Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9751641	MARY ANN MARTINEZ MD	Dermatology	ABSORICA LD	*DERMATOLOGICALS*	acne vulgaris	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Isotretinoin (Accutane equivalent- Amnesteem, Claravis, Myorisan, or Zenatane). Please note, depending on your plan, certain isotretinoin 30 mg products may not be covered. Additionally, topical clindamycin (tried) or erythromycin, tretinoin, adapalene (Differin) or Epiduo 9tried), and one oral antibiotic (doxycycline, minocycline, Sulfamethoxazole/Trimethoprim, cephalexin). Prior authorization may be required. Benzoyl peroxide is available without a prescription. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8903382	SONIA YOUSUF III MD	Rheumatology	ACTEMRA ACTPEN	*ANALGESICS - ANTI-INFLAMMATORY*	M31.6	Our prior authorization criteria for Actemra have not been met. From the records that we have received, the following caused the denial of Actemra. 1) One of the following tests was not completed to verify diagnosis: temporal artery biopsy, Doppler ultrasound, magnetic resonance angiography (MRA), OR positron emission tomography (PET). 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 Actemra have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Actemra for the treatment of Giant Cell Arteritis (initial coverage). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Rheumatologist; AND 2) Diagnosis of GCA must be confirmed by one of the following: temporal artery biopsy, Doppler ultrasound, magnetic resonance angiography (MRA), OR positron emission tomography (PET); AND 3) Member must have relapsed while on methotrexate and corticosteroids; OR 4) Corticosteroids and methotrexate are unable to achieve remission; OR 5) Member has experienced unacceptable side effects with corticosteroids. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
8755870	SEAN MCKINLEY CHAMBERLAIN DO	Family Practice	ADAPALENE	*DERMATOLOGICALS*	scar prevention	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.		
9359180	KATHERINE STACY LABINER MD	Neurology, Pediatric	ADZENYS XR-ODT	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	ADHD	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER(tried), Adderall XR, Vyvanse(tried), dextroamphetamine ER(tried). Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9111406	GREG MICHAEL THAERA	Neurology	AIMOVIG	*MIGRAINE PRODUCTS*	G43.709	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) More information is needed to show that Botox injections for the treatment of migraine will not 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 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.		
9287058	LENA NICOLE HOWERTON DO	Internal Medicine	AIMOVIG	*MIGRAINE PRODUCTS*	G43.909	Our prior authorization criteria for Aimovig have not been met. From the records that we have received, Aimovig was denied for these reasons: 1) More information is needed to know if this drug will be used with Botox injections for migraine. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Aimovig have not been met. From the information we have received, the member does not meet number(s) 5 of our prior authorization criteria for Aimovig (Initial Therapy). 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: (a) Prescriber is, or has consulted, a Neurologist; (b) United Council for Neurologic Subspecialties (UCNS)-certified headache medicine specialist; (c) Member of the American Headache Society; Or Member of the National Headache Foundation; (d) Member of the International Headache Society; (e) Has a Certificate of Added Qualification in Headache Medicine; OR (f) American Board of Headache Management Certified; AND 3) Member has four (4) or more migraine days per month for at least the previous three (3) 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: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such as propranolol, metoprolol, etc.), or (c) antidepressants (such as amitriptyline, venlafaxine, etc.); AND 5) Member will NOT continue to receive onabotulinumtoxinA (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.		
8839098	LENA NICOLE HOWERTON DO	Internal Medicine	AJOVY	*MIGRAINE PRODUCTS*	migraine	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 AIMOVIG, EMGALITY. Prior authorization required for all. 2) Records showing medical history and past treatments were not received. 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 or 3 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9582502	IRIS SOFIA WINGROVE MD	Neurology	AJOVY	*MIGRAINE PRODUCTS*	G43.709 daily headaches/migraines.	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Aimovig and Emgality. Prior authorization required for both, and quantity limits may apply. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8712908	JULIE ANN REARDON MD	Family Practice	ALINIA	*ANTI-INFECTIVE AGENTS - MISC.*	Bacterial intestinal infection (A04.9) diverticulosis of small intestine (K57.11)	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, and 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.		
9623003	SYED MUHAMMAD RIZVI	Internal Medicine	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) Amitiza is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female patient, or opioid-induced constipation (OIC). 2) Trulance has not been tried and failed. Prior authorization may be required. 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 and 2 of our prior authorization criteria for Amitiza. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member AND A trial of Trulance was ineffective, contraindicated, or not tolerated; OR 2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in a woman 18 years of age or older AND A trial of Trulance was ineffective, contraindicated, or not tolerated; OR 3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member with chronic, non-cancer pain, including a member with chronic pain related to prior cancer or its treatment who does not require frequent (e.g. weekly) opioid dosage escalation AND A trial of Movantik was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
9644444	JUAN ANGEL DAVILA MD	Family Practice	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) Amitiza is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female patient, or opioid-induced constipation (OIC). 2) Trulance has not been tried and failed. Prior authorization may be required. 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 and 2 of our prior authorization criteria for Amitiza. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member AND A trial of Trulance was ineffective, contraindicated, or not tolerated; OR 2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in a woman 18 years of age or older AND A trial of Trulance was ineffective, contraindicated, or not tolerated; OR 3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member with chronic, non-cancer pain, including a member with chronic pain related to prior cancer or its treatment who does not require frequent (e.g. weekly) opioid dosage escalation AND A trial of Movantik was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
8951800	ADRIANA GUERRA GUERRA	Family Practice	AMPHETAMINE SULFATE	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	F90.1	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 dexmethylphenidate, dextroamphetamine, amphetamine/dextroamphetamine(tried) and methylphenidate(tried). 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.		
9472171	SUNITA SWAMY MD	Family Practice	AMPHETAMINE/DEXTROAMPHETA	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	F90.2	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Adderall XR, dexmethylphenidate extended release (ER), methylphenidate ER, Vyvanse, and dextroamphetamine ER. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9668211	CYNTHIA COYNE DONNA	Obstetrics & Gynecology	ANNOVERA	*CONTRACEPTIVES*	Z30.018	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Nuvaring (tried), xulane patch, jolessa, amethia, gianvi, ocella, junel, and others. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		

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8941668	EDWARD HURTADO ORTIZ MD	Pulmonary Disease	ARMODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.419	Our prior authorization criteria for Armodafinil have not been met. From the records that we have received, the following caused the denial of Armodafinil. 1) The drug is being used for narcolepsy or excessive sleepiness, but the records do not include a full nighttime sleep study and a daytime sleepiness test that shows an average time to fall asleep of less than 10 minutes. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Armodafinil have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Armodafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Diagnosis of Narcolepsy or Idiopathic Hypersomnolence and documentation of a full nocturnal polysomnogram and a multiple sleep latency test showing mean onset to sleep less than 10 minutes is provided; OR 2) Diagnosis of Obstructive Sleep Apnea/Hypopnea Syndrome on positive airway pressure (CPAP) therapy; OR 3) Diagnosis of Shift Work Sleep Disorder. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
9161451	TOAN QUOC VU MD	Neurology	ARMODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.33	Our prior authorization criteria for armodafinil (NUVIGIL) have not been met. From the records that we have received, Armodafinil was denied for these reasons: 1) Records did not show that you have tried Positive Airway Pressure (PAP) to help your health issue. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for armodafinil (NUVIGIL) have not been met. From the information we have received, the member does not meet #2 of our prior authorization criteria for Armodafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed to treat Narcolepsy or Idiopathic Hypersomnolence; AND documentation of both (A) full nocturnal polysomnogram AND (B) multiple sleep latency test are received (documentation must be provided); AND (C) Sleep studies must show mean onset to sleep less than 10 minutes; OR 2) Prescribed for adjunct therapy to standard treatment for the underlying obstruction due to Obstructive Sleep Apnea / Hypopnea Syndrome. An adequate trial of Positive Airway Pressure (PAP) therapy should be made prior to initiation of armodafinil, and when used adjunctively, the encouragement of and periodic assessment of PAP therapy compliance is necessary; OR 3) Prescribed to treat Shift Work Disorder. 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.		
9190885	TOAN QUOC VU MD	Neurology	ARMODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.33 OBSTRUCTIVE SLEEP APNEA	Our prior authorization criteria for armodafinil (NUVIGIL) have not been met. From the records that we have received, Armodafinil was denied for these reasons: 1) Records did not show that you have tried Positive Airway Pressure (PAP) to help your health issue. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for armodafinil (NUVIGIL) have not been met. From the information we have received, the member does not meet #2 of our prior authorization criteria for Armodafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed to treat Narcolepsy or Idiopathic Hypersomnolence; AND documentation of both (A) full nocturnal polysomnogram AND (B) multiple sleep latency test are received (documentation must be provided); AND (C) Sleep studies must show mean onset to sleep less than 10 minutes; OR 2) Prescribed for adjunct therapy to standard treatment for the underlying obstruction due to Obstructive Sleep Apnea / Hypopnea Syndrome. An adequate trial of Positive Airway Pressure (PAP) therapy should be made prior to initiation of armodafinil, and when used adjunctively, the encouragement of and periodic assessment of PAP therapy compliance is necessary; OR 3) Prescribed to treat Shift Work Disorder. 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.		
9267617	EDWARD JOSEPH FOX MD	Neurology	ARMODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G35	Our prior authorization criteria for Armodafinil have not been met. From the records that we have received, the following caused the denial of Armodafinil. 1) The drug is not being used for narcolepsy, excessive sleepiness, sleep apnea, or shift work sleep disorder. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Armodafinil have not been met. From the information we have received, the member does not meet number 1, 2 and 3 of our prior authorization criteria for Armodafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Diagnosis of Narcolepsy or Idiopathic Hypersomnolence and documentation of a full nocturnal polysomnogram and a multiple sleep latency test showing mean onset to sleep less than 10 minutes is provided; OR 2) Diagnosis of Obstructive Sleep Apnea/Hypopnea Syndrome on positive airway pressure (CPAP) therapy; OR 3) Diagnosis of Shift Work Sleep Disorder. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
9294903	EDWARD JOSEPH FOX MD	Neurology	ARMODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.41	Our prior authorization criteria for armodafinil (NUVIGIL) have not been met. From the records that we have received, Armodafinil was denied for these reasons: 1) A sleep study called a Full Nocturnal Polysomnogram (PSG) was not sent to us. This is an overnight sleep study. 2) A sleep study called a Multiple Sleep Latency (MSLT) was not sent to us. This may also be called a daytime nap study. 3) Records did not show that the average amount of time needed for you to fall asleep was less than 10 minutes. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for armodafinil (NUVIGIL) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Armodafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed to treat Narcolepsy or Idiopathic Hypersomnolence; AND all of the following are met: (A) full nocturnal polysomnogram is received (documentation must be provided); (B) multiple sleep latency test is received (documentation must be provided); AND (C) Sleep studies must show mean onset to sleep less than 10 minutes; OR 2) Prescribed for adjunct therapy to standard treatment for the underlying obstruction due to Obstructive Sleep Apnea / Hypopnea Syndrome; AND both of the following are met: (A) An adequate trial of Positive Airway Pressure (PAP) therapy should be made prior to initiation of armodafinil; AND (B) When used adjunctively, the encouragement of and periodic assessment of PAP therapy compliance is necessary; OR 3) Prescribed to treat Shift Work Disorder. 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.		
9367506	MICHAEL LAWRENCE SCHINDEL MD	Internal Medicine	ARMODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.419	The requested amount of armodafinil is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover armodafinil at 1 tablet per day for this use. The higher number of 2 tablets per day is not an approved dose for your health issue. In order for the higher quantity to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.		
9548365	ASWINI RAJAN MD	Internal Medicine	AZELASTINE HYDROCHLORIDE/	*NASAL AGENTS - SYSTEMIC AND TOPICAL*	J30.2	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are nasal steroids; budesonide, flunisolide, fluticasone, mometasone, triamcinolone, Beconase and Zetonna (quantity limtis apply for all and step therapy may be required) and nasal antiallergy sprays; azelastine 0.1% and 0.15% and olopatadine. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9096400	HISHAM ALI KHAN	Anesthesiology	BELBUCA	*ANALGESICS - OPIOID*	G89.4	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 morphine sulfate ER (MS Contin equivalent), Xtampza ER (oxycodone ER), fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER)-tried, Hysingla ER (hydrocodone ER), tramadol ER (Ultram ER equivalent), buprenorphine patch (Butrans equiv). Quantity limits may apply. 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.		
9127654	JOSEMARIA JOSEMARIAP PATERNO	Anesthesiology	BELBUCA	*ANALGESICS - OPIOID*	G89.4 CHRONIC PAIN SYNDROME	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 morphine sulfate extended release (ER) (MS Contin equivalent) (TRIED), Xtampza ER (oxycodone ER), fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), Hysingla ER (hydrocodone ER), tramadol ER (Ultram ER equivalent), buprenorphine patch (Butrans equiv). Quantity limits may apply 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.		
9269154	PAUL HIEN LE MD	Anesthesiology	BELBUCA	*ANALGESICS - OPIOID*	G89.4	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER (oxycodone ER), fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), Hysingla ER (hydrocodone ER), tramadol ER (Ultram ER equivalent), buprenorphine patch (Butrans equivalent). Quantity limits may apply. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9403256	ANTHONY PETE PERARDI PA	Physician Assistant	BELBUCA	*ANALGESICS - OPIOID*	G89.4	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent-TRIED), Xtampza ER (oxycodone ER), fentanyl patch (Duragesic equivalent-TRIED), Nucynta ER (tapentadol ER), Hysingla ER (hydrocodone ER), tramadol ER (Ultram ER equivalent), buprenorphine patch (Butrans equiv). Quantity limits may apply. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9572618	SHAGUFTA RAHIM SADRUDDIN	Nurse Practitioner	BELBUCA	*ANALGESICS - OPIOID*	G89.4	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER (oxycodone ER), fentanyl patch (Duragesic equivalent-TRIED), Nucynta ER (tapentadol ER), Hysingla ER (hydrocodone ER), tramadol ER (Ultram ER equivalent), buprenorphine patch (Butrans equiv). Quantity limits may apply. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9646538	IAN STEVEN ALWARD MD	Family Practice	BENZOYL PEROXIDE	*DERMATOLOGICALS*	L66.2	This request cannot be approved because this drug can be purchased over the counter (OTC) without a prescription. Drugs or products available OTC are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9624663	ANTHONY MARK PROPST MD	Endocrinology, Reproductive	BONJESTA	*ANTIEMETICS*	O21.9 VOMITING OF PREGNANCY	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are doxylamine (tried) and pyridoxine (tried). These drugs are available over the counter, without a prescription. Additionally, one (1) of the following: meclizine, dimenhydrinate, diphenhydramine (all available over the counter, without a prescription) AND one (1) of the following: metoclopramide, promethazine, prochlorperazine, must be tried and failed. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8999833	POOJA VARSHNEY MD	Allergy & Immunology, Pediatric	BUDESONIDE/FORMOTEROL FUM	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	asthma	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 Advair Diskus and Dulera. 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.		
9032816	HOPE MODUPE FOLARIN MD	Internal Medicine	BUDESONIDE/FORMOTEROL FUM	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J45.21	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 fluticasone/salmeterol, Dulera, Breo Ellipta. 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.		
9199155	ANTHONY CHARLES MONTEIRO JR DO	Obstetrics & Gynecology	BUDESONIDE/FORMOTEROL FUM	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J45.21 Mild intermittent asthma with (acute) exacerbation	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are fluticasone/salmeterol, Dulera, Breo Ellipta. Please look at the formulary to see what drugs are 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 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. Prior authorization may be required and quantity limits may apply to covered drugs.		
8919354	ALLISON LEIGH TURNER	Nurse Practitioner	BUPRENORPHINE HCL	*ANALGESICS - OPIOID*	G89.4 Chronic pain syndrome	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 morphine sulfate ER (MS Contin equivalent), Xtampza ER (oxycodone ER), fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), Hysingla ER (hydrocodone ER), tramadol ER (Ultram ER equivalent), buprenorphine patch (Butrans equiv). Quantity limits may apply. 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.		
9470941	JOSEMARIA JOSEMARIAP PATERNO	Anesthesiology	BUPRENORPHINE HCL	*ANALGESICS - OPIOID*	G89.4	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER (oxycodone ER), fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), Hysingla ER (hydrocodone ER), tramadol ER (Ultram ER equivalent), buprenorphine patch (Butrans equiv). Quantity limits may apply. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9672386	PAUL HIEN LE MD	Anesthesiology	BUPRENORPHINE HCL	*ANALGESICS - OPIOID*	G89.4	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER (oxycodone ER), fentanyl patch (Duragesic equivalent-TRIED), Nucynta ER (tapentadol ER), Hysingla ER (hydrocodone ER), tramadol ER (Ultram ER equivalent), buprenorphine patch (Butrans equiv). Quantity limits may apply. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8792349	KRISHNA POKALA MD	Internal Medicine	BUTALBITAL/ACETAMINOPHEN/	*ANALGESICS - NonNarcotic*	G43.709	This request is being denied because the safety and effectiveness of this medication has either not been established or shown to be inconclusive for treatment of this diagnosis. For all formulary exceptions, the requested medication must be used for a medically accepted diagnosis. Butalbital/Acetaminophen/Caffeine tablet has not been approved by the United States Food and Drug Administration (FDA) to treat chronic migraine headaches. Based on Micromedex, the drug package insert, and our Pharmacy and Therapeutics Committee guidelines, treatment is considered to be experimental.		
9009620	KRISHNA POKALA MD	Internal Medicine	BUTALBITAL/ACETAMINOPHEN/	*ANALGESICS - NonNarcotic*	G43.709	This request is being denied because the safety and effectiveness of this medication has either not been established or shown to be inconclusive for treatment of this diagnosis. For all formulary exceptions, the requested medication must be used for a medically accepted diagnosis. Butalbital-Acetaminophen-Caffeine has not been approved by the United States Food and Drug Administration (FDA) to treat migraine headaches. Based on Micromedex, the drug package insert, and our Pharmacy and Therapeutics Committee guidelines, treatment is considered to be experimental.		
9464029	HOPE MODUPE FOLARIN MD	Internal Medicine	BUTALBITAL/ACETAMINOPHEN/	*ANALGESICS - NonNarcotic*	G44.53	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) This drug is being used for thunderclap headache. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ibuprofen, naproxen, diclofenac tablet, rizatriptan, sumatriptan, naratriptan, ergotamine/caffeine (Cafergot equiv), and others. Quantity limits may apply. Acetaminophen (Tylenol equiv) and Acetaminophen/Caffeine (Excedrin Tension Headache equiv) are available without a prescription. Please look at the formulary to see what drugs are 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 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 1 and 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9555350	CHRISTOPHER ANDREW LEWIS MD	Family Practice	BUTALBITAL/ACETAMINOPHEN/	*ANALGESICS - NonNarcotic*	G43.909	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) This drug is being used for migraine. This is not an approved use. Must have FDA approved indication of Tension or Muscle Contraction headaches. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ibuprofen, naproxen, diclofenac tablet, rizatriptan, sumatriptan, naratriptan, ergotamine/caffeine (Cafergot equiv), and others. Quantity limits may apply. Acetaminophen (Tylenol equiv) and Acetaminophen/Caffeine (Excedrin Tension Headache equiv) are available without a prescription. 3) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are 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 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 1, 2 and 3 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9368781	JOHN DAVID WALSH APN	Advanced Practice Nurse	CAPLYTA	*ANTIPSYCHOTICS/ANTIMANIC AGENTS*	F25.9 Schizoaffective disorder, unspecified	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) This drug is being used for Schizoaffective disorder. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ziprasidone, Latuda (requires step therapy), quetiapine (TRIED), risperidone, olanzapine(TRIED), aripirazole(TRIED), Saphris, paliperidone extended-release (ER), and other formulary antipsychotics. Prior authorization may be required and quantity limits may apply. Please look at the formulary to see what drugs are 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 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 numbers 1 and 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9681899	ELENA GRIGOREVNA POGOSIAN MD	Family Practice	CHLORDIAZEPOXIDE HYDROCHL	*ULCER DRUGS*	R10.13	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) This drug is being used for Epigastric pain. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dicyclomine (TRIED), hyoscyamine, amitriptyline, nortriptyline, imipramine, desipramine, and loperamide. 3) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are 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 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 1, 2 and 3 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8819039	STACIA CHRISTINE MILES MD	Dermatology	CLOBETASOL PROPIONATE	*DERMATOLOGICALS*	L40.0	Our prior authorization criteria for Clobetasol have not been met. From the records that we have received, the following caused the denial of Clobetasol. 1) Lower strength topical steroids such as betamethasone valerate, mometasone furoate or triamcinolone have not been tried and failed. 2) Augmented betamethasone dipropionate or clobetasol solution have not been tried and failed. Recent claim for clobetasol solution, more information is needed to see if this medication has not worked for you. 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 or 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.		
8967516	DOMINIQUE JULIE ISAAC MD	Family Practice	CLOBETASOL PROPIONATE	*DERMATOLOGICALS*	L29.9	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) 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.		
9061730	JOSHUA PAUL MANISCALCO MD	Psychiatry	CLONIDINE HCL ER	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	F90.2	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 one stimulant drug (ie. amphetamine/dextroamphetamine, methylphenidate, etc.), clonidine immediate-release (IR) (tried), guanfacine extended-release (ER) (tried), and atomoxetine (Strattera equiv.). 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.		
9297693	JESSLYN JIAEN LU MD	Endocrinology, Diabetes & Metabolism	CONTOUR BLOOD GLUCOSE TES	*DIAGNOSTIC PRODUCTS*	none provided	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) The name of your insulin pump was not received. 2) Records did not show that your blood glucose meter has connectivity with your insulin pump. 3) The names of your glucose meter and test strips were not received. 4) Records did not show that you use the connectivity feature between your insulin pump and blood glucose meter. Please look at the formulary for a list of covered drugs. Formulary alternatives are available, including FreeStyle, Accu-Chek, and Precision Xtra meters and supplies. Quantity limits may apply. 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 numbers 2 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Patient is using an insulin pump (insulin pump name required); AND 2) Glucose meter has connectivity with the insulin pump (glucose meter and test strip name required); AND 3) Patient utilizes the connectivity feature. 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. Prior authorization may be required and quantity limits may apply to covered drugs.		
9708909	SIMONA MARIANA SCUMPIA MD	Endocrinology, Diabetes & Metabolism	CONTOUR NEXT BLOOD GLUCOS	*DIAGNOSTIC PRODUCTS*	DM2	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) Records did not show that you are using an insulin pump. 2) The name of your insulin pump was not received. 3) Records did not show that your blood glucose meter has connectivity with your insulin pump. 4) The names of your glucose meter and test strips were not received. 5) Records did not show that you use the connectivity feature between your insulin pump and blood glucose meter. Please look at the formulary for a list of covered drugs. Formulary alternatives are available, including FreeStyle, Accu-Chek, and Precision Xtra meters and supplies. Quantity limits may apply. 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 1, 2 or 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Patient is using an insulin pump (insulin pump name required); AND 2) Glucose meter has connectivity with the insulin pump (glucose meter and test strip name required); AND 3) Patient utilizes the connectivity feature. 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. Prior authorization may be required and quantity limits may apply to covered drugs.		
8920331	GREG MICHAEL THAERA	Neurology	COPAXONE	*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*	G35	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) A completed Food and Drug Administration (FDA) MedWatch form was not submitted with this request. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. 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 3 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 generic form of the drug has been tried and failed. 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) An FDA MedWatch form documenting efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
						Our prior authorization criteria for Corlanor have not been met. From the records that we have received, the following caused the denial of Corlanor. 1) The drug is not being used for stable, symptomatic heart failure. This is a disease where the heart cannot pump blood as well as it should. 2) Records did not show that your heart is in sinus rhythm. This is the normal, regular beating of your heart. 3) Records did not show that you have New York Heart Association (NYHA) Class II-IV or American College of Cardiology Foundation (ACCF)/American Heart Association (AHA) Class C, D chronic heart failure. These classifications show how severe your symptoms are. 4) Records did not show your current left ventricular ejection fraction (LVEF). The LVEF shows how much blood is being pumped out of your heart each time it beats. 5) Your resting heart rate was not received. 6) Records did not show that you are on a maximally tolerated dose of a beta blocker (e.g. atenolol, bisoprolol, carvedilol, or metoprolol) OR that you have tried and failed a beta blocker. Beta blocker drugs help lower blood pressure and control heart rate. 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.		
9194258	PARUL MAHENDRA DESAI MD	Cardiology	CORLANOR	*CARDIOVASCULAR AGENTS - MISC.*	R00.0	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Corlanor have not been met. From the information we have received, the member does not meet number 1, 3, 5, 6, 7, 8 of our prior authorization criteria for Corlanor. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of stable, symptomatic heart failure; AND 2) Prescribed by, or in consultation with, a Cardiology Specialist; AND 3) Member is in sinus rhythm; AND 4) Member is 18 years of age or older; AND 5) New York Heart Association (NYHA) Class II-IV or American College of Cardiology Foundation (ACCF)/American Heart Association (AHA) Class C, D chronic heart failure; AND 6) Baseline OR current left ventricular ejection fraction (LVEF) less than or equal to 35 percent; AND 7) Resting heart rate (HR) greater than or equal to 70 beats per minute (bpm); AND 8) Indicate ONE (1) of the following: a) Member is on a maximally tolerated dose of a beta blocker (e.g. atenolol, bisoprolol, carvedilol, or metoprolol); OR b) A trial of beta blockers 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		
9195925	KRISTEN NEUMANN POTTER PA-C	Physician Assistant	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.		
9245262	TRICIA LYNN WINTERS PA	Physician Assistant	COSENTYX SENSOREADY PEN	*DERMATOLOGICALS*	L40.0 Psoriasis vulgaris	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.		
9304398	KRISTEN NEUMANN POTTER PA-C	Physician Assistant	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.		
9403372	JENNIFER JEAN JORDAN PA	Physician Assistant	COSENTYX SENSOREADY PEN	*DERMATOLOGICALS*	r21	The requested amount of Cosentyx is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Cosentyx at 8 injections per 28 days (loading dose), then 2 injections per 28 days for this use. The higher amount of 10 injections per 35 days (loading dose) is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered. This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are zolpidem (tried), zaleplon, trazodone, eszopiclone (tried). Quantity limits may apply. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9631590	MALIA MEGAN SCOTT	Physician Assistant	DAYVIGO	*HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS*	F51.01	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are zolpidem (tried), zaleplon, trazodone, eszopiclone (tried). Quantity limits may apply. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9641627	MALIA MEGAN SCOTT	Physician Assistant	DAYVIGO	*HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS*	F51.01			
8726667	ELLEN LANHAM SIMMS APN	Nurse Practitioner	DESCOVY	*ANTIVIRALS*	Z77.21 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.		
8834754	DAVID PHILIP WRIGHT MD	Family Practice	DESCOVY	*ANTIVIRALS*	Z77.21	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 tablets are covered for pre-exposure prophylaxis (PrEP).		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8908660	DONALD ROBERT BRODE MD	Family Practice	DESCOVY	*ANTIVIRALS*	Z20.6 HIV PREP	Based on the information we have received, you do not meet number 2 of our prior authorization criteria because records do not show a treatment failure of Truvada or that you have poor kidney function. 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, OR 2) Prescribed for pre-exposure prophylaxis of HIV infection, AND (a) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval), OR (b) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval) Since criteria have not been met, we are unable to approve coverage for this drug at this time. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy. 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Records did not show that your kidney function measures between 30 to 60 mL per minute. 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.		
9119470	DAVID PHILIP WRIGHT MD	Family Practice	DESCOVY	*ANTIVIRALS*	Z77.21	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy. 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Records did not show that your kidney function measures between 30 to 60 mL per minute. 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.		
9131000	KATHLEEN DAILEY HOLMES	Nurse Practitioner	DESCOVY	*ANTIVIRALS*	Z77.21 - Contact with and (suspected) exposure to potentially hazardous body fluids	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy. 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Documentation of side effects experienced with Truvada was not received. 4) Records did not show that your kidney function measures between 30 to 60 mL per minute. 5) Documentation of your kidney function was not received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9250845	IAN STEVEN ALWARD MD	Family Practice	DESCOVY	*ANTIVIRALS*	Z20.2	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy. 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Documentation of side effects experienced with Truvada was not received. 4) Records did not show that your kidney function measures between 30 to 60 mL per minute. 5) Documentation of your kidney function was not received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9263468	MATTHEW COMPTON ROBINSON MD	Infectious Diseases	DESCOVY	*ANTIVIRALS*	Z20.6	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy. 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Documentation of your kidney function was not received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9282008	MARK ELLIOT LEVINE MD	Family Practice	DESCOVY	*ANTIVIRALS*	Z72.52	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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.		

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						Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy: 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Records did not show that your kidney function measures between 30 to 60 mL per minute. 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.		
9302390	KATHLEEN DAILEY HOLMES	Nurse Practitioner	DESCOVY	*ANTIVIRALS*	Z77.21	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy: 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Records did not show that your kidney function measures between 30 to 60 mL per minute. 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.		
9303606	DAN MANH NGUYEN MD	Family Practice	DESCOVY	*ANTIVIRALS*	Z77.21	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy: 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Records did not show that your kidney function measures between 30 to 60 mL per minute. 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.		
9330473	IAN STEVEN ALWARD MD	Family Practice	DESCOVY	*ANTIVIRALS*	Z72.52	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy: 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Documentation of side effects experienced with Truvada was not received. 4) Records did not show that your kidney function measures between 30 to 60 mL per minute. 5) Documentation of your kidney function was not received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9367369	DAN MANH NGUYEN MD	Family Practice	DESCOVY	*ANTIVIRALS*	Z77.21	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy: 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Documentation of side effects experienced with Truvada was not received. 4) Records did not show that your kidney function measures between 30 to 60 mL per minute. 5) Documentation of your kidney function was not received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9407836	STEVEN BRIAN HUTTO MD	Family Practice	DESCOVY	*ANTIVIRALS*	z72.52	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy: 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Records did not show that your kidney function measures between 30 to 60 mL per minute. 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.		
9434074	IAN STEVEN ALWARD MD	Family Practice	DESCOVY	*ANTIVIRALS*	Z72.52	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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.		

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						Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy: 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Documentation of side effects experienced with Truvada was not received. 4) Records did not show that your kidney function measures between 30 to 60 mL per minute. 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.		
9491179	ROSE MARY DURAN FNP-C	Nurse Practitioner	DESCOVY	*ANTIVIRALS*	Z77.21	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy: 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Documentation of side effects experienced with Truvada was not received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9505515	DANIEL JOSEPH KELLY MD	Family Practice	DESCOVY	*ANTIVIRALS*	Z20.6	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy: 1) Records did not show that you had kidney problems while on Truvada. 2) Records did not show that you had bone mineral density problems while on Truvada. 3) Documentation of side effects experienced with Truvada was not received. 4) Documentation of your kidney function was not received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9521833	KAZIA LUCILLE PARSONS MD	Family Practice	DESCOVY	*ANTIVIRALS*	PrEP	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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. Our prior authorization criteria for Descovy have not been met. From the records that we have received, the following caused the denial of Descovy: 1) This drug is not being used for pre-exposure prevention of human immunodeficiency virus (HIV) infection. 2) Records did not show that you had kidney problems while on Truvada. 3) Records did not show that you had bone mineral density problems while on Truvada. 4) Documentation of side effects experienced with Truvada was not received. 5) Documentation of your kidney function was not received. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9706102	STEVEN BRIAN HUTTO MD	Family Practice	DESCOVY	*ANTIVIRALS*	Z77.21	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Descovy 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 Descovy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of human immunodeficiency virus (HIV) infection; OR 2) Prescribed for pre-exposure prophylaxis of HIV infection; AND 3) Member is unable to take emtricitabine/tenofovir disoproxil fumarate (TRUVADA) due to ONE (1) of the following: (A) Documentation is provided of a renal adverse event or decreases in bone mineral density experienced while on emtricitabine/tenofovir disoproxil fumarate (TRUVADA) (Documentation is required to be submitted for an approval); OR (B) Documentation is provided of an estimated creatinine clearance between 30 and 60 mL per minute (Documentation is required to be submitted for an approval). 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.		
9443790	GERALD THOMAS FINCKEN DO	Family Practice	DEXCOM G6 SENSOR	*MEDICAL DEVICES*	E10.9	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 Dexcom G6. 1) Records do not show that you meet one of these: (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 do well with a Continuous Glucose Monitor (CGM) based on a professional trial, OR (e) You are pregnant. 2) Records do not show you are under the care of a Diabetes care expert. 3) Records do not show that you have been shown how to use the Continuous Glucose Monitor (CGM), that you are driven and willing to use the CGM the right way, and that your doctor believes the CGM will help control 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 2, 3, 4, 5, 6 of our prior authorization criteria for Dexcom G6 (Initial Therapy). 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 meets one (1) of the following: (i) Member is unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) Member fails to test with sufficient frequency; OR (D) Member is expected to benefit from ongoing Continuous Glucose Monitor (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 use 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		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9639664	HOPE MODUPE FOLARIN MD	Internal Medicine	DEXCOM G6 SENSOR	*MEDICAL DEVICES*	E11.8	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 Dexcom G6. 1) Records do not show that you are using insulin. 2) Records do not show that you meet one of these: (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 do well with a Continuous Glucose Monitor (CGM) based on a professional trial, OR (e) You are pregnant. 3) Records do not show you are under the care of a Diabetes care expert. 4) Records do not show that you have been shown how to use the Continuous Glucose Monitor (CGM), that you are driven and willing to use the CGM the right way, and that your doctor believes the CGM will help control 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, 7 of our prior authorization criteria for Dexcom G6 (Initial Therapy). 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 meets one (1) of the following: (i) Member is unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) Member fails to test with sufficient frequency; OR (D) Member is expected to benefit from ongoing Continuous Glucose Monitor (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 use 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		
9047896	OLIVIA DAYEA YUN MD	Family Practice	DEXILANT	*ULCER DRUGS*	K21.0	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 omeprazole (tried), pantoprazole (tried), esomeprazole, lansoprazole, rabeprazole. 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.		
9246508	KIAN VUI LEONG MD	Internal Medicine	DEXILANT	*ULCER DRUGS*	k21.9	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole(tried), pantoprazole(tried), rabeprazole, lansoprazole (Prevacid equivalent), esomeprazole. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9467299	MAHMOUD NABIL SOUBRA	Internal Medicine	DEXILANT	*ULCER DRUGS*	K21.9 Gastro-esophageal reflux disease without esophagitis	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole, pantoprazole (tried), esomeprazole, lansoprazole, rabeprazole. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8940036	CLEMENT CAROL YEH MD	Anesthesiology	DICLOFENAC SODIUM	*DERMATOLOGICALS*	osteoarthritis of the knee M17.9	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. 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 Migergot suppository, ergotamine tartrate/caffeine tablet (CAFERGOT equiv), sumatriptan, rizatriptan, eletriptan, frovatriptan, almotriptan, zolmitriptan and naratriptan. Quantity limits may apply. 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.		
9015968	CRAIG HEWELL COUCH MD	Neurology	DIHYDROERGOTAMINE MESYLAT	*MIGRAINE PRODUCTS*	G43.709	Our prior authorization criteria for Doptelet have not been met. From the records that we have received, the following caused the denial of Doptelet. 1) The drug is not being used before a scheduled procedure. 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 Doptelet have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Doptelet. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of thrombocytopenia due to chronic liver disease (CLD); AND 2) Prescribed for increasing platelet count prior to a scheduled procedure; AND 3) Platelet count less than 50,000 per microliter is provided and must be current (within 2 weeks). 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.		
8859953	BRIAN JAY SHIMKUS MD	Hematology & Oncology	DOPTELET	*HEMATOPOIETIC AGENTS*	C22.0			

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9672595	AMMAR MOIN AHMED MD	Adolescent Medicine	DOXEPIN HYDROCHLORIDE	*DERMATOLOGICALS*	G54.8 OTHER NERVE ROOT AND PLEXUS DISORDERS	Our prior authorization criteria for doxepin cream have not been met. From the records that we have received, the following caused the denial of doxepin cream. 1) The drug is not being used for short-term (up to 8 days) treatment of atopic dermatitis or lichen simplex. These are conditions that cause itching of the skin. 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 doxepin cream have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for doxepin cream. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the short-term management (up to 8 days) of moderate pruritis in an adult with atopic dermatitis or lichen simplex chronicus. 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.		
8807511	ADAM JOSEPH MAMELAK MD	Dermatology	DUPIXENT	*DERMATOLOGICALS*	L20.89	Our prior authorization criteria for Dupixent have not been met. From the records that we have received, the following caused the denial of Dupixent. 1) Records showing this drug is working well 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 Dupixent have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Dupixent. The reason for denial is explained to the member above. The criteria are listed here. 1) Documentation with chart notes of positive clinical response has been provided. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
9043455	JOEL DIETRICH GOODE MD	Family Practice	DYMISTA	*NASAL AGENTS - SYSTEMIC AND TOPICAL*	J30.9	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 azelastine nasal spray 0.1%, azelastine nasal spray 0.15%, olopatadine nasal spray, budesonide nasal spray, flunisolide nasal spray, fluticasone nasal spray (tried), mometasone nasal spray, triamcinolone nasal spray, and others. Quantity limits may apply. 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.		
9625489	IRIS SOFIA WINGROVE MD	Neurology	EMGALITY	*MIGRAINE PRODUCTS*	G43.709	Our prior authorization criteria for Emgality 120mg have not been met. From the records that we have received, Emgality 120mg was denied for these reasons: 1) You have not tried and failed (after using for at least 3 months) other drugs from at least TWO of the following drug classes: anticonvulsants (such as topiramate, sodium valproate, etc.), vasoactive agents (such as propranolol, metoprolol, etc.), antidepressants (such as amitriptyline, venlafaxine, etc.). Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Emgality 120mg have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Emgality 120mg for Migraine (Initial Therapy). 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: (a) Prescriber is, or has consulted, a Neurologist; (b) United Council for Neurologic Subspecialties (UCNS)-certified headache medicine specialist; (c) Member of the American Headache Society; Or Member of the National Headache Foundation; (d) Member of the International Headache Society; (e) Has a Certificate of Added Qualification in Headache Medicine; OR (f) American Board of Headache Management Certified; AND 3) Member has four (4) or more migraine days per month for at least the previous three (3) 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: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such as propranolol, metoprolol, etc.), or (c) antidepressants (such as amitriptyline, venlafaxine, etc.); AND 5) Member will NOT continue to receive onabotulinumtoxinA (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		
9736857	CRAIG HEWELL COUCH MD	Neurology	EMGALITY	*MIGRAINE PRODUCTS*	G43.709	Our prior authorization criteria for Emgality 120mg have not been met. From the records that we have received, Emgality 120mg was denied for these reasons: 1) Records show this drug is being used with Botox injections for migraine. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Emgality 120mg have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Emgality 120mg for Migraine (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the prevention of migraine; AND 2) Member has experienced a meaningful improvement in frequency and/or severity of migraine; AND 3) galcanezumab (EMGALITY) will NOT be used concomitantly with Botox injections for migraine; AND 4) If Emgality was initiated using manufacturer samples or any other mechanism, all of the following are met: (A) Prescriber meets any one of the following: (i) Prescriber is, or has consulted, a Neurologist, (ii) United Council for Neurologic Subspecialties (UCNS)-certified headache medicine specialist, (iii) Member of the American Headache Society; Or Member of the National Headache Foundation, (iv) Member of the International Headache Society, (v) Has a Certificate of Added Qualification in Headache Medicine, OR (vi) American Board of Headache Management Certified; AND (B) Member had four (4) or more migraine days per month for at least three (3) months prior to starting treatment with galcanezumab (EMGALITY); AND (C) 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: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such as propranolol, metoprolol, etc.), or (c) antidepressants (such as amitriptyline, venlafaxine, etc.). 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.		
9170003	MARISA RODRIGUEZ IZAGUIRRE MD	Gastroenterology, Pediatric	ENSURE COMPACT	*DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS*	K50.00	This request cannot be approved because this drug is in a class of drugs called nutritional supplements. Drugs of this type are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.		
9328337	JESSLYN JIAEN LU MD	Endocrinology, Diabetes & Metabolism	FREESTYLE LIBRE 14 DAY/SE	*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 LIBRE. 1) Records do not show that you meet one of these: (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 do well with a Continuous Glucose Monitor (CGM) based on a professional trial, OR (e) You are pregnant. 2) Records do not show that you have been shown how to use the Continuous Glucose Monitor (CGM), that you are driven and willing to use the CGM the right way, and that your doctor believes the CGM will help control 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 2, 4, 5, 6, and 7 of our prior authorization criteria for FREESTYLE LIBRE (Initial Therapy). 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 meets one (1) of the following: (i) Member is unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) Member fails to test with sufficient frequency; OR (D) Member is expected to benefit from ongoing Continuous Glucose Monitor (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 use 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		

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9385758	BENJAMIN THOMAS PAGANO CNS	Clinical Nurse Specialist	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) Records do not show that you are using insulin. 2) Records do not show that you meet one of these: (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 do well with a Continuous Glucose Monitor (CGM) based on a professional trial, OR (e) You are pregnant. 3) Records do not show you are under the care of a Diabetes care expert. 4) Records do not show that you have been shown how to use the Continuous Glucose Monitor (CGM), that you are driven and willing to use the CGM the right way, and that your doctor believes the CGM will help control 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 and 7 of our prior authorization criteria for Freestyle Libre (Initial Therapy). 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 meets one (1) of the following: (i) Member is unable to test capillary glucose readings due to physical or cognitive limitation, OR (ii) Member has widely fluctuating glucose levels, OR (iii) Member fails to test with sufficient frequency; OR (D) Member is expected to benefit from ongoing Continuous Glucose Monitor (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 use 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		
8831768	MELISSA BATTIEST MILLER MD	Hospitalist	FREESTYLE LIBRE/SENSOR/FL	*MEDICAL DEVICES*	Z79.84	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 KIT SENSOR 1) The requested product is not being used for Type 1 or Type 2 Diabetes in a member using insulin. 2) Records received do not show you are under the care of a Diabetes specialist. 3) Records did not show that you have been instructed on how to use the CGM. 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, 3 or 4 of our prior authorization criteria for FREESTYLE KIT SENSOR. 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		
9009857	MUNIRA GIRIN MEHTA DO	Endocrinology, Diabetes & Metabolism	HUMALOG	*ANTIDIABETICS*	E10.65	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 Novolog or Aspart insulin. 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.		
9145954	STACIA CHRISTINE MILES MD	Dermatology	HUMIRA	*ANALGESICS - ANTI-INFLAMMATORY*	none provided	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) Records do not show moderate to severe plaque psoriasis with significant functional disability OR debilitating palmar/plantar psoriasis. 2) At least 15 sessions of phototherapy have not been tried and failed. 3) Methotrexate or soriatane has not been tried and failed. 4) Supporting chart notes and documentation 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, 3, 4, 5 of our prior authorization criteria for Humira 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% of body surface involved) with significant functional disability OR have debilitating palmar/plantar psoriasis; AND 3) Member has failed a minimum of 15 sessions of phototherapy (or phototherapy is contraindicated); AND 4) Methotrexate (minimum dose of 15mg per week) OR soriatane has been tried and failed; AND 5) Supporting chart notes or other documentation of the severity of disease and progression, medications and therapies tried, and the outcomes from those medications and therapies must be provided. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
8760787	HAYS LAVASHIOUS ARNOLD III	Gastroenterology	HUMIRA PEN	*ANALGESICS - ANTI-INFLAMMATORY*	K51.90	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 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 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.		
8826673	MASI KHAJA MD	Gastroenterology	HUMIRA PEN	*ANALGESICS - ANTI-INFLAMMATORY*	k51.90	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 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 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8938334	RAJESH MOOLJIBHAI MEHTA MD	Gastroenterology	HUMIRA PEN	*ANALGESICS - ANTI-INFLAMMATORY*	K51.0	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 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 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.		
9125403	STACIA CHRISTINE MILES MD	Dermatology	HUMIRA PEN	*ANALGESICS - ANTI-INFLAMMATORY*	none provided	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) Records do not show moderate to severe plaque psoriasis with significant functional disability OR debilitating palmar/plantar psoriasis. 2) At least 15 sessions of phototherapy have not been tried and failed. 3) Methotrexate or soriatane has not been tried and failed. 4) Supporting chart notes and documentation 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, 3, 4, 5 of our prior authorization criteria for Humira 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% of body surface involved) with significant functional disability OR have debilitating palmar/plantar psoriasis; AND 3) Member has failed a minimum of 15 sessions of phototherapy (or phototherapy is contraindicated); AND 4) Methotrexate (minimum dose of 15mg per week) OR soriatane has been tried and failed; AND 5) Supporting chart notes or other documentation of the severity of disease and progression, medications and therapies tried, and the outcomes from those medications and therapies must be provided. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
8852353	KIAN VUI LEONG MD	Internal Medicine	HUMULIN N	*ANTIDIABETICS*	E11.9	Humulin N requires step therapy. Step therapy means that other drugs will need to be tried and failed first. Another drug is Novolin N. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered.		
9174997	SWAPNA MANTHENA MD	Family Practice	HYDROCORTISONE ACETATE	*ANORECTAL AGENTS*	K64.4 residual hemorrhoidal skin tags	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are proctosol HC cream (ANUSOL HC equivalent), pramoxine/hydrocortisone cream kit (ANALPRAM HC equivalent), lidocaine/hydrocortisone cream (ANAMANTLE equivalent), PROCTOFOAM HC FOAM, and others. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8837472	KIMPHUONG PHAM TRUONG MD	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 or 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.		
8928882	JAVIER ENRIQUE TELLEZ DO	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.		
9084090	VIMAL THOMAS GEORGE MD	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. Quantity limits may apply. 2) Farxiga, Xigduo/Xigduo XR, or Qtern has not been tried and failed. Quantity limits may apply. 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 numbers 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.		
9651600	JEFFREY NEAL KOCUREK MD	Urology	JATENZO	*ANDROGENS-ANABOLIC*	E29.1	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are testosterone cypionate injection, ANDRODERM patch, testosterone gel 1% (ANDROGEL equiv), testosterone gel 1.62% (ANDROGEL equiv), testosterone solution(AXIRON equiv), testosterone gel 2% (FORTESTA equiv), testosterone gel (VOGELXO equiv), ANDROID capsule, TESTRED capsule, METHITEST tablet, METHYLTESTOSTERONE capsule, and ANDROXY tablet. Prior authorization may be required. Quantity limits may apply. Please note: information sent to us stated that you have previously tried and failed an injectable and topical testosterone product. More information is needed about what drugs you have previously tried and failed. 2) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are 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 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 and 3 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9388936	KENNETH ALLEN PEREZ DO	Family Practice	JUBLIA	*DERMATOLOGICALS*	B35.1	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ciclopirox topical solution (Penlac equivalent), terbinafine tablet, itraconazole capsule (prior authorization may be required), griseofulvin. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8820740	ANGELA DENICE SHIPE	Nurse Practitioner	KAPSPARGO SPRINKLE	*BETA BLOCKERS*	hypertension	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 acebutolol, atenolol, bisoprolol, metoprolol (paid claims) and other cardio-selective beta blockers. 2) Records showing medical history and past treatments were not received. 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 or 3 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.		
8796954	RODOLFO GABRIEL GUTIERREZ-MACIAS MD	Family Practice	LATUDA	*ANTIPSYCHOTICS/ANTIMANIC AGENTS*	F41.9	LATUDA requires step therapy. Step therapy means that another drug will need to be tried and failed first. This other drug is QUETIAPINE. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered. Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, Latuda was denied for these reasons: 1) Quetiapine has not been tried and failed. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered.		
9369605	JOHN ROBERT BENSON PMHNP	Advanced Practice Nurse	LATUDA	*ANTIPSYCHOTICS/ANTIMANIC AGENTS*	F31.9	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. 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.		
9107870	ADRIENNE MELISSA CHAGOLY NP	Advanced Practice Nurse	LEVOTHYROXINE SODIUM	*THYROID AGENTS*	E03.9	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 Synthroid. 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.		
8676494	FLORENCE OLABISI FALOLA NP	Nurse Practitioner	LIALDA	*GASTROINTESTINAL AGENTS - MISC.*	K51.00	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) The generic version of this drug, called mesalamine DR tab, must be tried and failed. There is one claim for this medication in December 2019, but more information is needed if this medication did not work for you. 2) All other formulary drugs used for your condition must be tried and failed. Other drugs that can be used are mesalamine ER capsule (APRISO equiv), mesalamine DR cap(DELZICOL equiv), mesalamine tablet (ASACOL equiv). 3) A completed Food and Drug Administration (FDA) MedWatch form was not submitted with this request. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. 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 1, 2 or 3 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 generic form of the drug has been tried and failed. 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) An FDA MedWatch form documenting efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. 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.		
9073612	GREG MICHAEL THAERA	Neurology	LYRICA	*ANTICONVULSANTS*	G35	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) A completed Food and Drug Administration (FDA) MedWatch form was not submitted with this request. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. 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 3 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 generic form of the drug has been tried and failed. 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) An FDA MedWatch form documenting efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9497625	GREG MICHAEL THAERA	Neurology	MAVENCLAD	*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*	G35	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Aubagio, Avonex, dimethyl fumarate DR capsule (TECFIDERA equiv), Extavia, Gilenya, glatiramer injection (COPAXONE equiv), Mayzent, Plegridy, Rebif. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8842797	CHRISHANTHI MARY SUSAN PERERA MD	Internal Medicine	METFORMIN HYDROCHLORIDE E	*ANTIDIABETICS*	E11.8 Type 2 diabetes mellitus with unspecified complications	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 metformin IR (tried), metformin ER (Glucophage XR equiv), sulfonylureas (glimepiride(tried), glipizide, glyburide), DPP-4 inhibitors (Januvia, Tradjenta), GLP-1 agonists (Victoza, Bydureon), meglitinides (nateglinide, repaglinide), thiazolidinediones (pioglitazone), SGLT-2 inhibitors (Farxiga, Jardiance), and alpha-glucosidase inhibitors (acarbose). Quantity limits may apply. Please note: not all alternatives from all classes are listed. 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.		
8654705	WILLIAM GORDON FRANKLIN MD	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) 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 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.		
8670746	WILLIAM GORDON FRANKLIN MD	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.		
8960436	LARRY CHARLES KRAVITZ MD	Family Practice	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.00	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 numbers 1, 2 and 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.		
9038722	EDWARD HURTADO ORTIZ MD	Pulmonary Disease	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.		
9046181	PETER GERARD GOSSELINK MD	Family Practice	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	R53.82 Chronic fatigue	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 or 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9403855	KEITH ELLIOTT DYER MD	Physical Medicine & Rehabilitation	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	R41.840	Our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the records that we have received, Modafinil was denied for these reasons: 1) The drug is not being used for narcolepsy, excessive sleepiness, sleep apnea, or shift work sleep disorder. These are health issues that can make you feel tired during the day. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the information we have received, the member does not meet number(s) 1 or 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) Prescribed to treat Narcolepsy or Idiopathic Hypersomnolence; AND documentation of both all of the following are met: (A) full nocturnal polysomnogram is received (documentation must be provided); AND (B) multiple sleep latency test are is received (documentation must be provided); AND (C) Sleep studies must show mean onset to sleep less than 10 minutes; OR 2) Prescribed to treat excessive sleepiness related to obstructive sleep apnea / hypopnea syndrome and not as treatment for the underlying obstruction; AND If continuous positive airway pressure (CPAP) is the treatment of choice for a patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating and during treatment with modafinil for excessive sleepiness; OR 3) Prescribed to treat shift work sleep disorder. 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.		
9487237	IAN STEVEN ALWARD MD	Family Practice	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.21	Our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the records that we have received, Modafinil was denied for these reasons: 1) The drug is not being used for narcolepsy, excessive sleepiness, sleep apnea, or shift work sleep disorder. These are health issues that can make you feel tired during the day. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the information we have received, the member does not meet number(s) 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) Prescribed to treat Narcolepsy or Idiopathic Hypersomnolence; AND documentation of both all of the following are met: (A) full nocturnal polysomnogram is received (documentation must be provided); AND (B) multiple sleep latency test are is received (documentation must be provided); AND (C) Sleep studies must show mean onset to sleep less than 10 minutes; OR 2) Prescribed to treat excessive sleepiness related to obstructive sleep apnea / hypopnea syndrome and not as treatment for the underlying obstruction; AND If continuous positive airway pressure (CPAP) is the treatment of choice for a patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating and during treatment with modafinil for excessive sleepiness; OR 3) Prescribed to treat shift work sleep disorder. 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.		
9502602	GREG MICHAEL THAERA	Neurology	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G35 MULTIPLE SCLEROSIS M47.12	Our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the records that we have received, Modafinil was denied for these reasons: 1) The drug is not being used for narcolepsy, excessive sleepiness, sleep apnea, or shift work sleep disorder. These are health issues that can make you feel tired during the day. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the information we have received, the member does not meet number(s) 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) Prescribed to treat Narcolepsy or Idiopathic Hypersomnolence; AND documentation of both all of the following are met: (A) full nocturnal polysomnogram is received (documentation must be provided); AND (B) multiple sleep latency test are is received (documentation must be provided); AND (C) Sleep studies must show mean onset to sleep less than 10 minutes; OR 2) Prescribed to treat excessive sleepiness related to obstructive sleep apnea / hypopnea syndrome and not as treatment for the underlying obstruction; AND If continuous positive airway pressure (CPAP) is the treatment of choice for a patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating and during treatment with modafinil for excessive sleepiness; OR 3) Prescribed to treat shift work sleep disorder. 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.		
9624070	JEREMY DOUGLAS WISEMAN MD	Family Practice	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	F90.2	Our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the records that we have received, Modafinil was denied for these reasons: 1) The drug is not being used for narcolepsy, excessive sleepiness, sleep apnea, or shift work sleep disorder. These are health issues that can make you feel tired during the day. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the information we have received, the member does not meet number(s) 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) Prescribed to treat Narcolepsy or Idiopathic Hypersomnolence; AND documentation of both all of the following are met: (A) full nocturnal polysomnogram is received (documentation must be provided); AND (B) multiple sleep latency test are is received (documentation must be provided); AND (C) Sleep studies must show mean onset to sleep less than 10 minutes; OR 2) Prescribed to treat excessive sleepiness related to obstructive sleep apnea / hypopnea syndrome and not as treatment for the underlying obstruction; AND If continuous positive airway pressure (CPAP) is the treatment of choice for a patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating and during treatment with modafinil for excessive sleepiness; OR 3) Prescribed to treat shift work sleep disorder. 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.		
9662169	IAN STEVEN ALWARD MD	Family Practice	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.411	Our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the records that we have received, Modafinil was denied for these reasons: 1) A sleep study called a Multiple Sleep Latency (MSLT) was not sent to us. This may also be called a daytime nap study. 2) Records did not show that the average amount of time needed for you to fall asleep was less than 10 minutes. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Modafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed to treat Narcolepsy or Idiopathic Hypersomnolence; AND documentation of both all of the following are met: (A) full nocturnal polysomnogram is received (documentation must be provided); AND (B) multiple sleep latency test are is received (documentation must be provided); AND (C) Sleep studies must show mean onset to sleep less than 10 minutes; OR 2) Prescribed to treat excessive sleepiness related to obstructive sleep apnea / hypopnea syndrome and not as treatment for the underlying obstruction; AND If continuous positive airway pressure (CPAP) is the treatment of choice for a patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating and during treatment with modafinil for excessive sleepiness; OR 3) Prescribed to treat shift work sleep disorder. 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.		
9679644	IAN STEVEN ALWARD MD	Family Practice	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.21 R40.0	Our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the records that we have received, Modafinil was denied for these reasons: 1) A sleep study called a Multiple Sleep Latency (MSLT) was not sent to us. This may also be called a daytime nap study. 2) Records did not show that the average amount of time needed for you to fall asleep was less than 10 minutes. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Modafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed to treat Narcolepsy or Idiopathic Hypersomnolence; AND documentation of both all of the following are met: (A) full nocturnal polysomnogram is received (documentation must be provided); AND (B) multiple sleep latency test are is received (documentation must be provided); AND (C) Sleep studies must show mean onset to sleep less than 10 minutes; OR 2) Prescribed to treat excessive sleepiness related to obstructive sleep apnea / hypopnea syndrome and not as treatment for the underlying obstruction; AND If continuous positive airway pressure (CPAP) is the treatment of choice for a patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating and during treatment with modafinil for excessive sleepiness; OR 3) Prescribed to treat shift work sleep disorder. 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9731029	REBECCA FISHER MD	PSYCHIATRY & NEUROLOGY	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	G47.419	Our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the records that we have received, Modafinil was denied for these reasons: 1) A sleep study called a Full Nocturnal Polysomnogram (PSG) was not sent to us. This is an overnight sleep study. 2) A sleep study called a Multiple Sleep Latency (MSLT) was not sent to us. This may also be called a daytime nap study. 3) Records did not show that the average amount of time needed for you to fall asleep was less than 10 minutes. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for modafinil (PROVIGIL) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Modafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed to treat Narcolepsy or Idiopathic Hypersomnolence; AND documentation of both all of the following are met: (A) full nocturnal polysomnogram is received (documentation must be provided); AND (B) multiple sleep latency test are is received (documentation must be provided); AND (C) Sleep studies must show mean onset to sleep less than 10 minutes; OR 2) Prescribed to treat excessive sleepiness related to obstructive sleep apnea / hypopnea syndrome and not as treatment for the underlying obstruction; AND If continuous positive airway pressure (CPAP) is the treatment of choice for a patient, a maximal effort to treat with CPAP for an adequate period of time should be made prior to initiating and during treatment with modafinil for excessive sleepiness; OR 3) Prescribed to treat shift work sleep disorder. 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.		
9593307	RYAN MENZIES TIERNEY MD	Radiation Oncology	MUGARD	*MOUTH/THROAT/DENTAL AGENTS*	K12.33 - Oral mucositis (ulcerative) due to radiation C01 - Malignant neoplasm of base of tongue	This request has not been approved because this product was approved by the United States Food and Drug Administration (FDA) as a medical device. Medical devices are non-drug products that are meant to help diagnose and treat health issues. Medical devices cannot be approved and are excluded from coverage under your pharmacy benefit. This product may be covered under your medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. There also may be over-the-counter (OTC) products that you can buy without a prescription that may treat your health issue. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.		
8877903	SHANNON MITCHELL COHN MD	Hematology & Oncology, Pediatric	NEUPOGEN	*HEMATOPOIETIC AGENTS*	C74.9	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 Nivestym injection and Zarxio injection. 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.		
9439662	STACIA CHRISTINE MILES MD	Dermatology	NORITATE	*DERMATOLOGICALS*	rosacea	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, NORITATE CREAM 1% was denied for these reasons: 1) Azelaic acid (FINACEA equiv) has not been tried and failed. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. 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.		
9347088	KRISTYN MAGOON PA-C	Physician Assistant	NURTEC	*MIGRAINE PRODUCTS*	G43.909 Migraine, unspecified	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are sumatriptan (TRIED), rizatriptan, naratriptan, zolmitriptan, eletriptan, frovatriptan, and almotriptan. Quantity limits apply. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9414132	IRIS SOFIA WINGROVE MD	Neurology	NURTEC	*MIGRAINE PRODUCTS*	G43.709	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are four (4) covered medications used to stop a migraine: sumatriptan, rizatriptan, naratriptan, zolmitriptan, eletriptan. Quantity limits apply. Prior authorization may be required. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9672375	CRAIG HEWELL COUCH MD	Neurology	NURTEC	*MIGRAINE PRODUCTS*	G43.709 CHRONIC MIGRAINE	Our prior authorization criteria for rimegepant (NURTEC) have not been met. From the records that we have received, Nurtec was denied for these reasons: 1) Records did not show that you have tried and failed a triptan medication (e.g. sumatriptan-TRIED, rizatriptan-TRIED, or others) when taken WITH a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, naproxen, or others). Quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for rimegepant (NURTEC) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of migraine; AND 2) A trial of a triptan WITH a nonsteroidal anti-inflammatory drug (NSAID) was ineffective, contraindicated, or not tolerated; AND 3) A trial of a second triptan 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8939935	FOTINI MARIA CHALKIAS MD	Cardiology	OLMESARTAN MEDOXOMIL/AMLO	*ANTIHYPERTENSIVES*	i11.9	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 amlodipine/olmesartan along with hydrochlorothiazide (HCTZ) or angiotensin II receptor blockers (ARBs) combined with HCTZ (losartan/HCTZ (tried), valsartan/HCTZ (tried), olmesartan/HCTZ, irbesartan/HCTZ) along with amlodipine. Additionally, another combination medication on formulary is amlodipine/valsartan/HCTZ (tried). 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.		
9080624	YESSAR MUFEED HUSSAIN MD	Neurology	ONPATTRO	*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*	E85.1	This request has not been approved because this medication is a non-formulary medication and not covered by the prescription medication plan. This medication may be covered as a medical benefit as determined by the health plan. Please refer to the policy for specific information on what is covered. Our prior authorization criteria for Invega have not been met. From the records that we have received, the following caused the denial of Invega. 1) At least two of the following drugs have not been tried and failed: aripiprazole, ziprasidone, risperidone, quetiapine, and olanzapine. 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.		
9435484	PAUL RICHARD WHITELOCK MD	Psychiatry	PALIPERIDONE ER	*ANTIPSYCHOTICS/ANTIMANIC AGENTS*	F25.0	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Invega have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Invega. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of ONE (1) of the following: Schizophrenia, Schizoaffective disorder, OR Acute manic or mixed episodes in bipolar I disorder; AND 2) Trials of TWO (2) of the following were ineffective or not tolerated: aripiprazole, ziprasidone, risperidone, quetiapine, and olanzapine. 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.		
8880582	LAUREN REBECCA UPTON PA	Physician Assistant	PAZEO	*OPHTHALMIC AGENTS*	H10.45 Other chronic allergic conjunctivitis	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 olopatadine 0.1% (Patanol equiv), olopatadine 0.2% (Pataday equiv), azelastine, epinastine (Elestat equiv), ketotifen, Emadine, Lastacaft, Bepreve, and cromolyn eye drops. Quantity limits may apply. 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.		
8907116	LAUREN REBECCA UPTON PA	Physician Assistant	PAZEO	*OPHTHALMIC AGENTS*	H10.45 Other chronic allergic conjunctivitis	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 olopatadine 0.1% (Patanol equiv), olopatadine 0.2% (Pataday equiv) (TRIED), azelastine, epinastine (Elestat equiv), ketotifen, Emadine, Lastacaft, Bepreve, and cromolyn eye drops. Quantity limits may apply. 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.		
9708199	ZHOUWEN TANG MD	Gastroenterology	PEG-3350,SODIUM SULF,NACL	*LAXATIVES*	K52.9	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, PEG/NASUL,C SOL NACL/POT was denied for these reasons: 1) Clenpiq has not been tried and failed. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. 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.		
8922489	CLEMENT CAROL YEH MD	Anesthesiology	PENNSAID	*DERMATOLOGICALS*	M17.9	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 diclofenac 1.5% solution (PENNSAID equiv) (quantity limits apply), diclofenac 1% gel (Voltaren equivalent) (TRIED), and 4 oral nonsteroidal anti-inflammatory drugs (NSAIDs) (TRIED-diclofenac, ibuprofen, meloxicam, naproxen). 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.		
9004254	HEIDI ZIMMERMAN SIMMONS RN	Nurse Practitioner	POMALYST	*ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES*	C90.02	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 Revlimid (tried) and Ninlaro. Prior authorization may be required. Quantity limits may apply. 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9248021	EMMANUEL JOHN LEE MD	Family Practice	PRENATAL	*MULTIVITAMINS*	Pregnancy	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Concept DHA Capsule, Mynatal-Z, Prenatal 19 tablet/chewable tablet, Prenatabs RX, Prental Vitamins (PRENATAL PLUS, PREPLUS, PRENAPLUS), VP-PNV-DHA capsule, and other formulary alternatives. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9550847	HALEY CLARK OVERSTREET MD	Family Practice	PULMICORT FLEXHALER	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J45.40	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Arnuity Ellipta, Asmanex HFA or Twisthaler, Flovent Diskus or HFA. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9279903	DIVYANSU DHIRENDRA PATEL MD	Psychiatry	QUILLIVANT XR	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	F90.2	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ADDERALL XR CAPSULES, dextroamphetamine extended-release capsules, dexmethylphenidate extended-release capsules(TRIED), methylphenidate extended-release(TRIED) and VYVANSE CAPSULES. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8750050	ELIZABETH SILVA-BAEZA NP	Nurse Practitioner	QVAR REDIHALER	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J45.30	This drug is not on our list of covered drugs, also known as a 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 Arnuity Ellipta, Asmanex HFA or twisthaler, and Flovent HFA or Diskus. 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.		
9073118	RUY CARRASCO MD	Pediatrics	RASUVO	*ANALGESICS - ANTI-INFLAMMATORY*	M08.09	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 methotrexate tablets and methotrexate vials for injection. 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.		
9093905	MAHAN OSTADIAN DO	Anesthesiology	RELISTOR	*GASTROINTESTINAL AGENTS - MISC.*	K59.03	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 Movantik(tried), Symproic, Amitiza, and (prior authorization required for all). 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9097947	CLAIRE MCDONOUGH PMHNPBC	Advanced Practice Nurse	REXULTI	*ANTIPSYCHOTICS/ANTIMANIC AGENTS*	F33.9 MAJOR DEPRESIVE DISORDER	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 the Rexulti exception policy have not been met. From the records that we have received, the following caused the denial. 1) Aripiprazole has not been tried and failed. 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 1 of the Rexulti exception policy criteria for the adjunctive treatment of Major Depressive Disorder. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Trial and failure of Aripiprazole; AND 2) Member has had an inadequate response to antidepressant therapy during the current episode; AND 3) Trial and failure of two or more antidepressant medications; AND 4) Trial and failure of quetiapine or olanzapine. 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.		
9258846	CHRISTINA RACHEL ZAZAY	Advanced Practice Nurse	REXULTI	*ANTIPSYCHOTICS/ANTIMANIC AGENTS*	F41.1	This request cannot be approved because this drug has not been shown to be safe or helpful to treat generalized anxiety disorder. For all requests, the drug must be used for a medically accepted health issue. Rexulti has not been approved by the United States Food and Drug Administration (FDA) to treat this health issue. Based on Micromedex and guidance from our Pharmacy and Therapeutics Committee, this use is viewed as experimental.		
9574361	MICHAEL ANDREW MUSGROVE MD	Psychiatry	REXULTI	*ANTIPSYCHOTICS/ANTIMANIC AGENTS*	F33.2 - Major depressive disorder, recurrent severe without psychotic features	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 the Rexulti exception policy have not been met. From the records that we have received, the following caused the denial. 1) Aripiprazole has not been tried and failed. 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 1 of the Rexulti exception policy criteria for the adjunctive treatment of Major Depressive Disorder. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Trial and failure of Aripiprazole; AND 2) Member has had an inadequate response to antidepressant therapy during the current episode; AND 3) Trial and failure of two or more antidepressant medications; AND 4) Trial and failure of quetiapine or olanzapine. 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.		
9607066	CATHY ANNE CASTILLO MD	Family Practice	REYVOW	*MIGRAINE PRODUCTS*	G43.009	Our prior authorization criteria for lasmiditan (REYVOW) have not been met. From the records that we have received, Reyvow was denied for these reasons: 1) Records did not show that you have tried and failed a triptan medication (e.g. sumatriptan, rizatriptan, or others) when taken WITH a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, naproxen, or others). Quantity limits may apply. (Records show you have tried eletriptan but more information is needed to determine if it was used with an NSAID). 2) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for lasmiditan (REYVOW) have not been met. From the information we have received, the member does not meet number(s) 2 and 3 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of migraine; AND 2) A trial of a triptan with a nonsteroidal anti-inflammatory drug (NSAID) was ineffective, contraindicated, or not tolerated; AND 3) A trial of a second triptan 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.		
9412093	ASHVIN BARU MD	Internal Medicine	SAXENDA	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	E66.01 MORBID SEVERE OBESITY DUE TO EXCESS CALORIES	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.		
9588053	SRIYUTHA ALAVALAPATI REDDY MD	Internal Medicine	SAXENDA	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	E66.01	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.		
9342327	SARITA HARILAL PRAJAPATI MD	Family Practice	SHINGRIX	*VACCINES*	Z23	This drug is not on our list of covered drugs, also known as our formulary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.		
9693877	SHARON VANICE SHEPHERD NP	Nurse Practitioner	SHINGRIX	*VACCINES*	B02.9	This request cannot be approved because your plan has chosen this drug to be excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue. PLEASE NOTE: Not being able to use other covered options will not change the exclusion of this drug from coverage.		
9468699	RALPH M HADLEY JR PA	Physician Assistant	SILDENAFIL CITRATE	*CARDIOVASCULAR AGENTS - MISC.*	N52.01	Our prior authorization criteria for Pulmonary Arterial Hypertension have not been met. From the records that we have received, the following caused the denial of SILDENAFIL TAB 20MG. 1) The drug was not prescribed by, or together with, a heart or lung specialist. 2) The drug is not being used for Pulmonary Arterial Hypertension (PAH). This is a health issue where you would have high blood pressure in the blood vessels that go from the heart to the lungs. 3) Records did not show that your condition has been confirmed by a right heart catheterization. This is a test that checks how well your heart is pumping and is used to diagnose your health issue. 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 Pulmonary Arterial Hypertension have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Cardiologist or Pulmonologist; AND 2) Member has Pulmonary Arterial Hypertension (PAH) as diagnosed by right heart catheterization. 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.		
9610168	CARSON PAUL HIGGS MD	Family Practice	SILDENAFIL CITRATE	*CARDIOVASCULAR AGENTS - MISC.*	N52.9	Our prior authorization criteria for Pulmonary Arterial Hypertension have not been met. From the records that we have received, the following caused the denial of sildenafil 5mg tablet. 1) The drug was not prescribed by, or together with, a heart or lung specialist. 2) The drug is not being used for Pulmonary Arterial Hypertension (PAH). This is a health issue where you would have high blood pressure in the blood vessels that go from the heart to the lungs. 3) Records did not show that your condition has been confirmed by a right heart catheterization. This is a test that checks how well your heart is pumping and is used to diagnose your health issue. 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 Pulmonary Arterial Hypertension have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Cardiologist or Pulmonologist; AND 2) Member has Pulmonary Arterial Hypertension (PAH) as diagnosed by right heart catheterization. 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.		
8818760	KAILA ALISON SMITH APN	Nurse Practitioner	SOLOSEC	*AMEBICIDES*	bacterial vaginois	Based on the information we have received, you do not meet number 1, 2, 3 of our prior authorization criteria because member met 2 out of 4 of Amsel's criteria, has had 1 episode in the last year, and has not tried either 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9662996	SHAWN R AGENBROAD-ELANDER FNP-C	Nurse Practitioner	SOLOSEC	*AMEBICIDES*	Abscess of vulva	Our prior authorization criteria for secnidazole (SOLOSEC) have not been met. From the records that we have received, Solosec was denied for these reasons: 1) This drug is not used for bacterial vaginosis. This is a health issue where there is an excessive growth of bacteria in the vagina. 2) Records did not show that your health issue meets 3 of the 4 Amsel's criteria: (a) white discharge on the vaginal walls, (b) clue cells, (c) pH level greater than 4.5, (d) fishy odor. 3) Records do not show that you have had three (3) or more episodes of this health issue in the past year. 4) Two (2) of these drugs have been tried and failed: metronidazole (recent claim), clindamycin, tinidazole. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for secnidazole (SOLOSEC) have not been met. From the information we have received, the member does not meet number 1, 2, and 3 of our prior authorization criteria for Solosec. The reason for denial is explained to the member above. The criteria are listed here. 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. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8764945	RAJEEV KUMAR GUPTA MD	General 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. more information is needed to determine treatment failure or intolerance to medication. 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.		
9005843	BRIAN TERRY MILLER DO	Allergy & Immunology	SPIRIVA HANDIHALER	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J45.20	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) The drug is not being used for Chronic Obstructive Pulmonary Disease (COPD). 2) 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 1 and 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. PLEASE NOTE: Spiriva Respimat inhaler 1.25mcg/act is approved for the treatment of asthma and is covered after trial of Advair HFA or Diskus, Breo Ellipta, Dulera, or fluticasone/salmeterol. Quantity limits may apply.		
9114746	JACQUELINE MARIE KERR MD	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.		
9389079	HOPE MODUPE FOLARIN MD	Internal Medicine	SPIRIVA HANDIHALER	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J44.9	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Incruse Ellipta, Anoro Ellipta, Stiolto Respimat, Lonhala Magnair (step therapy requires trial of Incruse Ellipta). Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9439313	GRACE PATRICIA TAMESIS MD	Allergy & Immunology	SPIRIVA RESPIMAT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J45.41	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) The drug is not being used for Chronic Obstructive Pulmonary Disease (COPD). 2) 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 1 and 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. PLEASE NOTE: Spiriva Respimat 1.25mcg inhaler is covered on your pharmacy benefit for your health issue. Step Therapy requires trial of ADVAIR, BREO, DULERA (tried), or FLUTICASONE/SALMETEROL. Quantity limits apply.		
9662556	MICHELLE LE MARKLEY MD	Family Practice	SPRIX	*ANALGESICS - ANTI-INFLAMMATORY*	G43.411	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ketorolac tablets and three other nonsteroidal anti-inflammatory drugs (NSAIDS) (ibuprofen, naproxen, nabumetone, etodolac, sulindac, ketoprofen, diclofenac, indomethacin, salsalate, piroxicam). Quantity limits may apply. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9675610	APURVA NAVIN TRIVEDI MD	Gastroenterology	STELARA	*DERMATOLOGICALS*	K51.50 Left sided colitis without complications	Our prior authorization criteria for Stelara have not been met. From the records that we have received, Stelara was denied for these reasons: 1) More information is needed to know that your health issue has gotten better while using this drug. 2) Chart notes from within the past year that show disease improvement with treatment have not been sent to us. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Stelara 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 Stelara for Ulcerative Colitis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Ulcerative Colitis; AND 2) Prescribed by a Gastroenterology Specialist; AND 3) Member has demonstrated a significant improvement in their condition; AND 4) Documentation (written explanation accepted) of improvement within the past year is submitted with the request (documentation is required for an approval). 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.		
9128193	STEVEN ZACHARY POWELL MD	Family Practice	SUBLOCADE	*ANALGESICS - OPIOID*	F11.20	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 buprenorphine/naloxone sublingual film/tablet (Suboxone equiv), Zubsolv sublingual film. 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.		
8949114	DAVID PHILIP WRIGHT MD	Family Practice	SUMATRIPTAN SUCCINATE	*MIGRAINE PRODUCTS*	G43.909	The requested quantity of SUMATRIPTAN TABLET 50MG is greater than the quantity limit for the drug. A quantity limit is a limit on the amount of a drug covered at a time. We will cover SUMATRIPTAN TABLET 50MG at 9 tablets per fill, 2 fills per 30 days for this use. The higher quantity of 30 tablets per fill is not covered by your plan. Please look at our formulary for a list of covered drugs and any limits for coverage of those drugs.		
9071290	EDWARD HURTADO ORTIZ MD	Pulmonary Disease	SUNOSI	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	sleep disorder/excessive-daytime sleepiness associated with narcolepsy	Our prior authorization criteria for Sunosi have not been met. From the records that we have received, the following caused the denial of Sunosi. 1) Sleep studies were not received. 2) It is unknown if you have tried and failed armodafinil or modafinil. Prior authorization may be required. Quantity limits may apply. 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 Sunosi have not been met. From the information we have received, the member does not meet number 2 or 3 of our prior authorization criteria for Sunosi (Initial Therapy) for Excessive Daytime Sleepiness with Narcolepsy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Neurologist or board-certified sleep medicine specialist; AND 2) Documentation of a full nocturnal polysomnogram and a multiple sleep latency test showing mean onset to sleep of less than (<) 8 minutes and two (2) or more sleep onset rapid eye movement (REM) sleep periods is provided with the request (documentation is required to be submitted for an approval); AND 3) A trial of ONE (1) of the following was ineffective, contraindicated, or not tolerated: armodafinil (NUVIGIL) OR modafinil (PROVIGIL). 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.		
9746769	KAVITHA KUMBUM MD	Gastroenterology	SUPREP BOWEL PREP KIT	*LAXATIVES*	colonoscopy prep	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, Suprep was denied for these reasons: 1) Clenpiq has not been tried and failed. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. 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.		
8657182	HUAIZHEN CHEN MD	Internal Medicine	SYMBICORT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J45.40	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 fluticasone/salmeterol (tried), Dulera, Breo Ellipta (tried). 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.		
8766514	DEBRA LEE DOLLAR MD	Internal Medicine	SYMBICORT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J45.41 Moderate persistent asthma with (acute) exacerbation	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 fluticasone/salmeterol, Dulera, Breo Ellipta. 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.		
8899051	STEVEN KIRK FOSTER MD	General Practice	SYMBICORT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J06.9 ACUTE UPPER REPIRATORY INFECTION	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 fluticasone/salmeterol, Dulera, Breo Ellipta. 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9052087	MANUEL JOSEPH MARTIN MD	Family Practice	SYMBICORT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	none provided	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) A diagnosis was not received with this request and is required for a not-covered drug to be considered for approval. 2) All formulary drugs used for your condition have not been tried and failed. Other drugs that can be used for asthma are fluticasone/salmeterol, Dulera and Breo Ellipta (tried). 3) Records showing medical history and past treatments were not received. 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 numbers 1, 2 and 3 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9233378	BRIAN TERRY MILLER DO	Allergy & Immunology	SYMBICORT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J45.30	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are BREO ELLIPTA, DULERA INHALER, fluticasone/salmeterol inahler. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9365434	CAMERON MAXWELL KIELHORN MD	Family Practice	SYMBICORT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	R05	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) This drug is being used for cough. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Advair HFA/Diskus, Dulera, Breo Ellipta. Please look at the formulary to see what drugs are 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 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 numbers 1 and 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9372347	ELISABETH ANNE CLAYTON MD	Allergy & Immunology	SYMBICORT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	R05	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are fluticasone/salmeterol, Dulera, Breo Ellipta. Please look at the formulary to see what drugs are 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 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 numbers 1 and 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9384686	BRIAN TERRY MILLER DO	Allergy & Immunology	SYMBICORT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J45.41J45.41	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) This drug is being used for cough. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Advair HFA/Diskus, Dulera, Breo Ellipta. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9386707	ELISABETH ANNE CLAYTON MD	Allergy & Immunology	SYMBICORT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	R05	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 numbers 1 and 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9641726	SEAN JOSEPH COUGHLIN MD	Internal Medicine	SYMBICORT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J45.901	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are fluticasone/salmeterol, Dulera, Breo Ellipta. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8907667	SCOTT ALDEN SMITH MD	Surgery, Orthopedic	SYNVISC ONE	*MUSCULOSKELETAL THERAPY AGENTS*	M17.12	This request has not been approved because this medication is a non-formulary medication and not covered by the prescription medication plan. This medication may be covered as a medical benefit as determined by the health plan. Please refer to the policy for specific information on what is covered.		
8810619	HOPE MODUPE FOLARIN MD	Internal Medicine	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. 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.		
8831760	MELISSA BATTIEST MILLER MD	Hospitalist	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	E11.69 Erectile dysfunction due to diabetes	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 or 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. 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) 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.		
8853667	ERIC JAMES GIESLER MD	Urology	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	n/a	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, 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. 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) Cialis was not prescribed by, or in consultation with, a Urologist. 2) A medication, in a class of drugs called androgen hormone inhibitors, has not been tried and failed for a minimum of 90 days. Since the criteria have not been met, we are not able to approve.		
9499191	JOHN SANG HEE KIM MD	Family Practice	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	N40.1	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 2 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. 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) Cialis was not prescribed by, or in consultation with, a Urologist. 2) Records do not show that a medication, in a class of drugs called androgen hormone inhibitors, has been tried and failed for a minimum of 90 days. Since the criteria have not been met, we are not able to approve.		
9507091	MANUEL JOSEPH MARTIN MD	Family Practice	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	N40.1	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 2 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 (Documentation is required for approval); AND 4) An androgen hormone inhibitor (dutasteride, finasteride) must be tried and failed for at least 90 days (Documentation is required for approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time. 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) Records do not show that a medication, in a class of drugs called alpha blockers, has been tried and failed for a minimum of 30 days. 4) Records do not show that a medication, in a class of drugs called androgen hormone inhibitors, has been tried and failed for a minimum of 90 days. Since the criteria have not been met, we are not able to approve.		
9588960	VANESSA DAWN SADD FNP	Nurse Practitioner	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	R53.83 - Other fatigue	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 (Documentation is required for approval); AND 4) An androgen hormone inhibitor (dutasteride, finasteride) must be tried and failed for at least 90 days (Documentation is required for approval). Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
8698616	SONIA YOUSUF III MD	Rheumatology	TALTZ	*DERMATOLOGICALS*	Active Psoriatic Arthritis	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 Enbrel, Humira (tried), Cosentyx, Cimzia, Otezla, Orencia, Stelara, Xeljanz (Prior authorization required for all). 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.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8723523	LOREN RAYMOND JONES MD	Urology	TESTOPEL	*ANDROGENS-ANABOLIC*	E29.1	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 testosterone cypionate inj, TESTOSTERONE GEL 1%, testosterone gel 1.62%, ANDRODERM PATCH 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.		
9041727	RICHARD SEAN OMSBERG PA	Physician Assistant	TESTOPEL	*ANDROGENS-ANABOLIC*	E29.1 Testicular hypofunction	This request has not been approved because this medication is a non-formulary medication and not covered by the prescription medication plan. This medication may be covered as a medical benefit as determined by the health plan. Please refer to the policy for specific information on what is covered.		
8911975	MICHAEL EDWARD KILLIAN MD	Family Practice	TESTOSTERONE	*ANDROGENS-ANABOLIC*	E29.1	Based on the formulary requirements for the coverage of TESTOSTERONE GEL 1% (25MG) as determined by the Pharmacy and Therapeutics Committee, we will continue to cover 1 packet per day.. This request has not been approved because the quantity requested exceeds the maximum quantity allowed under the pharmacy benefit. The documentation provided does not support the need for more than 1 packet per day. The prescribed dose is 50MG per day. This medication is available in a TESTOSTERONE GEL 1% (50MG). The same dose can be achieved by taking one TESTOSTERONE GEL 1% (50MG) packet per day. Please refer to the formulary for specific information on what is covered.		
9361723	MICHAEL KEITH FLOYD MD	Urology	TESTOSTERONE	*ANDROGENS-ANABOLIC*	R68.82	Our prior authorization criteria for Androgens: Testosterone Products have not been met. From the records that we have received, testosterone gel was denied for these reasons: 1) The drug is not being used for primary or secondary hypogonadism. This is a condition in which the body does not make enough testosterone. 2) More information is needed to know if your low levels of testosterone are age-related. 3) Two low testosterone levels have not been sent to us. The labs must be drawn in the morning and must be from two different days. 4) A second lab value from within the last 24 months was not sent to us. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Androgens: Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1, 3, 4, and 5 of our prior authorization criteria for Initial Therapy. 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 (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 4) Two (2) lab values are submitted with the request (date, time, level, and reference range must be documented); AND 5) One lab value must be from within the last 12 months, AND the second lab value must be from within the last 24 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.		
9724555	DONALD DAVIS COLE III MD	Family Practice	TESTOSTERONE	*ANDROGENS-ANABOLIC*	E29.1	Our prior authorization criteria for Androgens: Testosterone Products have not been met. From the records that we have received, testosterone gel was denied for these reasons: 1) More information is needed to know if your low levels of testosterone are age-related. 2) Records do not show you are currently using testosterone replacement therapy. 3) The one morning testosterone level that was sent to us does not include a reference range. This lab draw must be from within the last 12 months. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Androgens: Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 2 and 3 of our prior authorization criteria for Continuing Therapy. 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 been established on testosterone replacement therapy; AND 3) At least ONE (1) morning testosterone level from the last 12 months has been provided with the request (date, time of draw, level, and reference range must be documented). 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.		
9555736	ROBERT ORCUTT NORTHWAY III MD	Urology	THIOLA EC	*GENITOURINARY AGENTS - MISCELLANEOUS*	E72.01	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) This drug is being used for cystinuria without information on current urinary cystine concentration. This is not an approved use. 2) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are 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 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 1 and 3 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9111772	ANNE CLAIRE ADAMS	Family Practice	TOSYMRA	*MIGRAINE PRODUCTS*	G43.109	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 eletriptan tablet, naratriptan tablet, rizatriptan tablet or orally disintegrating tablet, sumatriptan tablet, sumatriptan injection, sumatriptan nasal spray (IMITREX equivalent), almotriptan tablet, frovatriptan tablet, zolmitriptan tablet or orally disintegrating tablet, and Zomig Nasal Spray. Quantity limits apply. 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. Prior authorization may be required and quantity limits may apply to covered drugs.		
9599788	ADRIANA GUERRA GUERRA	Family Practice	TRAMADOL HYDROCHLORIDE	*ANALGESICS - OPIOID*	M25.561 Pain in right knee□	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are tramadol 50mg tablets (Ultram equivalent), codeine (allergy), hydromorphone, meperedine (allergy), morphine tablets, oxycodone (allergy), and others. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9638499	ADRIANA GUERRA GUERRA	Family Practice	TRAMADOL HYDROCHLORIDE	*ANALGESICS - OPIOID*	M25.561	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are tramadol 50mg tablets (Ultram equivalent), codeine (allergy), hydromorphone, meperedine (allergy), morphine tablets, oxycodone (allergy), and others. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9479770	MELANIE MARIE PICKETT MD	Dermatology	TRETINOIN	*DERMATOLOGICALS*	L81.1	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, tretinoin cream 0.025% was denied for these reasons: 1) This drug is not being used to treat acne, rosacea, or actinic keratosis. These are health issues of the skin. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Acne Agents have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for tretinoin cream 0.025%. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment 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. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
8822120	RODOLFO GABRIEL GUTIERREZ-MACIAS MD	Family Practice	TRINTELLIX	*ANTIDEPRESSANTS*	F41.8 OTHER SPECIFIED ANXIETY DISORDERS	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, 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 or 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.		
9270221	REBECCA MARIE SCADUTO PMHNPBC	Advanced Practice Nurse	TRINTELLIX	*ANTIDEPRESSANTS*	F33.1 Major depressive disorder, recurrent, moderate	The requested amount of Trintellix is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Trintellix at 1 tablet per day for this use. The prescribed dose is Trintellix 5mg at 3 tablets per day. This drug comes in a 10mg. The same dose can be reached by taking 1.5 tablets per day. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered.		
9488641	CARRIE CHANDLER BARLOW PA-C	Physician Assistant	TRULICITY	*ANTIDIABETICS*	Type 2 DM	The requested amount of TRULICITY INJ 1.5/0.5 is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover TRULICITY INJ 1.5/0.5 at 4 pens per 28 days (maximum of 28 days per fill) for this use. The higher amount of an 84 day supply is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered.		
9086697	KRISHNA POKALA MD	Internal Medicine	UBRELVY	*MIGRAINE PRODUCTS*	G43.709	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 sumatriptan(tried), naratriptan, rizatriptan(tried), eletriptan(tried), and zolmitriptan(tried). Quantity limits may apply. Prior authorization may be required. 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.		
9100715	KRISHNA POKALA MD	Internal Medicine	UBRELVY	*MIGRAINE PRODUCTS*	G43.709	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 sumatriptan, naratriptan, rizatriptan, eletriptan, and zolmitriptan. Quantity limits may apply. 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.		
9242680	KRISHNA POKALA MD	Internal Medicine	UBRELVY	*MIGRAINE PRODUCTS*	G43.709	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are sumatriptan(tried), rizatriptan(tried), naratriptan, zolmitriptan, eletriptan. Quantity limits apply. Prior authorization may be required.. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8861886	JACQUE ANGERSTEIN DO	Family Practice	UNITHROID	*THYROID AGENTS*	E03.9	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 Synthroid tablet (brand name). 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.		
9176868	HOPE MODUPE FOLARIN MD	Internal Medicine	VANIQA	*DERMATOLOGICALS*	L68.0 Hirsutism□	This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.		
8728285	CARLOS LEO ROMERO DPM	Podiatrist	VIMOVO	*ANALGESICS - ANTI-INFLAMMATORY*	GERD, S92.344A	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) This drug is being used for a broken foot in a patient with gastrointestinal symptoms. This is not an approved use. 2) All formulary drugs used for your condition have not been tried and failed. Other drugs that can be used are a formulary Proton Pump Inhibitor (PPI - e.g. omeprazole, pantoprazole, rabeprazole, Prevacid OTC, esomeprazole) taken with a formulary Non-Steroidal Anti-Inflammatory Drug (NSAID - e.g. naproxen-tried, ibuprofen, nabumetone, diclofenac, etodolac). 3) Records showing medical history and past treatments were not received. 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 1, 2, and 3 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.		
9742977	JEANNE LOUISE BEATTIE MD	Neurology	VIMPAT	*ANTICONVULSANTS*	G40.909 EPILEPSY	The requested amount of Vimpat is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Vimpat 100mg at 2 tablets per day for this use. The prescribed dose is 4 tablets per day. This drug comes in a 200mg. The same dose can be reached by taking 2 tablets per day. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered.		
9074520	EDUARDO JAVIER CEPEDA MD	Rheumatology	XELJANZ	*ANALGESICS - ANTI-INFLAMMATORY*	M05.79	Our prior authorization criteria for Xeljanz have not been met. From the records that we have received, the following caused the denial of Xeljanz. 1) Two of the following have not been tried and failed; Rinvoq tablets, Enbrel (tried) and Humira. All drugs require prior authorization. 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 Xeljanz have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Xeljanz for the treatment of Rheumatoid Arthritis. The reason for denial is explained to the member above. The criteria are listed here. 1) Diagnosis of Rheumatoid Arthritis; AND 2) Prescribed by a Rheumatology Specialist; AND 3) Trials of TWO of the following; Rinvoq tablets, Enbrel or Humira were ineffective, contraindicated, or not tolerated. All drugs require prior authorization. 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.		
8948530	MELISSA PALMER SAULS NP	Nurse Practitioner	XIFAXAN	*ANTI-INFECTIVE AGENTS - MISC.*	SIBO W/ DIARRHEA	Our prior authorization criteria for Xifaxan 550mg have not been met. From the records that we have received, the following caused the denial of Xifaxan. 1) Records do not show the medication is being used for the treatment of irritable bowel syndrome with diarrhea (IBS-D). 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 Xifaxan 550mg have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Xifaxan. The reason for denial is explained to the member above. The criteria are listed here. 1) Member must have a diagnosis of irritable bowel syndrome with diarrhea (IBS-D); AND 2) Quantities must not exceed 3 tablets per day; AND 3) Each fill may be for a maximum of 14 days; AND 4) A maximum of 3 fills are allowed per year. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
9605528	MARIA EZIAFA CHIEJINA MD	Internal Medicine	XIFAXAN	*ANTI-INFECTIVE AGENTS - MISC.*	K63.89 R10.9	Our prior authorization criteria for Xifaxan 550mg have not been met. From the records that we have received, the following caused the denial of Xifaxan 550mg. 1) The drug is not being used for Hepatic Encephalopathy. This is a condition where brain function declines due to severe liver disease. 2) The drug is not being used for Irritable Bowel Syndrome with Diarrhea (IBS-D). This is a condition that affects the large intestine. 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 Xifaxan 550mg 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 Xifaxan 550mg. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Hepatic Encephalopathy; OR 2) Member has a diagnosis of Irritable Bowel Syndrome with Diarrhea (IBS-D). 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.		
9648302	JESSICA MARIE TREVINO MD	Gastroenterology	XIFAXAN	*ANTI-INFECTIVE AGENTS - MISC.*	CROHN'S DISEASE	Our prior authorization criteria for Xifaxan 550mg have not been met. From the records that we have received, the following caused the denial of Xifaxan 550mg. 1) The drug is not being used for Hepatic Encephalopathy. This is a condition where brain function declines due to severe liver disease. 2) The drug is not being used for Irritable Bowel Syndrome with Diarrhea (IBS-D). This is a condition that affects the large intestine. 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 Xifaxan 550mg have not been met. From the information we have received, the member does not meet number 1, 2 of our prior authorization criteria for Xifaxan 550mg. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Hepatic Encephalopathy; OR 2) Member has a diagnosis of Irritable Bowel Syndrome with Diarrhea (IBS-D). 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.		
9136129	SHAWN R AGENBROAD-ELANDER FNP-C	Nurse Practitioner	XIGDUO XR	*ANTIDIABETICS*	E11.65	The requested amount of XIGDUO XR TAB 5-500MG is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover XIGDUO XR TAB 5-500MG at 1 tablet per day for this use. The prescribed dose is 2 tablets per day. This drug comes in a 10-500mg. The same dose can be reached by taking one 10-500mg Xigduo XR tablet with one metformin 500mg tablet. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered. NOTE: Xigduo XR 2.5-1000mg and 5-1000mg are covered at 2 tablets per day and Xigduo XR 5-500mg and 10-500mg are covered at 1 tablet per day.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
8665110	FARHAN ALI IRSHAD MD	Ophthalmology	XIIDRA	*OPHTHALMIC AGENTS*	H16.229	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 Restasis (may be restricted to ophthalmology or optometry specialist), Artificial Tears (tried)/over-the-counter (OTC) ophthalmic lubricants (tried). 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.		
8880205	KURT WELDON ANDREASON MD	Ophthalmology	XIIDRA	*OPHTHALMIC AGENTS*	H16.143	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 Restasis (may be restricted to ophthalmology or optometry specialist) and Artificial Tears / over-the-counter (OTC) ophthalmic lubricants (tried). 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.		
9200844	NATHAN EVAN OSTERMAN OD	Optometrist	XIIDRA	*OPHTHALMIC AGENTS*	H04.123	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Restasis (restricted to ophthalmology or optometry specialist) and Artificial Tears / over-the-counter (OTC) ophthalmic lubricants (tried). Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9307881	VIVIANA CAROLINA FRAZIER MD	Family Practice	XOPENEX HFA	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	asthma	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, XOPENEX HFA was denied for these reasons: 1) VENTOLIN HFA has not been tried and failed. Quantity limits apply. Records did not show that you had side effects or had other reasons why some other drug could not be used. Since step therapy has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Step Therapy have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The patient tried and failed, or was intolerant to, the step criteria listed per the formulary for the medication requested. 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.		
8926170	ABILIO MUNOZ JR MD	Family Practice	XULTOPHY 100/3.6	*ANTIDIABETICS*	E11.65	Our prior authorization criteria for Xultophy have not been met. From the records that we have received, the following caused the denial of Xultophy. 1) Records do show current use of a long-acting (basal) insulin together with a type of diabetes drug called a glucagon-like peptide-1 (GLP-1) receptor agonist. Examples of basal insulins are Lantus, Levemir, Basaglar, Toujeo, Tresiba and others. Not all of these may be covered by your plan. Examples of GLP-1 agonists are Bydureon, Ozempic, Trulicity, Victoza, Byetta, and others. These drugs have limits on the quantity covered at a time and may not all be covered by your plan. OR 2) Records do not show you cannot get an A1c test result less than or equal to 7% after 3 months of using a good doses of a type of diabetes drug called a glucoagon-like peptide-1 (GLP-1) receptor agonist. An A1c test is a blood test to see how well blood sugar has been controlled over the past few months. A result less than 7% usually means good blood sugar control. Examples of GLP-1 agonists are Bydureon, Ozempic, Trulicity, Victoza, Byetta, and others. These drugs have limits on the quantity covered at a time and may not all be covered by your plan. OR 3) Records do not show you cannot get an A1c test result less than or equal to 7% after 3 months of using at least 30 units a day of a long-acting (basal) insulin. An A1c is a blood test to see how well blood sugar has been controlled over the past few months. A result less than 7% usually means good blood sugar control. Examples of basal insulins are Lantus, Levemir, Basaglar, Toujeo, Tresiba and others. Not all of these may be covered by your plan. 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 Xultophy have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Xultophy. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Type 2 Diabetes Mellitus. AND 2) Member must meet ONE (1) of the following: a) Member is currently using a basal insulin in combination with a glucagon-like peptide-1 (GLP-1) receptor agonist. OR b) Member is unable to achieve an A1c less than or equal to 7% after 3 months of treatment with a maximally dosed GLP-1 receptor agonist. OR c) Member is unable to achieve an A1c less than or equal to 7% after 3 months of treatment with a basal insulin greater than or equal to 30 units per day. 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.		
9673217	MONIQUE DENISE MULVANY APN	Nurse Practitioner	XYWAV	*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*	narcolepsy	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are armodafinil, modafinil, Sunosi, Wakix, and Xyrem (TRIED). Prior authorization required for all. Quantity limits may apply. Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
9746967	MONIQUE DENISE MULVANY APN	Nurse Practitioner	XYWAV	*PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.*	NARCOLEPSY	This drug is not on our list of covered drugs, also known as a 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, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are armodafinil, modafinil, Sunosi, Wakix, and Xyrem (TRIED). Please look at the formulary to see what drugs are 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 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 information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9625054	FARHAN ALI IRSHAD MD	Ophthalmology	ZIOPTAN	*OPHTHALMIC AGENTS*	H40.1131	Our prior authorization criteria for Ophthalmic Prostaglandins have not been met. From the records that we have received, the following caused the denial of Zioptan. 1) Bimatoprost (tried), latanoprost (tried) and travoprost ophthalmic solutions 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 Ophthalmic Prostaglandins have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Zioptan. The reason for denial is explained to the member above. The criteria is listed here. 1) Trials of ALL of the following were ineffective, contraindicated, or not tolerated: bimatoprost ophthalmic solution (LUMIGAN 0.01%) AND latanoprost ophthalmic solution AND travoprost ophthalmic solution (TRAVATAN Z). 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.		
9322020	ANTHONY PETE PERARDI PA	Physician Assistant	ZORVOLEX	*ANALGESICS - ANTI-INFLAMMATORY*	G89.4	This request cannot be approved because this drug has not been shown to be safe or helpful to treat chronic pain syndrome related to low back pain and neck pain. For all requests, the drug must be used for a medically accepted health issue. Zorvolex has not been approved by the United States Food and Drug Administration (FDA) to treat this health issue. Based on Mircomedex, the drug package insert, and guidance from our Pharmacy and Therapeutics Committee, this use is viewed as experimental.		
8897163	JENNIFER L GLASSHAGEL	Nurse Practitioner	ZTLIDO	*DERMATOLOGICALS*	B02.29	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 lidocaine ointment, gabapentin (tried) and amitriptyline or nortriptyline (tried). 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.		
8921179	DAVID LAWRENCE PHILLIPS MD	Urology	ZYTIGA	*ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES*	C61, C79.51, C77.5	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) A completed Food and Drug Administration (FDA) MedWatch form was not submitted with this request. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. 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 3 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 generic form of the drug has been tried and failed. 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) An FDA MedWatch form documenting efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. 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.		