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
9718115	APURVA NAVIN TRIVEDI MD	Gastroenterology	BUDESONIDE ER	CORTICOSTEROIDS	K51.913	Our prior authorization criteria for budesonide (Uceris equivalent) have not been met. From the records that we have received, the following caused the denial of budesonide. 1) Mesalamine 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 budesonide (Uceris equivalent) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for budesonide. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has tried and failed or was intolerant to mesalamine; AND 2) Budesonide tablets are requested for a member with active mild to moderate ulcerative colitis; OR 3) Budesonide rectal foam is requested for a member with active mild to moderate distal ulcerative colitis extending up to 40 cm from the anal verge. 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.		
9759084	COURTNEY ADAM SHEINBEIN MD	Radiation Oncology	DRONABINOL	ANTIEMETICS	C81.10	Our prior authorization criteria for dronabinol (MARINOL) have not been met. From the records that we have received, the following caused the denial of dronabinol. 1) The drug is not being used to treat nausea and vomiting associated with cancer chemotherapy. More information about your current chemotherapy treatment is needed. 2) More information is needed to know if you have tried and failed other drugs for nausea and vomiting from cancer chemotherapy. Information about other drugs you have tried 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. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dronabinol (MARINOL) have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for dronabinol. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of anorexia associated with weight loss in patients with acquired immune deficiency syndrome (AIDS); OR 2) Prescribed for nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments. Please provide the therapy tried and the doses and dates. 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.		
9769952	KATHLEEN LESLIE KRAFT	Nurse Practitioner	DESCOVY	ANTIVIRALS	Exposure to HIV	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. 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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9776721	PRATIMA VIJAY KUMAR MD	Internal Medicine	FREESTYLE LIBRE 14 DAY/SE	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 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 and 6 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.		
9777922	MINYING GU 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 1.62% was denied for these reasons: 1) 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. (The lab received was an afternoon lab and no reference range was provided). 2) A lab value from within the last 12 months was not sent to us. 3) 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) 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.		
9782792	CRAIG HEWELL COUCH MD	Neurology	UBRELVY	MIGRAINE PRODUCTS	G43.709	Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrelvy 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 ubrogepant (UBRELVY) 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.		

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9795993	KEVIN WAYNE LEWIS DO	Family Practice	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ed	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 . 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. 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 numbers 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.		
9803431	MINYING GU 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) 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. 2) A lab value from within the last 12 months was not sent to us. 3) 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) 3, 4, 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.		
9821252	CRAIG HEWELL COUCH MD	Neurology	UBRELVY	MIGRAINE PRODUCTS	G43.709	Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrelvy 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. 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 ubrogepant (UBRELVY) have not been met. From the information we have received, the member does not meet number(s) 1 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.		
9824039	KEVIN WAYNE LEWIS DO	Family Practice	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	PAH	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. 1) The drug was not prescribed by, or together with, a heart or lung specialist. 2) 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.		

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9851522	MICHAEL SCOTT GRAD MD	Cardiology, Interventional	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	E78.5 - Hyperlipidemia, unspecified	Our prior authorization criteria for Repatha have not been met. From the records that we have received, Repatha was denied for these reasons: 1) Records did not show your Low-Density Lipoprotein (LDL) level has been lowered by at least 10% while taking Repatha. 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 Repatha have not been met. From the information we have received, the member does not meet 1 of our prior authorization criteria for Repatha (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Greater than or equal to 10% reduction in low-density lipoprotein (LDL) occurred as a result of Repatha treatment. 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.		
9859524	ALANNA CHERIE ALLEN PA	Physician Assistant	DESCOVY	ANTIVIRALS	unknown	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) This drug is not being used to treat human immunodeficiency virus (HIV) infection. 2) This drug is not being used to block infection if you are exposed to human immunodeficiency virus (HIV) and do not have HIV infection. This is called pre-exposure prophylaxis, or PrEP. 3) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 4) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 5) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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 1, 2, 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.		
9864312	DAVID PHILIP WRIGHT MD	Family Practice	DESCOVY	ANTIVIRALS	Z77.21	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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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9870352	ALANNA CHERIE ALLEN PA	Physician Assistant	DESCOVY	ANTIVIRALS	Z72.82	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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.		
9872623	KATHLEEN DAILEY HOLMES	Nurse Practitioner	DESCOVY	ANTIVIRALS	Z77.21	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada (emtricitabine/tenofovir disoproxil fumarate). 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada (emtricitabine/tenofovir disoproxil fumarate. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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.		
9874419	HANS MICHAEL SANDER MD	Dermatology	HUMIRA PEN-PS/UV STARTER	TARGETED IMMUNOMODULATORS	L40.0	Our prior authorization criteria for adalimumab (HUMIRA) have not been met. From the records that we have received, Humira was denied for these reasons: 1) Records did not show that your health issue is causing significant functional disability for you. More information is needed to show how your health issue is impacting you. 2) Chart notes about your health condition were not sent to us. More information is needed. Since the criteria have 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 adalimumab (HUMIRA) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Humira for Plaque Psoriasis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Moderate to severe plaque psoriasis (PP) (greater than or equal to 10% body surface involved) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND 3) Indicate ONE (1) of the following (documentation is required to be submitted for an approval): (A) A trial of a minimum of 15 sessions of phototherapy that was ineffective or not tolerated; OR (B) Member has contraindication to phototherapy, AND contraindication is specified; AND 4) A trial of ONE (1) of the following was ineffective or not tolerated (documentation is required to be submitted for an approval): (A) methotrexate (minimum dose of 15 mg/week); OR (B) soriatane; OR (C) Member has contraindication to BOTH, AND contraindication is specified. 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
9877239	CYNTHIA LYNN BENTON MD	Psychiatry	LATUDA	ANTIPSYCHOTICS/ ANTIMANIC AGENTS	unknown	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.		
9879568	KATHLEEN LESLIE KRAFT	Nurse Practitioner	SOLIQUA 100/33	ANTIDIABETICS	E11.65	Our prior authorization criteria for insulin glargine/lixisenatide (SOLIQUA) have not been met. From the records that we have received, Soliqua was denied for these reasons: 1) Records do not 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. 2) Records do not show you cannot get an A1c test result less than or equal to 7 after 3 months of using an appropriate dose 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. 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 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 insulin glargine/lixisenatide (SOLIQUA) have not been met. From the information we have received, the member does not meet number(s) 2 of our prior authorization criteria for Soliqua. 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 meets 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 a glycated hemoglobin (A1c) less than or equal to 7.0 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 7.0 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.		
9911536	MINYING GU MD	Family Practice	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	ed	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 20 mg. 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.		

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9919408	TITILOPE AFUSAT LAWAL	Advanced Practice Nurse	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.		
9929024	IAN STEVEN ALWARD MD	Family Practice	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.		
9971832	MORGAN JANELLE MCCARTY DO	Dermatology	STELARA	TARGETED IMMUNOMODULATORS	L40.9	Our prior authorization criteria for ustekinumab (STELARA) have not been met. From the records that we have received, Stelara was denied for these reasons: 1) Chart notes were not sent to us to show your response to this drug. Since the criteria have 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 ustekinumab (STELARA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Stelara for Plaque Psoriasis (Continuing Therapy). 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 submitted with this request (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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9972053	IAN STEVEN ALWARD MD	Family Practice	MODAFINIL	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	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) 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. 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, 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.		
10009370	EDWARD JOSEPH FOX MD	Neurology	MODAFINIL	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	R53.83 Other fatigue, MS	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.		
10014755	ANABEL GRAY WINIECKI NP	Advanced Practice Nurse	LATUDA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	unknown	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.		
10032337	REBECCA ANN COX	Nurse Practitioner	DRONABINOL	ANTIEMETICS	R64	Our prior authorization criteria for dronabinol (MARINOL) have not been met. From the records that we have received, the following caused the denial of dronabinol. 1) The drug is not being used to treat anorexia associated with weight loss due to acquired immune deficiency syndrome (AIDS); OR 2) The drug is not being used to treat nausea and vomiting associated with cancer chemotherapy, and more information is needed to know if you have tried and failed other drugs for nausea and vomiting from cancer chemotherapy. Information about other drugs you have tried 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. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for dronabinol (MARINOL) have not been met. From the information we have received, the member does not meet number 1 or 2 and 3 of our prior authorization criteria for dronabinol. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of anorexia associated with weight loss in patients with acquired immune deficiency syndrome (AIDS); OR 2) Prescribed for nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments. Please provide the therapy tried and the doses and dates. 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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10041368	MEGAN LYN MCCOIN MD	Obstetrics & Gynecology	ORILISSA	ENDOCRINE AND METABOLIC AGENTS - MISC.	N80.9, ENDOMETRIOSIS	Our prior authorization criteria for Orilissa have not been met. From the records that we have received, Orilissa was denied for these reasons: 1) A non-steroidal anti-inflammatory drug (NSAID; e.g. ibuprofen, naproxen, meloxicam, and others) has not been tried and failed. Quantity limits may apply. 2) A hormonal contraceptive has not been tried and failed. 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 Orilissa have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Orilissa. 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: Endometriosis OR Cyclic pelvic pain suspected to be related to endometriosis; AND 2) Prescribed by, or in consultation with, an OB/GYN or other women's health/reproductive specialist; AND 3) Member does NOT have known osteoporosis; AND 4) Trials of BOTH of the following classes of medications were ineffective, contraindicated, or not tolerated: (A) Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), AND (B) a hormonal contraceptive. 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.		
10052533	APURVA NAVIN TRIVEDI MD	Gastroenterology	HUMIRA PEN	TARGETED IMMUNOMODULATORS	Ulcerative Colitis	Our prior authorization criteria for adalimumab (HUMIRA) have not been met. From the records that we have received, Humira was denied for these reasons: 1) Chart notes were not sent to us to show your response to this drug. Since the criteria have 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 adalimumab (HUMIRA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Humira for Ulcerative Colitis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Gastroenterology Specialist; AND 2) Member has demonstrated a significant improvement in their condition; AND 3) Documented (written explanation accepted) improvement within the past year submitted with this request (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.		
10058074	JENNIFER ELIZABETH ZUCCARELLI	Family Practice	NURTEC	MIGRAINE PRODUCTS	G43.909	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.		
10061384	SHWOL-HUO DANNY KIANG DO	Dermatology	TALTZ	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Our prior authorization criteria for ixekizumab (TALTZ) have not been met. From the records that we have received, Taltz was denied for these reasons: 1) Records did not show that this drug is working well for you. 2) Chart notes were not sent to us to show your response to this drug. Since the criteria have 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 ixekizumab (TALTZ) 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 Taltz for 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. 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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10073976	SRIDHAR PATLOLLA REDDY MD	Internal Medicine	LEDIPASVIR/SOFOSBUVIR	ANTIVIRALS	B18.2	Our prior authorization criteria for ledipasvir/sofosbuvir (HARVONI equivalent) have not been met. From the records that we have received, ledipasvir/sofosbuvir was denied for these reasons: 1) Records show Hepatitis C viral level is 6 million units per milliliter or greater. 2) Records show cirrhosis. Cirrhosis is severe liver damage. 3) Records do not show your Human Immunodeficiency Virus (HIV) status. This determines length of treatment and the best drug to use. 4) Greater than 8 weeks of treatment with Harvoni is being requested. This plan only covers Harvoni for members who have not been treated for Hepatitis C before, who do not have severe liver damage (cirrhosis), and who have low Hepatitis C viral levels (less than 6 million units per milliliter). Since the criteria 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 ledipasvir/sofosbuvir (HARVONI equivalent) have not been met. From the information we have received, the member does not meet number(s) 3, 4, 6, and 7 of our prior authorization criteria for ledipasvir/sofosbuvir. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 2) Diagnosis of Hepatitis C viral infection (HCV) genotype 1; AND 3) Current viral level (HCV-RNA titer and date) has been provided and must be from within the past 3 months and less than 6 million IU/mL (documentation is required for an approval); AND 4) Member does NOT have cirrhosis; AND 5) Member is treatment naïve; AND 6) Member is human immunodeficiency viruses (HIV)-uninfected; AND 7) Duration of therapy will be 8 weeks. Other products are covered with prior authorization for members for whom 8 weeks of treatment with Harvoni is not appropriate. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
10076391	DAVID DAVENPORT SWETT JR MD	Cardiology	PRALUENT	ANTIHYPERLIPIDEMICS	E78.00	Our prior authorization criteria for Praluent have not been met. From the records that we have received, Praluent was denied for these reasons: 1) Records did not show that you have a health issue called Clinical Atherosclerotic Cardiovascular Disease (ASCVD). ASCVD is a health issue where cholesterol build-up impacts blood flow from the heart. Records must be sent in showing you meet one of these: (a) acute coronary syndromes (ACS), (b) previous heart attack, (c) ongoing chest pain (angina), (d) previous coronary or other arterial revascularization, (e) previous stroke or transient ischemic attack (TIA), OR (f) peripheral arterial disease of atherosclerotic origin. 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 Praluent have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Praluent for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) in a member who is unable to tolerate statins. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has Clinical Atherosclerotic Cardiovascular Disease (ASCVD) defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin; AND 2) Member is unable to tolerate statin therapy; AND 3) Member has failed at least TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin); AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on maximally tolerated statin therapy OR member is taking a 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. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
10112751	GRACE LORENA HONLES 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 1.62% was denied for these reasons: 1) 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. 2) A lab value from within the last 12 months was not sent to us. 3)) 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) 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.		

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
10123627	STEVEN ALAN TAYLOR JR	Endocrinology, Diabetes & Metabolism	DEXCOM G6 SENSOR	MEDICAL DEVICES	E10.65 - Type 1 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 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 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 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 quantity limits may apply to covered drugs.		
10141842	MICHAEL JAMES SAMAAN MD	Family Practice	DESCOVY	ANTIVIRALS	Z72.52	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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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10147976	JUSTIN ALLEN MEUSE MD	Neurology	EMGALITY	MIGRAINE PRODUCTS	g43.719	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. 2) Records did not show that this drug was previously approved by your prescription drug plan. 3) 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) 3 and 4 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.		
10148063	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.		
10156285	MARCUS JOHN WAUSON PA-C	Physician Assistant	UBRELVY	MIGRAINE PRODUCTS	G43.909 - Migraine, unspecified, not intractable, without status migrainosus	Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrelvy 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. 2) Two triptan medications (e.g. sumatriptan(tried), 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 ubrogepant (UBRELVY) 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.		

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
10156609	IAN STEVEN ALWARD MD	Family Practice	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. 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.		
10159206	IAN STEVEN ALWARD MD	Family Practice	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) 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.		
10166510	RAJESH MOOLJIBHAI MEHTA MD	Gastroenterology	HUMIRA PEN	TARGETED IMMUNOMODULATORS	K51.80	Our prior authorization criteria for adalimumab (HUMIRA) have not been met. From the records that we have received, Humira was denied for these reasons: 1) Chart notes were not sent to us to show your response to this drug. Since the criteria have 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 adalimumab (HUMIRA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Humira for Ulcerative Colitis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Gastroenterology Specialist; AND 2) Member has demonstrated a significant improvement in their condition; AND 3) Documented (written explanation accepted) improvement within the past year submitted with this request (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.		

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
10172449	PATRICIA MARTENS COLE MD	Family Practice	ITRACONAZOLE	ANTIFUNGALS	Z77.120	Our prior authorization criteria for itraconazole (SPORANOX) have not been met. From the records that we have received, Itraconazole was denied for these reasons: 1) More information is needed to know if this drug is being used to treat a systemic fungal infection, a nail fungus, or a fungal infection on the skin. 2) The drug was not prescribed by an appropriate specialist for your condition. 3) Topical antifungals have not been tried and failed. 4) Oral terbinafine has not been tried and failed. 5) Records did not show that your diagnosis has been confirmed by a positive stain or culture test. 6) More information is needed to know if you have diabetes, a blood disease called peripheral vascular compromise, a weakened immune system, a widespread fungal infection of the skin, a fingernail infection, OR a painful toenail infection. 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 itraconazole (SPORANOX) 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 Itraconazole. The reason for denial is explained to the member above. The criteria are listed here. 1) The drug is being used to treat a Systemic Fungal infection; AND the drug is prescribed by, or in consultation with, an Infectious Disease Specialist or Pulmonologist; OR 2) The drug is being used to treat Onychomycosis; AND meets all of the following: (A) Prescribed by Dermatologist or Podiatrist; (B) Member experienced a failure, intolerance, or contraindication to oral terbinafine (LAMISIL); (C) Diagnosis confirmed by positive potassium hydroxide (KOH) or periodic acid-Schiff (PAS) stain or fungal culture; AND (D) Member meets at least one (1) of the following characteristics: (i) diagnosed as diabetic; (ii) has significant peripheral vascular compromise; (iii) is immunocompromised; (iv) has systemic dermatosis with impaired skin integrity; (v) has a fingernail infection; OR (vi) has significant pain due to infected toenail(s); OR 3) The drug is being used to treat a Dermatologic Fungal Infection; AND meets all of the following: (A) Prescribed by Dermatologist or Podiatrist; (B) Member had no response to topical antifungals; (C) Diagnosis confirmed by positive potassium hydroxide (KOH) or periodic acid-Schiff (PAS) stain or fungal culture; AND (D) Member meets at least one (1) of the following characteristics: (i) diagnosed as diabetic; (ii) has significant peripheral vascular compromise; (iii) is immunocompromised; (iv) has systemic dermatosis with impaired skin integrity; (v) has a fingernail infection; OR (vi) has significant pain due to infected toenail(s). 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.		
10176344	JOSEPH KHALIL IMSAIS MD	Cardiology	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	I25.110	Our prior authorization criteria for Repatha have not been met. From the records that we have received, Repatha was denied for these reasons: 1) Records did not show that your body cannot handle other cholesterol drugs called statins. 2) More information is needed about what statin drugs you have tried in the past. 3) Records did not show that you have tried and failed a low-intensity statin (e.g. pravastatin) or an alternatively-dosed statin (e.g. twice weekly low-dose rosuvastatin or atorvastatin). Quantity limits may apply. 5) Records were not sent to us that show your low density lipoprotein (LDL) level did not go below 95mg/dL while taking the highest dose of cholesterol-lowering drugs you could handle. 4) Records were not sent to us that show your low density lipoprotein (LDL) level did not go below 70mg/dL while taking ezetimibe (Zetia equivalent) with the highest dose of cholesterol-lowering drugs you could handle. 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 Repatha have not been met. From the information we have received, the member does not meet number(s) 2, 3, and 4 of our prior authorization criteria for Repatha for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) in a member who is unable to tolerate statins. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has Clinical Atherosclerotic Cardiovascular Disease (ASCVD) defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin; AND 2) Member is unable to tolerate statin therapy; AND 3) Member has failed at least TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin); AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on maximally tolerated statin therapy OR member is taking a 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. 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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10198117	STEVEN LAWRENCE PARIS	Advanced Practice Nurse	DESCOVY	ANTIVIRALS	Z77.21	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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.		
10207604	PRAKASH SAMUEL EAPEN MD	Internal Medicine	HYDROCODONE BITARTRATE/AC	ANALGESICS - OPIOID	M54.16	We have received a request for 90 tablets for a 30 day supply for Hydrocodone-Acetaminophen. This amount is more than the amount covered for members who are new to using an opioid pain reliever. Our Pharmacy and Therapeutics (P&T) committee, which is a group of doctors and pharmacists, selects which drugs have dispensing limits. We will only cover up to a 7 days for the FIRST fill of an opioid pain reliever such as the drug requested. For future fills, a longer day supply may be dispensed if our records show recent use of an opioid drug. For members who do not show recent use of an opioid pain reliever, more than a 7 day supply for this first fill can be approved if records are sent in showing one of these: 1) Records show that you have recent use of an opioid pain reliever; OR 2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered.		
10227691	JOSEPH KHALIL IMSAIS MD	Cardiology	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	cholesterol	Our prior authorization criteria for Repatha have not been met. From the records that we have received, Repatha was denied for these reasons: 1) Records did not show that you have a health issue called Clinical Atherosclerotic Cardiovascular Disease (ASCVD). ASCVD is a health issue where cholesterol build-up impacts blood flow from the heart. Records must be sent in showing you meet one of these: (a) acute coronary syndromes (ACS), (b) previous heart attack, (c) ongoing chest pain (angina), (d) previous coronary or other arterial revascularization, (e) previous stroke or transient ischemic attack (TIA), OR (f) peripheral arterial disease of atherosclerotic origin. 2) Records did not show that your body cannot handle other cholesterol drugs called statins or zetia. 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 Repatha have not been met. From the information we have received, the member does not meet number(s) 1 and 2 of our prior authorization criteria for Repatha for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) in a member who is unable to tolerate statins. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has Clinical Atherosclerotic Cardiovascular Disease (ASCVD) defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin; AND 2) Member is unable to tolerate statin therapy; AND 3) Member has failed at least TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin); AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on maximally tolerated statin therapy OR member is taking a 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. 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
10231208	MANUEL JOSEPH MARTIN MD	Family Practice	FREESTYLE LIBRE 14 DAY/RE	MEDICAL DEVICES	DM	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 you are under the care of a Diabetes care expert. 2) Records do not show that you have been shown how to use the Continuous Glucose Monitor (CGM) and that you are driven and willing to use the CGM the right way. 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 3 and 4 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.		
10245258	IAN STEVEN ALWARD MD	Family Practice	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. 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.		
10245359	KEVIN WAYNE LEWIS DO	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 1.62% was denied for these reasons: 1) 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. 2) 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) 3, 4, 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.		

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10247989	ADRIANA GUERRA GUERRA	Family Practice	ANDROGEL	ANDROGENS-ANABOLIC	hypogonadism, e29	Our prior authorization criteria for Androgens: Testosterone Products have not been met. From the records that we have received, Androgel 1% (50mg) was denied for these reasons: 1) 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. 2) 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) 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.		
10257732	ROBERT RYAN ENLOE DO	General Practice	TRINTELLIX	ANTIDEPRESSANTS	F41.8	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) One serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressant, such as duloxetine or venlafaxine, has not been tried and failed. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 1 and 3 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) 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.		
10260726	IAN STEVEN ALWARD MD	Family Practice	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 Multiple Sleep Latency (MSLT) was not sent to us. This may also be called a daytime nap study. This test should show that the average amount of time needed for you to fall asleep was less than 10 minutes. Since the criteria have 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, 3, or 4 of our prior authorization criteria for Modafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of narcolepsy; AND 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 show mean onset to sleep of less than 10 minutes; OR 2) Member has a diagnosis of obstructive sleep apnea / hypopnea syndrome; AND member is on positive airway pressure; OR 3) Member has a diagnosis of shift work disorder; OR 4) Member has a diagnosis of multiple sclerosis-related fatigue. 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.		
10282979	MICHAEL JAMES SAMAAN MD	Family Practice	DESCOVY	ANTIVIRALS	Z79.889	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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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10301839	JUDITH JOSEPH CHEDVILLE	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 Kit. 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. 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 Kit (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.		
10304339	IVAN ROBERT NEPUSTIL MD	Internal Medicine	NURTEC	MIGRAINE PRODUCTS	G43.909	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, 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.		
10323740	ALINDA ROBERTA COX MD	Obstetrics & Gynecology	SOLOSEC	AMEBICIDES	N76.0	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) 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. 2) Records do not show that you have had three (3) or more episodes of this health issue in the past year. 3) Two (2) of these drugs have been tried and failed: metronidazole (tried), 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, 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.		

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10324000	ALANNA CHERIE ALLEN PA	Physician Assistant	DESCOVY	ANTIVIRALS	PrEP	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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.		
10324652	IVAN ROBERT NEPUSTIL MD	Internal Medicine	NURTEC	MIGRAINE PRODUCTS	G43.909	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, 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.		
10325919	RANI DAS MD	Internal Medicine	EMGALITY	MIGRAINE PRODUCTS	G43.711	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.). 2) 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 Emgality 120mg have not been met. From the information we have received, the member does not meet number(s) 4 and 5 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 quantity limits may apply to covered drugs.		

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10340316	AMBER CHANEL ARMSTRONG	Advanced Practice Nurse	MOTEGRITY	GASTROINTESTINAL AGENTS - MISC.	K59.04	Our prior authorization criteria for Motegrity have not been met. From the records that we have received, the following caused the denial of Motegrity. 1) 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. 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 Motegrity have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Motegrity. 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; AND 2) A trial of Trulance was ineffective, contraindicated, or not tolerated; AND 3) Member is NOT currently using opioids. 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.		
10350623	STACIA CHRISTINE MILES MD	Dermatology	HUMIRA PEN	TARGETED IMMUNOMODULATORS	L40.9 - Psoriasis, unspecified	Our prior authorization criteria for adalimumab (HUMIRA) have not been met. From the records that we have received, Humira was denied for these reasons: 1) Records did not show that this drug is working well for you. 2) Chart notes were not sent to us to show your response to this drug. Since the criteria have 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 adalimumab (HUMIRA) 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 Humira for Plaque Psoriasis (Continuing Therapy). 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 submitted with this request (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.		
10375730	CHRISTINA DIANE KIM PA-C	Physician Assistant	SUPREP BOWEL PREP KIT	LAXATIVES	Colonoscopy	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.		
10433303	AMY ROMINGER MASON MD	Dermatology	STELARA	TARGETED IMMUNOMODULATORS	PP, L40.0	Our prior authorization criteria for ustekinumab (STELARA) have not been met. From the records that we have received, Stelara was denied for these reasons: 1) Records did not show that this drug is working well for you. 2) Chart notes were not sent to us to show your response to this drug. Since the criteria have 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 ustekinumab (STELARA) 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 Stelara for Plaque Psoriasis (Continuing Therapy). 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 submitted with this request (documentation is required to be submitted for an approval); AND 4) If the 90mg dose is requested, member's weight is greater than (>) 100kg and is provided with the request. 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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10445375	AMY ROMINGER MASON MD	Dermatology	STELARA	TARGETED IMMUNOMODULATORS	PP, L40.0	Our prior authorization criteria for ustekinumab (STELARA) have not been met. From the records that we have received, Stelara was denied for these reasons: 1) Records did not show that this drug is working well for you. Since the criteria have 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 ustekinumab (STELARA) 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 Stelara for Plaque Psoriasis (Continuing Therapy). 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 submitted with this request (documentation is required to be submitted for an approval); AND 4) If the 90mg dose is requested, member's weight is greater than (>) 100kg and is provided with the request. 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.		
10445819	GRACE LORENA HONLES 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 1.62% was denied for these reasons: 1) One morning testosterone level has not been sent to us. 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) 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.		
10463707	MICHAEL LAWRENCE SCHINDEL MD	Internal Medicine	SPIRIVA RESPIMAT	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.		
10477556	MATTHEW ALLEN ANDERSON MD	Internal Medicine	VORICONAZOLE	ANTIFUNGALS	B44.9	Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, Voriconazole was denied for this reason: 1) The drug is not prescribed by a Infectious Disease Specialist. 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 Restricted to Specialist prior authorization criteria have not been met. From the information we have received, the member does not meet 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The provider's specialty matches the Restricted Specialty requirements 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.		
10482873	MOLLY THOMPSON CAMPA	Dermatology	TRETINOIN	DERMATOLOGICALS	melasma	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, TRETINOIN CREAM 0.1% was denied for these reasons: 1) This drug is not being used to treat skin problems such as pimples, redness, or skin thickening from sun exposure. 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 0.1%. 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.		

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
10485564	MELANIE MARIE PICKETT MD	Dermatology	OTEZLA	TARGETED IMMUNOMODULATORS	L40.0	Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) Records did not show that this drug is working well for you. 2) Chart notes were not sent to us to show your response to this drug. Since the criteria have 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 apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 2, 3 and 4 of our prior authorization criteria for Otezla for Plaque Psoriasis (Continuing Therapy). 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 submitted with this request (documentation is required to be submitted for an approval); AND 4) Apremilast (OTEZLA) will not be used in combination with biologic therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
10529091	THETSU MON MD	Psychiatry	TRINTELLIX	ANTIDEPRESSANTS	F41.1	Our prior authorization criteria for Trintellix have not been met. From the records that we have received, the following caused the denial of Trintellix. 1) The drug is not being used for Major Depressive Disorder (MDD). Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Trintellix have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Trintellix. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Major Depressive Disorder (MDD), AND 2) Patient has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs), AND 3) Patient has tried and failed, or was intolerant to, one serotonin-norepinephrine reuptake inhibitor (SNRI). Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
10532937	HEATHER HILL	Nurse Practitioner	DESCOVY	ANTIVIRALS	PrEP	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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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10558395	LAURELIN NICOLE MULLINS FNP	Nurse Practitioner	DEXCOM G6 SENSOR	MEDICAL DEVICES	E11.65 DM2.	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 and 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 quantity limits may apply to covered drugs.		
10566692	GERALD THOMAS FINCKEN DO	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 1% was denied for these reasons: 1) 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. 2) A lab value from within the last 12 months was not sent to us. 3) 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) 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.		
10594482	ROBERT JOHN KOVAL JR MD	Internal Medicine	HUMIRA PEN	TARGETED IMMUNOMODULATORS	PsA	Our prior authorization criteria for adalimumab (HUMIRA) have not been met. From the records that we have received, Humira was denied for these reasons: 1) Records did not show that you have tried and failed methotrexate OR sulfasalazine OR that you have a contraindication to both of these drugs and cannot take either of them. Since the criteria have 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 adalimumab (HUMIRA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Humira for Peripheral Ankylosing Spondylitis, Psoriatic Arthritis, or Reactive Arthritis. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Rheumatology Specialist; AND 2) Member has a diagnosis of ONE (1) of the following: (A) Peripheral Ankylosing Spondylitis (AS); OR (B) Psoriatic Arthritis (PsA); OR (C) Reactive Arthritis; AND 3) A trial of ONE (1) of the following was ineffective or not tolerated: (A) methotrexate; OR (B) sulfasalazine; OR (C) Member has contraindication to BOTH and the contraindication is specified. 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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10594979	APURVA NAVIN TRIVEDI MD	Gastroenterology	XIFAXAN	ANTI-INFECTIVE AGENTS - MISC.	IBS-C	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 and 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.		
10602048	DONALD DAVIS COLE III MD	Family Practice	ITRACONAZOLE	ANTIFUNGALS	B36.0	Our prior authorization criteria for itraconazole (SPORANOX) have not been met. From the records that we have received, Itraconazole was denied for these reasons: 1) The drug was not prescribed by, or together with, an Infectious Disease Specialist or a Lung Specialist. 2) Records did not show the drug is being used for a fungal infection inside the body. 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 itraconazole (SPORANOX) 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 Itraconazole for a Systemic Fungal Infection. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Infectious Disease Specialist or Pulmonologist; AND 2) Prescribed for a systemic fungal infection. 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.		
10619905	ROYA ABBASIAN AZADI MD	Internal Medicine	NUEDEXTA	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	F48.2	Our prior authorization criteria for Nuedexta have not been met. From the records that we have received, the following caused the denial of Nuedexta. 1) Nuedexta is not prescribed by a Neurologist. 2) The drug is not being used for Pseudobulbar Affect (PBA) secondary to a neurologic condition. PBA is a condition that is characterized by sudden and uncontrollable emotional outbursts such as laughing or crying. 3) A score used to help doctors diagnose your condition has not been received. This is called a Baseline Center for Neurologic Study-Lability Scale (CNS-LS). 4) Records did not show that a selective serotonin reuptake inhibitor (SSRI) has 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 Nuedexta 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 Nuedexta (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 Neurologist; AND 2) Member is diagnosed with Pseudobulbar Affect (PBA) secondary to a structural neurologic condition (amyotrophic lateral sclerosis, multiple sclerosis, Parkinson's disease, traumatic brain injury, or stroke); AND 3) Baseline Center for Neurologic Study - Lability Scale (CNS-LS) score is at least 13; AND 4) A trial of one (1) selective serotonin reuptake inhibitor (SSRI) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
10629213	ALBERT JAMES WONG MD	Family Practice	LEVALBUTEROL TARTRATE HFA	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	R05	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, levalbuterol inhaler was denied for these reasons: 1) Ventolin HFA 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.		

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10637865	MATTHEW SCOTT HILL DO	Family Practice	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	F52.21	Our prior authorization criteria for tadalafil (Cialis) have not been met. From the records that we have received, the following caused the denial of tadalafil (Cialis). 1) Records do not show a diagnosis of benign prostatic hyperplasia (BPH). 2) Tadalafil (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. 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.		
10643542	KAZIA LUCILLE PARSONS MD	Family Practice	DESCOVY	ANTIVIRALS	F66	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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.		
10663544	HELEN MARGARET BRONTE-STEWART MD	Neurology	MODAFINIL	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	G20	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, sleep apnea, shift work sleep disorder, or multiple sclerosis-related fatigue. These are health issues that can make you feel tired during the day. Since the criteria have 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, 3 or 4 of our prior authorization criteria for Modafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of narcolepsy; AND 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 show mean onset to sleep of less than 10 minutes; OR 2) Member has a diagnosis of obstructive sleep apnea / hypopnea syndrome; AND member is on positive airway pressure; OR 3) Member has a diagnosis of shift work disorder; OR 4) Member has a diagnosis of multiple sclerosis-related fatigue. 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
10667435	EMMANUEL JOHN LEE MD	Family Practice	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	F52.21	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. 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.		
10695726	ADAM JOSEPH MAMELAK MD	Dermatology	TREMFYA	TARGETED IMMUNOMODULATORS	L40.0	Our prior authorization criteria for guselkumab (TREMFYA) have not been met. From the records that we have received, Tremfya was denied for these reasons: 1) Two (2) of these drugs have not been tried and failed: Enbrel, Humira, Otezla, Skyrizi, Stelara, Taltz. Prior authorization may be required. Quantity limits may apply. Since the criteria have 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 guselkumab (TREMFYA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Tremfya for Plaque Psoriasis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of moderate-to-severe Plaque Psoriasis (PP); AND 2) Prescribed by a Dermatologist; AND 3) Trials of TWO (2) of the following were ineffective, not tolerated, or ALL untried alternatives are contraindicated: (A) etanercept (ENBREL), (B) adalimumab (HUMIRA), (C) apremilast (OTEZLA), (D) risankizumab (SKYRIZI), (E) ustekinumab (STELARA), (F) ixekizumab (TALTZ). 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.		
10695824	SWATI PRASHANT JADHAV MD	Family Practice	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	sexual dysfunction	This request cannot be approved because this drug is being used for sexual 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.		
10698066	JAMES ALLEN ZACHARY MD	Infectious Diseases	TESTOSTERONE	ANDROGENS-ANABOLIC	R79.89	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) Records do not show you have symptoms of low testosterone. 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 and 2 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.		

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10698563	FREDERICK HO FUNG MD	Internal Medicine	ITRACONAZOLE	ANTIFUNGALS	B35.4	Our prior authorization criteria for itraconazole (SPORANOX) have not been met. From the records that we have received, Itraconazole was denied for these reasons: 1) The drug was not prescribed by a Dermatologist or Podiatrist. 2) More information is needed to know if topical antifungals have been tried and failed. 3) Records did not show that your health issue has been confirmed by a positive stain or culture test. 4) More information is needed to show that you have one of these: diabetes, a blood disease called peripheral vascular compromise, a weakened immune system, a widespread fungal infection of the skin, a fingernail infection, OR a painful toenail infection. 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 itraconazole (SPORANOX) have not been met. From the information we have received, the member does not meet number 1, 3, 4, and 5 of our prior authorization criteria for Itraconazole for a Dermatologic Fungal Infection. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist or Podiatrist; AND 2) Member has a dermatologic fungal infection; AND 3) Member had no response to topical antifungals; AND 4) Diagnosis confirmed by positive potassium hydroxide (KOH) or periodic acid-Schiff (PAS) stain or fungal culture; AND 5) Indicate at least one (1) of the following characteristics: (a) Member diagnosed as diabetic; (b) Member has significant peripheral vascular compromise; (c) Member is immunocompromised; (d) Member has systemic dermatosis with impaired skin integrity; (e) Member has a fingernail infection; OR (f) Member has significant pain due to infected toenail(s). 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.		
10698584	DAVID JON REVERE MD	Cardiology	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	I25.84	Our prior authorization criteria for Repatha have not been met. From the records that we have received, Repatha was denied for these reasons: 1) Records did not show if you have a health issue called Clinical Atherosclerotic Cardiovascular Disease (ASCVD). ASCVD is a health issue where cholesterol build-up impacts blood flow from the heart. Records must be sent in showing you meet one of these: (a) acute coronary syndromes (ACS), (b) previous heart attack, (c) ongoing chest pain (angina), (d) previous coronary or other arterial revascularization, (e) previous stroke or transient ischemic attack (TIA), OR (f) peripheral arterial disease of atherosclerotic origin. 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 Repatha have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Repatha for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) in a member who is unable to tolerate statins. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has Clinical Atherosclerotic Cardiovascular Disease (ASCVD) defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin; AND 2) Member is unable to tolerate statin therapy; AND 3) Member has failed at least TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin); AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on maximally tolerated statin therapy OR member is taking a 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. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
10701762	KATHRYN KATRINA CRINER	Nurse Practitioner	TRETINOIN	DERMATOLOGICALS	Disorder of pigmentation, unspecified	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, tretinoin was denied for these reasons: 1) This drug is not being used to treat skin problems such as pimples, redness, or skin thickening from sun exposure. 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. 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.		

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10707214	DAVID JON REVERE MD	Cardiology	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	E78.5	Our prior authorization criteria for Repatha have not been met. From the records that we have received, Repatha was denied for these reasons: 1) Records did not show that you have a health issue called Clinical Atherosclerotic Cardiovascular Disease (ASCVD). ASCVD is a health issue where cholesterol build-up impacts blood flow from the heart. Records must be sent in showing you meet one of these: (a) acute coronary syndromes (ACS), (b) previous heart attack, (c) ongoing chest pain (angina), (d) previous coronary or other arterial revascularization, (e) previous stroke or transient ischemic attack (TIA), OR (f) peripheral arterial disease of atherosclerotic origin. 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 Repatha have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Repatha for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) in a member who is unable to tolerate statins. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has Clinical Atherosclerotic Cardiovascular Disease (ASCVD) defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin; AND 2) Member is unable to tolerate statin therapy; AND 3) Member has failed at least TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin); AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on maximally tolerated statin therapy OR member is taking a 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. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
10708298	MARGARET KATHERINE HART MD	Dermatology	ITRACONAZOLE	ANTIFUNGALS	Pityrosporum Folliculitis	Our prior authorization criteria for itraconazole (SPORANOX) have not been met. From the records that we have received, Itraconazole was denied for these reasons: 1) More information or clarification is needed to know if the drug is being used for a fungal infection on the skin. 2) Records did not show that topical antifungals have been tried and failed. 3) Records did not show that your health issue has been confirmed by a positive stain or culture test. 4) More information is needed to show that you have one of these: diabetes, a blood disease called peripheral vascular compromise, a weakened immune system, a widespread fungal infection of the skin, a fingernail infection, OR a painful toenail infection. 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 itraconazole (SPORANOX) have not been met. From the information we have received, the member does not meet number 2, 3, 4, and 5 of our prior authorization criteria for Itraconazole for a Dermatologic Fungal Infection. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist or Podiatrist; AND 2) Member has a dermatologic fungal infection; AND 3) Member had no response to topical antifungals; AND 4) Diagnosis confirmed by positive potassium hydroxide (KOH) or periodic acid-Schiff (PAS) stain or fungal culture; AND 5) Indicate at least one (1) of the following characteristics: (a) Member diagnosed as diabetic; (b) Member has significant peripheral vascular compromise; (c) Member is immunocompromised; (d) Member has systemic dermatosis with impaired skin integrity; (e) Member has a fingernail infection; OR (f) Member has significant pain due to infected toenail(s). 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.		
10710666	ALICE DIANE FRIEDMAN MD	Gastroenterology	SUPREP BOWEL PREP KIT	LAXATIVES	colonoscopy	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 kit 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.		

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10714577	MARGARET KATHERINE HART MD	Dermatology	ITRACONAZOLE	ANTIFUNGALS	B36.8	Our prior authorization criteria for itraconazole (SPORANOX) have not been met. From the records that we have received, Itraconazole was denied for these reasons: 1) Records did not show that your health issue has been confirmed by a positive stain or culture test. 2) Records did not show that you have one of these: diabetes, a blood disease called peripheral vascular compromise, a weakened immune system, a widespread fungal infection of the skin, a fingernail infection, OR a painful toenail infection. 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 itraconazole (SPORANOX) have not been met. From the information we have received, the member does not meet number 4 and 5 of our prior authorization criteria for Itraconazole for a Dermatologic Fungal Infection. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist or Podiatrist; AND 2) Member has a dermatologic fungal infection; AND 3) Member had no response to topical antifungals; AND 4) Diagnosis confirmed by positive potassium hydroxide (KOH) or periodic acid-Schiff (PAS) stain or fungal culture; AND 5) Indicate at least one (1) of the following characteristics: (a) Member diagnosed as diabetic; (b) Member has significant peripheral vascular compromise; (c) Member is immunocompromised; (d) Member has systemic dermatosis with impaired skin integrity; (e) Member has a fingernail infection; OR (f) Member has significant pain due to infected toenail(s). 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.		
10717067	JEREMY SCOTT SEBASTIAN MD	Otolaryngology	HYDROCODONE BITARTRATE/AC	ANALGESICS - OPIOID	J34.2	We have received a request for 900 milliliters for a 10 day supply for hydrocodone/acetaminophen solution. This amount is more than the amount covered for members who are new to using an opioid pain reliever. Our Pharmacy and Therapeutics (P&T) committee, which is a group of doctors and pharmacists, selects which drugs have dispensing limits. We will only cover up to a 7 days for the FIRST fill of an opioid pain reliever such as the drug requested. For future fills, a longer day supply may be dispensed if our records show recent use of an opioid drug. For members who do not show recent use of an opioid pain reliever, more than a 7 day supply for this first fill can be approved if records are sent in showing one of these: 1) Records show that you have recent use of an opioid pain reliever; OR 2) Your pain is linked to an active cancer diagnosis, a life-ending health issue, or hospice care. Please look at the list of covered drugs, also known as our formulary, for which drugs are covered.		
10773743	JOSEPH KHALIL IMSAIS MD	Cardiology	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	I25.10	Our prior authorization criteria for Repatha have not been met. From the records that we have received, Repatha was denied for these reasons: 1) Records did not show that you have a health issue called Clinical Atherosclerotic Cardiovascular Disease (ASCVD). ASCVD is a health issue where cholesterol build-up impacts blood flow from the heart. Records must be sent in showing you meet one of these: (a) acute coronary syndromes (ACS), (b) previous heart attack, (c) ongoing chest pain (angina), (d) previous coronary or other arterial revascularization, (e) previous stroke or transient ischemic attack (TIA), OR (f) peripheral arterial disease of atherosclerotic origin. 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 Repatha have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Repatha for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) in a member who is unable to tolerate statins. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has Clinical Atherosclerotic Cardiovascular Disease (ASCVD) defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin; AND 2) Member is unable to tolerate statin therapy; AND 3) Member has failed at least TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin); AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on maximally tolerated statin therapy OR member is taking a 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. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
10777082	FLORENCE OLABISI FALOLA NP	Nurse Practitioner	SUPREP BOWEL PREP KIT	LAXATIVES	none	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 kit 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.		

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10781475	JASON SCOTT REICHENBERG MD	Dermatology	RESTASIS MULTIDOSE	OPHTHALMIC AGENTS	H01.9	Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, Restasis was denied for this reason: 1) The drug is not prescribed by a Ophthalmology or Optometry specialist. 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 Restricted to Specialist prior authorization criteria have not been met. From the information we have received, the member does not meet 1 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) The provider's specialty matches the Restricted Specialty requirements 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.		
10795194	SHWOL-HUO DANNY KIANG DO	Dermatology	OTEZLA	TARGETED IMMUNOMODULATORS	L40.0	Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) Records did not show that your health issue is causing significant functional disability for you. More information is needed to show how your health issue is impacting you. 2) You have not tried and failed methotrexate (at a dose of at least 15mg per week) or soriatane. Since the criteria have 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 apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 2 and 4 of our prior authorization criteria for Otezla for Plaque Psoriasis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Moderate to severe plaque psoriasis (PP) (greater than or equal to 10% body surface involved) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND 3) Indicate ONE (1) of the following (documentation is required to be submitted for an approval): (A) A trial of a minimum of 15 sessions of phototherapy that was ineffective or not tolerated; OR (B) Member has contraindication to phototherapy, AND contraindication is specified; AND 4) A trial of ONE (1) of the following was ineffective or not tolerated (documentation is required to be submitted for an approval): (A) methotrexate (minimum dose of 15 mg/week); OR (B) soriatane; OR (C) Member has contraindication to BOTH, AND contraindication is specified; AND 5) Apremilast (OTEZLA) will not be used in combination with biologic therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
10797953	ASHLEY ELIZABETH RAYMOND	Nurse Practitioner	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 or Xigduo/Xigduo XR 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 or Xigduo/Xigduo XR). Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
10802256	JAMES JOHN TEET DO	Family Practice	DESCOVY	ANTIVIRALS	PrEP	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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, 4, or 5 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.		

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
10807068	DAVID JON REVERE MD	Cardiology	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	CAD	Our prior authorization criteria for Repatha have not been met. From the records that we have received, Repatha was denied for these reasons: 1) Records did not show that you have a health issue called Clinical Atherosclerotic Cardiovascular Disease (ASCVD). ASCVD is a health issue where cholesterol build-up impacts blood flow from the heart. Records must be sent in showing you meet one of these: (a) acute coronary syndromes (ACS), (b) previous heart attack, (c) ongoing chest pain (angina), (d) previous coronary or other arterial revascularization, (e) previous stroke or transient ischemic attack (TIA), OR (f) peripheral arterial disease of atherosclerotic origin. 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 Repatha have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Repatha for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) in a member who is unable to tolerate statins. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has Clinical Atherosclerotic Cardiovascular Disease (ASCVD) defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin; AND 2) Member is unable to tolerate statin therapy; AND 3) Member has failed at least TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin); AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on maximally tolerated statin therapy OR member is taking a 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. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
10814506	CARLY MICHELLE MELANCON	Advanced Practice Nurse	ARIPIPRAZOLE ODT	ANTIPSYCHOTICS/ ANTIMANIC AGENTS	F84.0	Our prior authorization criteria for aripiprazole orally disintegrating tablets (ODT) and oral solution have not been met. From the records that we have received, the following caused the denial of aripiprazole ODT or oral solution. 1) Risperidone ODT or solution was not tried and failed. 2) Olanzapine ODT or solution was not 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 aripiprazole orally disintegrating tablets (ODT) and oral solution 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 aripiprazole ODT or oral solution. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for one of the following: Schizophrenia, Bipolar I disorder, Adjunctive treatment of Major depressive disorder (MDD), Irritability associated with Autistic disorder, OR Tourette's syndrome; AND 2) Member is unable to swallow tablets; AND 3) A trial of risperidone ODT or solution was ineffective, contraindicated, or not tolerated; AND 4) A trial of olanzapine ODT or solution was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
10823266	DANIEL NEIL SKOGLUND MD	Psychiatry	LATUDA	ANTIPSYCHOTICS/ ANTIMANIC AGENTS	bipolar	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.		
10845352	APURVA NAVIN TRIVEDI MD	Gastroenterology	DRONABINOL	ANTIEMETICS	R11.2	Our prior authorization criteria for dronabinol (MARINOL) have not been met. From the records that we have received, dronabinol was denied for these reasons: 1) The drug is not being used to treat anorexia or loss of appetite in a person with acquired immune deficiency syndrome (AIDS) who has lost weight. 2) The drug is not being used for nausea and vomiting related to cancer treatments. Since the criteria have 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 dronabinol (MARINOL) 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 dronabinol. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of anorexia associated with weight loss in patients with acquired immune deficiency syndrome (AIDS); OR 2) Prescribed for nausea and vomiting associated with cancer chemotherapy in patients who have failed to respond adequately to conventional antiemetic treatments. Please list at least one antiemetic tried and the doses and dates of the trial. (Documentation is required for 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.		

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
10852447	MARIA CATALINA CUERVO MD MPH	Family Practice	INVOKANA	ANTIDIABETICS	e11.65	Our prior authorization criteria for Invokana tablets have not been met. From the records that we have received, the following caused the denial of Invokana. 1) Jardiance, Synjardy, or Glyxambi has not been tried and failed. Quantity limits may apply. 2) Farxiga or Xigduo/Xigduo XR 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 or Xigduo/Xigduo XR). Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
10865121	JASON SCOTT REICHENBERG MD	Dermatology	STELARA	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Our prior authorization criteria for ustekinumab (STELARA) have not been met. From the records that we have received, Stelara was denied for these reasons: 1) Records did not show that this drug is working well for you. Since the criteria have 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 ustekinumab (STELARA) 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 Stelara for Plaque Psoriasis (Continuing Therapy). 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 submitted with this request (documentation is required to be submitted for an approval); AND 4) If the 90mg dose is requested, member's weight is greater than (>) 100kg and is provided with the request. 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.		
10943556	GRACE PATRICIA TAMESIS MD	Allergy & Immunology	ODACTRA	ALLERGENIC EXTRACTS/BIOLOGICALS MISC	J30.1	Our prior authorization criteria for Odactra have not been met. From the records that we have received, the following caused the denial of Odactra. 1) More information is needed to know if the drug will be used in combination with another drug that works on the immune system. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Odactra (initial coverage) have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Odactra. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by an Allergist, Immunologist, or Ears Nose and Throat (ENT) Physician; AND 2) Member will NOT use in combination with another sublingual or subcutaneous immunotherapy regimen. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
10949491	MOLLY THOMPSON CAMPA	Dermatology	OTEZLA	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Our prior authorization criteria for apremilast (OTEZLA) have not been met. From the records that we have received, Otezla was denied for these reasons: 1) Records did not show that you have tried at least 15 sessions of light therapy for your health issue OR that you have a contraindication to light therapy and cannot use it. 2) You have not tried and failed methotrexate (at a dose of at least 15mg per week) or soriatane. Since the criteria have 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 apremilast (OTEZLA) have not been met. From the information we have received, the member does not meet number(s) 3 and 4 of our prior authorization criteria for Otezla for Plaque Psoriasis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist; AND 2) Member has a diagnosis of at least ONE (1) of the following (documentation is required to be submitted for an approval): (A) Moderate to severe plaque psoriasis (PP) (greater than or equal to 10% body surface involved) AND Member has significant functional disability; OR (B) Debilitating palmoplantar psoriasis; AND 3) Indicate ONE (1) of the following (documentation is required to be submitted for an approval): (A) A trial of a minimum of 15 sessions of phototherapy that was ineffective or not tolerated; OR (B) Member has contraindication to phototherapy, AND contraindication is specified; AND 4) A trial of ONE (1) of the following was ineffective or not tolerated (documentation is required to be submitted for an approval): (A) methotrexate (minimum dose of 15 mg/week); OR (B) soriatane; OR (C) Member has contraindication to BOTH, AND contraindication is specified; AND 5) Apremilast (OTEZLA) will not be used in combination with biologic therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time. 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
10951908	NIMA AMJADI MD	Cardiology, Interventional	PRALUENT	ANTIHYPERLIPIDEMICS	E78.5 - Hyperlipidemia, unspecified	Our prior authorization criteria for Praluent have not been met. From the records that we have received, Praluent was denied for these reasons: 1) More information is needed about what statin drugs you have tried in the past. 2) Records did not show that you have tried and failed a low-intensity statin (e.g. pravastatin) or an alternatively-dosed statin (e.g. twice weekly low-dose rosuvastatin or atorvastatin). 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 Praluent have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Praluent for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) in a member who is unable to tolerate statins. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has Clinical Atherosclerotic Cardiovascular Disease (ASCVD) defined as one (1) of the following: acute coronary syndromes (ACS), history of myocardial infarction (MI), ongoing angina (stable or unstable), prior coronary or other arterial revascularization, prior stroke or transient ischemic attack (TIA), or peripheral arterial disease of atherosclerotic origin; AND 2) Member is unable to tolerate statin therapy; AND 3) Member has failed at least TWO (2) attempts with statin therapy, including an attempt with a low-intensity or alternatively-dosed statin (twice weekly low-dose rosuvastatin or atorvastatin, low-intensity pitavastatin or pravastatin); AND 4) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on maximally tolerated statin therapy OR member is taking a 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. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
10964080	GRACE PATRICIA TAMESIS MD	Allergy & Immunology	ODACTRA	ALLERGENIC EXTRACTS/BIOLOGICALS MISC	J30.1	Our prior authorization criteria for Odactra have not been met. From the records that we have received, the following caused the denial of Odactra. 1) The drug is being used in combination with another drug that works on the immune system. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Odactra (initial coverage) have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Odactra. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by an Allergist, Immunologist, or Ears Nose and Throat (ENT) Physician; AND 2) Member will NOT use in combination with another sublingual or subcutaneous immunotherapy regimen. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
10967601	HANA JANE PALADICHUK MD	Dermatology	TRETINOIN	DERMATOLOGICALS	L24.89 - Irritant contact dermatitis due to other agents	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, tretinoin cream was denied for these reasons: 1) This drug is not being used to treat skin problems such as pimples, redness, or skin thickening from sun exposure. 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. 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.		
10971213	DAVID IRA WARTENBERG MD	Family Practice	DESCOVY	ANTIVIRALS	Z20.6	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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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10971214	DAVID IRA WARTENBERG MD	Family Practice	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	Male erectile dysfunction, unspecified	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). This is a health issue where the prostate is enlarged and can cause bladder, urinary tract, or kidney problems. 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. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for tadalafil (Cialis) have not been met. From the information we have received, the member does not meet numbers 1, 2, 3, and 4 of our prior authorization criteria for tadalafil (Cialis). The reason for denial is explained to the member above. The criteria are listed here. 1) Member must have a diagnosis of Benign Prostatic Hyperplasia (BPH); AND 2) Must be prescribed by, or in consultation with, a Urologist; AND 3) An alpha blocker (alfuzosin, doxazosin, tamsulosin, terazosin, prazosin, etc.) must be tried and failed for at least 30 days (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.		
10971284	MONTIDA SUPANYA FLEMING	Family Practice	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	F52.21	Our prior authorization criteria for tadalafil (Cialis) have not been met. From the records that we have received, the following caused the denial of tadalafil (Cialis). 1) Records do not show a diagnosis of benign prostatic hyperplasia (BPH). This is a health issue where the prostate is enlarged and can cause bladder, urinary tract, or kidney problems. 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. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for tadalafil (Cialis) have not been met. From the information we have received, the member does not meet numbers 1, 2, 3, and 4 of our prior authorization criteria for tadalafil (Cialis). The reason for denial is explained to the member above. The criteria are listed here. 1) Member must have a diagnosis of Benign Prostatic Hyperplasia (BPH); AND 2) Must be prescribed by, or in consultation with, a Urologist; AND 3) An alpha blocker (alfuzosin, doxazosin, tamsulosin, terazosin, prazosin, etc.) must be tried and failed for at least 30 days (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.		
10975043	AMBER CHANEL ARMSTRONG	Advanced Practice Nurse	SUPREP BOWEL PREP KIT	LAXATIVES	Z12.11 - Encounter for screening for malignant neoplasm of colon	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 kit 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.		

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10985424	KAZIA LUCILLE PARSONS MD	Family Practice	DESCOVY	ANTIVIRALS	PrEP, F66	Our prior authorization criteria for Descovy have not been met. From the records we received, Descovy was denied for these reasons: 1) Records were not sent to us to show you had kidney issues while taking a drug called Truvada. 2) Records were not sent to us to show your bones got weaker while taking a drug called Truvada. 3) Records were not sent to us to show your kidneys are not working like normal based on lab tests. 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. Pre-approval may be needed and there may be limits on the amount of drug covered at a time. 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.		
10987274	LIDIA YESENIA LOPEZ	Physician Assistant	SPORANOX	ANTIFUNGALS	B35.1	Our prior authorization criteria for itraconazole (SPORANOX) have not been met. From the records that we have received, Itraconazole was denied for these reasons: 1) The drug was not prescribed by a Dermatologist or Podiatrist. 2) Records did not show that you have one of these: diabetes, a blood disease called peripheral vascular compromise, a weakened immune system, a widespread fungal infection of the skin, a fingernail infection, OR a painful toenail infection. 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 itraconazole (SPORANOX) have not been met. From the information we have received, the member does not meet number 1 and 5 of our prior authorization criteria for Itraconazole for Onychomycosis. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Dermatologist or Podiatrist; AND 2) Member has a diagnosis of onychomycosis; AND 3) Member experienced a failure, intolerance, or contraindication to oral terbinafine (LAMISIL); AND 4) Diagnosis confirmed by positive potassium hydroxide (KOH) or periodic acid-Schiff (PAS) stain or fungal culture; AND 5) Indicate at least one (1) of the following characteristics: (a) Member diagnosed as diabetic; (b) Member has significant peripheral vascular compromise; (c) Member is immunocompromised; (d) Member has systemic dermatosis with impaired skin integrity; (e) Member has a fingernail infection; OR (f) Member has significant pain due to infected toenail(s). 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.		
10988234	DAVID KEVIN WEBER MD	Psychiatry	LATUDA	ANTIPSYCHOTICS/ ANTIMANIC AGENTS	MDD w/mixed features	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.		
11023274	RICHARD DEAN TALLMAN MD	Neurology	NUEDEXTA	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	I63.311 - Cerebral infarction due to thrombosis of right middle cerebral artery	Our prior authorization criteria for Nuedexta have not been met. From the records that we have received, the following caused the denial of Nuedexta. 1) A score used to help doctors diagnose your condition has not been received. This is called a Baseline Center for Neurologic Study-Lability Scale (CNS-LS). 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 Nuedexta have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for Nuedexta (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 Neurologist; AND 2) Member is diagnosed with Pseudobulbar Affect (PBA) secondary to a structural neurologic condition (amyotrophic lateral sclerosis, multiple sclerosis, Parkinson's disease, traumatic brain injury, or stroke); AND 3) Baseline Center for Neurologic Study - Lability Scale (CNS-LS) score is at least 13; AND 4) A trial of one (1) selective serotonin reuptake inhibitor (SSRI) was ineffective, contraindicated, or not tolerated. 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
11028232	APURVA NAVIN TRIVEDI MD	Gastroenterology	HUMIRA PEN	TARGETED IMMUNOMODULATORS	UC - K51.90	Our prior authorization criteria for adalimumab (HUMIRA) have not been met. From the records that we have received, Humira was denied for these reasons: 1) Chart notes were not sent to us to show your response to this drug. Since the criteria have 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 adalimumab (HUMIRA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Humira for Ulcerative Colitis (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by a Gastroenterology Specialist; AND 2) Member has demonstrated a significant improvement in their condition; AND 3) Documented (written explanation accepted) improvement within the past year submitted with this request (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.		