Episode	Prescriber Name	Prescriber Specialty	Drug Name	Drug Category	Diagnosis Provied	Denial Reason	Prescriber Decision Notes	Denials Overturned on internal appeal	Denials overturned by an independet review organization
11081717	RANI DAS MD	Internal Medicine	NURTEC	MIGRAINE PRODUCTS	G43.909	Not Covered	The requested amount of Nurtec is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Nurtec at 8 tablets per 30 days, 6 fills per year for this use. The higher number of 15 tablets per 32 days is not a covered amount of this drug per your plan. Please note that your plan does not cover Nurtec when used for migraine prevention. Covered drugs that may be used for migraine prevention include anti-seizure drugs (e.g. topiramate immediate release (IR), valproic acid), beta-blockers (e.g. propranolol, metoprolol, timolol), Aimovig, Emgality, and others. Prior authorization may be required. Quantity limits may apply. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.		
11118051	RACHEL ELIZABETH DOCKRAY PA-C	Physician Assistant	TESTOSTERONE	ANDROGENS-ANABOLIC	E29.1 - Testicular hypofunction	Criteria Not Met	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) More information is needed to know if your low levels of testosterone are age-related. 2) 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. 3) A lab value from within the last 12 months was not sent to us. 4) A second lab value from within the last 24 months was not sent to us. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered.		
11128907	CODY PAULINE SEEL	Physician Assistant	OTEZLA	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Androgens: Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1, 3, 4 and 5 of our prior authorization criteria for Initial Therapy. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of primary or secondary hypogonadism and does NOT have age-related hypogonadism; AND 2) Member has symptoms of hypogonadism; AND 3) TWO (2) morning testosterone levels on separate days fall below the normal range for a healthy adult male are provided with the request; AND 4) Two (2) lab values are submitted with the request (date, time, level, and reference range must be documented); AND 5) One lab value must be from within the last 12 months, AND the second lab value must be from within the last 24 months. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to 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 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.		
11131946	LESLIE NOEL BRICE PA	Physician Assistant	CLOMIPHENE CITRATE	ENDOCRINE AND METABOLIC AGENTS -	E29.1	Plan Exclusion	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 This request cannot be approved because this drug is being used for testicular hypofunction. 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. Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi was denied for these reasons: 1) Your doctor indicated that you may not be able to use methotrexate or soriatane, but more information is needed to show why these drugs are not right for you. 2) Chart notes about your health condition were not sent to us to show what percent of your Body Surface Area (BSA) is affected, that your health issue is causing significant functional disability for you, and 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. 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.		
11136803	CODY PAULINE SEEL	Physician Assistant	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for risankizumab (SKYRIZI) 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 Skyrizi 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		
11151488	NATHANIEL NEVITT MD	-	ABILIFY MAINTENA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F20.9 - Schizophrenia, unspecified	Plan Exclusion	This drug is not on our list of covered drugs, also known as our formulary. Abilify Maintena Injection is a medication that must be given by a health care provider. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in your benefit summary. This drug may be covered as a medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs.		
11153871	MANUEL JOSEPH MARTIN MD	Family Practice	TRUVADA	ANTIVIRALS	Z79.899 - Other long term (current) drug therapy	Criteria Not Met	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) The generic version of this drug, called emtricitabine/tenofovir disoproxil fumarate tablets, has not been tried and failed. 2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior authorization may be required. Quantity limits may apply to covered drugs.		
11154130	TODD ALAN THACKER DO	Family Practice	ADDERALL XR	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	none provided	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER), Vyvanse. 2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior authorization may be required. Quantity limits may apply to covered drugs.		
11154203	STEPHEN REID MINOT APN	Advanced Practice Nurse	LATUDA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F31.32	Criteria Not Met	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.		

11164273	CODY PAULINE SEEL	Physician Assistant	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Criteria Not Met	Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi was denied for these reasons: 1) You have not tried and failed methotrexate or soriatane. 2) Chart notes about your health condition were not sent to us. 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 risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Skyrizi 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
11174521	ROBERT CHARLES MIGNACCA MD	Hematology & Oncology, Pediatric	COAGADEX	HEMATOLOGICAL AGENTS - MISC.	D86.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) More information is needed to show that you will be injecting this medication at your home, without the help of a health care provider. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 5 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. 5) The drug will be self-administered at the patient's home. Prescription drugs that are administered during home care, in an office setting, in confinement, during an emergency room visit, or in urgent care settings are excluded from coverage as indicated in the plan benefit summary. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11195314	MICHAEL GORMAN HUMMER MD	Neurology	ADDERALL XR	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	F90.2 - Attention-deficit hyperactivity disorder, combined type	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) The generic version of this drug, called amphetamine/dextroamphetamine extended-release (ER) capsule (Adderall XR equivalent), has not been tried and failed. 2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate ER capsule (Focalin XR equivalent), methylphenidate ER capsule or tablet, Vyvanse capsule or chewable tablet. 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1, 2, and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior authorization may be required. Quantity limits may apply to covered drugs.
11203068	ERIN JENNIFER SILVERTOOTH MD	Psychiatry	ADDERALL XR	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	F90.2	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended-release (ER) capsule (Focalin XR equivalent), methylphenidate ER (TRIED), Vyvanse capsule or chewable tablet. 2) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior authorization may be required. Quantity limits may apply to covered drugs.
11203686	JACQUELINE MARIE CHAMPLAIN MD	Family Practice	WEGOVY	ADHD/ANTI-NARCOLEPSY/ANTI-	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue. This drug, duloxetine capsule (IRENKA equivalent), is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are duloxetine capsule (CYMBALTA equivalent), in 20mg, 30mg, and 60mg strengths. Note that two of the 20mg capsules may be taken together to achieve a dose of 40mg. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11206504	FREDERIC JEAN-FRANCOISE WILSON MD	Psychiatry	DULOXETINE HYDROCHLORIDE	ANTIDEPRESSANTS	F33.2 - Major depressive disorder, recurrent severe without psychotic features	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug, duloxetine capsule (IRENKA equivalent), is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to
11208353	CHRISTOPHER GLENN SEEKER MD	Obstetrics & Gynecology	HYDROCORTISONE ACETATE/PR	ANORECTAL AND RELATED PRODUCTS	K64.9 - Unspecified hemorrhoids	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are proctosol HC cream (Anusol HC equivalent), pramoxine/hydrocortisone cream kit (Analpram-HC equivalent), lidocaine/hydrocortisone cream (Anamantle equivalent), Proctofoam HC foam, and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

11209564	ANDREW ALAN COLLINS MD	Neurology	NURTEC	MIGRAINE PRODUCTS	G43.109 - Migraine with aura, not intractable, without status migrainosus	Criteria Not Met	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 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) 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
11216636	DONOVAN DAVIDSON RUNYAN MD	Family Practice	SPIRIVA RESPIMAT	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J45.20 - Mild intermittent asthma, uncomplicated	Criteria Not Met	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.
11228970	ALLEN LEE DENNIS MD	Anesthesiology	BUPRENORPHINE HCL	ANALGESICS - OPIOID	G89.4	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for chronic pain. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended-release (ER) tablet (TRIED-MS Contin equivalent), Xtampza ER capsule, Nucynta ER tablet, hydrocodone ER tablet (Hysingla equivalent) or hydrocodone ER capsule (Zohydro equivalent), tramadol ER tablet (TRIED-Ultram ER equivalent), buprenorphine patch (TRIED-Butrans equivalent), fentanyl patch (TRIED-Duragesic equivalent). Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11229116	EMMANUEL JOHN LEE MD	Family Practice	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F41.8	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Rexulti exception policy have not been met. From the records that we have received, these reasons caused the denial: 1) Aripiprazole (Abilify equivalent) has not been tried and failed. 2) One of these has not been tried and failed: quetiapine OR olanzapine. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 and 5 of the Rexulti exception policy criteria for Major Depressive Disorder. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is prescribed for the adjunctive treatment of Major Depressive Disorder; AND 2) Aripiprazole (ABILIFY equivalent) has been tried and failed; AND 3) Member has had an inadequate response to antidepressant therapy during the current episode; AND 4) Member has a history of failure or intolerance to two (2) or more antidepressant medications; AND 5) Member has tried and failed or was intolerant to quetiapine (SEROQUEL or SEROQUEL XR equivalent) OR olanzapine (ZYPREXA equivalent). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to
11243422	JOE HIDROGO III DO	Neurology	EMGALITY	MIGRAINE PRODUCTS	G43.909 - Migraine, unspecified, not intractable, without status migrainosus	Criteria Not Met	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.)(TRIED). 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
11252790	MUNIRA ABIZAR KHAMBATI MD	Family Practice	TESTOSTERONE	ANDROGENS-ANABOLIC	E29.1 - Testicular hypofunction	Criteria Not Met	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. 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
11263320	STEPHANIE MARIE BORGSTRAND NP	Advanced Practice Nurse	BUTALBITAL/ACETAMINOPHEN/	ANALGESICS - NONNARCOTIC	G44.209 - Tension-type headache, unspecified, not intractable	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ibuprofen, naproxen, diclofenac tablet, and rizatriptan. Quantity limits may apply. Acetaminophen (Tylenol equivalent) and Acetaminophen/Caffeine (Excedrin Tension Headache equivalent) are available without a prescription. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are zolpidem, zaleplon, trazodone(tried), and eszopiclone. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11268169	ISAAC FOSTER FRIEDMAN	Physician Assistant	DAYVIGO	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS	G47.00 - Insomnia, unspecified	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11281546	STEVEN ENIUM RASMUSSEN MD	Dermatology	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Criteria Not Met	Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi 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 risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi 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.
11282400	JAY LELAND VIERNES MD	Dermatology	TALTZ	TARGETED IMMUNOMODULATORS	OTHER PSORIATIC ARTHROPATHY	Criteria Not Met	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) 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) 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.
11284992	DARUSH RAHMANI DO	General Practice	TERIPARATIDE	ENDOCRINE AND METABOLIC AGENTS - MISC.	AGE-RELATED OSTEOPOROSIS WITHOUT CURRENT PATHOLOGICAL FRACTURE	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Forteo(tried), Tymlos, and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11291984	PAULA AMARO FNP	Nurse Practitioner	INVOKANA	ANTIDIABETICS	E11.9	Criteria Not Met	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).
11292330	BRENNA KATHERINE GERDELMAN MD	Family Practice	WEGOVY	ADHD/ANTI-NARCOLEPSY/ANTI-	Z68.30 - Body mass index [BMI] 30.0-30.9, adult	Plan Exclusion	Since criteria have not been met, we are unable to approve coverage for this drug at this time. This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
11304534	JENNIFER JEAN JORDAN PA	Physician Assistant	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	psoraisis	Criteria Not Met	Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi 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 risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi 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.
11312731	PAUL HIEN LE MD	Anesthesiology	TRAMADOL HCL	ANALGESICS - OPIOID	G89.4 - Chronic pain syndrome	Criteria Not Met	We have received a request for 60 tablets for a 30 day supply for TRAMADOL 50mg. 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.
11313389	NANCY ANN DASSO FNP	Nurse Practitioner	LOMAIRA	ADHD/ANTI-NARCOLEPSY/ANTI-	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
11316038	STEVEN ENIUM RASMUSSEN MD	Dermatology	SKYRIZI PEN	TARGETED IMMUNOMODULATORS	L40.0 - Psoriasis vulgaris	Criteria Not Met	Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi 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 risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi 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.

							Our prior authorization criteria for Androgens: Testosterone Products have not been met. From the records that we have received, TESTOSTERONE GEL 1%(25MG) 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.
11345977	MUNIRA ABIZAR KHAMBATI MD	Family Practice	TESTOSTERONE	ANDROGENS-ANABOLIC	E29.1 - Testicular hypofunction	Criteria Not Met	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
11351680	FRANK PASCUALIN DE PAULA MD	Family Practice	SPIRIVA HANDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J45.40 - Moderate persistent asthma, uncomplicated	Criteria Not Met	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.
11360284	PAULA AMARO FNP	Nurse Practitioner	INVOKANA	ANTIDIABETICS	T2DM	Criteria Not Met	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.
11364419	JACQUELINE ANN SCHNEIDER RNC ANP	Advanced Practice Nurse	TIROSINT	THYROID AGENTS	E03.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are SYNTHROID. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11379196	CYNTHIA BRISBANE STEWART NP	Nurse Practitioner	EPCLUSA	ANTIVIRALS	B19.20 - Unspecified viral hepatitis C without hepatic coma	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) The generic version of this drug, called sofosbuvir/velpatasvir tablet (Epclusa equivalent), has not been tried and failed. 2) All other covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are ledipasvir/sofosbuvir tablet (Harvoni equivalent), Mavyret tablet, and Vosevi tablet. Prior authorization required and quantity limits apply. 3) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1, 2, and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior authorization may be required. Quantity limits may apply to covered drugs.
11394255	NANCY JUDITH EISEN DO	Family Practice	NURTEC	MIGRAINE PRODUCTS	migraines	Criteria Not Met	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 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) 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
11395006	DANIEL TAVARES COELHO MD	Pediatrics	EUCRISA	DERMATOLOGICALS	eczema	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in our Eucrisa exception policy have not been met. From the records that we have received, the following caused the denial. 1) Tacrolimus ointment (Protopic equivalent) and pimecrolimus cream (Elidel equivalent) have not been tried and failed. 2) A very high potency topical steroid (e.g. halobetasol, augmented betamethasone) has not been tried and failed. Please look at the formulary for a list of covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet numbers 2 and 3 of the Eucrisa exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) Member has a diagnosis of mild to moderate atopic dermatitis; AND 2) Member has tried and failed all formulary topical calcineurin inhibitors (tacrolimus and pimecrolimus); OR Member is less than 2 years of age; AND 3) Member has tried and failed one (1) very high potency topical steroid; OR If a very high potency topical steroid is not clinically appropriate, the highest potency steroid that can appropriately be used must be tried. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

11396069	EMMANUEL JOHN LEE MD	Family Practice	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F41.8	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for other specified anxiety disorders. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are buspirone, duloxetine, escitalopram, paroxetine, venlafaxine, bupropion, sertraline(tried) and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11396213	HAROLD BURTON ESKEW III PA	Physician Assistant	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	E29.1 - Testicular hypofunction	Criteria Not Met	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 number 1,2 and 3 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.
11462772	CELIA BETH SERVIN MD	Family Practice	EMGALITY	MIGRAINE PRODUCTS	G43.109	Criteria Not Met	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 did not show that this drug was previously approved by your prescription drug plan. 2) The drug is not prescribed by, or together with, a Neurologist or other headache treatment specialist. 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.)(TRIED), vasoactive agents (such as propranolol, metoprolol, etc.), antidepressants (such as amitriptyline, venlafaxine, etc.). Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Emgality 120mg have not been met. From the information we have received, the member does not meet number(s) 4 of our prior authorization criteria for Emgality 120mg for Migraine (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
11464771	MELANIE MARIE PICKETT MD	Dermatology	TRETINOIN	DERMATOLOGICALS	L57.8 - Other skin changes due to chronic exposure to nonionizing radiation	Criteria Not Met	Our prior authorization criteria for Acne Agents have not been met. From the records that we have received, TRETINOIN CREAM 0.025% was denied for these reasons: 1) This drug is not being used to treat 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 0.025%. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of acne vulgaris, acne rosacea, or actinic keratosis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11469035	AMY HERRIN KOWALSKI APN	Advanced Practice Nurse	UBRELVY	MIGRAINE PRODUCTS	G43.019	Criteria Not Met	Our prior authorization criteria for ubrogepant (UBRELVY) have not been met. From the records that we have received, Ubrevy 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) 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.
11475341	BRAD ERIC VENGHAUS MD	Hospitalist	TESTOSTERONE	ANDROGENS-ANABOLIC	R97.20 - Elevated prostate specific antigen [PSA]	Criteria Not Met	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) 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. 4) 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. 5) A lab value from within the last 12 months was not sent to us. 6) A second lab value from within the last 24 months was not sent to us. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Androgens: Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1, 2, 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
11486080	MANUEL JOSEPH MARTIN MD	Family Practice	DAYVIGO	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS	F51.01 - Primary insomnia	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are zolpidem (TRIED), zaleplon, trazodone, eszopiclone. Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

11499885	JAMES COCHRAN ANDERSON IV MD	Pediatrics	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	F90.2 - Attention-deficit hyperactivity disorder, combined type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equiv), Vyvanse, dextroamphetamine ER. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11502093	SCOTT WAYNE OBERHOFF MD	Allergy & Immunology	DUPIXENT	DERMATOLOGICALS	L20.9 - Atopic dermatitis, unspecified	Criteria Not Met	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) Documentation showing that sensitive areas are affected was not received. 2) Records showing the minimum disease severity score for coverage have not been received. Accepted scores are: Scoring of Atopic Dermatitis (SCORAD) index with score greater than 40, OR Eczema Area Severity Index (EASI) with score greater than 21, OR documentation of continued disease severity and impaired activities of daily living on most successful treatment regimen. 3) Documentation showing that a medium to very high potency topical steroid, such as betamethasone or halobetasol cream, has been tried and failed was not received. 4) Documentation showing that a topical calcineurin inhibitor, such as tacrolimus ointment, has been tried and failed was not received. 5) Light therapy or an immunosuppressant, such as azathioprine, cyclosporine, methotrexate, or mycophenolate mofetil, has not been tried and failed. 6) Chart notes showing previous treatments that have been tried and failed were not received. 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 3, 4, 5, and 6 of our prior authorization criteria for Dupixent for the treatment of Atopic Dermatitis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 6 years of age or older; AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, or Dermatologist; AND 3) Member has a diagnosis of chronic, severe atopic dermatitis (eczema) at baseline with greater than or equal to 10% body surface area (BSA) affected OR BSA affected is less than 10%, but member has involvement of sensitive areas (documentation required); AND 4) Level of severity documented via ONE of the following: SCORAD score greater than 40, OR Eczema Area and Severity Index (EASI) score greater than 21, OR submission of supporting documentation of continued disease severity and impaired activities of daily living while on most successful treatment regimen (documentation required); AND 5) A medium to very high potency topical steroid AND topical calcineurin inhibitor have been ineffective, contraindicated, or not tolerated (documentation required); AND 6) Member has tried Narrow Band UVB Phototherapy OR an Immunosuppressant such as azathioprine, cyclosporine, methotrexate, or mycophenolate mofetil (documentation required). 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
11502965	KERRY ALLISON RAMON APN	Nurse Practitioner	NURTEC	MIGRAINE PRODUCTS	G43.909 - Migraine, unspecified, not intractable, without status migrainosus	Criteria Not Met	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. Records show this drug will be used to PREVENT migraine headaches. This is not a covered use. 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) 3, 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.
11513811	ERIN JENNIFER SILVERTOOTH MD	Psychiatry	ADDERALL XR	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	f90.2	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior authorization may be required. Quantity limits may apply to covered drugs.
11514040	ERIN JENNIFER SILVERTOOTH MD	Psychiatry	ADDERALL XR	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	f90.2	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The criteria in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) A completed United States Food and Drug Administration (FDA) MedWatch form was not sent to us. An FDA MedWatch form is used to alert the FDA of efficacy and safety problems with the generic drug. Please look at the formulary to see what drugs are covered. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The generic form of the drug has been tried and failed; AND 2) All formulary alternatives have been tried, or medical reasons have been provided why all other covered drugs cannot be tried; AND 3) A United States Food and Drug Administration (FDA) MedWatch form, which documents efficacy and safety problems with the generic drug, has been completed and submitted with the request. The form can be downloaded from http://www.fda.gov/medwatch/getforms.htm or submitted online at https://www.accessdata.fda.gov/scripts/medwatch/. Since criteria have not been met, we are not able to approve coverage for this drug at this time. Please refer to the formulary for specific information on what is covered. Prior authorization may be required. Quantity limits may apply to covered drugs.
11515033	ANITA RAMINDER SANDHU MD	Obstetrics & Gynecology	FIRST-PROGESTERONE VGS 20	VAGINAL AND RELATED PRODUCTS	O26.872 - Cervical shortening, second trimester	Criteria Not Met	Our prior authorization criteria for Vaginal Progesterone Products have not been met. From the records that we have received, the following caused the denial of PROGESTERONE VAGINAL SUPPOSITORY. 1) The date of the last positive pregnancy test was not received (must be within the last 3 months). Since the criteria have not been met, we are not able to approve. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Vaginal Progesterone Products have not been met. From the information we have received, the member does not meet number 3 of our prior authorization criteria for PROGESTERONE VAGINAL SUPPOSITORY. The reason for denial is explained to the member above. The criteria are listed here. 1) The drug is being prescribed for infertility. Please note that coverage for this diagnosis is dependent on plan benefit design; OR 2) The drug is being prescribed for the maintenance of pregnancy; AND 3) The date of the last positive pregnancy test (must be within the last 3 months) has been received. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

							Our prior authorization criteria for 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) 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.
11520901	SUZANNE SINGERMAN ALBERT FNP-C	Nurse Practitioner	NURTEC	MIGRAINE PRODUCTS	G43.009 - Migraine without aura, not intractable, without status migrainosus	Criteria Not Met	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 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
11534819	CHRISTOPHER PAUL THOMPSON MD	Otolaryngology	XHANCE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J34.3 - Hypertrophy of nasal turbinates	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for hypertrophy of nasal turbinates. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are budesonide nasal spray, fluticasone nasal spray (TRIED), mometasone nasal spray, Beconase AQ nasal spray (Step Therapy requires trial of two (2) of these: flunisolide, fluticasone, triamcinolone, mometasone), and others. Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11538732	CAMERON MAXWELL KIELHORN MD	Family Practice	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ ANTICHOLINERGICS	K21.00	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11547832	MASI KHAJA MD	Gastroenterology	SUTAB	LAXATIVES	Z12.11 - Encounter for screening for malignant neoplasm of colon	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are PEG-3350/electrolytes (TRIED), Gavilyte-C, Trilyte, Clenpiq, Moviprep (Step Therapy requires trial of Clenpiq), Suprep (Step Therapy requires trial of Clenpiq), and others. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11549056	PAUL HIEN LE MD	Anesthesiology	BUPRENORPHINE HCL	ANALGESICS - OPIOID	Z79.891	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for chronic pain. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended-release (ER) tablet (MS Contin equivalent), Xtampza ER capsule, Nucynta ER tablet, hydrocodone ER tablet (Hysingla equivalent) or hydrocodone ER capsule (Zohydro equivalent), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent), fentanyl patch (Duragesic equivalent). Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11549485	KRISTI KINNEY HARVEY MD	Pediatrics	AZELASTINE HYDROCHLORIDE/	NASAL AGENTS - SYSTEMIC AND TOPICAL	J30.9	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

11554467	CAMERON MAXWELL KIELHORN MD	Family Practice	DEXLANSOPRAZOLE	ULCER DRUGS/ANTISPASMODICS/ ANTICHOLINERGICS	GERD	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole (TRIED), pantoprazole (TRIED), esomeprazole, lansoprazole, and rabeprazole. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11560901	AROLDO JOSE IBARRA JR PA	Physician Assistant	PEDIALYTE	MINERALS & ELECTROLYTES	none	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) We did not receive records from your doctor showing what health issue this drug is being used to treat. We tried to reach your doctor for those records. We did not get a reply. 2) Chart notes showing your health records and past treatments were not received. NOTE: This product is available over the counter (OTC) without a prescription. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11562352	TRICIA LYNN WINTERS PA	Physician Assistant	TALTZ	TARGETED IMMUNOMODULATORS	PP	Criteria Not Met	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) 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) 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.
11563473	COURTNEY SCAMARDO PA-C	Physician Assistant	SKYRIZI	TARGETED IMMUNOMODULATORS	L40.0	Criteria Not Met	Our prior authorization criteria for risankizumab (SKYRIZI) have not been met. From the records that we have received, Skyrizi 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 risankizumab (SKYRIZI) have not been met. From the information we have received, the member does not meet number(s) 3 of our prior authorization criteria for Skyrizi 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.
11566696	ERIC JAMES GIESLER MD	Urology	ERLEADA	ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES	C61 - Malignant neoplasm of prostate	Criteria Not Met	Our prior authorization criteria for Erleada have not been met. From the records that we have received, the following caused the denial of Erleada. 1) The drug is not prescribed by, or together with, an Oncology Specialist. 2) Abiraterone (Zytiga) 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 Erleada 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 Erleada. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, an Oncology Specialist; AND 2) Prescribed for a diagnosis of non-metastatic castration-resistant prostate cancer (non-mCRPC) and prostate-surface antigen doubling-time (PSADT) is less than or equal to 10 months; OR 3) Prescribed for a diagnosis of metastatic castration-sensitive prostate cancer (mCSPC) and a trial of abiraterone (Zytiga) 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.
11571781	AMY KRISTIN EASTERLING DO	Emergency Medicine	DICLOFENAC SODIUM	DERMATOLOGICALS	M17.2 - Bilateral post-traumatic osteoarthritis of knee	Criteria Not Met	Our prior authorization criteria for Diclofenac 3% (SOLARAZE) have not been met. From the records that we have received, diclofenac 3% gel was denied for these reasons: 1) This drug is not being used to treat actinic keratosis. This is a skin issue caused by too much sun. It causes scaly, rough, or bumpy spots on 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 Diclofenac 3% (SOLARAZE) have not been met. From the information we have received, the member does not meet number 1 of our prior authorization criteria for diclofenac 3% gel. The reason for denial is explained to the member above. The criteria are listed here. 1) The medication is prescribed for the treatment of Actinic Keratosis. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11574891	CHRISTOPHER KEILTY DARNALL MD	Internal Medicine	ARMODAFINIL	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	G47.419 - Narcolepsy without cataplexy	Criteria Not Met	Our prior authorization criteria for armodafinil (NUVIGIL) have not been met. From the records that we have received, Armodafinil was denied for these reasons: 1) A sleep study called a Full Nocturnal Polysomnogram (PSG) was not sent to us. This is an overnight sleep study. 2) A sleep study called a Multiple Sleep Latency (MSLT) was not sent to us. This may also be called a daytime nap study. 3) Records did not show that the average amount of time needed for you to fall asleep was less than 10 minutes. Since the criteria has not been met, we are not able to approve. Please look at our list of covered drugs, also known as the formulary, to see what is covered ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for armodafinil (NUVIGIL) have not been met. From the information we have received, the member does not meet number(s) 1 of our prior authorization criteria for Armodafinil. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed to treat Narcolepsy or Idiopathic Hypersomnolence; AND all of the following are met: (A) full nocturnal polysomnogram is received (documentation must be provided); (B) multiple sleep latency test is received (documentation must be provided); AND (C) Sleep studies must show mean onset to sleep less than 10 minutes; OR 2) Prescribed for adjunct therapy to standard treatment for the underlying obstruction due to Obstructive Sleep Apnea / Hypopnea Syndrome; AND Member is on positive airway pressure; OR 3) Prescribed to treat Shift Work Disorder. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

11578023	ELLEN LANHAM SIMMS APN	Nurse Practitioner	DESCOVY	ANTIVIRALS	Z77.21 - Contact with and (suspected) exposure to potentially hazardous body fluids	Criteria Not Met	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
11579321	ROBERT RYAN ENLOE DO	General Practice	NURTEC	MIGRAINE PRODUCTS	G43.909 - Migraine, unspecified, not intractable, without status migrainosus	Criteria Not Met	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 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) 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.
11587282	MARCIA DIANE FAGERBERG MD	Internal Medicine	ICOSAPENT ETHYL	ANTIHYPERLIPIDEMICS	high cholesterol	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) We did not receive records from your doctor showing what health issue this drug is being used to treat. We tried to reach your doctor for those records. We did not get a reply. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Vascepa, omega-3 acid ethyl ester caps (Lovaza equivalent, one statin (e.g. rosuvastatin), one fibrate (e.g. fenofibrate), and niacin ER (Niaspan ER equivalent). 3) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11588485	AUDRA LEIGH WOLFE APRN	Nurse Practitioner	NURTEC	MIGRAINE PRODUCTS	migraine	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number(s) 1, 2, and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. 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(tried), or others) have not been tried and failed. Quantity limits may apply. 3) 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.
11594620	BLYTHE ELIZABETH MONHEIT MD	Ophthalmology	VYZULTA	OPHTHALMIC AGENTS	H40.10X0	Not 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, 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 This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are latanoprost, travoprost (Travatan Z equivalent), and bimatoprost (Lumigan equivalent) or Lumigan. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11614319	CELIA BETH SERVIN MD	Family Practice	STEGLATRO	ANTIDIABETICS	E11.9 - Type 2 diabetes mellitus without complications	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Farxiga, Jardiance, Invokana. Prior authorization may be required, and quantity limits apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11630501	PAMELA JAYNE HOWARD MD	Neurology	SAVELLA	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	M79.7 - Fibromyalgia	Formulary Alternatives Available	The requested amount of Savella is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Savella at 2 tablets per day for this use. The prescribed dose is 50 mg in the morning and 100 mg in the evening. This drug comes in a 100 mg tablet. The same dose can be reached by taking one (1) 50 mg tablet in the morning and one (1) 100 mg tablet in the evening. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered.

							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) 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.
11631021	ROBERT RYAN ENLOE DO	General Practice	NURTEC	MIGRAINE PRODUCTS	G43.909	Criteria Not Met	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) 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
11631318	CHRISTINE ANN TREVINO DO	Pediatrics	NEXIUM	ULCER DRUGS/ANTISPASMODICS/ ANTICHOLINERGICS	K29.00 - Acute gastritis without bleeding	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are omeprazole capsule, First omeprazole suspension, pantoprazole tablet, esomeprazole capsule, lansoprazole capsule, lansoprazole suspension, rabeprazole. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11631345	STEVEN CURTIS CROW MD	Family Practice	SPIRIVA RESPIMAT	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	B94.8 - Sequelae of other specified infectious and parasitic diseases	Criteria Not Met	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, 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.
11634037	MAHAN OSTADIAN DO	Anesthesiology	PENNSAID	DERMATOLOGICALS	M17.9 - Osteoarthritis of knee, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are diclofenac 1% gel (Voltaren equivalent) (TRIED), diclofenac 1.5% solution, and 4 oral nonsteroidal anti-inflammatory drugs (NSAIDs) (TRIED) (eg. ibuprofen, diclofenac, meloxicam, etodolac, naproxen, celecoxib, nabumetone). Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11643131	HISHAM ALI KHAN	Anesthesiology	BUPRENORPHINE HCL	ANALGESICS - OPIOID	opioid dependence.	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are buprenorphine/naloxone sl film (SUBOXONE equivalent, buprenorphine/naloxone SL tab (SUBOXONE equivalent), Zubsolv. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11647400	IAN STEVEN ALWARD MD	Family Practice	HORIZANT	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	G25.81 - Restless legs syndrome	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are documentation of daily or refractory symptoms, gabapentin immediate release (IR)(tried), pregabalin, pramipexole (tried), ropinirole (current paid claims), Neupro patch, carbidopa-levodopa and oral analgesics such as opioids for refractory symptoms. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11647727	MAHAN OSTADIAN DO	Anesthesiology	ZTLIDO	DERMATOLOGICALS	G89.4 - Chronic pain syndrome	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for chronic pain. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are lidocaine ointment, gabapentin, amitriptyline, nortriptyline, pregabalin, and others. Quantity limits may apply Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

							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). 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.
11649207	STEVEN CURTIS CROW MD	Family Practice	SPIRIVA RESPIMAT	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	B94.8 - Sequelae of other specified infectious and parasitic diseases	Criteria Not Met	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 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.
11655848	FLORENCE OLABISI FALOLA NP	Nurse Practitioner	SUPREP BOWEL PREP KIT	LAXATIVES	Z12.11 - Encounter for screening for malignant neoplasm of colon	Formulary Alternatives Available	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.
11659200	DONALD DAVIS COLE III MD	Family Practice	FINASTERIDE	DERMATOLOGICALS	Nonscarring hair loss, unspecified	Plan Exclusion	This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
11662855	SARAH BUTTREY MD	Family Practice	OZEMPIC	ANTIDIABETICS	DM2	Not Covered	The requested amount of OZEMPIC is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover OZEMPIC at 1 pack per 28 days for this use. The higher amount of 2 packs per 28 days is not covered by your plan. Please look at the list of covered drugs, also known as our formulary, to see what is covered.
11667618	JACK CALHOUN LONG MD	Urology	GEMTESA	URINARY ANTISPASMODICS	R35.0 - Frequency of micturition	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Myrbetriq and 3 of 5 of the following: oxybutynin (tried), trospium, tolterodine, darifenacin, solifenacin (tried). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11680145	SRIYUTHA ALAVALAPATI REDDY	Internal Medicine	EMTRICITABINE/TENOFOVIR D	ANTIVIRALS	Z79.899 - Other long term (current) drug therapy	Not Covered	The requested amount of emtricitabine/tenofovir disoproxil fumarate is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover emtricitabine/tenofovir disoproxil fumarate at 30 tablets for 30 days for this use. The higher amount of 60 tablets for 60 days is not covered by your plan. Please look at the list of covered drugs, also known as our formularv. to see what is covered. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical clindamycin(tried) or erythromycin, tretinoin(tried), adapalene (Differin equiv) or adapalene/benzoyl peroxide (Epiduo equiv), and one oral antibiotic (doxycycline, minocycline, Sulfamethoxazole/Trimethoprim, cephalexin). Prior authorization may be required. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11684316	DIANA REYES PA-C	Physician Assistant	SEYSARA	TETRACYCLINES	L70.0 - Acne vulgaris	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11688098	JOSEPH EDWARD HURT NP	Nurse Practitioner	CLOMIPHENE CITRATE	ENDOCRINE AND METABOLIC AGENTS - MISC.	E29.1 - Testicular hypofunction	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for testicular hypofunction. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are testosterone gel (androgel equivalent), testosterone cypionate inj (DEPO-TESTOSTERONE equiv), testosterone soln (AXIRON equiv) and other formulary alternatives. 3) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1,2 and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11690305	LAURA KATE EASTEP MD	Obstetrics & Gynecology	ESTRADIOL	ESTROGENS	HRT	Not Covered	The requested amount of ESTRADIOL DIS 0.1MG is more than 2.5 times the recommended highest daily dose for the drug. We will still cover 2 patches per week for this use. The higher dose of 8 patches per week is not an approved dose for your health issue. In order for the higher amount to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formularv. to see what is covered bv vour plan.
11695300	KARTHIK VENKATA GARAPATI MD	Gastroenterology	BUDESONIDE ER	CORTICOSTEROIDS	K52.838 - Other microscopic colitis	Criteria Not Met	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.

							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical clindamycin (tried) or erythromycin, tretinoin (tried), adapalene (Differin equiv) or adapalene/benzoyl peroxide (Epiduo equiv), doxycycline (tried), minocycline (tried). Prior authorization may be required. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11706503	DIANA REYES PA-C	Physician Assistant	SEYSARA	TETRACYCLINES	L70.0 - Acne vulgaris	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11707514	KRISHNA POKALA MD	Internal Medicine	NURTEC	MIGRAINE PRODUCTS	G43.019	Not Covered	The requested amount of Nurtec is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Nurtec at 8 tablets per 30 days, 6 fills per year for this use. The higher number of 1 tablet every other day is not a covered amount of this drug per your plan. Please note that your plan does not cover Nurtec when used for migraine prevention. Covered drugs that may be used for migraine prevention include anti-seizure drugs (e.g. topiramate immediate release (IR), valproic acid), beta-blockers (e.g. propranolol (tried), metoprolol, timolol), Aimovig, Ajovy, Emgality, and others. Prior authorization may be required. Quantity limits may apply. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
11714593	WILLIAM MARC LEWIS DO	Internal Medicine	LOMAIRA	ADHD/ANTI-NARCOLEPSY/ANTI-	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
11722107	SCOTT WAYNE OBERHOFF MD	Allergy & Immunology	HIZENTRA	PASSIVE IMMUNIZING AND TREATMENT AGENTS	D80.3	Criteria Not Met	Our prior authorization criteria for Subcutaneous Immune Globulin (SCIG) Products have not been met. From the records that we have received, HIZENTRA was denied for these reasons: 1) More information is needed to show that you will be injecting this medication at your home. 2) The drug is not being used for primary immunodeficiency. This is a health issue where the immune system is weakened. 3) Records did not show that you have not responded as expected to a vaccine. 4) Records did not show that you have a history of serious infections. 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 Subcutaneous Immune Globulin (SCIG) Products have not been met. From the information we have received, the member does not meet number(s) 1, 2, 4, 5 of our prior authorization criteria. The reason for denial is explained to the member above. The criteria are listed here. 1) Records sent to us indicate ONE (1) of the following: (A) Product will be self-administered; OR (B) Product will be health care professional/office-administered (Please note: injectables administered in the office by a health care professional may not be covered under your pharmacy benefit); AND 2) Member has a diagnosis of primary immunodeficiency such as: agammaglobulinemia due to absence of B cells, hypogammaglobulinemia, normal immunoglobulins with poor antibody function or a genetically defined primary immunodeficiency disease; AND 3) Prescribed by, or in consultation with, an Allergist, Immunologist, or Hematologist; AND 4) Member had inadequate responsiveness to specific antigens (e.g. pneumococcal polysaccharide); OR 5) Member has a history of recurrent significant 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.
11750156	MANSI PATEL	Nurse Practitioner	CETIRIZINE HYDROCHLORIDE	ANTIHISTAMINES	J01.00 - Acute maxillary sinusitis, unspecified	Plan Exclusion	This request cannot be approved because your plan has chosen this drug to be excluded from coverage. Other drugs for your health issue may be covered by your plan. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue. PLEASE NOTE: Not being able to use other covered options will not change the exclusion of this drug from coverage. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Xyrem (tried), modafinil (tried), armodafinil, Sunosi, and Wakix. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11761877	IAN STEVEN ALWARD MD	Family Practice	XYWAV	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	narcolepsy	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11766130	KY QUOC NGUYEN MD	Pediatrics	METHYLPHENIDATE HYDROCHLO	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	Attention-deficit hyperactivity disorder, combined type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER) (TRIED), methylphenidate ER (Ritalin LA equiv, Concerta equiv), amphetamine/dextroamphetamine ER (Adderall XR equiv), Vyvanse, dextroamphetamine ER. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11767206	CHRISTOPHER RIDDELL JONES JR MD	Dermatology	COSENTYX SENSOREADY PEN	TARGETED IMMUNOMODULATORS	PSORIASIS VULGARIS	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Enbrel (TRIED), Humira (TRIED), Taltz, Tremfya, Cimzia, Otezla, Skyrizi, Stelara (TRIED). Prior authorization may be required and quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11770923	RUDXANDRA AGUIAR MD	Internal Medicine	LUBIPROSTONE	GASTROINTESTINAL AGENTS - MISC.	Drug induced constipation	Criteria Not Met	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) 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 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.

							Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, TESTOSTERONE GEL 1.62% was denied for these reasons: 1) Records show that this drug is being used for age-related low testosterone levels. This is not a covered use on your drug 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.
11773849	RACHEL ELIZABETH DOCKRAY PA-C	Physician Assistant	TESTOSTERONE	ANDROGENS-ANABOLIC	E29.1 - Testicular hypofunction	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 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) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue 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.
11797164	STACIA CHRISTINE MILES MD	Dermatology	HUMIRA PEN	TARGETED IMMUNOMODULATORS	L40.9 - Psoriasis, unspecified	Criteria Not Met	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 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.
11810943	KARTHIK VENKATA GARAPATI MD	Gastroenterology	TALICIA	ULCER DRUGS/ANTISPASMODICS/ ANTICHOLINERGICS	B96.81 - Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equivalent) and Pylera. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11812121	DONALD DAVIS COLE III MD	Family Practice	ALBUTEROL SULFATE HFA	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	J45.20	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Another drug that can be used is Ventolin HFA. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11816740	RODOLFO GABRIEL GUTIERREZ-MACIAS MD	Family Practice	DRONABINOL	ANTIEMETICS	Abnormal weight loss	Criteria Not Met	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. 3) Records did not show you have tried and failed at least one other drug for nausea and vomiting related to cancer treatments. Records showing the other drug you tried were not received. Other drugs we cover that can help with nausea and vomiting are meclizine, promethazine, prochlorperazine, metoclopramide, trimethobenzamide, ondansetron, granisetron, aprepitant, and others 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 numbers 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.
11825778	RACHEL LEAH MILLER PA-C	Physician Assistant	RHOFADE	DERMATOLOGICALS	Rosacea	Plan Exclusion	This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
11825940	RACHEL LEAH MILLER PA-C	Physician Assistant	IVERMECTIN	DERMATOLOGICALS	L71.8	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are metronidazole gel 0.75% and azelaic acid (Finacea equivalent). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11829855	KARTHIK VENKATA GARAPATI MD	Gastroenterology	TALICIA	ULCER DRUGS/ANTISPASMODICS/ ANTICHOLINERGICS	B96.81 - Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equivalent) and Pylera. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11836536	ELIZABETH LYNN POLLOCK MD	Family Practice	WEGOVY	ADHD/ANTI-NARCOLEPSY/ANTI-	Z68.41 - Body mass index [BMI] 40.0-44.9, adult	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

11839676	DEVIKA MARANGATTU MADHAVAN	Endocrinology, Diabetes & Metabolism	LEVOTHYROXINE SODIUM	THYROID AGENTS	E89.0 - Postprocedural hypothyroidism	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are SYNTHROID. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11857216	CHRISTOPHER TR PARKER DO	Rheumatology	STELARA	TARGETED IMMUNOMODULATORS	L40.50	Criteria Not Met	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 show you weigh under 100 kilograms (220 pounds). The 90mg dose of this drug is not covered for this health issue for members that weigh under 100 kilograms. 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) 4 of our prior authorization criteria for Stelara 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) If the 90mg dose is requested, BOTH of the following are met: (A) Member has co-morbid moderate-to-severe plaque psoriasis (PP); AND (B) 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.
11859332	ADRIANA AZAR PRATT MD	Family Practice	TROKENDI XR	ANTICONVULSANTS	G43.009	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are a total of 5 preferred alternatives, including: topiramate immediate release (IR) plus 1 other anti-seizure medication (eg. valproic acid), 1 beta-blocker (eg. propranolol, metoprolol, timolol), and 2 other formulary alternatives appropriate for migraine prevention. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11859725	NARENDRA SHIVRAM PUNJABI MD	Allergy & Immunology	ALBUTEROL SULFATE HFA	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	R06.00 - Dyspnea, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are VENTOLIN HFA INHALER. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11862854	MEGAN ALYSE JUAREZ NP-C	Nurse Practitioner	LISINOPRIL	ANTIHYPERTENSIVES	I10 - Essential (primary) hypertension	Plan Limits Exceeded	The requested amount of LISINOPRIL is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover LISINOPRIL at a 30 day supply. The higher amount of a 90 day supply is not covered by your plan. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for attention deficit hyperactivity disorder (ADHD) in an adult patient. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended-release (ER) capsule, amphetamine/dextroamphetamine ER capsule (Adderall XR equivalent), methylphenidate ER tablet or capsule, and Vyvanse (TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11867244	ADRIANA GUERRA GUERRA	Family Practice	AMPHETAMINE SULFATE	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	F90.0	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11876421	ADRIANA AZAR PRATT MD	Family Practice	TROKENDI XR	ANTICONVULSANTS	G43.009 - Migraine without aura, not intractable, without status migrainosus	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are a total of five (5) covered alternatives, including topiramate tablet (TRIED), one (1) other anti-seizure medication (eg. valproic acid), one (1) beta-blocker (eg. propranolol, metoprolol, timolol), and two (2) other covered alternatives appropriate for migraine prevention. Prior authorization may be required, and quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are proctosol HC cream (Anusol-HC equivalent), pramoxine/hydrocortisone cream kit (Analpram-HC equivalent), lidocaine/hydrocortisone cream (Anamantle equivalent), and Proctofoam-HC foam. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11885016	KAYLEIGH PAIGE HEAD FNP	Nurse Practitioner	PRAMOXINE HCL	ANORECTAL AND RELATED PRODUCTS	K64.5 - Perianal venous thrombosis	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are proctosol HC cream (Anusol-HC equivalent), pramoxine/hydrocortisone cream kit (Analpram-HC equivalent), lidocaine/hydrocortisone cream (Anamantle equivalent), and Proctofoam-HC foam. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11885067	KAYLEIGH PAIGE HEAD FNP	Nurse Practitioner	ANUCORT-HC	ANORECTAL AGENTS	K64.5 - Perianal venous thrombosis	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11886533	LAURA KATE EASTEP MD	Obstetrics & Gynecology	ESTRADIOL	ESTROGENS	HRT	Not Covered	The requested amount of Estradiol patches is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover Estradiol patches at twice weekly dosing for this use. The higher number of 3 times weekly dosing is not an approved dose for your health issue. In order for the higher quantity to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) The records that were provided did not include a diagnosis. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Bydureon, Ozempic(tried), Rybelsus, Trulicity(tried), Victoza, and Byetta. 3) Chart notes showing your health records and past treatments were not received. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11886847	JESSLYN JIAEN LU MD	Endocrinology, Diabetes & Metabolism	MOUNJARO	ANTIDIABETICS	not provided	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet numbers 1, 2, and 3 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are anti-allergy nasal sprays azelastine nasal spray 0.1% (ASTELIN equivalent), azelastine nasal spray 0.15% (ASTEPRO equivalent), olopatadine nasal spray (PATANASE equivalent) used together with steroid nasal sprays budesonide nasal spray (RHINOCORT AQUA equivalent, FLUNISOLIDE NASAL SPRAY, fluticasone nasal spray (FLONASE equivalent), mometasone nasal spray (NASONEX equivalent), Nasacort/triamcinolone nasal spray, Beconase AQ (Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone, or mometasone), Zetonna (Step Therapy requires trial of 2: flunisolide, fluticasone, triamcinolone, or mometasone). Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11892125	JEANETTE LYN BETTES PA	Physician Assistant	AZELASTINE HYDROCHLORIDE/	NASAL AGENTS - SYSTEMIC AND TOPICAL	J30.9 - Allergic rhinitis, unspecified	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11899460	KENNETH ALLEN PEREZ DO	Family Practice	MODAFINIL	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	ADHD	Criteria Not Met	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, idiopathic hypersomnolence, or multiple sclerosis-related fatigue. These are health issues that can make you feel tired during the day. Please note: additional requirements for each health issue 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 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 or idiopathic hypersomnolence; 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.
							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Alternatives include aripiprazole (Abilify), risperidone (Risperdal)-(tried) AND one of the following: quetiapine(tried), olanzapine, ziprasidone, or asenapine. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11899930	ORLANDO ISSAI GUARDIOLA	Advanced Practice Nurse	REXULTI	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F25.0	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

							Our prior authorization criteria for finerenone (Kerendia) have not been met. From the records that we have received, Kerendia was denied for these reasons: 1) Records did not show you have a diagnosis of Type 2 Diabetes. This is a health issue where your blood sugar is too high. 2) Records did not show that you have tried another drug called Farxiga. 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.
11901108	PAUL CHARLES NADER MD	Nephrology/Renal Medicine	KERENDIA	ENDOCRINE AND METABOLIC AGENTS - MISC.	N26.9 - Renal sclerosis, unspecified	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for finerenone (Kerendia) 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 Kerendia. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has a diagnosis of BOTH Type 2 Diabetes AND Chronic Kidney Disease (CKD); AND 2) A trial of dapagliflozin (Farxiga) was not tolerated or contraindicated. 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.
11903535	ELIZABETH LYNN POLLOCK MD	Family Practice	WEGOVY	ADHD/ANTI-NARCOLEPSY/ANTI-	Z68.41 - Body mass index [BMI] 40.0-44.9, adult	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Proctosol HC cream (ANUSOL HC equivalent), pramoxine/hydrocortisone cream kit (ANALPRAM-HC equivalent), lidocaine/hydrocortisone cream (ANAMANTLE equivalent), Proctofoam HC foam, and Analpram-E kit. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11905818	DURRESHAHWAR KHURSHEED KHAN MD	Internal Medicine	HYDROCORTISONE ACETATE	ANORECTAL AND RELATED PRODUCTS	K64.1 - Second degree hemorrhoids	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11906224	ANGUS MCCLELLAN LOWRY MD	Anesthesiology	BELBUCA	ANALGESICS - OPIOID	chronic pain syndrome	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER or oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent-TRIED). Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11937680	CARLOS LEO ROMERO DPM	Podiatrist	HYDROCODONE BITARTRATE/AC	ANALGESICS - OPIOID	M20.0	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. We have received a request for 30 tablets for a 10 day supply for hydrocodone/acetaminophen tablet. This amount is more than the amount covered for members who are new to using an opioid pain reliever (or who have not used an opioid pain reliever recently). 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.
11946964	TODD ALAN CANON MD	Family Practice	TESTOSTERONE	ANDROGENS-ANABOLIC	E29.1 - Testicular hypofunction	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, testosterone gel was denied for these reasons: 1) Records show that this drug is being used for age-related low testosterone levels. This is not a covered use on your drug 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 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) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue 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.
11954933	MICHAEL K FLOYD	Urology	GEMTESA	URINARY ANTISPASMODICS	R35.1	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Myrbetriq, and three (3) of the following: oxybutynin, trospium, tolterodine, darifenacin, solifenacin. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11963783	JEFFREY NORMAN HIGGINBOTHAM MD	Anesthesiology	SAVELLA	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	M79.7 - Fibromyalgia	Not Covered	The requested amount of SAVELLA tablet is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover SAVELLA 50MG tablet at 2 tablets per day for this use. The prescribed dose is 3 tablets per day (one tablet every morning and two (2) tablets at night). This drug comes in a 100mg tablet. The same dose can be reached by taking one 50mg tablet every morning and one 100mg tablet at night. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are amoxicillin/clarithromycin/lansoprazole kit (Prevpac equivalent) and Pylera. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
11969138	KARTHIK VENKATA GARAPATI MD	Gastroenterology	TALICIA	ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS	B96.81 - Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

11989696	PRATIMA VIJAY KUMAR MD	Internal Medicine	DEXCOM G6 SENSOR	MEDICAL DEVICES	T1DM	Criteria Not Met	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. 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 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.
11992522	GRACE LORENA HONLES MD	Family Practice	TESTOSTERONE	ANDROGENS-ANABOLIC	E29.1 - Testicular hypofunction	Criteria Not Met	Our prior authorization criteria for Androgens: Transdermal Testosterone Products have not been met. From the records that we have received, Testosterone 1.62% gel was denied for these reasons: 1) Records show that this drug is being used for age-related low testosterone levels. This is not a covered use on your drug 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 Androgens: Transdermal Testosterone Products have not been met. From the information we have received, the member does not meet number(s) 1 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) Member is being monitored, has benefitted from topical androgen therapy, and it is appropriate to continue 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.
12001849	WH HARRIS JR NP	Nurse Practitioner	DESCOVY	ANTIVIRALS	Z77.21 - Contact with and (suspected) exposure to potentially hazardous body fluids	Criteria Not Met	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
12003253	DANIEL ANTHONY CARRASCO MD	Dermatology	VTAMA	DERMATOLOGICALS	L30.8 - Other specified dermatitis	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for eczema. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical steroids (e.g. clobetasol cream/ointment, betamethasone dipropionate (tried) and others), topical calcinuerin inhibitors (e.g. tacrolimus ointment and pimecrolimus cream), Opzelura. Prior authorization may apply. 3) Chart notes showing your health records and past treatments were not received. 4) Samples were used to start treatment with this drug. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1, 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12013213	IAN STEVEN ALWARD MD	Family Practice	XYWAV	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	G47.419 - Narcolepsy without cataplexy	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are modafinil (TRIED), armodafinil, Xyrem (TRIED), Wakix, and Sunosi. Prior authorization may be required and quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12032980	SIMONA MARIANA SCUMPIA MD	Endocrinology, Diabetes & Metabolism	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	Z95.5 - Presence of coronary angioplasty implant and graft	Criteria Not Met	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 were not sent to us that show your low density lipoprotein (LDL) level did not go below 95mg/dL while taking a strong dose of a statin drug. 2) Records were not sent to us that show your low density lipoprotein (LDL) level did not go below 70mg/dL while taking ezetimibe (Zetia equiv) with a strong dose of a statin drug. 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) 4 of our prior authorization criteria for Repatha for Clinical Atherosclerotic Cardiovascular Disease (ASCVD) in a member who is unable to meet their Low-density lipoprotein (LDL) goal. The reason for denial is explained to the member above. The criteria are listed here. 1) Member has Clinical Atherosclerotic Cardiovascular Disease (ASCVD), defined by at least one (1) of the following: (a) acute coronary syndromes (ACS), (b) history of myocardial infarction (MI), (c) ongoing angina (stable or unstable), (d) prior coronary or other arterial revascularization, (e) prior stroke or transient ischemic attack (TIA), OR (f) peripheral arterial disease of atherosclerotic origin; AND 2) Member is unable to meet low-density lipoprotein (LDL) goal; AND 3) Member has failed a minimum 8-week trial of one (1) of the following high-intensity statin therapies: (a) atorvastatin (dose of 40 mg per day or greater); OR (b) rosuvastatin (dose of 20mg per day or greater); AND 4) Member meets one (1) of the following: (a) Low-density lipoprotein (LDL) level remains greater than or equal to 95 mg/dL while on high-intensity statin therapy; OR (b) LDL level remains greater than or equal to 70 mg/dL while on high-intensity statin therapy in combination with ezetimibe. 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.
12034012	SARAH MACLEOD DAVIDSON	Nurse Practitioner	MOUNJARO	ANTIDIABETICS	Z68.43 - Body mass index [BMI] 50.0-59.9, adult	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.

							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are formulary nasal antihistamines (azelastine 0.1% nasal spray, azelastine 0.15% nasal spray, olopatadine nasal spray) used in combination with a formulary nasal steroid (budesonide nasal spray, flunisolide nasal spray, fluticasone nasal spray, mometasone nasal spray, triamcinolone nasal spray, Flonase Sensimist nasal spray, Beconase AQ nasal spray, Zetonna nasal spray). Step therapy and/or quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12038753	AMY HERRIN KOWALSKI APN	Advanced Practice Nurse	AZELASTINE HYDROCHLORIDE/	NASAL AGENTS - SYSTEMIC AND TOPICAL	R09.81 - Nasal congestion	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12045757	BHASKARA MICHAEL GANTI MD	Anesthesiology	MOVANTIK	GASTROINTESTINAL AGENTS - MISC.	Z79.891	Criteria Not Met	Our prior authorization criteria for naloxegol (MOVANTIK) have not been met. From the records that we have received, Movantik was denied for these reasons: 1) More information is needed to know if you need frequent (e.g. weekly) increases in your pain medication dose. 2) One or more of the following drugs has not been tried for at least 1 month: stimulants (bisacodyl, sennosides), Miralax, Glycolax, Metamucil, Citrucel, or Fibercon. These drugs are available over the counter (OTC) without a prescription. Your pharmacy benefit may not cover these OTC drugs. 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 naloxegol (MOVANTIK) 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 Movantik. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed for the treatment of Opioid-Induced Constipation (OIC) in an adult who does not require frequent (e.g. weekly) opioid dosage escalation; AND 2) A one-month trial (minimum) of ONE (1) of the following was ineffective or not tolerated: (A) stimulants (bisacodyl, sennosides); OR (B) PEG 3350 (MIRALAX, GLYCOLAX); OR (C) bulk-forming laxatives (METAMUCIL, CITRUCEL, FIBERCON). Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to
							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended-release (ER) tablet, oxycodone ER tablet, Xtampza ER, Nucynta ER, hydrocodone ER tablet (Hysingla equivalent) or hydrocodone ER capsule (Zohydro equivalent), tramadol ER tablet, buprenorphine patch (Butrans equivalent), fentanyl patch (Duragesic equivalent). Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12050043	PAMELA JAYNE HOWARD MD	Neurology	BELBUCA	ANALGESICS - OPIOID	G89.4	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12053537	PAUL BENARD MOORE MD	Endocrinology, Diabetes & Metabolism	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	E10.9 - Type 1 diabetes mellitus without complications	Criteria Not Met	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, tadalafil 5mg tablet was denied for these reasons: 1) One of these drugs has not been tried and failed: doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, tamsulosin cap, OR dustasteride/tamsulosin cap. 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.
12063764	DONALD DAVIS COLE III MD	Family Practice	ALBUTEROL SULFATE HFA	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	Mild intermittent asthma with (acute) exacerbation	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Ventolin. Paid claim seen - need more information on if member has failed. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12069104	TODD ALAN CANON MD	Family Practice	DESCOVY	ANTIVIRALS	Z20.6 - Contact with and (suspected) exposure to human immunodeficiency virus [HIV]	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs. 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
12071184	ELIZABETH ANNE SORENSEN MD	Family Practice	MEMANTINE HYDROCHLORIDE	PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.	G90.50 - Complex regional pain syndrome I, unspecified	Not Covered	The requested amount of memantine 10mg tablet is more than 2.5 times the recommended highest daily dose for the drug. We will still cover 2 tablets per day (20mg) per day for this use. The higher dose of 6 tablets per day (60mg) per day is not an approved dose for your health issue. In order for the higher amount per day to be approved, medical support must be sent in. This should include published studies from major peer reviewed medical journals, treatment guidelines showing the higher dose is safe and helpful for this health issue, chart notes that show all other drugs and treatments that have been failed, and reasons why other treatments cannot be used. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.

12071875	MORGAN OLIVIA CAREY	Physician Assistant	CAPLYTA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	F33.1 - Major depressive disorder, recurrent, moderate	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for major depressive disorder. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are 2 formulary antipsychotic agents (risperidone, aripiprazole, olanzapine, ziprasidone, quetiapine, and others). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12086953	JOSEPH KHALIL IMSAIS MD	Cardiology	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	I25.10 - Atherosclerotic heart disease of native coronary artery without angina pectoris	Criteria Not Met	Our prior authorization criteria for Repatha have not been met. From the records that we have received, Repatha 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 Repatha have not been met. From the information we have received, the member does not meet number(s) 3 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.
12092109	MICHELLE LE MARKLEY MD	Family Practice	MOUNJARO	ANTIDIABETICS	E66.9 - Obesity, unspecified	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
12099392	CHRISTOPHER RYAN OXNER MD	Surgery, General	PEG-3350/ELECTROLYTES/ASC	LAXATIVES	C18.6 - Malignant neoplasm of descending colon	Criteria Not Met	Our prior authorization criteria for Step Therapy have not been met. Step Therapy means that other drugs will need to be tried and failed first. From the records that we have received, PEG-3350/electrolytes (MOVIPREP equivalent) 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.
12105102	COLLEEN MARIE ENOS PA	Physician Assistant	DESCOVY	ANTIVIRALS	Z77.21 - Contact with and (suspected) exposure to potentially hazardous body fluids	Criteria Not Met	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
12118077	JOSEPH KHALIL IMSAIS MD	Cardiology	REPATHA SURECLICK	ANTIHYPERLIPIDEMICS	I25.10	Criteria Not Met	Our prior authorization criteria for Repatha have not been met. From the records that we have received, Repatha 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 Repatha have not been met. From the information we have received, the member does not meet number(s) 3 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.
12122467	ELIZABETH REBECCA GEDDES-BRUCE MD	Dermatology	DOXYCYCLINE	DERMATOLOGICALS	L70.0 - Acne vulgaris	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) This drug is being used for acne vulgaris. This is not an approved use. 2) All covered drugs used for your health issue have not been tried and failed. Covered formulations of doxycycline and minocycline are: doxycycline hyclate capsule (Vibramycin equivalent), doxycycline hyclate tablet (Vibratab equivalent), doxycycline monohydrate capsule (Monodox equivalent), doxycycline monohydrate tablet (Adoxa equivalent), minocycline capsule (Minocin equivalent), and minocycline tablet (Dynacin equivalent). Other drugs that can be used are topical clindamycin or erythromycin, tretinoin, adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (e.g. doxycycline, minocycline, others). Prior authorization may be required. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 1 and 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

12122580	DAVID IRA WARTENBERG MD	Family Practice	DESCOVY	ANTIVIRALS	Z20.6 - Contact with and (suspected) exposure to human immunodeficiency virus [HIV]	Criteria Not Met	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
12123368	CODY PAULINE SEEL	Physician Assistant	TALTZ	TARGETED IMMUNOMODULATORS	Psoriasis vulgaris	Criteria Not Met	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) 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) 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
12141456	KATHRYN CHRISTEN SIEMS PA	Physician Assistant	FINASTERIDE	DERMATOLOGICALS	L64.9 - Androgenic alopecia, unspecified	Plan Exclusion	This request cannot be approved because this drug is a non-formulary drug. This drug is not covered based on guidance from our Pharmacy and Therapeutics (P&T) Committee, related to the review of not covered drugs. Also, drugs used for a cosmetic purpose, such as improving your appearance, are excluded from coverage. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan.
12144994	JEFFREY MICHAEL BENZICK MD	Psychiatry	QUVIVIQ	HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS	F51.01 - Primary insomnia	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are zolpidem (tried), zaleplon, trazodone, eszopiclone. Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12154713	KAILA ALISON SMITH APN	Nurse Practitioner	IMVEXXY MAINTENANCE PACK	VAGINAL AND RELATED PRODUCTS	N95.2 - Postmenopausal atrophic vaginitis	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are estradiol vaginal tablets (tried), estradiol cream (Estrace equivalent) (tried), Premarin vaginal cream, Estring. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12157600	CHAD FRANCIS BABCOCK MD	Emergency Medicine	NURTEC	MIGRAINE PRODUCTS	G43.811	Criteria Not Met	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) 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) 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
12174111	DANIEL ANTHONY CARRASCO MD	Dermatology	VTAMA	DERMATOLOGICALS	L40.0 - Psoriasis vulgaris	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are two topical steroids (such as clobetasol, betamethasone), one topical vitamin D analog (such as calcipotriene, calcitriol), tazarotene, tacrolimus and pimecrolimus Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

12185041	RAJESH ANAND SHETTY MD	Pulmonary Disease	NUCALA	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	EGPA	Criteria Not Met	Our prior authorization criteria for mepolizumab (NUCALA) for subcutaneous injection have not been met. From the records that we have received, Nucala was denied for these reasons: 1) One of the following drugs has not been tried and failed: azathioprine, cyclophosphamide, leflunomide, or methotrexate. 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 mepolizumab (NUCALA) for subcutaneous injection have not been met. From the information we have received, the member does not meet number(s) 7 of our prior authorization criteria for Nucala for Eosinophilic Granulomatosis with Polyangiitis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Records sent to us indicate ONE (1) of the following: (A) Product will be self-administered; OR (B) Product will be health care professional/office-administered (Please note: injectables administered in the office by a health care professional may not be covered under your pharmacy benefit); AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, Pulmonologist, or Rheumatologist; AND 3) Member has a diagnosis of Eosinophilic Granulomatosis with Polyangiitis (EGPA) (also known as Churg-Strauss Syndrome); AND 4) Member is 18 years of age or older; AND 5) Documentation of ONE (1) of the following is provided with the request (Documentation is required for approval): (A) Baseline blood eosinophil count greater than 1,000 cells per microliter; OR (B) Baseline blood eosinophil count greater than 10% of the total leukocyte count; AND 6) A trial of oral corticosteroid therapy (equivalent to prednisone 7.5 mg/day for a minimum of 4 weeks) was ineffective, contraindicated, or not tolerated; AND 7) A trial of ONE (1) of the following was ineffective, contraindicated, or not tolerated: azathioprine, cyclophosphamide, leflunomide, OR methotrexate. 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.
12188705	MUHAMMAD OMAIR AHSAN ATA	Psychiatry	DULOXETINE HYDROCHLORIDE	ANTIDEPRESSANTS	MDD	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Duloxetine 20mg, 30mg, and 60mg (tried). Please note two (2) 20mg tablets to equal 40mg. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12196316	JAY LELAND VIERNES MD	Dermatology	DUPIXENT	DERMATOLOGICALS	AD	Criteria Not Met	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. 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 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 a positive clinical response has been provided (documentation is required to be submitted for an approval); AND 2) Dupixent will NOT be used in combination with another targeted immunomodulator product. 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.
12211013	JAMES COCHRAN ANDERSON IV MD	Pediatrics	ADZENYS XR-ODT	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	F90.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equiv), Vyvanse. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12212145	JAY LELAND VIERNES MD	Dermatology	WINLEVI	DERMATOLOGICALS	L70.0 - Acne vulgaris	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical clindamycin or erythromycin, tretinoin, adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline, minocycline, Sulfamethoxazole/Trimethoprim, cephalexin). Prior authorization may be required. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12212879	JANE SPERRY CHAWLA MD	Oncology, Medical	PREGABALIN	ANTICONVULSANTS	M62.830	Not Covered	The requested amount of pregabalin is greater than the quantity limit for the drug. A quantity limit is the largest amount of the drug allowed by the plan. It is used to make sure a drug is used the right way. We will cover pregabalin at 3 capsules per day for this use. The prescribed dose is 75 mg twice daily for 1 week, then 150 mg twice daily. This drug comes in a 150 mg capsule. The same dose can be reached by taking one 75 mg capsule twice daily for 1 week, then one 150 mg capsule twice daily. Please look at the list of covered drugs, also known as the formulary, to see what drugs are covered.
12214140	RAISSA MIJARES BEHM FNP	Nurse Practitioner	DESCOVY	ANTIVIRALS	Z20.6 - Contact with and (suspected) exposure to human immunodeficiency virus [HIV]	Criteria Not Met	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
12219089	BRAD ERIC VENGHAUS MD	Hospitalist	MOUNJARO	ANTIDIABETICS	E66.01 - Morbid (severe) obesity due to excess calories	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue. Please note: Similar medications covered for type 2 diabetes include Bydureon/Bvetta, Ozempic, Rybelsus, Trulicity, Victoza. Quantity limits may apply

12220726	MOLLY THOMPSON CAMPA	Dermatology	TRETINOIN	DERMATOLOGICALS	L81.1 - Chloasma	Criteria Not Met	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.
12224407	HAROLD BURTON ESKEW III PA	Physician Assistant	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	E29.1 - Testicular hypofunction	Plan Exclusion	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. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Myrbetriq and 3 of the following: oxybutynin, trospium, tolterodine (tried), darifenacin, solifenacin. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12234219	MICHAEL K FLOYD	Urology	GEMTESA	URINARY ANTISPASMODICS	OAB	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12257906	SIMONA MARIANA SCUMPIA MD	Endocrinology, Diabetes & Metabolism	DEXCOM G6 SENSOR	MEDICAL DEVICES	E10.9 - Type 1 diabetes mellitus without complications	Criteria Not Met	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 still 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 doctor believes your blood sugar will not be controlled without a Continuous Glucose Monitor (CGM), OR (d) You have done well with CGM use and are likely to continue to benefit. 2) 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 1, 2 of our prior authorization criteria for DEXCOM G6 CONTINUOUS GLUCOSE MONITOR (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.
12258967	PRIYANKA KAMATH MD	Obstetrics & Gynecology	MUGARD	MOUTH/THROAT/DENTAL AGENTS	K12.31 - Oral mucositis (ulcerative) due to antineoplastic therapy	Plan Exclusion	This request has not been approved because this product was approved by the United States Food and Drug Administration (FDA) as a medical device. Medical devices are non-drug products that are meant to help diagnose and treat health issues. Medical devices cannot be approved and are excluded from coverage under your pharmacy benefit. This product may be covered under your medical benefit, as decided by your health plan. Please review your medical benefit policy to see what is covered by your health plan. There also may be over-the-counter (OTC) products that you can buy without a prescription that may treat your health issue. Please look at our formulary to see what drugs are covered on your pharmacy benefit. Prior authorization may be required. Quantity limits may apply to covered drugs. This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are testosterone cypionate injection, Androderm patch, testosterone gel 1% (tried), testosterone gel 1.62% (tried), testosterone solution (Axiron equivalent).. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12280237	JASON HALL RAMSDELL PA	Physician Assistant	TESTOSTERONE ENANTHATE	ANDROGENS-ANABOLIC	E29.1 - Testicular hypofunction	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12288922	AMANDA LYNN WEBSTER PA-C	Physician Assistant	NURTEC	MIGRAINE PRODUCTS	G43.009 - Migraine without aura, not intractable, without status migrainosus	Criteria Not Met	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 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) 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.
12296251	RAJESH ANAND SHETTY MD	Pulmonary Disease	NUCALA	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	M30.1 - Polyarteritis with lung involvement [Churg-Strauss]	Criteria Not Met	Our prior authorization criteria for mepolizumab (NUCALA) for subcutaneous injection have not been met. From the records that we have received, Nucala was denied for these reasons: 1) One of the following drugs has not been tried and failed: azathioprine, cyclophosphamide, leflunomide, or methotrexate. 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 mepolizumab (NUCALA) for subcutaneous injection have not been met. From the information we have received, the member does not meet number(s) 7 of our prior authorization criteria for Nucala for Eosinophilic Granulomatosis with Polyangiitis (Initial Therapy). The reason for denial is explained to the member above. The criteria are listed here. 1) Records sent to us indicate ONE (1) of the following: (A) Product will be self-administered; OR (B) Product will be health care professional/office-administered (Please note: injectables administered in the office by a health care professional may not be covered under your pharmacy benefit); AND 2) Prescribed by, or in consultation with, an Allergist, Immunologist, Pulmonologist, or Rheumatologist; AND 3) Member has a diagnosis of Eosinophilic Granulomatosis with Polyangiitis (EGPA) (also known as Churg-Strauss Syndrome); AND 4) Member is 18 years of age or older; AND 5) Documentation of ONE (1) of the following is provided with the request (Documentation is required for approval): (A) Baseline blood eosinophil count greater than 1,000 cells per microliter; OR (B) Baseline blood eosinophil count greater than 10% of the total leukocyte count; AND 6) A trial of oral corticosteroid therapy (equivalent to prednisone 7.5 mg/day for a minimum of 4 weeks) was ineffective, contraindicated, or not tolerated; AND 7) A trial of ONE (1) of the following was ineffective, contraindicated, or not tolerated: azathioprine, cyclophosphamide, leflunomide, OR methotrexate. 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.

12303435	ALICE DIANE FRIEDMAN MD	Gastroenterology	SODIUM SULFATE/POTASSIUM	LAXATIVES	Z12.11 - Encounter for screening for malignant neoplasm of colon	Formulary Alternatives Available	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, SODIUM/POTAS SUL MAGNESIUM 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.
12320433	NATHAN WALLACE ANDERSON MD	Family Practice	FREESTYLE LIBRE/SENSOR/FL	MEDICAL DEVICES	Type 2 diabetes mellitus with diabetic polyneuropathy (HCC)	Criteria Not Met	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. 4) Records do not show you are under the care of a diabetes care expert. 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 and 3 of our prior authorization criteria for FREESTYLE LIBRE. The reason for denial is explained to the member above. The criteria are listed here. 1) Member with Type 1 or Type 2 Diabetes using insulin; AND 2) Member meets one of the following: (A) Member has demonstrated hypoglycemia unawareness; OR (B) Undetected hypoglycemia poses an occupational safety risk; OR (C) Member has suboptimal diabetes control and 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) 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.
12328271	ISELA ARRIETA WERCHAN MD	Psychiatry	BUPRENORPHINE HCL	ANALGESICS - OPIOID	F11.20	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are buprenorphine/naloxone SL film/tablet (SUBOXONE equivalent) (We show recent paid claims. More information is needed if this does not work for you.), Zubsolv SL tablet. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12332315	HALEY CLARK OVERSTREET MD	Family Practice	XHANCE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J33.9 - Nasal polyp, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are budesonide nasal spray (RHINOCORT AQUA equiv), fluticasone nasal spray (FLONASE equiv)(TRIED), mometasone nasal spray (NASONEX equiv), BECONASE AQ nasal spray. Step-therapy may be required. Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12340438	SHANNA BOYD BARRY APN	Nurse Practitioner	DESCOVY	ANTIVIRALS	Z72.53 - High risk bisexual behavior	Criteria Not Met	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
12360963	MICHAEL ANDREW MUSGROVE MD	Psychiatry	QELBREE	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	F90.2 - Attention-deficit hyperactivity disorder, combined type	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are atomoxetine. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.

							Our prior authorization criteria for Somatropin Products have not been met. From the records that we have received, GENOTROPIN was denied for these reasons: 1) Records did not show the amount your height has increased is greater than 2.5 cm per year. 2) More information is needed to know if you have reached your expected final adult height. 3) Records did not show if your bones are still able to grow. 4) Records did not show that you grew at least 50 percent faster after starting growth hormone than before you had growth hormone. 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.
12366485	SUSAN BALITE NUNEZ MD	Endocrinology, Pediatric	GENOTROPIN	ENDOCRINE AND METABOLIC AGENTS - MISC.	E23.0	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for Somatropin Products 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 GENOTROPIN. The reason for denial is explained to the member above. The criteria are listed here. 1) Member is 17 year of age or younger; AND 2) Annual growth velocity is greater than 2.5 cm/year; AND 3) Expected final adult height has NOT yet been achieved; AND 4) Epiphyses remain open; AND 5) If for initial (first) renewal: increase in growth velocity is greater than 50%. 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.
12368463	MARIA GABRIELLA PRUDHOMME NP	Nurse Practitioner	UREA	DERMATOLOGICALS	L84 - Corns and callosities	Not Covered	This drug is not on our list of covered drugs, also known as our formulary. Similar drugs used for this condition are available over the counter (OTC) without a prescription. These other drugs include Ureacin, Rea-Lo, Gordon's Urea 40 and others. Please note these other drugs are not covered by your prescription drug benefit. Please refer to the formulary for specific information on what is covered.
12375865	AMANDA LYNN WEBSTER PA-C	Physician Assistant	QULIPTA	MIGRAINE PRODUCTS	G43.909 - Migraine, unspecified, not intractable, without status migrainosus	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Aimovig(tried), Emgality, and Ajovy. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12380727	STACIA CHRISTINE MILES MD	Dermatology	TRETINOIN	DERMATOLOGICALS	L81.4 - Other melanin hyperpigmentation	Criteria Not Met	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.
12383554	MERLIN JOICE ABRAHAM MD	Family Practice	LEVOTHYROXINE SODIUM	THYROID AGENTS	E03.9 - Hypothyroidism, unspecified	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Another drug that can be used is Synthroid. We show previous paid claims for Synthroid. More information is needed to know why it does not work for you. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12386323	SWATI PRASHANT JADHAV MD	Family Practice	SILDENAFIL CITRATE	CARDIOVASCULAR AGENTS - MISC.	Sexual dysfunction, unspecified	Plan Exclusion	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.
12424229	EMMANUEL JOHN LEE MD	Family Practice	MOUNJARO	ANTIDIABETICS	R73.01 - Impaired fasting glucose	Criteria Not Met	Our Diagnosis Restricted criteria have not been met. From the records that we have received, MOUNJARO was denied for this reason: 1) The drug is not being used for Type 2 Diabetes. This is a health issue where your blood sugar is too high. Please note: Step therapy may also be required and 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 Restricted Diagnosis criteria have not been met. From the information we have received, the member does not meet number 1 of our Restricted Diagnosis criteria. 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. 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.
12425282	GRACE LORENA HONLES MD	Family Practice	UBRELVY	MIGRAINE PRODUCTS	migraine	Criteria Not Met	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, 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.
12425815	LEIGHA ANA SHARP MD	Dermatology	DUPIXENT	DERMATOLOGICALS	L20.9	Criteria Not Met	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. 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 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 a positive clinical response has been provided (documentation is required to be submitted for an approval); AND 2) Dupixent will NOT be used in combination with another targeted immunomodulator product. 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.

12433162	KRISTEN BARBARA MALONE PA-C	Physician Assistant	XHANCE	NASAL AGENTS - SYSTEMIC AND TOPICAL	J33.0 - Polyp of nasal cavity	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are budesonide nasal spray (RHINOCORT AQUA equiv), fluticasone nasal spray (FLONASE equiv) (tried), mometasone nasal spray (NASONEX equiv), BECONASE AQ nasal spray. Quantity limits apply and step therapy may be required. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12443301	LIZA CHABOKROW DPM	Podiatrist	ALLOPURINOL	GOUT AGENTS	m10.072	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are allopurinol tablet (ZYLOPRIM equivalent, 100mg, 300mg), colchicine tablet (COLCRYS equivalent), febuxostat tablet (ULORIC equivalent) (Step Therapy requires trial of allopurinol). Please note: Your dose of 200mg per day can be achieved by taking two 100mg tablets per day. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12454209	ALBERTO GLENDALYZ MD	Geriatric Medicine	WEGOVY	ADHD/ANTI-NARCOLEPSY/ANTI-	obesity	Plan Exclusion	This request cannot be approved because this drug is being used for obesity (weight loss). Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
12458116	ANAS DAGHESTANI MD	Internal Medicine	TADALAFIL	CARDIOVASCULAR AGENTS - MISC.	N52.9 - Male erectile dysfunction, unspecified	Formulary Alternatives Available	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, Tadalafil was denied for these reasons: 1) One of these drugs has not been tried and failed: doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, tamsulosin cap, or dustasteride/tamsulosin cap. 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.
12458567	JUSTINE YIJIUN HUNG OD	Optometrist	XIIDRA	OPHTHALMIC AGENTS	H16.143	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used is Restasis (may be restricted to ophthalmology or optometry specialist). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12463143	RAISSA MIJARES BEHM FNP	Nurse Practitioner	XYOSTED	ANDROGENS-ANABOLIC	F64.9	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are testosterone cypionate injection, testosterone gel 1%, testosterone gel 1.62%, testosterone solution, Androderm patch. Prior authorization may be required and quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12468611	CALEB GREER FNP	Nurse Practitioner	BELBUCA	ANALGESICS - OPIOID	G89.4 - Chronic pain syndrome	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are morphine sulfate extended release (ER) (MS Contin equivalent), Xtampza ER, oxycodone ER, fentanyl patch (Duragesic equivalent), Nucynta ER (tapentadol ER), hydrocodone bitartrate ER (Hysingla ER or Zohydro ER equivalent)-(tried), tramadol ER tablet (Ultram ER equivalent), buprenorphine patch (Butrans equivalent)-(more information is needed on why this was discontinued). Quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12473827	SHWOL-HUO DANNY KIANG DO	Dermatology	DUPIXENT	DERMATOLOGICALS	L20.89 - Other atopic dermatitis	Criteria Not Met	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. 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 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 a positive clinical response has been provided (documentation is required to be submitted for an approval); AND 2) Dupixent will NOT be used in combination with another targeted immunomodulator product. 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.

							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are opical clindamycin (TRIED) or erythromycin, tretinoin (TRIED), adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline, minocycline, Sulfamethoxazole/Trimethoprim, cephalexin). Prior authorization may be required. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12524325	CHRISTOPHER RIDDELL JONES JR MD	Dermatology	WINLEVI	DERMATOLOGICALS	L70.8	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical clindamycin(TRIED) or erythromycin, tretinoin, adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline(TRIED), minocycline, Sulfamethoxazole/Trimethoprim, cephalexin). Prior authorization may be required. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12529322	CHRISTOPHER RIDDELL JONES JR MD	Dermatology	WINLEVI	DERMATOLOGICALS	I70.8	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12534153	ANNE CLAIRE ADAMS	Family Practice	WEGOVY	ADHD/ANTI-NARCOLEPSY/ANTI-	Morbid (severe) obesity due to excess calories (HCC)	Plan Exclusion	This request cannot be approved because this drug is being used for weight loss. Drugs used for this purpose are excluded from coverage as stated in your benefit summary. Please look at the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue.
							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Arnuity Ellipta, Asmanex HFA or twisthaler, Flovent HFA or Diskus. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12537080	MARYANN CECELIA GAMBLE	Family Practice	QVAR REDIHALER	ANTIASTHMATIC AND BRONCHODILATOR AGENTS	Mild intermittent asthma with (acute) exacerbation	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12541945	ONLY PAXUSE	-	COMPOUND DRUG	MISSING	G93.32-myalgic encephalomyltis, chronic fatigue syndrome.	Plan Exclusion	This request cannot be approved because this is a compounded product made up of bulk chemicals. Medications made with bulk chemicals are excluded from coverage as stated in your benefit summary. Please check the list of covered drugs, also known as the formulary, to see what is covered by your plan. Your doctor or health care provider may be able to suggest other treatments for your health issue. Please note: More information is needed to know the specific ingredients of the compound being requested.
12542718	MARGARET HOWELL WHITE FNP-BC	Nurse Practitioner	DESCOVY	ANTIVIRALS	Z72.52 - High risk homosexual behavior	Criteria Not Met	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. Please note: Records did not show that your estimated creatinine clearance is less than 60 mL per minute. 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.
							This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are Aimovig, Ajovy and Emgality. Prior authorization may be required and quantity limits may apply. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12543138	KERRY ALLISON RAMON APN	Nurse Practitioner	QULIPTA	MIGRAINE PRODUCTS	G43.909 - Migraine, unspecified, not intractable, without status migrainosus	Not Covered	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12554556	JOSEPH GIATTINO DO	Internal Medicine	INVOKANA	ANTIDIABETICS	e11.9	Criteria Not Met	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, 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.

							Our prior authorization criteria for ruxolitinib (OPZELURA) have not been met. From the records that we have received, Opzelura was denied for these reasons: 1) More information is needed to know if your health issue is mild to moderate in severity. 2) Records did not show that a topical steroid, such as betamethasone or triamcinolone, has been tried and failed. 3) Records did not show that a topical calcineurin inhibitor, such as pimecrolimus cream or tacrolimus ointment, has been tried and failed. 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.
12556402	AMY AYRES MCCLUNG MD	Dermatology	OPZELURA	DERMATOLOGICALS	I20.84	Criteria Not Met	ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because our prior authorization criteria for ruxolitinib (OPZELURA) 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 Opzelura. The reason for denial is explained to the member above. The criteria are listed here. 1) Prescribed by, or in consultation with, a Dermatologist; AND 2) Member has a diagnosis of mild to moderate atopic dermatitis (AD); AND 3) Trials of BOTH of the following have been ineffective, contraindicated, or not tolerated: (A) a topical corticosteroid, AND (B) a topical calcineurin inhibitor. 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.
12559220	CHRISTOPHER RIDDELL JONES JR MD	Dermatology	WINLEVI	DERMATOLOGICALS	I70.8	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are topical clindamycin (TRIED) or erythromycin, tretinoin, adapalene (Differin equivalent) or adapalene/benzoyl peroxide (Epiduo equivalent), and one oral antibiotic (doxycycline (TRIED), minocycline, Sulfamethoxazole/Trimethoprim, cephalexin). Prior authorization may be required. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12562061	EMMANUEL JOHN LEE MD	Family Practice	MYDAYIS	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	F90.0-ADHD	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are dexmethylphenidate extended release (ER), methylphenidate ER, amphetamine/dextroamphetamine ER (Adderall XR equiv), Vyvanse. Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12565064	MARGARET HOWELL WHITE FNP-BC	Nurse Practitioner	DESCOVY	ANTIVIRALS	Z72.52-PrEP	Criteria Not Met	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
12576162	SUSANNA-RACHEL SALOME SEAY PMHNP	Advanced Practice Nurse	AUVELITY	ANTIDEPRESSANTS	F33.2	Not Covered	This drug is not on our list of covered drugs, also known as a formulary. Our Coverage Determinations - Exceptions policy is used to decide if a not-covered drug can be approved. The conditions in this policy have not been met. From the records that we have received, these reasons caused the denial: 1) All covered drugs used for your health issue have not been tried and failed. Other drugs that can be used are bupropion SR, bupropion XL, ONE (1) serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., venlafaxine, duloxetine), and TWO (2) selective serotonin reuptake inhibitors (SSRIs) (TRIED). Please look at the formulary to see what drugs are covered. Prior authorization may be required and quantity limits may apply to covered drugs. ADDITIONAL INFORMATION FOR YOUR HEALTH CARE PROVIDER: This request has not been approved because this drug is not on formulary. An exception to allow coverage of a non-formulary drug may be granted if all conditions in our Coverage Determinations - Exceptions policy are met. From the information we have received, the member does not meet number 2 of the exception policy criteria. The reason for denial is explained to the member above. The criteria from the policy are listed here. 1) The drug is being used for a condition approved by the United States Food and Drug Administration (FDA). 2) All formulary alternatives have been tried or medical reasons have been provided why all other covered drugs cannot be tried. 3) Records have been received showing the requested drug is medically necessary. These should include relevant medical history and lab results, past treatments tried with dates of trial and responses, and any other evidence to show the covered drugs are likely to be ineffective or unsafe for the member. 4) Prescription drug samples were not used to establish treatment. Since criteria have not been met, we are unable to approve coverage for this drug at this time. Please refer to the formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.
12607290	DAVID WARREN BROWN MD	Psychiatry	FETZIMA	ANTIDEPRESSANTS	MDD	Criteria Not Met	Our prior authorization criteria for Fetzima have not been met. From the records that we have received, Fetzima was denied for these reasons: 1) At least TWO (2) other drugs called selective serotonin reuptake inhibitor (SSRI) antidepressants (e.g. sertraline, citalopram, escitalopram, fluoxetine, and paroxetine) have not been tried and failed. 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 levomilnacipran (FETZIMA) have not been met. From the information we have received, the member does not meet number 2 of our prior authorization criteria for Fetzima. 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) Member has tried and failed, or was intolerant to, two selective serotonin reuptake inhibitors (SSRIs); AND 3) Member 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. Please refer to our formulary for information on what is covered. Prior authorization may be required and quantity limits may apply to covered drugs.