency), OR (d) Member is expected to benefit from ongoing CGM use based upon a professional CGM trial, OR (e) Member is pregnant; AND 3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabetes; AND 4) Member will be instructed in use of the CGM products; AND 5) Provider has assessed the member's motivation and willingness to properly utilize CGM; AND 6) Provider believes that CGM may lead to considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia; AND 7) If above criteria are not met, rationale and/or documentation of any extenuating circumstance requiring use of CGM is provided. 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
8442059	Advanced Practice Nurse	EMGALITY	*MIGRAINE PRODUCTS*	G43.009	Our prior authorization criteria for Emgality have not been met. From the records that we have received, the following caused the denial of Emgality. 1) The prescriber does not meet one of the following: prescriber is, or has consulted, a Neurologist, OR United Council for Neurologic Subspecialties (UCNS)-certified headache medicine specialist OR member of the American Headache Society OR member of the National Headache Foundation OR member of the International Headache Society OR has a Certificate of Added Qualification in Headache Medicine OR American Board of Headache Management Certified. 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 Emgality (initial coverage) have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Emgality. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the prevention of migraine; AND 2) Prescriber meets any one (1) of the following: prescriber is, or has consulted, a Neurologist, OR United Council for Neurologic Subspecialties (UCNS)-certified headache medicine specialist OR member of the American Headache Society OR member of the National Headache Foundation OR member of the International Headache Society OR has a Certificate of Added Qualification in Headache Medicine OR American Board of Headache Management Certified; AND 3) Member has four or more migraine days per month for at least the previous three months; AND 4) Member has tried and failed, is intolerant to, or is contraindicated from trying a minimum three month trial from TWO of the following drug classes: Anticonvulsants (such as topiramate, sodium valproate, etc.) AND/OR Vasoactive agents (such as propranolol, metoprolol, etc.) AND/OR Antidepressants (such as amitriptyline, venlafaxine, etc.); AND 5) Member will NOT continue to receive Botox injections for migraine. 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

Episode	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8487062	Internal Medicine	EMGALITY	*MIGRAINE PRODUCTS*	(G43.709) Chronic Migraine without aura, not intractable, without status migrainosus	Our prior authorization criteria for Emgality have not been met. From the records that we have received, the following caused the denial of Emgality. 1) Records received do not show the drug is not being used with Botox injections. 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 Emgality (initial coverage) have not been met. From the information we have received, the member does not meet number 5 of our prior authorization criteria for Emgality. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the prevention of migraine; AND 2) Prescriber meets any one (1) of the following: prescriber is, or has consulted, a Neurologist, OR United Council for Neurologic Subspecialties (UCNS)-certified headache medicine specialist OR member of the American Headache Society OR member of the National Headache Foundation OR member of the International Headache Society OR has a Certificate of Added Qualification in Headache Medicine OR American Board of Headache Management Certified; AND 3) Member has four or more migraine days per month for at least the previous three months; AND 4) Member has tried and failed, is intolerant to, or is contraindicated from trying a minimum three month trial from TWO of the following drug classes: Anticonvulsants (such as topiramate, sodium valproate, etc.) AND/OR Vasoactive agents (such as propranolol, metoprolol, etc.) AND/OR Antidepressants (such as amitriptyline, venlafaxine, etc.); AND 5) Member will NOT continue to receive Botox injections for migraine. 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
8603024	Family Practice	DYMISTA	*NASAL AGENTS - SYSTEMIC AND TOPICAL*	R06.02 Shortness of breath	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 numbers 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
8650427	Allergy & Immunology	ZETONNA	*NASAL AGENTS - SYSTEMIC AND TOPICAL*	J30.9	ZETONNA requires step therapy. Step therapy means that other drugs will need to be tried and failed first. These other drugs are a trial of 2: flunisolide, fluticasone, triamcinolone or mometasone. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered.	No	No