Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes
9184291	CLAYTON ADAMS 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 (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.
9187077	ANDRE SHAW CHEN MD	Family Practice	BUPRENORPHINE HCL	*ANALGESICS - OPIOID*	F11.20	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 buprenorphine/naloxone (Suboxone equiv) (recent claims but no information if this medication did not work for you) and Zubsolv SL tablet. 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.
9534837	SHERRY LAMAR NEYMAN MD	Nuclear Medicine	BUTALBITAL/ASPIRIN/CAFFEI	*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. 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.
8849329	CHRISTOPHER CHANG MD	Family Practice	CLOBETASOL PROPIONATE	*DERMATOLOGICALS*	L21.9	Our prior authorization criteria for Clobetasol have not been met. From the records that we have received, the following caused the denial of Clobetasol. 1) Lower strength topical steroids such as betamethasone valerate, mometasone furoate or triamcinolone have not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Clobetasol have not been met. From the information we have received, the member does not meet number 1 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.
8859238	STACIA CHRISTINE MILES MD	Dermatology	CLOBETASOL PROPIONATE	*DERMATOLOGICALS*	L40.9	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.

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes
9590301	STEVEN LAWRENCE PARIS	Advanced Practice Nurse	DESCOVY	*ANTIVIRALS*	PReP , Z77.21 SUSPECTED CONTACT	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. 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.
9231452	MAHMOUD NABIL SOUBRA	Internal Medicine	DEXILANT	*ULCER DRUGS*	GERD	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 esomeprazole(TRIED), lansoprazole, omeprazole(TRIED), pantoprazole(TRIED) and 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.
9290209	MAHMOUD NABIL SOUBRA	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), lansoprazole/Prevacid OTC, esomeprazole, 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.
9076808	KRISHNA POKALA MD	Internal Medicine	EMGALITY	*MIGRAINE PRODUCTS*	G43.109	Our prior authorization criteria for Emgality have not been met. From the records that we have received, the following caused the denial of Emgality. 1) Records received do not show a minimum three (3) month trial from TWO (2) of the following drug classes has not been tried and failed: Anticonvulsants (such as topiramate(tried), sodium valproate, etc.) AND/OR Vasoactive agents (such as propranolol, metoprolol, etc.) AND/OR Antidepressants (such as amitriptyline, venlafaxine, etc.). Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Emgality (initial coverage) have not been met. From the information we have received, the member does not meet number 4 of our prior authorization criteria for Emgality. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the prevention of migraine; AND 2) Prescriber meets any one (1) of the following: prescriber is, or has consulted, a Neurologist, OR United Council for Neurologic Subspecialties (UCNS)-certified headache medicine specialist OR member of the American Headache Society OR member of the National Headache Foundation OR member of the International Headache Society OR has a Certificate of Added Qualification in Headache Medicine OR American Board of Headache Management Certified; AND 3) Member has four or more migraine days per month for at least the previous three months; AND 4) Member has tried and failed, is intolerant to, or is contraindicated from trying a minimum three month trial from TWO of the following drug classes: Anticonvulsants (such as topiramate, sodium valproate, etc.) AND/OR Vasoactive agents (such as propranolol, metoprolol, etc.) AND/OR Antidepressants (such as amitriptyline, venlafaxine, etc.); AND 5) Member will NOT continue to receive Botox injections for migraine. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes
9395275	PRAKASH SAMUEL EAPEN MD	Internal Medicine	FERREX 150	*HEMATOPOIETIC AGENTS*	D64.9 Anemia, 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 ferrex 150 forte capsule, folbee tablet, Multigen plaus tablet, tricon capsule, 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.
8975081	WAIS ALEMI MD	Family Practice	FREESTYLE LIBRE 14 DAY/RE	*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 MIS READER. 1) Records did not show that: (a) You have trouble feeling when your blood sugar is low, OR (b) Low blood sugar may put your safety at risk when working, OR (c) Your blood sugar is not currently controlled, OR (d) You are expected to benefit from CGM based on a professional trial, OR (e) You are pregnant. 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, that you are motivated and willing to properly use the CGM, and that your provider believes the CGM will help improve the control of your blood sugar. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 2 through 7 of our prior authorization criteria for FREESTYLE MIS READER. The reason for denial is explained to the member above. The criteria are listed here. 1) Member with Type 1 or Type 2 Diabetes using insulin; AND 2) Member meets one of the following: (a) Member has demonstrated hypoglycemia unawareness, OR (b) undetected hypoglycemia poses an occupational safety risk, OR (c) Member has suboptimal diabetes control (and is unable to test capillary glucose readings due to physical or cognitive limitation, OR has widely fluctuating glucose levels, OR fails to test with sufficient frequency), OR (d) Member is expected to benefit from ongoing CGM use based upon a professional CGM trial, OR (e) Member is pregnant; AND 3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabetes; AND 4) Member will be instructed in use of the CGM products; AND 5) Provider has assessed the member's motivation and willingness to properly utilize CGM; AND 6) Provider believes that CGM may lead to considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia; AND 7) If above criteria are not met, rationale and/or documentation of any extenuating circumstance requiring use of CGM is provided. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
8810043	SUSAN KATHLEEN DUBOIS MD	Endocrinology, Diabetes & Metabolism	FREESTYLE LIBRE 14 DAY/SE	*MEDICAL DEVICES*	none provided	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 did not show that: (a) You have trouble feeling when your blood sugar is low, OR (b) Low blood sugar may put your safety at risk when working, OR (c) Your blood sugar is not currently controlled, OR (d) You are expected to benefit from CGM based on a professional trial, OR (e) You are pregnant. 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, that you are motivated and willing to properly use the CGM, and that your provider believes the CGM will help improve the control of your blood sugar. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 2, 3, 4, 5, 6 and 7 of our prior authorization criteria for Freestyle Libre. The reason for denial is explained to the member above. The criteria are listed here. 1) Member with Type 1 or Type 2 Diabetes using insulin; AND 2) Member meets one of the following: (a) Member has demonstrated hypoglycemia unawareness, OR (b) undetected hypoglycemia poses an occupational safety risk, OR (c) Member has suboptimal diabetes control (and is unable to test capillary glucose readings due to physical or cognitive limitation, OR has widely fluctuating glucose levels, OR fails to test with sufficient frequency), OR (d) Member is expected to benefit from ongoing CGM use based upon a professional CGM trial, OR (e) Member is pregnant; AND 3) Member is under the care of a certified diabetic educator (CDE) and/or provider with expertise in diabetes; AND 4) Member will be instructed in use of the CGM products; AND 5) Provider has assessed the member's motivation and willingness to properly utilize CGM; AND 6) Provider believes that CGM may lead to considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia; AND 7) If above criteria are not met, rationale and/or documentation of any extenuating circumstance requiring use of CGM is provided. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
9027751	CLAUDIA MARGARITA MOLINA-BATLLE MD	Family Practice	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 did not show you have experienced significant improvement in blood sugar control with CGM or that episodes of low blood sugar have been reduced. 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 of our prior authorization criteria for Freestyle Libre. The reason for denial is explained to the member above. The criteria are listed here. 1) Member meets one of the following: (a) Member continues to demonstrate hypoglycemia unawareness, OR (b) Undetected hypoglycemia continues to pose an occupational safety risk, OR (c) Member would be expected to have suboptimal diabetes control without CGM use (and is unable to test capillary glucose readings due to physical or cognitive limitation, OR has widely fluctuating glucose levels, OR is unlikely to test with sufficient frequency), OR (d) Member has experienced considerable benefit from CGM use and would be expected to continue to benefit from ongoing use; AND 2) Member has experienced considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia. 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
9298213	JESSLYN JIAEN LU MD	Endocrinology, Diabetes & Metabolism	FREESTYLE LIBRE 14 DAY/SE	*MEDICAL DEVICES*	E11.65 Type 2 diabetes mellitus with hyperglycemia	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 Sensor: 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, and 6 of our prior authorization criteria for Freestyle Sensor (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 quantity limits may apply to covered drugs.
9702482	SUSAN KATHLEEN DUBOIS MD	Endocrinology, Diabetes & Metabolism	FREESTYLE LIBRE 14 DAY/SE	*MEDICAL DEVICES*	none provided	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, 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 quantity limits may apply to covered drugs.
8782444	JOHN FRANCISCO VILLACIS MD	Allergy & Immunology	GAMMAGARD LIQUID	*PASSIVE IMMUNIZING AGENTS*	D83.9	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.
9042208	ROBERT J FOX JR MD	Dermatology	HUMIRA PEN	*ANALGESICS - ANTI-INFLAMMATORY*	L40.0 - Psoriasis vulgaris	Our prior authorization criteria for Humira have not been met. From the records that we have received, the following caused the denial of Humira. 1) Documentation of improvement within the past year has not been received. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Humira have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Humira. The reason for denial is explained to the member above. The criteria are listed here. 1) Must be prescribed by a Dermatologist; AND 2) Member must have demonstrated significant improvement in psoriatic condition; AND 3) Documentation (written explanation accepted) of improvement within the past year must be submitted. Since criteria have not been met, we are unable to approve coverage for this drug at this time.
9171860	TOM RIMBERT ROARK MD	Dermatology	HUMIRA PEN	*ANALGESICS - ANTI-INFLAMMATORY*	L40.0	Our prior authorization criteria for Humira have not been met. From the records that we have received, the following caused the denial of Humira. 1) Documentation of improvement within the past year has not been received. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Humira have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Humira. The reason for denial is explained to the member above. The criteria are listed here. 1) Must be prescribed by a Dermatologist; AND 2) Member must have demonstrated significant improvement in psoriatic condition; AND 3) Documentation (written explanation accepted) of improvement within the past year must be submitted. Since criteria have not been met, we are unable to approve coverage for this drug at this time.
9211286	TOM RIMBERT ROARK MD	Dermatology	HUMIRA PEN	*ANALGESICS - ANTI-INFLAMMATORY*	L40.0	Our prior authorization criteria for Humira have not been met. From the records that we have received, the following caused the denial of Humira. 1) Documentation of improvement within the past year has not been received. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Humira have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Humira. The reason for denial is explained to the member above. The criteria are listed here. 1) Must be prescribed by a Dermatologist; AND 2) Member must have demonstrated significant improvement in psoriatic condition; AND 3) Documentation (written explanation accepted) of improvement within the past year must be submitted. Since criteria have not been met, we are unable to approve coverage for this drug at this time.
8660321	JASVANT ADUSUMALLI MD	Maternal & Fetal Medicine	HYDROXYPROGESTERONE CAPRO	*PROGESTINS*	O09.219	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.

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes
9494923	JEAN ANN HERTEL DPM	Podiatrist	IBUPROFEN	*ANALGESICS - ANTI-INFLAMMATORY*	G62.9	This request cannot be approved because this is a compounded product made up of bulk chemicals. Medications made with bulk chemicals are excluded from coverage as stated in your benefit summary. Please check 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.
9540012	JEAN ANN HERTEL DPM	Podiatrist	IBUPROFEN	*ANALGESICS - ANTI-INFLAMMATORY*	G62.9	This request cannot be approved because this is a compounded product made up of bulk chemicals. Medications made with bulk chemicals are excluded from coverage as stated in your benefit summary. Please check 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.
8995401	JASNEET RIAR MD	Internal Medicine	INVOKANA	*ANTIDIABETICS*	E11.8	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 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.
8935952	HARVEY BLAKE BOWERS APN	Advanced Practice Nurse	LATUDA	*ANTIPSYCHOTICS/ANTIMANIC AGENTS*	F31.9	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.
9651041	HARVEY BLAKE BOWERS APN	Advanced Practice Nurse	LATUDA	*ANTIPSYCHOTICS/ANTIMANIC AGENTS*	bipolar I disorder	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. 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.
9439768	APURVA NAVIN TRIVEDI MD	Gastroenterology	LINZESS	*GASTROINTESTINAL AGENTS - MISC.*	K94.19, Obstructure of the stomach, Chronic Idiopathic Constipation (CIC)	Our prior authorization criteria for Linzess have not been met. From the records that we have received, the following caused the denial of Linzess. 1) Records did not show that you have tried and failed a one (1) month trial (minimum) of one of the following Over-the-Counter (OTC) types of medications: stimulants (bisacodyl, sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). 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 Linzess have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Linzess. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of an adult with ONE (1) of the following: Chronic Idiopathic Constipation (CIC) OR Irritable Bowel Syndrome with Constipation (IBS-C); AND 2) A one-month trial (minimum) of ONE (1) of the following was ineffective, contraindicated, or not tolerated: stimulants (bisacodyl, sennosides); PEG 3350 (MIRALAX, GLYCOLAX); OR bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). 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.
9654064	CHRISTA ELIZABETH SELIGMAN	Advanced Practice Nurse	MELATONIN	*ALTERNATIVE MEDICINES*	tremendous headache - extreme headache	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) We did not receive records from your doctor showing what health issue this drug is being used to treat. We tried to reach your doctor for those records. We did not get a reply. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are zolpidem, zaleplon, trazodone, eszopiclone, and others. Quantity limits may apply. 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(s) 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.
8675539	JONATHAN ALAN LEE MD	Family Practice	MODAFINIL	*ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS*	R41.840 Attention and concentration deficit	Our prior authorization criteria for modafinil have not been met. From the records that we have received, the following caused the denial of modafinil. 1) The drug is not being used for Narcolepsy or Idiopathic Hypersomnolence. Both of these conditions involve too much daytime sleepiness. 2) The drug is not being used for Obstructive Sleep Apnea / Hypopnea Syndrome. This involves shallow breathing or pauses in breathing during sleep. 3) The drug is not being used for Shift Work Sleep Disorder. This is the result of a work schedule that overlaps the normal sleep period. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for modafinil have not been met. From the information we have received, the member does not meet number 1, 2, or 3 of our prior authorization criteria for modafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Narcolepsy or idiopathic hypersomnolence when full nocturnal polysomnogram and a multiple sleep latency test shows mean onset to sleep less than 10 minutes, OR 2) Obstructive sleep apnea / hypopnea syndrome on positive airway pressure (CPAP) therapy, OR 3) Shift work sleep disorder. Since criteria have not been met, we are unable to approve coverage for this drug at this time.

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes
9403771	KRISHNA POKALA MD	Internal Medicine	NURTEC	*MIGRAINE PRODUCTS*	G44.009	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, 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.
9753896	KRISHNA POKALA MD	Internal Medicine	NURTEC	*MIGRAINE PRODUCTS*	G43.709	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, or others) when taken WITH a nonsteroidal anti-inflammatory drug (NSAID) (e.g. ibuprofen, naproxen, or others). Quantity limits may apply. 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 rimegepant (NURTEC) 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.
8956897	KYMBERLI KAY MCCLAIN FNP	Nurse Practitioner	ONETOUCH VERIO TEST STRIP	*DIAGNOSTIC PRODUCTS*	none provided	This product is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered product can be approved. The conditions in this policy have not been met. From the records that we have received, the following caused the denial. 1) All formulary products used for your condition have not been tried and failed. Other products that can be used are Accu-chek meters and supplies. Please look at the formulary for a list of covered products. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this product is not on formulary. An exception to allow coverage of a non-formulary product may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The product is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered products cannot be tried. 3) Records have been received showing the requested product is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered products are likely to be ineffective or unsafe for the member. 4) Prescription samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this product at this time. Please refer to the formulary for specific information on what is covered.
9587313	MAHAN OSTADIAN DO	Anesthesiology	PENNSAID	*DERMATOLOGICALS*	M25.569	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 diclofenac 1% gel (Voltaren equivalent), diclofenac 1.5% solution (Pennsaid equivalent), and 4 oral nonsteroidal anti-inflammatory drugs (NSAIDs) (eg. ibuprofen(tried), diclofenac(tried), meloxicam(tried), etodolac, naproxen(tried), celecoxib(tried), nabumetone). 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.
9143660	SHANTI NULU MD	Internal Medicine	REPATHA	*ANTIHYPERLIPIDEMICS*	I25.5	Based on the information we have received, you do not meet number 4 of our prior authorization criteria because a current LDL level was not provided with this request. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Repatha for Primary Hyperlipidemia-Clinical Atherosclerotic Cardiovascular Disease (ASCVD), this drug is covered for members who meet the following criteria: 1) Member has ASCVD defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin, AND 2) Member is unable to meet low-density lipoprotein (LDL) goal, AND 3) Member has failed an 8-week trial of high-intensity statin (atorvastatin 40 mg per day or greater or rosuvastatin 20mg per day or greater), AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on high-intensity statin therapy (or member is taking statin in combination with ezetimibe and LDL level remains greater than or equal to 70 mg/dL). Since criteria have not been met, we are unable to approve coverage for this drug at this time.
8747246	BOONE WILDER GOODGAME MD	Oncology, Medical	RYDAPT	*ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES*	AML	The requested quantity of RYDAPT 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 RYDAPT at 56 capsules every 28 days for this use. The higher quantity of 112 capsules every 28 days 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 medical studies and/or treatment guidelines showing the higher dose is safe and helpful for this health issue, list of all other drugs that have been failed, and reasons why other drugs cannot be used. Please look at our formulary for a list of covered drugs and any limits for coverage of those drugs.
9510884	JENNIFER RENEE MANUEL	Physician Assistant	SILDENAFIL CITRATE	*CARDIOVASCULAR AGENTS - MISC.*	N52.9	This request cannot be approved because this drug is being used for erectile dysfunction. 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.

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes
8945302	LYNDA LEA MUELLER MD	Family Practice	SPIRIVA HANDIHALER	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	E78.2	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.
9041882	KIRTI VINAYAK MANJREKAR MD	Internal Medicine	SPIRIVA HANDIHALER	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J44.9 COPD	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.
8880602	BILAL NAWAZ KHAN MD	Internal Medicine	SPIRIVA RESPIMAT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	DYSPNEA, SHORTNESS OF BREATH, R06.02 , C78.01, HISTORY OF LUNG CANCER , POSSIBLE COPD	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.
9634039	RABIN KHERADPOUR MD	Internal Medicine	SPIRIVA RESPIMAT	*ANTIASTHMATIC AND BRONCHODILATOR AGENTS*	J44.9 Chronic obstructive pulmonary disease, unspecified	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.
9591019	JIVANTIKA BIRUDBHAI SINDHAV MD	Family Practice	SYMBICORT	*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 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.
8999589	ANNA KEJR DVORAK MD	Internal Medicine	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	no diagnosis provided	Based on the information we have received, you do not meet number 1 of our prior authorization criteria because more information is needed to determine if you have a diagnosis of pulmonary arterial hypertension confirmed by a right heart catheterization. Based on our Pharmacy and Therapeutics Committee prior authorization criteria for Pulmonary Arterial Hypertension (PAH) Agents, including TADALAFIL TABLET 20MG, this drug is covered for members who meet the following criteria: 1) Diagnosis of pulmonary arterial hypertension confirmed by a right heart catheterization AND 2) Prescriber is a Cardiologist or Pulmonologist. Since criteria have not been met, we are unable to approve coverage for this drug at this time.

Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Prescriber Decision Notes
9139434	JOSEPH HESSE MD	Family Practice	TADALAFIL	*CARDIOVASCULAR AGENTS - MISC.*	N52.9	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 alpha blockers, has not been tried and failed for a minimum of 30 days. 3) A medication, in a class of drugs called androgen hormone inhibitors, has not been tried and failed for a minimum of 90 days. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for tadalafil (Cialis) have not been met. From the information we have received, the member does not meet numbers 2, 3 and 4 of our prior authorization criteria for tadalafil (Cialis). The reason for denial is explained to the member above. The criteria are listed here. 1) Member must have a diagnosis of Benign Prostatic Hyperplasia (BPH); AND 2) Must be prescribed by, or in consultation with, a Urologist; AND 3) An alpha blocker (alfuzosin, doxazosin, tamsulosin, terazosin, prazosin, etc.) must be tried and failed for at least 30 days; AND 4) An androgen hormone inhibitor (dutasteride, finasteride) must be tried and failed for at least 90 days. Since criteria have not been met, we are unable to approve coverage for this drug at this time.
9597898	ANJALI SHASHANK NEMAWARKAR MD	Internal Medicine	VENLAFAXINE HYDROCHLORIDE	*ANTIDEPRESSANTS*	N95.1 MENOPAUSE	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 venlafaxine ER capsules (We show a paid claim on 10/27/20. More information is needed to show this drug did not work for you.), desvenlafaxine ER tablets (Pristiq equivalent), paroxetine, citalopram, estradiol tablets, estradiol patches, Premphase/Prempro tablets, 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.
8801182	JOHN DAVID ODETTE MD	Ophthalmology	XIIDRA	*OPHTHALMIC AGENTS*	H04.123	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.
9504806	DAVID LAWRENCE PHILLIPS MD	Urology	ZYTIGA	*ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES*	C61, C77.2, C77.5	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 abiraterone tab 250mg (ZYTIGA equivalent). 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

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

Denials Overturned on internal appeal	Denials overturned by an independet review organization

Denials Overturned on internal appeal	Denials overturned by an independet review organization

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Denials Overturned on internal appeal	Denials overturned by an independet review organization

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Denials Overturned on internal appeal	Denials overturned by an independet review organization

Denials Overturned on internal appeal	Denials overturned by an independet review organization

Denials Overturned on internal appeal	Denials overturned by an independet review organization