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
9834635	JUSTIN ALLEN MEUSE MD	Neurology	EMGALITY	MIGRAINE PRODUCTS	G43.719 Chronic migraine without aura, intractable, without status migrainosus	Our prior authorization criteria for Emgality 120mg have not been met. From the records that we have received, Emgality 120mg was denied for these reasons: 1) Records show this drug is being used with Botox injections for migraine. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Emgality 120mg have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Emgality 120mg for Migraine (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the prevention of migraine; AND 2) Member has experienced a meaningful improvement in frequency and/or severity of migraine; AND 3) galcanezumab (EMGALITY) will NOT be used concomitantly with Botox injections for migraine; AND 4) If Emgality was initiated using manufacturer samples or any other mechanism, all of the following are met: (A) Prescriber meets any one of the following: (i) Prescriber is, or has consulted, a Neurologist, (ii) United Council for Neurologic Subspecialties (UCNS)-certified headache medicine specialist, (iii) Member of the American Headache Society; Or Member of the National Headache Foundation, (iv) Member of the International Headache Society, (v) Has a Certificate of Added Qualification in Headache Medicine, OR (vi) American Board of Headache Management Certified; AND (B) Member had four (4) or more migraine days per month for at least three (3) months prior to starting treatment with galcanezumab (EMGALITY); AND (C) Member has tried and failed, is intolerant to, or is contraindicated from trying a minimum three month trial from TWO of the following drug classes: (a) anticonvulsants (such as topiramate, sodium valproate, etc.), (b) vasoactive agents (such as propranolol, metoprolol, etc.), or (c) antidepressants (such as amitriptyline, venlafaxine, etc.). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9894000	LIDIA YESENIA LOPEZ	Physician Assistant	ITRACONAZOLE	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. 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 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.		
9935789	RABIN KHERADPOUR MD	Internal Medicine	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J44.9	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) Incruse Ellipta has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Spiriva have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Spiriva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Obstructive Pulmonary Disease (COPD); AND 2) A trial of umeclidinium (Incruse Ellipta) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.		
9969059	BOONE WILDER GOODGAME MD	Oncology, Medical	TAGRISSO	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	C34.9 - Malignant neoplasm of unspecified part of bronchus or lung	Based on the information we have received, you do not meet number 3 of our prior authorization criteria because chart notes showing if your cancer has a specific mutation were not provided. Based on our Pharmacy and Therapeutics (P&T) Committee prior authorization criteria for Tagrisso, this drug is covered for members who meet the following criteria: 1) Prescribed by, or in consultation with, an Oncologist; AND 2) Member is diagnosed with metastatic non-small cell lung cancer (NSCLC); AND 3) Documentation of ONE (1) of the following is provided with the request: a) Epidermal Growth Factor (EGFR) exon 19 deletions or exon 21 L858R mutations, OR b) EGFR T790M mutation, after prior use of an EGFR targeted therapy. Since criteria have not been met, we are unable to approve coverage for this drug at this time.		
9974651	BOONE WILDER GOODGAME MD	Oncology, Medical	HYDROCODONE BITARTRATE/AC	ANALGESICS - OPIOID	pain	We have received a request for 30 tablets for a 15 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.		
9985655	TINA CHADHA BUNCH MD	Internal Medicine	OTEZLA	TARGETED IMMUNOMODULATORS	PsA	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 and failed methotrexate OR sulfasalazine OR that you have a contraindication to both of these drugs and cannot take either of them. 2) More information is needed to know if this drug is being used together with biologic therapy. 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 Psoriatic 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 Psoriatic Arthritis (PsA); 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; 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.		

10053863	KAVITHA KUMBUM MD	Gastroenterology	AMITIZA	GASTROINTESTINAL AGENTS - MISC.	K62.5	Our prior authorization criteria for Amitiza have not been met. From the records that we have received, the following caused the denial of Amitiza. 1) Amitiza is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female patient, or opioid-induced constipation (OIC). 2) Trulance has not been tried and failed. Prior authorization may be required. 3) Movantik has not been tried and failed. Prior authorization may be required. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Amitiza have not been met. From the information we have received, the member does not meet number 1, 2 and 3 of our prior authorization criteria for Amitiza. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member AND A trial of Trulance was ineffective, contraindicated, or not tolerated; OR 2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in a woman 18 years of age or older AND A trial of Trulance was ineffective, contraindicated, or not tolerated; OR 3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member with chronic, non-cancer pain, including a member with chronic pain related to prior cancer or its treatment who does not require frequent (e.g. weekly) opioid dosage escalation AND A trial of Movantik was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time.
10076805	VINCENZ LIM DECASTRO	Family Practice	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J44.9	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) Incruse Ellipta has not been tried and failed. (We show a recent paid claim. More information is needed if this does not work for you.) Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for 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.
10099029	KERMIT VINCENT SPEEG JR MD	Gastroenterology	VELTASSA	MISCELLANEOUS THERAPEUTIC CLASSES	Z94.4	Our prior authorization criteria for patiromer (VELTASSA) have not been met. From the records that we have received, Veltassa was denied for these reasons: 1) The drug was not prescribed by, or together with, a Nephrologist, Cardiologist, or Endocrinologist. 2) Records did not show a high blood potassium level (above 5.3mmol/L). 3) Records do not show that you have tried to change your diet to control the blood potassium level. 4) Records do not show that a diuretic (also known as a water pill) has been tried and failed. 5) Lokelma has not been tried and failed. Prior authorization may be required. 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 patiromer (VELTASSA) have not been met. From the information we have received, the member does not meet number 1,2,3,4 and 5 of our prior authorization criteria for Veltassa. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Nephrologist, Cardiologist, or Endocrinologist; AND 2) Hyperkalemia (greater than (>) 5.3 mmol/L) persists despite dietary management; AND 3) Hyperkalemia (greater than (>) 5.3 mmol/L) persists despite use of diuretics (if appropriate); AND 4) A trial of sodium zirconium cyclosilicate (LOKELMA) was ineffective, contraindicated, or not tolerated; OR 5) Member has a condition for which sodium zirconium cyclosilicate (LOKELMA) would be inappropriate. 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.
10105040	AJAY ZACHARIAH MD	Family Practice	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J44.9	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) Incruse Ellipta has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Spiriva have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Spiriva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Obstructive Pulmonary Disease (COPD); AND 2) A trial of umeclidinium (Incruse Ellipta) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
10127498	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.
10138518	RABIN KHERADPOUR MD	Internal Medicine	HYDROCODONE BITARTRATE/AC	ANALGESICS - OPIOID	pain	We have received a request for 90 tablets for a 30 day supply for hydrocodone/actaminophen. 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.

10155700	KYMBERLI KAY MCCLAIN FNP	Nurse Practitioner	FREESTYLE LIBRE 2/SENSOR/	MEDICAL DEVICES	E11.65	Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of Freestyle Libre. 1) Records do not show you have done well with your blood sugar control with a Continuous Glucose Monitor (CGM) or that you have had less problems with low blood sugars. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Freestyle Libre (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Member meets one (1) of the following: (A) Member continues to demonstrate hypoglycemia unawareness; OR (B) Undetected hypoglycemia continues to pose an occupational safety risk; OR (C) Member would be expected to have suboptimal diabetes control without Continuous Glucose Monitor (CGM) use 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 is unlikely to test with sufficient frequency; OR (D) Member has experienced considerable benefit from CGM use and would be expected to continue to benefit from ongoing use; AND 2) Member has experienced considerable improvement in glycemic control and/or significant reduction in risk of symptomatic or unrecognized hypoglycemia. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
10186606	MANZURE MAWLA DO	Internal Medicine	MODAFINIL	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	I63.9	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 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.
10197693	KAVITHA KUMBUM MD	Gastroenterology	SUPREP BOWEL PREP KIT	LAXATIVES	K50.80	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 BOWEL PREP 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.
10199699	KAVITHA KUMBUM MD	Gastroenterology	AMITIZA	GASTROINTESTINAL AGENTS - MISC.	K62.5	Our prior authorization criteria for Amitiza have not been met. From the records that we have received, the following caused the denial of Amitiza. 1) Amitiza is not being used for chronic idiopathic constipation (CIC), irritable bowel syndrome with constipation (IBS-C) in a female patient, or opioid-induced constipation (OIC). 2) Trulance has not been tried and failed. Prior authorization may be required. 3) Movantik has not been tried and failed. Prior authorization may be required. Since the criteria have not been met, we are not able to approve. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Amitiza have not been met. From the information we have received, the member does not meet number 1, 2 or 3 of our prior authorization criteria for Amitiza. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Idiopathic Constipation (CIC) in an adult member AND A trial of Trulance was ineffective, contraindicated, or not tolerated; OR 2) Prescribed for the treatment of Irritable Bowel Syndrome with Constipation (IBS-C) in a woman 18 years of age or older AND A trial of Trulance was ineffective, contraindicated, or not tolerated; OR 3) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult member with chronic, non-cancer pain, including a member with chronic pain related to prior cancer or its treatment who does not require frequent (e.g. weekly) opioid dosage escalation AND A trial of Movantik was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time.
10200574	ALINA MILIAN RAMOS MD	Internal Medicine	INVOKANA	ANTIDIABETICS	Z79.4, T2DM	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.
10246005	ELIZABETH ANN NELSON MD	Internal Medicine	INVOKANA	ANTIDIABETICS	E11.10	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.
10252911	HARSH BABBAR MD	Internal Medicine	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	missing	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) The drug is not being used for Chronic Obstructive Pulmonary Disease (COPD). 2) Incruse Ellipta has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Spiriva have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria for Spiriva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Obstructive Pulmonary Disease (COPD); AND 2) A trial of umeclidinium (Incruse Ellipta) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

10337935	HARSH BABBAR MD	Internal Medicine	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J44.9	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) Incruse Ellipta has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Spiriva have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Spiriva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Obstructive Pulmonary Disease (COPD); AND 2) A trial of umeclidinium (Incruse Ellipta) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
10386130	SHANE ALVIN AHLERS	Internal Medicine	VORICONAZOLE	ANTIFUNGALS	none	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 an 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.
10403653	SHANE ALVIN AHLERS	Internal Medicine	VORICONAZOLE	ANTIFUNGALS	Z94.81	Our Restricted to Specialist prior authorization criteria have not been met. From the records that we have received, fluticasone/salmeterol, Dulera, Breo Ellipta was denied for this reason: 1) The drug is not prescribed by a infectious disease. 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.
10424190	SARAH MARGARET MCCRAY FNP	Nurse Practitioner	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	j45.909	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) The drug is not being used for Chronic Obstructive Pulmonary Disease (COPD). (Please note: Spiriva 1.25mcg Respimat is covered by your pharmacy benefit and may be right for your health issue. Step Therapy may be required. Quantity limits apply.) 2) Incruse Ellipta has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Spiriva have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria for Spiriva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Obstructive Pulmonary Disease (COPD); AND 2) A trial of umeclidinium (Incruse Ellipta) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
10432659	SUSAN KATHLEEN DUBOIS MD	Endocrinology, Diabetes & Metabolism	FREESTYLE LIBRE 14 DAY/SE	MEDICAL DEVICES	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 FREESTYLE LIBRE. 1) Records do not show that you are using insulin. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for FREESTYLE LIBRE (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.
10473338	ARON JEFFREY GEWIRTZMAN MD	Dermatology	DUPIXENT	DERMATOLOGICALS	L20.89	Our prior authorization criteria for dupilumab (DUPIXENT) have not been met. From the records that we have received, the following caused the denial of Dupixent. 1) Records showing this drug is working well have not been received. (Only part of fax and chart notes were received, missing information about improvement). 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 dupilumab (DUPIXENT) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for Dupixent (Continuing Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Documentation with chart notes of positive clinical response has been provided (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.

10484223	SUSAN KATHLEEN DUBOIS MD	Endocrinology, Diabetes & Metabolism	FREESTYLE LIBRE 14 DAY/SE	MEDICAL DEVICES	e11.9	Our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the records that we have received, the following caused the denial of FREESTYLE LIBRE. 1) Records do not show that you are using insulin. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Continuous Glucose Monitors (CGM) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for FREESTYLE LIBRE (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.
10505244	OM NARAYAN PANDEY MD	Internal Medicine	XPOVIO 60 MG TWICE WEEKLY	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	C90.0	Our prior authorization criteria for selinexor (XPOVIO) have not been met. From the records that we have received, Xpovio was denied for these reasons: 1) Records do not show that you have tried at least four (4) other treatments for your cancer. 2) Records do not show that you had progression during or within 60 days of therapy to all of the following: two (2) proteasome inhibitors, two (2) immunomodulatory agents, and one (1) anti-CD38 monoclonal antibody. Prior authorization may be required and quantity limits may apply. Coverage for some of these drugs may only be available through your medical benefit. 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 selinexor (XPOVIO) 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 Xpovio for multiple myeloma. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Hematologist or Oncologist; AND 2) Member has a diagnosis of relapsed or refractory multiple myeloma; AND 3) Member tried at least four (4) prior lines of therapy for multiple myeloma; AND 4) Progression occurred during or within 60 days following completion of therapy to ALL of the following: TWO (2) proteasome inhibitors, AND TWO (2) immunomodulatory agents, AND ONE (1) anti-CD38 monoclonal antibody. 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.
10522949	BRADLEY VICTOR CULLING DO	Anesthesiology	BUTRANS	ANALGESICS - OPIOID	M47.816	For a member that is new to using an opioid pain reliever, the Opioid Naive criteria for Step Therapy has not been met. Step Therapy means that another drug will need to be tried and failed first. From the records that we have received, Butrans patch was denied for these reasons: 1) One of these short-acting opioid pain relievers has not been recently tried: morphine sulfate immediate release (IR), oxycodone, oxycodone/APAP, hydrocodone/APAP, hydromorphone, tramadol. Please note: We will only cover up to 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. Records did not show that you have had recent use of an opioid pain reliever OR have an active cancer diagnosis, a life-ending health issue, or are in hospice care. 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 Opioid Naive criteria for Step Therapy have not been met. From the information we have received, the member does not meet numbers 1 or 2 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 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. 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.
10560060	BRADLEY VICTOR CULLING DO	Anesthesiology	HYDROCODONE BITARTRATE/AC	ANALGESICS - OPIOID	chronic pain	We have received a request for 60 tablets for a 30 day supply for Hydrocodone-Acetaminophen tablets. 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.
10571654	SAMANTHA COYLEEN SHAPIRO MD	Internal Medicine	CIMZIA STARTER KIT	TARGETED IMMUNOMODULATORS	M05.9	Our prior authorization criteria for certolizumab pegol (CIMZIA) have not been met. From the records that we have received, Cimzia was denied for these reasons: 1) Two (2) of these have not been tried and failed: Enbrel, Humira, Rinvoq, Xeljanz. 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 certolizumab pegol (CIMZIA) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Cimzia for Rheumatoid 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 Rheumatoid Arthritis (RA); 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) upadacitinib (RINVOQ), (D) tofacitinib (XELJANZ/XELJANZ XR). 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.
10596125	HARSH BABBAR MD	Internal Medicine	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	asthma	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) The drug is not being used for Chronic Obstructive Pulmonary Disease (COPD). 2) Incruse Ellipta has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Spiriva have not been met. From the information we have received, the member does not meet number 1 and 2 of our prior authorization criteria for Spiriva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Obstructive Pulmonary Disease (COPD); AND 2) A trial of umeclidinium (Incruse Ellipta) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

10646488	CHRISTOPHER CHANG MD	Family Practice	NURTEC	MIGRAINE PRODUCTS	G43.839	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) The drug is not being used to treat a migraine headache. This is a severe throbbing headache, often on one side of the head. 2) Records show this drug will be used to prevent migraine headaches. This is not a covered use. 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) 1 and 4 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for acute treatment 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; AND 4) Prescriber attests that rimegepant (NURTEC) will NOT be used for the prevention of migraines. 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.
10662563	SUSAN KATHLEEN DUBOIS MD	Endocrinology, Diabetes & Metabolism	FREESTYLE LIBRE 2/SENSOR/	MEDICAL DEVICES	E11.00	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.
10676044	BRENDAN MICHAEL DE MARCO MD	Infectious Diseases	BECONASE AQ	NASAL AGENTS - SYSTEMIC AND TOPICAL	j30.9	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, BECONASE AQ was denied for these reasons: 1) Two (2) of these drugs has not been tried and failed: flunisolide, fluticasone, triamcinolone or mometasone. 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.
10746668	ALICE DIANE FRIEDMAN MD	Gastroenterology	SUPREP BOWEL PREP KIT	LAXATIVES	Screening Colonoscopy and change in bowel habits	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.
10754778	CHELLYANNE COLLEEN HINDS PA	Physician Assistant	MAVYRET	ANTIVIRALS	B18.2	Our prior authorization criteria for glecaprevir/pibrentasvir (MAVYRET) have not been met. From the records that we have received, Mavyret was denied for these reasons: 1) Documentation of a recent viral level was not sent to us. This must be from within the past 3 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 glecaprevir/pibrentasvir (MAVYRET) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Mavyret. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Gastroenterologist, Hepatologist, Infectious Disease or Transplant Specialist; AND 2) Member has a diagnosis of chronic Hepatitis C Virus (HCV); AND 3) HCV Genotype is provided; AND 4) Current viral level (HCV-RNA titer and date) is provided and must be from within the past 3 months (documentation is required for an approval); AND 5) Member does or does not have cirrhosis (must be indicated); AND 6) Member is treatment naïve, OR If member has been previously treated, records of prior therapies used is provided; AND 7) If 8 weeks treatment duration is requested, all of the following are met: (A) Member has not been previously treated with an NS5A inhibitor or NS3/4A protease inhibitor, AND (B) If genotype 3, member is treatment naïve; OR 8) If 12 weeks treatment duration is requested, all of the following are met: (A) Member has not been previously treated with an NS5A inhibitor, AND (B) Member meets one of the following: (i) HCV genotype 1, 2, 4, 5, or 6 with compensated cirrhosis and failed prior treatment with an interferon, ribavirin, and/or sofosbuvir, (ii) HCV genotype 1 and has failed prior treatment with an NS3/4A protease inhibitor, (iii) Prior liver or kidney transplant, OR (iv) Positive HCV-RNA titer after transplantation of an organ from a HCV-positive donor; OR 9) If 16 weeks treatment duration is requested, member meets one of the following: (A) HCV genotype 1 and has failed prior treatment with an NS5A inhibitor (without an NS3/4A protease inhibitor); OR (B) HCV genotype 3 and has failed prior treatment with an interferon, ribavirin, and/or sofosbuvir. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

10759774	ROBBIN BUBB MARROQUIN MD	Family Practice	TRETINOIN	DERMATOLOGICALS	psoriasis	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, tretinoin gel 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 gel. 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.
10831567	GRIFFIN LOWE FULLER MD	Family Practice	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	COPD	Our prior authorization criteria for Spiriva have not been met. From the records that we have received, the following caused the denial of Spiriva. 1) Incruse Ellipta has not been tried and failed. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Spiriva have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Spiriva. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Chronic Obstructive Pulmonary Disease (COPD); AND 2) A trial of umeclidinium (Incruse Ellipta) was ineffective, contraindicated, or not tolerated. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
10950776	STEVEN CURTIS CROW MD	Family Practice	DOXEPIN HYDROCHLORIDE	DERMATOLOGICALS	R21 - Rash and other nonspecific skin eruption	Our prior authorization criteria for doxepin cream have not been met. From the records that we have received, the following caused the denial of doxepin cream. 1) The drug is not being used for short-term (up to 8 days) treatment of atopic dermatitis or lichen simplex. These are conditions that cause itching of the skin. Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for doxepin cream have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for doxepin cream. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the short-term management (up to 8 days) of moderate pruritis in an adult with atopic dermatitis or lichen simplex chronicus. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
10957737	STEPHANIE ANJELIQUE AGRELLA APN	Nurse Practitioner	NURTEC	MIGRAINE PRODUCTS	G43.009	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) The drug is not being used to treat a migraine headache. This is a severe throbbing headache, often on one side of the head. 2) 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. 3) Two triptan medications (e.g. sumatriptan, rizatriptan, or others) have not been tried and failed. Quantity limits may apply. 4) More information is needed to know this drug will not be used to prevent migraine headaches. 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) 1, 2, 3, and 4 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for acute treatment 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; AND 4) Prescriber attests that rimegepant (NURTEC) will NOT be used for the prevention of migraines. 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.
10976949	PRATIMA VIJAY KUMAR MD	Internal Medicine	ISTURISA	ENDOCRINE AND METABOLIC AGENTS - MISC.	D35.2	Our prior authorization criteria for osilodrostat (ISTURISA) have not been met. From the records that we have received, Isturisa was denied for these reasons: 1) Records do not show a diagnosis of Cushing's Disease. This is a health issue of the body when the body produces too much cortisol, a hormone in the body. 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 osilodrostat (ISTURISA) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Isturisa (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of Cushing's Disease; AND 2) Prescribed by, or in consultation with, an Endocrinologist; AND 3) Pituitary surgery is NOT an option or was NOT curative. 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.
10998089	ALICE DIANE FRIEDMAN MD	Gastroenterology	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 was denied for these reasons: 1) More information is needed to show that CLENPIQ has 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.
10999695	SONIA YOUSUF III MD	Rheumatology	ORENCIA CLICKJECT	TARGETED IMMUNOMODULATORS	M05.79-RHEUMATOID ARTHRITIS WITH RHEUMATOID FACTOR OF MULTIPLE SITES WITHOUT ORGAN OR SYSTEMS INVOLVEMENT	Our prior authorization criteria for subcutaneous abatacept (ORENCIA SC) have not been met. From the records that we have received, Orencia was denied for these reasons: 1) You have not tried and failed two (2) of these: Enbrel, Humira (tried), Rinvoq, Xeljanz, OR Humira (tried) and Actemra. 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 subcutaneous abatacept (ORENCIA SC) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Orencia for Rheumatoid 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 rheumatoid arthritis (RA); AND 3) A trial of TWO (2) of the following was ineffective, not tolerated or ALL untried alternatives are contraindicated: (A) etanercept (ENBREL), (B) adalimumab (HUMIRA), (C) upadacitinib (RINVOQ), (D) tofacitinib (XELJANZ/XELJANZ XR); (E) tocilizumab (ACTEMRA) AND adalimumab (HUMIRA). 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.

11037761	SONIA YOUSUF III MD	Rheumatology	ORENCIA CLICKJECT	TARGETED IMMUNOMODULATORS	M05.79	Our prior authorization criteria for subcutaneous abatacept (ORENCIA SC) have not been met. From the records that we have received, Orencia was denied for these reasons: 1) You have not tried and failed two (2) of these: Enbrel, Humira (tried), Rinvoq, Xeljanz, OR Humira (tried) and Actemra. 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 subcutaneous abatacept (ORENCIA SC) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Orencia for Rheumatoid 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 rheumatoid arthritis (RA); AND 3) A trial of TWO (2) of the following was ineffective, not tolerated or ALL untried alternatives are contraindicated: (A) etanercept (ENBREL), (B) adalimumab (HUMIRA), (C) upadacitinib (RINVOQ), (D) tofacitinib (XELJANZ/XELJANZ XR); (E) tocilizumab (ACTEMRA) AND adalimumab (HUMIRA). 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.