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Prescription Benefit Medication Prior Authorization Criteria

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These criteria apply to drugs picked up at the pharmacy.

These medication prior authorization criteria do not apply to drugs picked up at the pharmacy for State and Local Government members or BadgerCare Plus and/or Medicaid SSI members.

State and Local Government members should call **Navitus** at **(866) 333-2757** or visit navitus.com for information about your prescription drug benefits.

Quartz BadgerCare Plus and/or Medicaid SSI members must call the **Wisconsin Department of Health and Family Services** at **(800) 362-3002** or visit forwardhealth.wi.gov for information about your prescription drug benefits.

April 1, 2024
Pharmacy Benefit Drug
Prior Authorization Criteria

A medication prior authorization request may be started by members, providers, or designated representatives by fax, electronically on Quartz's website, telephone, mail. Or, for medical benefit medications, also by Health Link, Plan Link, MyQuartzTools, or electronic prior authorization (e-PA) within the electronic medical record. Electronic (e-PA) via Surescripts verifies member eligibility and member benefit information. Quartz sends back e-PA criteria questions to the provider staff which can be answered, and medical records can be attached to the request.

Quartz strongly recommends that the health care provider initiate the prior authorization request process on behalf of the member. This is because the health care provider will be able to include the medical history necessary for a timely decision to be made based on all of the relevant information, including any case specific circumstances that can be considered. Once a request and the supporting documentation have been submitted, a pharmacist or appropriate staff review the prior authorization criteria and exception requirements separately to make a coverage decision.

Table of Contents

Prior Authorization Guideline

Guideline ID	GL-134598
Guideline Name	Actemra (tocilizumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Actemra	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active rheumatoid arthritis (RA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)**
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

3 - Trial and failure, contraindication or intolerance to TWO of the following:

- adalimumab
- certolizumab
- etanercept
- golimumab
- tofacitinib (ER)
- upadacitinib

AND

4 - Medication must be self-administered (not in clinic or provider office)

AND

5 - Prescribed by or in consultation with a rheumatologist

AND

6 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies **Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other

	chronic liver disease, immunodeficiency syndromes, bone marrow hyp erplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Actemra	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active rheumatoid arthritis (RA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)**
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

3 - Trial and failure, contraindication or intolerance to TWO of the following:

- adalimumab
- certolizumab
- etanercept
- golimumab
- tofacitinib (ER)
- upadacitinib

AND

4 - Medication must be self-administered (not in clinic or provider office)

AND

5 - Prescribed by or in consultation with a rheumatologist

AND

6 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies **Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Actemra	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Actemra	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Member is 2 years of age or older

AND

2 - Trial and failure, contraindication** or intolerance to ONE of the following for 3 months:

- corticosteroids
- methotrexate
- nonsteroidal anti-inflammatories

AND

3 - Medication must be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies **Absolute contraindications to methotrexate are pregnancy, nursing,

	alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leu kopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate

Product Name: Actemra	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Member is 2 years of age or older

AND

2 - Trial and failure, contraindication** or intolerance to ONE of the following for 3 months:

- corticosteroids
- methotrexate
- nonsteroidal anti-inflammatories

AND

3 - Medication must be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - Therapy must not be used in combination with other biologic disease modifying anti-

rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies **Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate

Product Name: Actemra	
Diagnosis	Systemic Juvenile Idiopathic Arhtritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria **1** - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Actemra	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans
Approval Criteria **1** - Diagnosis of polyarticular juvenile idiopathic arthritis (PJIA)	

AND

2 - Submission of medical records (e.g., chart notes) documenting documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following

- methotrexate (MTX)**
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

3 - Trial and failure, contraindication or intolerance to TWO of the following:

- adalimumab
- etanercept
- tofacitinib

AND

4 - Medication must be self-administered (not in clinic or provider office)

AND

5 - Prescribed by or in consultation with a rheumatologist

AND

6 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies **Absolute contraindications to methotrexate are pregnancy, nursing,

	alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyp erplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Actemra	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)**
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

3 - Trial and failure, contraindication or intolerance to TWO of the following:

- adalimumab
- etanercept
- tofacitinib

AND

4 - Medication must be self-administered (not in clinic or provider office)

AND

5 - Prescribed by or in consultation with a rheumatologist

AND

6 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies **Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Actemra	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Actemra	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of Giant Cell Arteritis (GCA)

AND

2 - ONE of the following:

2.1 Symptoms relapsed despite use of corticosteroids or methotrexate

OR

2.2 Contraindication** to methotrexate

OR

2.3 Inability to taper corticosteroids

AND

3 - Medication must be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies **Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate

Product Name: Actemra	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Giant Cell Arteritis (GCA)

AND

2 - ONE of the following:

2.1 Symptoms relapsed despite use of corticosteroids or methotrexate

OR

2.2 Contraindication** to methotrexate

OR

2.3 Inability to taper corticosteroids

AND

3 - Medication must be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies **Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate

Product Name: Actemra	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Actemra	
Diagnosis	Systemic Sclerosis - Associated Interstitial Lung Disease (SSc-ILD)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of Systemic Sclerosis – Associated Interstitial Lung Disease (SSc-ILD)

AND

2 - Submission of medical records (e.g., chart notes), documenting one of the following:

2.1 Decline in pulmonary function despite use of one of the following standard treatments:

- mycophenolate
- cyclophosphamide
- azathioprine

OR

2.2 Contraindication to one of the following standard agents:

- mycophenolate
- cyclophosphamide
- azathioprine

AND

3 - Medication must be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with one of the following:

- rheumatologist
- pulmonologist

AND

5 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Actemra	
Diagnosis	Systemic Sclerosis - Associated Interstitial Lung Disease (SSc-ILD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Systemic Sclerosis – Associated Interstitial Lung Disease (SSc-ILD)

AND

2 - Submission of medical records (e.g., chart notes), documenting one of the following:

2.1 Decline in pulmonary function despite use of one of the following standard treatments:

- mycophenolate
- cyclophosphamide

- azathioprine

OR

2.2 Contraindication to one of the following standard agents:

- mycophenolate
- cyclophosphamide
- azathioprine

AND

3 - Medication must be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with one of the following:

- rheumatologist
- pulmonologist

AND

5 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Actemra	
Diagnosis	Systemic Sclerosis - Associated Interstitial Lung Disease (SSc-ILD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Actemra	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis
Approval Length	12/31/2039
Guideline Type	Quantity Exception - All Plans Except IL and MN Plans

Approval Criteria

1 - Failure of an adherent 3-month trial of standard maintenance dosing with concomitant methotrexate (unless contraindicated or not appropriate for indication being requested)

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Actemra	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis
Approval Length	12 month(s)
Guideline Type	Quantity Exception - IL and MN Plans

Approval Criteria

1 - Failure of an adherent 3-month trial of standard maintenance dosing with concomitant methotrexate (unless contraindicated or not appropriate for indication being requested)

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Definitions

Definition	Description
Steroid Dependence:	Demonstrated steroid dependence (defined as equivalent to prednisone 10mg daily for >3 months) with the inability to taper or when tapering of dose leads to loss of symptom control

3 . Revision History

Date	Notes
12/1/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129620
Guideline Name	Actiq (Fentanyl)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Fentanyl	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - All of the following

1.1 Prescribed by, or in consultation with, an Oncologist or specialty in Pain Management

AND

1.2 Medication is limited to the treatment of breakthrough cancer pain

AND

1.3 Person is already tolerant to opioids, defined as:

1.3.1 oral morphine 60mg daily for one week

OR

1.3.2 transdermal fentanyl 25mcg/hr for one week

OR

1.3.3 oxycodone 30mg daily for one week

OR

1.3.4 oral hydromorphone 8mg daily for one week

OR

1.3.5 equianalgesic dose of another opioid for at least one week

AND

1.4 Person has failed an adequate trial of one of the following:

1.4.1 immediate release oxycodone

OR

1.4.2 immediate release oral hydromorphone

OR

1.4.3 immediate release morphine

OR

2 - (Minnesota plans only) – person has stage four metastatic cancer and the requested drug is being used to treat cancer-related pain

Product Name: Fentanyl	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Fentanyl	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Prescribed by, or in consultation with, an Oncologist or specialty in Pain Management

AND

2 - Medication is limited to the treatment of breakthrough cancer pain

AND

3 - Person is already tolerant to opioids, defined as:

3.1 oral morphine 60mg daily for one week

OR

3.2 transdermal fentanyl 25mcg/hr for one week

OR

3.3 oxycodone 30mg daily for one week

OR

3.4 oral hydromorphone 8mg daily for one week

OR

3.5 equianalgesic dose of another opioid for at least one week

AND

4 - Person has failed an adequate trial of one of the following:

4.1 immediate release oxycodone

OR

4.2 immediate release oral hydromorphone

OR **4.3** immediate release morphine

2 . Revision History

Date	Notes
11/6/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129870
Guideline Name	Actonel (risedronate)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: risedronate 5 mg	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- Diagnosis of osteoporosis due to corticosteroid use
- Trial and failure, contraindication, or intolerance to alendronate

OR

1.2 For diagnoses other than osteoporosis due to corticosteroid use, trial and failure, contraindication, or intolerance to ALL of the following:

- alendronate
- ibandronate
- other strengths of risedronate (i.e., 35 mg, 150 mg)

Product Name: risedronate 5 mg	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: risedronate 5 mg	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- Diagnosis of osteoporosis due to corticosteroid use
- Trial and failure, contraindication, or intolerance to alendronate

OR

1.2 For diagnoses other than osteoporosis due to corticosteroid use, trial and failure, contraindication, or intolerance to ALL of the following:

- alendronate
- ibandronate
- other strengths of risedronate (i.e., 35 mg, 150 mg)

2 . Revision History

Date	Notes
10/12/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-127880
Guideline Name	Acute Migraine Treatments
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Frovatriptan, Brand Reyvow	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure of at least 2 of the following:

- sumatriptan
- naratriptan
- rizatriptan
- eletriptan
- zolmitriptan

- almotriptan
- frovatriptan (not required for request for frovatriptan)

OR

2 - If the member has contraindication to triptan, than trial and failure of 2 non-triptan, prescription strength analgesics that are listed as effective for treatment of migraines by the American Headache Society treatment guidelines is required (ex. nonsteroidal anti-inflammatory drugs (NSAIDs), ergotamine derivatives, etc.)

Product Name: Generic Frovatriptan, Brand Reyvow	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Generic Frovatriptan, Brand Reyvow	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure of at least 2 of the following:

- sumatriptan
- naratriptan
- rizatriptan
- eletriptan
- zolmitriptan
- almotriptan
- frovatriptan (not required for request for frovatriptan)

OR

2 - If the member has contraindication to triptan, than trial and failure of 2 non-triptan, prescription strength analgesics that are listed as effective for treatment of migraines by the American Headache Society treatment guidelines is required (ex. nonsteroidal anti-inflammatory drugs (NSAIDs), ergotamine derivatives, etc.)

Product Name: Generic Frovatriptan, Brand Reyvow	
Approval Length	12/31/2039
Guideline Type	Quantity Limits - All Plans except IL and MN

Approval Criteria

1 - Member has greater than or equal to 2 migraine headaches per week

AND

2 - Member is on migraine headache prophylaxis treatment

Product Name: Generic Frovatriptan, Brand Reyvow	
Approval Length	12 month(s)
Guideline Type	Quantity Limits - IL and MN Plans

Approval Criteria

1 - Member has greater than or equal to 2 migraine headaches per week

AND

2 - Member is on migraine headache prophylaxis treatment

2 . Revision History

Date	Notes
8/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-128132
Guideline Name	Aczone (dapsone)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Dapsone 5%	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure of two different prior treatments for acne

- tretinoin 0.01% gel, 0.025% cream/gel, 0.05% cream/gel, 0.1% cream
- adapalene (0.1% gel/cream, 0.3% gel)
- azelaic acid
- tazarotene
- oral minocycline

- oral doxycycline
- clindamycin 1% gel
- clindamycin 1.2%/benzoyl peroxide 5% gel
- erythromycin 2% topical

Product Name: Generic Dapsone 7.5%	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure of two different prior treatments for acne

- tretinoin 0.01% gel, 0.025% cream/gel, 0.05% cream/gel, 0.1% cream
- adapalene (0.1% gel/cream, 0.3% gel)
- azelaic acid
- tazarotene
- oral minocycline
- oral doxycycline
- clindamycin 1% gel
- clindamycin 1.2%/benzoyl peroxide 5% gel
- erythromycin 2% topical

AND

2 - Trial and failure of generic dapsone 5%

Product Name: Generic Dapsone 5%, Generic Dapsone 7.5%	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Generic Dapsone 5%	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure of two different prior treatments for acne

- tretinoin 0.01% gel, 0.025% cream/gel, 0.05% cream/gel, 0.1% cream
- adapalene (0.1% gel/cream, 0.3% gel)
- azelaic acid
- tazarotene
- oral minocycline
- oral doxycycline
- clindamycin 1% gel
- clindamycin 1.2%/benzoyl peroxide 5% gel
- erythromycin 2% topical

Product Name: Generic Dapsone 7.5%	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure of two different prior treatments for acne

- tretinoin 0.01% gel, 0.025% cream/gel, 0.05% cream/gel, 0.1% cream
- adapalene (0.1% gel/cream, 0.3% gel)
- azelaic acid
- tazarotene
- oral minocycline
- oral doxycycline
- clindamycin 1% gel
- clindamycin 1.2%/benzoyl peroxide 5% gel

- erythromycin 2% topical

AND

2 - Trial and failure of generic dapsone 5%

2 . Revision History

Date	Notes
8/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-141101
Guideline Name	Adalimumab biosimilars
Formulary	• Quartz

Guideline Note:

Effective Date:	2/6/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans
Approval Criteria	

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of moderate to severe plaque psoriasis

AND

1.1.2 One of the following:

- Significant functional disability
- Body surface area (BSA) involvement of greater than or equal to 3%
- Debilitating palmer/plantar psoriasis or other vulnerable areas that are difficult to treat (e.g. nails, scalp, genitals, or intertriginous areas

AND

1.1.3 Prescribed by or in consultation with a dermatologist

AND

1.1.4 Trial and failure, contraindication, or intolerance to topical treatment (e.g., topical corticosteroids, calcipotriene, retinoids)

AND

1.1.5 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of prior therapy with Humira or an Adalimumab biosimilar, verified by paid claims, medical records (e.g. chart notes), or provider attestation.

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz

Diagnosis	Plaque Psoriasis
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of moderate to severe plaque psoriasis

AND

1.1.2 One of the following:

- Significant functional disability
- Body surface area (BSA) involvement of greater than or equal to 3%
- Debilitating palmer/plantar psoriasis or other vulnerable areas that are difficult to treat (e.g. nails, scalp, genitals, or intertriginous areas

AND

1.1.3 Prescribed by or in consultation with a dermatologist

AND

1.1.4 Trial and failure, contraindication, or intolerance to topical treatment (e.g., topical corticosteroids, calcipotriene, retinoids)

AND

1.1.5 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of prior therapy with Humira or an Adalimumab biosimilar, verified by paid claims, medical records (e.g. chart notes), or provider attestation.

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of moderate to severe and/or refractory hidradenitis suppurativa (HS) (Hurley II; Hurley III stage)

AND

1.1.2 Lesions are present despite treatment with topical antibiotics, systemic antibiotics, intralesional glucocorticoids, and/or surgical debridement

AND

1.1.3 Prescribed by or in consultation with a dermatologist

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation.

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of moderate to severe and/or refractory hidradenitis suppurativa (HS) (Hurley II; Hurley III stage)

AND

1.1.2 Lesions are present despite treatment with topical antibiotics, systemic antibiotics, intralesional glucocorticoids, and/or surgical debridement

AND

1.1.3 Prescribed by or in consultation with a dermatologist

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation.

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

1.1.2 Prescribed by or in consultation with a dermatologist or rheumatologist

AND

1.1.3 Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

1.1.2 Prescribed by or in consultation with a dermatologist or rheumatologist

AND

1.1.3 Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease

- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA), Moderate to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of one of the following:

- Moderate to severely active rheumatoid arthritis (RA)
- Polyarticular juvenile idiopathic arthritis (PJIA)

AND

1.1.2 Prescribed by or in consultation with a rheumatologist

AND

1.1.3 Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)**
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I. **Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA), Moderate to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of one of the following:

- Moderate to severely active rheumatoid arthritis (RA)
- Polyarticular juvenile idiopathic arthritis (PJIA)

AND

1.1.2 Prescribed by or in consultation with a rheumatologist

AND

1.1.3 Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)**
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I. **Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of ankylosing spondylitis (AS)

AND

1.1.2 Prescribed by or in consultation with a rheumatologist

AND

1.1.3 Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12/31/2039

Guideline Type	Prior Authorization – All Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of ankylosing spondylitis (AS)

AND

1.1.2 Prescribed by or in consultation with a rheumatologist

AND

1.1.3 Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Non-infectious Uveitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of non-infectious uveitis

AND

1.1.2 Prescribed by or in consultation with a rheumatologist and verified by an ophthalmologist or other eye specialist

AND

1.1.3 Condition classified as intermediate, posterior or panuveitis

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation.

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Non-infectious Uveitis
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of non-infectious uveitis

AND

1.1.2 Prescribed by or in consultation with a rheumatologist and verified by an ophthalmologist or other eye specialist

AND

1.1.3 Condition classified as intermediate, posterior or panuveitis

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation.

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Moderate to Severely Active Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of moderate to severely active Crohn's disease (CD)

AND

1.1.2 Prescribed by or in consultation with a gastroenterologist

AND

1.1.3 One of the following:

1.1.3.1 Member is considered high-risk based on ONE of the following characteristics:

- Age less than 30 years at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (e.g., uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy)

OR

1.1.3.2 Both of the following:

1.1.3.2.1 Member is considered low-risk

AND

1.1.3.2.2 One of the following:

- Trial and failure, contraindication, or intolerance to one conventional therapy (e.g., azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)
- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with one conventional therapy
- Demonstrated steroid dependence
- Conventional therapy clinically inappropriate based on location of disease

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation.

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Moderate to Severely Active Crohn's Disease (CD)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of moderate to severely active Crohn's disease (CD)

AND

1.1.2 Prescribed by or in consultation with a gastroenterologist

AND

1.1.3 One of the following:

1.1.3.1 Member is considered high-risk based on ONE of the following characteristics:

- Age less than 30 years at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (e.g., uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy)

OR

1.1.3.2 Both of the following:

1.1.3.2.1 Member is considered low-risk

AND

1.1.3.2.2 One of the following:

- Trial and failure, contraindication, or intolerance to one conventional therapy (e.g., azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)
- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with one conventional therapy
- Demonstrated steroid dependence
- Conventional therapy clinically inappropriate based on location of disease

AND

1.1.4 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation.

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Moderate to Severely Active Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of moderate to severely active ulcerative colitis (UC)

AND

1.1.2 Prescribed by or in consultation with a gastroenterologist

AND

1.1.3 Member is considered high-risk based on at least one of the following characteristics:

- Extensive colitis
- Deep ulcers
- Age less than 40 years
- High CRP and ESR
- Steroid-requiring disease
- History of hospitalization
- C. difficile infection

- CMV infection

AND

1.1.4 Trial and failure, contraindication, or intolerance to a short course (2 to 4 weeks) of oral corticosteroids

AND

1.1.5 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Moderate to Severely Active Ulcerative Colitis (UC)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of moderate to severely active ulcerative colitis (UC)

AND

1.1.2 Prescribed by or in consultation with a gastroenterologist

AND

1.1.3 Member is considered high-risk based on at least one of the following characteristics:

- Extensive colitis
- Deep ulcers
- Age less than 40 years
- High CRP and ESR
- Steroid-requiring disease
- History of hospitalization
- C. difficile infection
- CMV infection

AND

1.1.4 Trial and failure, contraindication, or intolerance to a short course (2 to 4 weeks) of oral corticosteroids

AND

1.1.5 Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

OR

1.2 Continuation of previous therapy with Humira or an Adalimumab biosimilar, confirmed by paid claims, medical records (e.g. chart notes), or provider attestation

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Prescriber provides clinical documentation from the previous 12 months of the member's response to therapy including individual improvements in functional status related to therapeutic response

Notes	*If clinical documentation or claims history indicate ongoing treatment with an increased quantity, the reauthorization approval should includ e the quantity limit exception. Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis, JIA, PSA, AS, plaque psoriasis
Approval Length	12/31/2039
Guideline Type	Quantity Exception – All Plans except IL and MN Plans

Approval Criteria

1 - Failure of an adherent 3-month trial of standard maintenance dosing with concomitant methotrexate (unless contraindicated or not appropriate for indication being requested)

OR

2 - There is a confirmed history of an approved quantity limit exception (via prior authorization or historical authorization on file) for any of the following:

- Humira
- Adalimumab biosimilar

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis, JIA, PSA, AS, plaque psoriasis
Approval Length	12 month(s)

Guideline Type	Quantity Exception – IL and MN Plans

Approval Criteria

1 - Failure of an adherent 3-month trial of standard maintenance dosing with concomitant methotrexate (unless contraindicated or not appropriate for indication being requested)

OR

2 - There is a confirmed history of an approved quantity limit exception (via prior authorization or historical authorization on file) for any of the following:

- Humira
- Adalimumab biosimilar

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Crohn's disease, ulcerative colitis
Approval Length	12 month(s)
Guideline Type	Quantity Exception – IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Failure of a two-month trial of monthly therapy after completion of induction dosing regimen

AND

1.1.2 Based on subtherapeutic drug concentrations and absence (or low levels) of drug antibodies

OR

1.2 There is a confirmed history of an approved quantity limit exception (via prior authorization or historical authorization on file) for any of the following:

- Humira
- Adalimumab biosimilar

Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

Product Name: Humira, Hadlima, Adalimumab-fkjp, Hyrimoz, Adalimumab-adaz	
Diagnosis	Crohn's disease, ulcerative colitis
Approval Length	12 month(s)
Guideline Type	Quantity Exception – IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Failure of a two-month trial of monthly therapy after completion of induction dosing regimen

AND

1.1.2 Based on subtherapeutic drug concentrations and absence (or low levels) of drug antibodies

OR

1.2 There is a confirmed history of an approved quantity limit exception (via prior authorization or historical authorization on file) for any of the following:

- Humira

• Adalimumab biosimilar	
Notes	*Place authorization at a GPI 8 with an Ignore Drug Status of I

2 . Background

Benefit/Coverage/Program Information

Quantity Limits

Drug Name	Drug Status	Quantity Limits (maintenance/28 days) based on indication	Approval Limits
Adalimumab-bwwd (Hadlima)	Preferred Restricted	#2 #4 for HS indication	None*
Adalimumab-fkjp (unbranded)	Preferred Restricted	#2 #4 for HS indication	None*
Adalimumab-adaz (Hyrimoz)	Preferred Restricted	#2 #4 for HS indication	None*
Adalimumab-adaz- (unbranded Hyrimoz)	Preferred Restricted	#2 #4 for HS indication	None*

*Initial and renewal approvals limited to 12 months for IL and MN plans

3 . Revision History

Date	Notes
2/5/2024	Update Guideline

Prior Authorization Guideline

Guideline ID	GL-129155
Guideline Name	Adlarity (donepezil)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Adlarity	
Approval Length	12/31/2039
Guideline Type	Prior Authorization- All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of dementia associated with Alzheimer's disease

AND

2 - Trial and failure, intolerance, or contraindication to two oral acetylcholinesterase inhibitors (eg donepezil, galantamine), one of which must be donepezil

AND

3 - Trial and failure, intolerance, or contraindication to an acetylcholinesterase inhibitor patch (eg rivastigmine patch)

Product Name: Adlarity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN plans

Approval Criteria

1 - Diagnosis of dementia associated with Alzheimer's disease

AND

2 - Trial and failure, intolerance, or contraindication to two oral acetylcholinesterase inhibitors (eg donepezil, galantamine), one of which must be donepezil

AND

3 - Trial and failure, intolerance, or contraindication to an acetylcholinesterase inhibitor patch (eg rivastigmine patch)

Product Name: Adlarity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
9/20/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129628
Guideline Name	Afrezza (Insulin Regular, Human)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Afrezza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of diabetes mellitus

AND

2 - Prescription is initiated by, or in consultation with, an Endocrinologist

AND

3 - Documented disability that does not physically allow the administration of insulin from conventional vials or pens

AND

4 - Does not have a documented chronic lung disease (asthma, COPD, etc.)

AND

5 - Is a nonsmoker

Product Name: Afrezza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Afrezza	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of diabetes mellitus

AND

2 - Prescription is initiated by, or in consultation with, an Endocrinologist

AND

3 - Documented disability that does not physically allow the administration of insulin from conventional vials or pens

AND

4 - Does not have a documented chronic lung disease (asthma, COPD, etc.)

AND

5 - Is a nonsmoker

2 . Revision History

Date	Notes
10/6/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-136350
Guideline Name	Alosetron
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Alosetron	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of diarrhea- predominant irritable bowel syndrome (IBS)

AND

2 - Member is female

AND

3 - Trial and failure of one-month trial of conventional therapy (such as loperamide or diphenoxylate/atropine)

Product Name: Generic Alosetron	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical notes (e.g., chart notes) from the past 12 months that the person is continuing therapy with the requested medication

Product Name: Generic Alosetron	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of diarrhea- predominant irritable bowel syndrome (IBS)

AND

1.1.2 Member is female

AND

1.1.3 Trial and failure of one-month trial of conventional therapy (such as loperamide or diphenoxylate/atropine)

OR

1.2 Member is new to the plan (within the past 90 days) and submission of medical notes (e.g., chart notes) from the past 12 months that the person is continuing therapy with the requested medication

2 . Revision History

Date	Notes
11/15/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129138
Guideline Name	Ampyra (Dalfampridine)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Dalfampridine	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis

AND

2 - Person is ambulatory with or without assistance

AND

3 - Baseline assessment (ex: timed 25-foot walk) or supporting documentation indicating difficulty ambulating (ex: gait contributing to falls, etc.)

Product Name: Generic Dalfampridine	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber provides clinical documentation from the previous 12 months that the person has a diagnosis of multiple sclerosis and remains ambulatory (with or without assistance).

2 . Revision History

Date	Notes
9/20/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129091
Guideline Name	Antifibrotic Agents
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic pirfenidone	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by high-resolution computed tomography

AND

2 - Member is 18 years of age or older

AND

3 - Prescribed by or in consultation with a pulmonologist

Product Name: Generic pirfenidone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by high-resolution computed tomography

AND

2 - Member is 18 years of age or older

AND

3 - Prescribed by or in consultation with a pulmonologist

Product Name: Ofev	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by high-resolution computed tomography

OR

1.2 Chronic Fibrosing Interstitial Lung Diseases with a Progressive Phenotype

OR

1.3 Both of the following:

- Diagnosis of systemic sclerosis associated lung disease (SSc-ILD)
- Trial and failure, contraindication or intolerance to cyclophosphamide

AND

2 - Member is 18 years of age or older

AND

3 - Prescribed by or in consultation with a pulmonologist

Product Name: Ofev	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by high-resolution computed tomography

OR

1.2 Chronic Fibrosing Interstitial Lung Diseases with a Progressive Phenotype

OR

1.3 Both of the following:

- Diagnosis of systemic sclerosis associated lung disease (SSc-ILD)
- Trial and failure, contraindication or intolerance to cyclophosphamide

AND

2 - Member is 18 years of age or older

AND

3 - Prescribed by or in consultation with a pulmonologist

Product Name: Generic pirfenidone, Ofev	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
9/19/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-128153
Guideline Name	Arikayce (amikacin inhaled)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Arikayce*	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans Only

Approval Criteria

1 - Diagnosis of Mycobacterium avium complex (MAC) lung disease

AND

2 - Prescribed by, or in consultation with, an Infectious Disease expert

AND

3 - Submission of medical records (e.g., chart notes) of positive sputum cultures despite at least 6 months of multidrug background therapy

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Arikayce*	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All Plans except IL and MN

Approval Criteria

1 - Diagnosis of Mycobacterium avium complex (MAC) lung disease

AND

2 - Prescribed by, or in consultation with, an Infectious Disease expert

AND

3 - Submission of medical records (e.g., chart notes) of positive sputum cultures despite at least 6 months of multidrug background therapy

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Arikayce*

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Mycobacterium avium complex (MAC) lung disease

AND

2 - Prescribed by, or in consultation with, an Infectious Disease expert

AND

3 - Person achieves and/or maintains negative sputum culture status by 6 months

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
11/3/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-128902
Guideline Name	Atacand (candesartan)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Candesartan	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN
Approval Criteria **1** - Diagnosis of heart failure	

Product Name: Generic Candesartan	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	IL and MN Plans Only

Approval Criteria

1 - Diagnosis of heart failure

Product Name: Generic Candesartan	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

2 . Revision History

Date	Notes
9/26/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129081
Guideline Name	Auryxia (Ferric Citrate)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Auryxia	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of chronic kidney disease (CKD)

AND

1.1.2 Member has hyperphosphatemia requiring dialysis

AND

1.1.3 Trial and failure or intolerance (e.g. side effects) from Both of the following:

- Sevelamer product (i.e., Renagel, Renvela)
- Fosrenol (lanthanum)

OR

1.2 All of the following:

1.2.1 Diagnosis of iron deficiency anemia

AND

1.2.2 Member has chronic kidney disease (CKD)

AND

1.2.3 Memebr is not on dialysis

AND

1.2.4 Trial and failure, or intolerance (e.g. side effects) to at least 2 forms of oral iron products (i.e., ferrous sulfate, polysaccharide complex, ferrous fumarate, ferrous gluconate)

Product Name: Auryxia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of chronic kidney disease (CKD)

AND

1.1.2 Member has hyperphosphatemia requiring dialysis

AND

1.1.3 Trial and failure or intolerance (e.g. side effects) from Both of the following:

- Sevelamer product (i.e., Renagel, Renvela)
- Fosrenol (lanthanum)

OR

1.2 All of the following:

1.2.1 Diagnosis of iron deficiency anemia

AND

1.2.2 Member has chronic kidney disease (CKD)

AND

1.2.3 Member is not on dialysis

AND **1.2.4** Trial and failure, or intolerance (e.g. side effects) to at least 2 forms of oral iron products (i.e., ferrous sulfate, polysaccharide complex, ferrous fumarate, ferrous gluconate)

Notes	*Members new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) must meet the initial criteria coverage

Product Name: Auryxia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans*
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug	
Notes	*Members new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) must meet the initial criteria coverage

2 . Revision History

Date	Notes
8/23/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129069
Guideline Name	Austedo (deutetrabenazine)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Austedo, Austedo XR	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of chorea associated with Huntington's disease

AND

1.1.2 Prescribed by or in consultation with a neurologist or other expert in the treatment of Huntington's disease

OR

1.2 All of the following:

1.2.1 Diagnosis of tardive dyskinesia

AND

1.2.2 One of the following:

- Symptoms persist despite discontinuation of the offending dopamine receptor blocking drug
- Submission of medical records (e.g. chart notes) why discontinuation of the drug is not a treatment option for the person based on their diagnosis and previous treatment history

AND

1.2.3 Trial and inadequate response to clonazepam (e.g., did not control symptoms, caused significant side effects)

AND

1.2.4 Trial and failure, contraindication or intolerance to an adequate trial of trihexyphenidyl with documentation of tardive dystonia

AND

1.2.5 Prescribed by or in consultation with a neurologist or other expert in the treatment of tardive dyskinesia/movement disorders

Product Name: Austedo, Austedo XR	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of chorea associated with Huntington's disease

AND

1.1.2 Prescribed by or in consultation with a neurologist or other expert in the treatment of Huntington's disease

OR

1.2 All of the following:

1.2.1 Diagnosis of tardive dyskinesia

AND

1.2.2 One of the following:

- Symptoms persist despite discontinuation of the offending dopamine receptor blocking drug
- Submission of medical records (e.g. chart notes) why discontinuation of the drug is not a treatment option for the person based on their diagnosis and previous treatment history

AND

1.2.3 Trial and inadequate response to clonazepam (e.g., did not control symptoms, caused significant side effects) **AND** **1.2.4** Trial and failure, contraindication or intolerance to an adequate trial of trihexyphenidyl with documentation of tardive dystonia **AND** **1.2.5** Prescribed by or in consultation with a neurologist or other expert in the treatment of tardive dyskinesia/movement disorders

Notes	*Members new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) must meet initial criteria for coverage

Product Name: Austedo, Austedo XR	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Notes	*Members new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) must meet initial criteria for coverage

2 . Revision History

Date	Notes
9/20/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-128137
Guideline Name	Auvelity (dextromethorphan-bupropion)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Auvelity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance of at least two preferred antidepressants within the Selective Serotonin Reuptake inhibitor (SSRI) or Serotonin Norepinephrine Reuptake inhibitor (SNRI) drug classes

- citalopram
- escitalopram
- sertraline

- paroxetine
- fluoxetine
- venlafaxine
- duloxetine

Product Name: Auvelity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Auvelity	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance of at least two preferred antidepressants within the Selective Serotonin Reuptake inhibitor (SSRI) or Serotonin Norepinephrine Reuptake inhibitor (SNRI) drug classes

- citalopram
- escitalopram
- sertraline
- paroxetine
- fluoxetine
- venlafaxine
- duloxetine

2 . Revision History

Date	Notes
8/21/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-127879
Guideline Name	Azelex, Finacea (Azelaic Acid)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Brand Finacea, Generic Azelaic Acid, Brand Azelex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Both of the following:

1.1 Trial and failure of one topical tretinoin

- tretinoin 0.01% gel
- tretinoin 0.025% gel/cream
- tretinoin 0.05% gel/cream

- tretinoin 0.1% cream

AND

1.2 Trial of topical adapalene (0.1% gel/cream, 0.3% gel)

OR

2 - For Generic Azelaic acid 15% or Brand Finacea 15% Foam: Diagnosis of rosacea

Product Name: Brand Finacea, Generic Azelaic Acid, Brand Azelex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Brand Finacea, Generic Azelaic Acid, Brand Azelex	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All Plans except IL and MN Plans

Approval Criteria

1 - Both of the following:

1.1 Trial and failure of one topical tretinoin

- tretinoin 0.01% gel
- tretinoin 0.025% gel/cream
- tretinoin 0.05% gel/cream
- tretinoin 0.1% cream

AND

1.2 Trial of topical adapalene (0.1% gel/cream, 0.3% gel)

OR

2 - For Generic Azelaic acid 15% or Brand Finacea 15% Foam: Diagnosis of rosacea

2 . Revision History

Date	Notes
8/25/2023	New Programs

Prior Authorization Guideline

Guideline ID	GL-136393
Guideline Name	Baxdela (Delafloxacin)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Baxdel	
Approval Length	See Note*
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Person has been receiving drug during hospitalization and needs to complete the course of therapy as an outpatient.

OR

1.2 Both of the following:

1.2.1 Outpatient treatment of bacterial resistant strains as ordered by, or in documented consultation with an Infectious Disease Specialist

AND

1.2.2 Report of cultures and susceptibilities documenting resistance to preferred alternatives needs to be provided for approval

Notes	* Approve for duration of treatment, usually 6-14 days for 1 fill

Product Name: Baxdela	
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Person has been receiving drug during hospitalization and needs to complete the course of therapy as an outpatient.

OR

2 - Both of the following

2.1 Outpatient treatment of bacterial resistant strains as ordered by, or in documented consultation with an Infectious Disease Specialist.

AND

2.2 Report of cultures and susceptibilities documenting resistance to preferred alternatives needs to be provided for approval

OR

3 - For Illinois Plans Only - the requested drug is being used for the long-term treatment of tick-borne disease

2 . Revision History

Date	Notes
11/17/2023	Update guideline

Prior Authorization Guideline

Guideline ID	GL-136538
Guideline Name	Belsomra (suvorexant)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Belsomra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Person needs the medication for sleep

AND

2 - Trial and failure, contraindication, or intolerance to two preferred alternatives (e.g., zolpidem, eszopiclone, zaleplon, trazodone, mirtazapine, quetiapine, temazepam, etc.)

Product Name: Belsomra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Belsomra	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Person needs the medication for sleep

AND

2 - Trial and failure, contraindication, or intolerance to two preferred alternatives (e.g., zolpidem, eszopiclone, zaleplon, trazodone, mirtazapine, quetiapine, temazepam, etc.)

2 . Revision History

Date	Notes
12/8/2023	Examples included in the criteria.

Prior Authorization Guideline

Guideline ID	GL-128907
Guideline Name	Bexarotene
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Bexarotene Gel	
Approval Length	12 month(s)
Guideline Type	Prior authorization - IL and MN Plans

Approval Criteria

1 - All of the following:

1.1 One of the following:

1.1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the person presents with*

OR

1.1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the person*

AND

1.2 Prescribed and monitored by an Oncologist, Hematologist, or other specialist in the treatment of malignancy

OR

2 - One of the following:

2.1 Both of the following:

2.1.1 If the request is for Minnesota Plans only, the requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the person based on one of the following:

- United States Pharmacopeia Drug Information
- The American Hospital Formulary Service Drug Information
- One article in a major peer- reviewed medical journal recognizes the safety and efficacy of the requested drug in the person's specific condition

AND

2.1.2 Prescribed and monitored by an Oncologist, Hematologist, or other specialist in the treatment of malignancy

OR

2.2 Both of the following:

2.2.1 If the request is for IL plans only, the requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the person based on one of the following:

- Thomson Micromedex Drugdex
- The American Hospital Formulary Service Drug Information
- Elsevier Gold Standard's Clinical Pharmacology
- Two articles in a peer- reviewed medical journal from the United States or Great Britain recognize the safety and efficacy of the requested drug in the person's specific condition

AND

2.2.2 Prescribed and monitored by an Oncologist, Hematologist, or other specialist in the treatment of malignancy

Notes	*includes any relevant genetic testing, mutations, etc.

Product Name: Generic Bexarotene Gel	
Approval Length	12/31/2039
Guideline Type	Prior authorization - All plans except IL and MN

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the person presents with*

OR

1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the person*

AND

2 - Prescribed and monitored by an Oncologist, Hematologist, or other specialist in the treatment of malignancy

Notes	*includes any relevant genetic testing, mutations, etc.

2 . Revision History

Date	Notes
11/3/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-127878
Guideline Name	Briviact (Brivaracetam)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Briviact	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance to at least TWO preferred anticonvulsants:

- lamotrigine
- levetiracetam
- carbamazepine
- valproate
- oxcarbazepine

- gabapentin
- pregabalin
- topiramate
- phenytoin
- zonisamide
- primidone

Product Name: Briviact	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Briviact	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All Plans Except IL and MN

Approval Criteria

1 - Trial and failure, contraindication, or intolerance to at least TWO preferred anticonvulsants:

- lamotrigine
- levetiracetam
- carbamazepine
- valproate
- oxcarbazepine
- gabapentin
- pregabalin
- topiramate
- phenytoin
- zonisamide
- primidone

2 . Revision History

Date	Notes
8/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129108
Guideline Name	Broad Spectrum Antifungal
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Cresemba, Generic posaconazole tablet, Generic voriconazole	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of confirmed (or suspected) serious fungal infection with probable resistance to other preferred antifungals, or other antifungals have been not tolerated, or significant drug-drug interactions exist with other antifungals

OR

2 - Prescribed by or in consultation with an Infectious Disease specialist

OR

3 - For generic posaconazole tablet only, used for prophylaxis of serious fungal infections in patients with hematologic malignancies with severely compromised immunity

OR

4 - For continuation of therapy initiated as an inpatient

OR

5 - For Illinois plans only - the requested FDA approved drug is being used for the long-term treatment of tick-borne disease.

OR

6 - For Minnesota plans only - member has stage four metastatic cancer and the requested drug is being used to prevent or treat cancer-related fungal infections

Product Name: Generic posaconazole suspension, Noxafil suspension packet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Diagnosis of confirmed (or suspected) serious fungal infection with probable resistance to other preferred antifungals, or other antifungals have been not tolerated, or significant drug-drug interactions exist with other antifungals

OR

1.2 Prescribed by or in consultation with an Infectious Disease specialist

OR

1.3 Used for prophylaxis of serious fungal infections in patients with hematologic malignancies with severely compromised immunity

OR

1.4 For continuation of therapy initiated as an inpatient

OR

1.5 For Minnesota plans only - member has stage four metastatic cancer and the requested drug is being used to prevent or treat cancer-related fungal infections

OR

1.6 For Illinois plans only - the requested FDA approved drug is being used for the long-term treatment of tick-borne disease.

AND

2 - Member is unable to tolerate solid dosage form

2 . Revision History

Date	Notes
9/7/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-135532
Guideline Name	Bylvay (odevixibat)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Bylvay	
Diagnosis	Progressive Familial Intrahepatic Cholestasis (PFIC))
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of progressive familial intrahepatic cholestasis (PFIC)

AND

2 - Disease is confirmed by one of the following:

- Genetic testing
- Diagnostic test (e.g., liver function test, liver ultrasound and biopsy, bile analysis)

AND

3 - Genetic testing does not indicate PFIC type 2 with ABCB11 variant encoding for nonfunctioning or absence of bile salt export pump protein (BSEP-3)

AND

4 - Member is experiencing moderate to severe cholestatic pruritus

AND

5 - Member has serum bile acid greater than 3x the upper limit of normal (ULN)

AND

6 - Member has not had a liver transplant, biliary diversion surgery within the past 6 months, or decompensated liver disease

AND

7 - Trial and failure, contraindication or intolerance to TWO of the following medications for pruritis:

- Ursodeoxycholic acid (e.g., Ursodiol)
- Antihistamines (e.g., diphenhydramine, hydroxyzine)
- Rifampin
- Bile acid sequestrants (e.g., Questran, Colestid, Welchol)

AND

8 - Prescribed by or in consultation with one of the following:

- hepatologist
- gastroenterologist

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies. **For members new to plan (as evidenced by coverage effective date of less than or equal to 90 days) prescriber provides submission of medical records (e.g., chart notes) documenting that from the previous 12 months, member demonstrates an improvement or stabilization in pruritus and the member is tolerating therapy.

Product Name: Bylvay	
Diagnosis	Alagille syndrome)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Alagille syndrome (ALGS)

AND

2 - Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene

AND

3 - One of the following:

- Total serum bile acid greater than 3x the upper limit of normal (ULN)
- Conjugated bilirubin greater than 1 mg/dL
- Fat soluble vitamin deficiency otherwise unexplainable
- Gamma-glutamyl transpeptidase (GGT) greater than 3x ULN

AND

4 - Member is experiencing moderate to severe cholestatic pruritus

AND

5 - Member has not had a liver transplant or decompensated liver disease

AND

6 - Trial and failure, contraindication or intolerance to TWO of the following medications for pruritis:

- Ursodeoxycholic acid (e.g., Ursodiol)
- Antihistamines (e.g., diphenhydramine, hydroxyzine)
- Rifampin
- Bile acid sequestrants (e.g., Questran, Colestid, Welchol)

AND

7 - Trial and failure, contraindication or intolerance to maralixibat

AND

8 - Prescribed by or in consultation with one of the following:

- hepatologist
- Expert in the treatment of cholestasis

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufactu rer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies. **For members new to plan (as evidenced by coverage effective date of less than or equal to 90 days) prescriber provides submission of me dical records (e.g., chart notes) documenting that from the previous 1

	2 months, member demonstrates an improvement or stabilization in pruritus and the member is tolerating therapy.

Product Name: Bylvay	
Diagnosis	All Indications)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months of therapy, member is experiencing improvement or stabilization in pruritus compared to baseline (e.g., change in member reported pruritus, change in sleeping habits due to itch) and the member is tolerating therapy (e.g., does not have chronic diarrhea requiring ongoing intravenous fluids, bile acid reduction)	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies. **For members new to plan (as evidenced by coverage effective date of less than or equal to 90 days) prescriber provides submission of medical records (e.g., chart notes) documenting that from the previous 12 months, member demonstrates an improvement or stabilization in pruritus and the member is tolerating therapy.

2 . Revision History

Date	Notes
11/2/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-128994
Guideline Name	Cablivi (caplacizumab-yhdp)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Cablivi	
Approval Length	1 month (30days)
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of severe acquired thrombotic thrombocytopenic purpura (aTTP) with at least one ADAMST13 level below 20 percent

AND

2 - Member is 18 years of age or older

AND

3 - Both of the following:

3.1 Member had been receiving plasma exchange (PEX) in combination with Cablivi (either as an inpatient or in an outpatient clinic setting)

AND

3.2 PEX has been discontinued and Cablivi therapy will continue

AND

4 - Used in combination with immunosuppressive therapy (e.g., systemic corticosteroids or rituximab)

AND

5 - Member has not had greater than 2 recurrences of aTTP while on Cablivi therapy

Product Name: Cablivi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of severe acquired thrombotic thrombocytopenic purpura (aTTP) with at least one ADAMST13 level below 20 percent

AND

2 - Member is 18 years of age or older

AND

3 - Both of the following:

3.1 Member had been receiving plasma exchange (PEX) in combination with Cablivi (either as an inpatient or in an outpatient clinic setting)

AND

3.2 PEX has been discontinued and Cablivi therapy will continue

AND

4 - Used in combination with immunosuppressive therapy (e.g., systemic corticosteroids or rituximab)

AND

5 - Member has not had greater than 2 recurrences of aTTP while on Cablivi therapy

AND

6 - Cablivi (caplacizumab) will be self-administered

2 . Revision History

Date	Notes
9/8/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-130131
Guideline Name	Camzyos (mavacamten)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Camzyos	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of obstructive hypertrophic cardiomyopathy with New York Heart Association (NYHA) class II-III symptoms

AND

2 - Left ventricular ejection fraction (LVEF) greater than or equal to 55%

AND

3 - Member is 18 years of age or older

AND

4 - Prescribed by, or in consultation with, a Cardiologist or other expert in the treatment of hypertrophic cardiomyopathy

AND

5 - Submission of medical records (e.g., chart notes) documenting trial and failure, contraindication, or intolerance to BOTH of the following:

- Beta-blockers (i.e., carvedilol, labetalol, metoprolol, propranolol)
- Calcium channel blockers (i.e., diltiazem, verapamil)

Notes	Member new to the plan (as evidenced by coverage effective date of l ess than or equal to 90 days) who initiated therapy using a manufactu rer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Camzyos	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of obstructive hypertrophic cardiomyopathy with New York Heart Association (NYHA) class II-III symptoms

AND **2** - Member is 18 years of age or older **AND** **3** - Person has been evaluated by a cardiologist, or other expert in the treatment of hypertrophic cardiomyopathy, within the previous 12 months **AND** **4** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member demonstrates positive clinical response to therapy	
Notes	Member new to the plan (as evidenced by coverage effective date of l ess than or equal to 90 days) who initiated therapy using a manufactu rer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
10/25/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129156
Guideline Name	Cardura XL (doxazosin ER)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Cardura XL	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - The prescriber provides an evidence-based clinical rationale for why the side effects are not likely to occur with the extended-release formulation

AND

2 - Use of at least one additional preferred alpha blocker (such as terazosin or prazosin) did not control symptoms or caused side effects

AND

3 - Trial and failure, contraindication or intolerance of immediate-release doxazosin (unable to achieve symptom control due to therapy-limiting side effects)

Product Name: Cardura XL	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Cardura XL	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - The prescriber provides an evidence-based clinical rationale for why the side effects are not likely to occur with the extended-release formulation

AND

2 - Use of at least one additional preferred alpha blocker (such as terazosin or prazosin) did not control symptoms or caused side effects

AND **3** - Trial and failure, contraindication or intolerance of immediate-release doxazosin (unable to achieve symptom control due to therapy-limiting side effects)

2 . Revision History

Date	Notes
9/11/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129106
Guideline Name	Cayston (Aztreonam Inhalation Solution)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Cayston	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of cystic fibrosis

AND

2 - Member has a history of recurrent Pseudomonas aeruginosa lung infections

AND

3 - Medication will be used for inhalation only

AND

4 - One of the following:

- Recurrence despite prior use of tobramycin inhalation solution
- Submission of medical records (e.g., chart notes) documenting tobramycin resistance

Product Name: Cayston	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of cystic fibrosis

AND

2 - Member has a history of recurrent Pseudomonas aeruginosa lung infections

AND

3 - Medication will be used for inhalation only

AND

4 - One of the following:

- Recurrence despite prior use of tobramycin inhalation solution
- Submission of medical records (e.g., chart notes) documenting tobramycin resistance

Product Name: Cayston	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
7/31/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-132716
Guideline Name	Chronic Constipation Medications
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Linzess, Trulance, Motegrity	
Diagnosis	Chronic Constipation
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of Chronic Constipation

AND

2 - Member is 18 years of age or older

AND

3 - Trial and failure, contraindication or intolerance to two first line therapies (e.g., Miralax, stimulants, fiber supplements, stool softeners)

AND

4 - For Linzess Only - Trial and failure, contraindication or intolerance to lubiprostone

AND

5 - For Trulance and Motegrity Only - Trial and failure, contraindication or intolerance to lubiprostone and linaclotide

Product Name: Linzess, Trulance, Motegrity	
Diagnosis	Chronic Constipation
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Chronic Constipation

AND

2 - Member is 18 years of age or older

AND

3 - Trial and failure, contraindication or intolerance to two first line therapies (e.g., Miralax, stimulants, fiber supplements, stool softeners)

AND

4 - For Linzess Only - Trial and failure, contraindication or intolerance to lubiprostone

AND

5 - For Trulance and Motegrity Only - Trial and failure, contraindication or intolerance to lubiprostone and linaclotide

Product Name: Linzess, Trulance	
Diagnosis	Irritable Bowel Syndrome - Constipation (IBS-C)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of Irritable Bowel Syndrome - Constipation (IBS-C)

AND

2 - Member is 18 years of age or older

AND

3 - Trial and failure, contraindication or intolerance of at least two alternative therapies (e.g., Miralax, fiber, stimulants, dicyclomine, hyoscyamine, tricyclic or SSRI antidepressants)

AND

4 - For Linzess Only - Trial and failure, contraindication or intolerance to lubiprostone

AND

5 - For Trulance Only - Trial and failure, contraindication or intolerance to lubiprostone and linaclotide

Product Name: Linzess, Trulance	
Diagnosis	Irritable Bowel Syndrome - Constipation (IBS-C)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Irritable Bowel Syndrome - Constipation (IBS-C)

AND

2 - Member is 18 years of age or older

AND

3 - Trial and failure, contraindication or intolerance of at least two alternative therapies (e.g., Miralax, fiber, stimulants, dicyclomine, hyoscyamine, tricyclic or SSRI antidepressants)

AND

4 - For Linzess Only - Trial and failure, contraindication or intolerance to lubiprostone

AND

5 - For Trulance Only - Trial and failure, contraindication or intolerance to lubiprostone and linaclotide

Product Name: Symproic, Movantik	
Diagnosis	Opioid-Induced Constipation
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of Opioid-Induced Constipation

AND

2 - Member is on chronic opioid therapy

AND

3 - Member is 18 years of age or older

AND

4 - Trial and failure, contraindication or intolerance to a concurrent combination of a stimulant (e.g., Senna) and an osmotic laxative (e.g., Miralax)

AND

5 - For Movantik Only - Trial and failure, contraindication or intolerance to lubiprostone

AND

6 - For Symproic Only - Trial and failure, contraindication or intolerance to lubiprostone and naloxegol

Product Name: Symproic, Movantik

Diagnosis	Opioid-Induced Constipation
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Opioid-Induced Constipation

AND

2 - Member is on chronic opioid therapy

AND

3 - Member is 18 years of age or older

AND

4 - Trial and failure, contraindication or intolerance to a concurrent combination of a stimulant (e.g., Senna) and an osmotic laxative (e.g., Miralax)

AND

5 - For Movantik Only - Trial and failure, contraindication or intolerance to lubiprostone

AND

6 - For Symproic Only - Trial and failure, contraindication or intolerance to lubiprostone and naloxegol

Product Name: Linzess, Trulance, Motegrity, Symproic, Movantik	
Diagnosis	Metastatic Cancer

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - MN Plans

Approval Criteria

1 - Diagnosis of stage four metastatic cancer

AND

2 - Member is on opioid therapy to treat cancer-related pain with opioid-induced constipation

Product Name: Linzess, Trulance, Motegrity, Symproic, Movantik	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Linzess	
Diagnosis	Functional Constipation
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of Functional Constipation

AND

2 - Member is between the age of 6 and 17 years of age

AND

3 - Trial and failure, contraindication or intolerance to an adequate trial of over-the-counter osmotic laxatives (e.g., polyethylene glycol, magnesium hydroxide)

AND

4 - Trial and failure, contraindication or intolerance to an adequate trial of over-the-counter stimulant laxative (e.g. bisacodyl, senna)

Product Name: Linzess	
Diagnosis	Functional Constipation
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Functional Constipation

AND

2 - Member is between the age of 6 and 17 years of age

AND

3 - Trial and failure, contraindication or intolerance to an adequate trial of over-the-counter osmotic laxatives (e.g., polyethylene glycol, magnesium hydroxide)

AND **4** - Trial and failure, contraindication or intolerance to an adequate trial of over-the-counter stimulant laxative (e.g. bisacodyl, senna)

2 . Revision History

Date	Notes
9/19/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-137231
Guideline Name	Cimzia (certolizumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Cimzia	
Diagnosis	Plaque Psoriasis
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans
Approval Criteria	

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - One of the following:

- Significant functional disability
- Body surface area (BSA) involvement of greater than or equal to 3%
- Debilitating palmer/plantar psoriasis or other vulnerable areas that are difficult to treat (e.g. nails, scalp, genitals, or intertriginous areas

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - Trial and failure, contraindication, or intolerance to topical treatment (e.g. topical corticosteroids, calcipotriene, retinoids)

AND

5 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication will be self-administered

Product Name: Cimzia	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - One of the following:

- Significant functional disability
- Body surface area (BSA) involvement of greater than or equal to 3%
- Debilitating palmer/plantar psoriasis or other vulnerable areas that are difficult to treat (e.g. nails, scalp, genitals, or intertriginous areas

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - Trial and failure, contraindication, or intolerance to topical treatment (e.g. topical corticosteroids, calcipotriene, retinoids)

AND

5 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication will be self-administered

Product Name: Cimzia	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12/31/2039

Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Cimzia	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Cimzia	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Rheumatoid arthritis (RA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- Methotrexate (MTX)*
- Leflunomide
- Hydroxychloroquine
- Sulfasalazine

AND

3 - Medication will be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	*Absolute contraindications to methotrexate are pregnancy, nursing, a lcoholism, alcoholic liver disease or other chronic liver disease, immun odeficiency syndromes, bone marrow hyperplasia, leukopenia, thromb ocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Cimzia	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Rheumatoid arthritis (RA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- Methotrexate (MTX)*
- Leflunomide
- Hydroxychloroquine
- Sulfasalazine

AND

3 - Medication will be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	*Absolute contraindications to methotrexate are pregnancy, nursing, a lcoholism, alcoholic liver disease or other chronic liver disease, immun odeficiency syndromes, bone marrow hyperplasia, leukopenia, thromb ocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Cimzia	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of ankylosing spondylitis (AS)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Cimzia	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of ankylosing spondylitis (AS)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Cimzia	
Diagnosis	Non-radiographic axial spondyloarthritis (nr-axSpA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) with elevated labs (e.g. C-reactive protein) and/or sacroiliitis on imaging

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Cimzia	
Diagnosis	Non-radiographic axial spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of active non-radiographic axial spondyloarthritis (nr-axSpA) with elevated labs (e.g. C-reactive protein) and/or sacroiliitis on imaging

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Cimzia	
Diagnosis	Moderate to Severely Active Crohn's Disease (CD)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Crohn's disease (CD)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - One of the following:

3.1 Member is considered high-risk based on ONE of the following characteristics:

- Age less than 30 years at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease

- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (e.g., uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy)

OR

3.2 Both of the following:

3.2.1 Member is considered low-risk

AND

3.2.2 One of the following:

- Trial and failure, contraindication, or intolerance to one conventional therapy (e.g., azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)
- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with one conventional therapy
- Demonstrated steroid dependence
- Conventional therapy clinically inappropriate based on location of disease

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Cimzia	
Diagnosis	Moderate to Severely Active Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Crohn's disease (CD)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - One of the following:

3.1 Member is considered high-risk based on ONE of the following characteristics:

- Age less than 30 years at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (e.g., uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy)

OR

3.2 Both of the following:

3.2.1 Member is considered low-risk

AND

3.2.2 One of the following:

- Trial and failure, contraindication, or intolerance to one conventional therapy (e.g., azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)

- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with one conventional therapy
- Demonstrated steroid dependence
- Conventional therapy clinically inappropriate based on location of disease

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Cimzia	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization – IL and MN Plans
Approval Criteria **1** - Prescriber provides clinical documentation from the previous 12 months of the member's response to therapy including individual improvements in functional status related to therapeutic response	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Cimzia	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis, PSA, AS, nr-axSpA, plaque psoriasis
Approval Length	12 month(s)
Guideline Type	Quantity Exception - IL and MN Plans

Approval Criteria

1 - Failure of an adherent 3-month trial of standard maintenance dosing with concomitant methotrexate (unless contraindicated or not appropriate for indication being requested)

Product Name: Cimzia	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis, PSA, AS, nr-axSpA, plaque psoriasis
Approval Length	12/31/2099
Guideline Type	Quantity Exception – All Plans except IL and MN Plans

Approval Criteria

1 - Failure of an adherent 3-month trial of standard maintenance dosing with concomitant methotrexate (unless contraindicated or not appropriate for indication being requested)

Product Name: Cimzia	
Diagnosis	Crohn’s disease
Approval Length	12 month(s)
Guideline Type	Quantity Exception - IL and MN Plans

Approval Criteria

1 - Failure of a two-month trial of monthly therapy after completion of induction dosing regimen

AND

2 - Based on subtherapeutic drug concentrations and absence (or low levels) of drug antibodies

Product Name: Cimzia

Diagnosis	Crohn’s disease
Approval Length	12/31/2099
Guideline Type	Quantity Exception – All Plans except IL and MN Plans

Approval Criteria

1 - Failure of a two-month trial of monthly therapy after completion of induction dosing regimen

AND

2 - Based on subtherapeutic drug concentrations and absence (or low levels) of drug antibodies

2 . Revision History

Date	Notes
12/4/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-128188
Guideline Name	Clomipramine (anafranil)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Clomipramine	
Diagnosis	Obsessive compulsive disorder:
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication or intolerance to, two preferred antidepressants within the Serotonin Selective Reuptake Inhibitor (SSRI) category category (e.g. citalopram, escitalopram, sertraline, fluoxetine, paroxetine)

Product Name: Generic Clomipramine	
Diagnosis	Other mood or anxiety disorders
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication or intolerance to, two preferred antidepressants within the Serotonin Selective Reuptake Inhibitor (SSRI) or Selective Norepinephrine Reuptake Inhibitor (SNRI) categories (e.g. citalopram, escitalopram, sertraline, fluoxetine, paroxetine, duloxetine, venlafaxine)

Product Name: Generic Clomipramine	
Diagnosis	Obsessive compulsive disorder, Other mood or anxiety disorders, non-behavioral heatlh/mood disorders
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Generic Clomipramine	
Diagnosis	Obsessive compulsive disorder:
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Trial and failure, contraindication or intolerance to, two preferred antidepressants within

the Serotonin Selective Reuptake Inhibitor (SSRI) category (e.g. citalopram, escitalopram, sertraline, fluoxetine, paroxetine

Product Name: Generic Clomipramine	
Diagnosis	Other mood or anxiety disorders
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Trial and failure, contraindication or intolerance to, two preferred antidepressants within the Serotonin Selective Reuptake Inhibitor (SSRI) or Selective Norepinephrine Reuptake Inhibitor (SNRI) categories (e.g. citalopram, escitalopram, sertraline, fluoxetine, paroxetine, duloxetine, venlafaxine)

2 . Revision History

Date	Notes
9/24/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129741
Guideline Name	Codeine and Tramadol-Containing Products
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Age greater than11 years

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Age greater than11 years

2 . Revision History

Date	Notes
10/24/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129116
Guideline Name	Compounded Hormones
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Compounded progesterone to maintain pregnancy in the first trimester	
Approval Length	4 month(s)
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Medication will be used to maintain pregnancy

AND

2 - Submission of medical records (e.g., chart notes) documenting the woman is currently pregnant in her 1st trimester

Product Name: Compounded progesterone to maintain pregnancy beyond the first trimester	
Approval Length	6 month(s)
Guideline Type	Prior Authorization – All plans except MN and IL

Approval Criteria

1 - Medication will be used to maintain pregnancy

AND

2 - Submission of medical records (e.g., chart notes) documenting the woman has a singleton pregnancy

AND

3 - Woman is beyond the 1st trimester

AND

4 - Submission of medical records (e.g., chart notes) documenting a history of preterm birth

Product Name: Compounded progesterone to maintain pregnancy	
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL and MN plans

Approval Criteria

1 - BOTH of the following:

- Medication will be used to maintain pregnancy
- Submission of medical records (e.g., chart notes) documenting the woman is currently pregnant in her 1st trimester

OR

2 - All of the following:

- Medication will be used to maintain pregnancy
- Submission of medical records (e.g., chart notes) woman has a singleton pregnancy
- Woman is beyond the 1st trimester
- Submission of medical records (e.g., chart notes) documenting a history of preterm birth

Product Name: Compounded progesterone to treat infertility	
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL Plans

Approval Criteria

1 - Infertility coverage as outlined in Illinois Insurance Code 215 ILCS 5/356m

Product Name: Estrogen, testosterone, and progesterone use outside of pregnancy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Trial and failure to all preferred alternatives available on the formulary of the requested hormone

AND

2 - Meets off-label criteria

AND **3** - For testosterone only, both of the following: **3.1** Submission of medical records (e.g., chart notes) documenting a diagnosis of primary or secondary hypogonadism or mixed hypogonadism that clinically appropriate laboratory data demonstrate androgen deficiency* **AND** **3.2** Member is symptomatic with symptoms other than sexual dysfunction

Notes	* Androgen deficiency is defined as a fasting, morning testosterone level (drawn between 7 and 10 AM or within 3 hours of waking for shift workers) below the lower limit of normal as defined by the laboratory reference range. A single low testosterone is not diagnostic for androgen deficiency and must be confirmed with a second fasting, morning testosterone level.

Product Name: Estrogen, testosterone, and progesterone use outside of pregnancy	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member demonstrates positive clinical response to therapy	
Notes	* Androgen deficiency is defined as a fasting, morning testosterone level (drawn between 7 and 10 AM or within 3 hours of waking for shift workers) below the lower limit of normal as defined by the laboratory reference range. A single low testosterone is not diagnostic for androgen deficiency and must be confirmed with a second fasting, morning testosterone level.

2 . Revision History

Date	Notes
12/8/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129124
Guideline Name	Compounded Prescriptions
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

These criteria will be applied only if a compound claim requires prior authorization (e.g., most expensive ingredient requires prior authorization)

1 . Criteria

Product Name: Compounded Prescription	
Approval Length	12 month(s)
Guideline Type	Prior Authorization – MN plans only

Approval Criteria

1 - For Minnesota plans only - One of the following:

1.1 Both of the following:

1.1.1 The compound is prescribed for a member with emotional disturbance or mental illness

AND

1.1.2 One of the following:

- Submission of medical records (e.g., chart notes) documenting that all equivalent drugs in the formulary for each active ingredient were considered and it has been determined that the compound prescribed will best treat the person's condition
- For continuation of care (formulary changes or new member) the member has been treated for 90 days prior to the change, the medication is working, and the prescriber attests that the compound prescribed will best treat the member's condition.

OR

1.2 ALL of the following:

- Stage four metastatic cancer and prescribed drug is used for cancer related treatment including but not limited to: pain, constipation, nausea, fatigue related to chemotherapy or bacterial, fungal or viral infection
- Medication is not commercially available in a formulation that is suitable for the person
- Medication is on the formulary or the medication is considered medically necessary by Quartz
- None of the products in the compound are otherwise excluded from coverage as defined by the person's benefit

OR

1.3 All of the following:

- Each active ingredient in the compounded drug is FDA-approved or national compendia* supported for the condition being treated
- The therapeutic amounts are supported by national compendia* or two peer-reviewed literature for the condition being treated in the requested route of delivery
- Compound is not commercially available in a formulation that is suitable for the person
- Each active ingredient in the compounded drug is on the formulary or meets the nonformulary criteria
- None of the active ingredient(s) in the compound are otherwise excluded from coverage as defined by the person's benefit

- None of the active ingredient(s) in the compound are experimental or limited by the FDA to investigational use only

Product Name: Compounded Prescription	
Approval Length	12 month(s)
Guideline Type	Prior Authorization – IL plans only

Approval Criteria

1 - For Illinois plans only - ONE of the following:

1.1 ALL of the following:

- Diagnosis of long-term treatment of tick-borne disease
- Medication is not commercially available in a formulation that is suitable for the person
- Medication is on the formulary or the medication is considered medically necessary by Quartz
- None of the products in the compound are otherwise excluded from coverage as defined by the person's benefit

OR

1.2 ALL of the following:

- Request is for a medication for a mental health condition under the mental and behavioral disorder chapter of the International Classification of Disease or is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders
- Medication is not commercially available in a formulation that is suitable for the person
- Medication is on the formulary or the medication is considered medically necessary by Quartz
- None of the products in the compound are otherwise excluded from coverage as defined by the person's benefit
- Determination should not be more restrictive than for non-behavioral health or substance use disorder diagnosis

OR

1.3 BOTH of the following:

- Request is for a medication for treating a substance use disorder
- Determination should be based on criteria established by American Society of Addiction Medicine and should not be more restrictive than non-behavioral health or substance use disorder diagnosis

OR

1.4 All of the following:

- Each active ingredient in the compounded drug is FDA-approved or national compendia* supported for the condition being treated
- The therapeutic amounts are supported by national compendia* or two peer-reviewed literature for the condition being treated in the requested route of delivery
- Compound is not commercially available in a formulation that is suitable for the person
- Each active ingredient in the compounded drug is on the formulary or meets the nonformulary criteria
- None of the active ingredient(s) in the compound are otherwise excluded from coverage as defined by the person's benefit
- None of the active ingredient(s) in the compound are experimental or limited by the FDA to investigational use only

Product Name: Compounded Prescription	
Approval Length	12 month(s)
Guideline Type	Prior Authorization – All plans except IL and MN

Approval Criteria

1 - Each active ingredient in the compounded drug is FDA-approved or national compendia* supported for the condition being treated

AND

2 - The therapeutic amounts are supported by national compendia* or two peer-reviewed literature for the condition being treated in the requested route of delivery

AND

3 - Compound is not commercially available in a formulation that is suitable for the person

AND

4 - Each active ingredient in the compounded drug is on the formulary or meets the nonformulary criteria

AND

5 - None of the active ingredient(s) in the compound are otherwise excluded from coverage as defined by the person's benefit

AND

6 - None of the active ingredient(s) in the compound are experimental or limited by the FDA to investigational use only

2 . Background

Benefit/Coverage/Program Information	
***Compendia Requirements**	
For all non-antineoplastic medications	• American Hospital Formulary Service Drug Information (AHFSDI); OR • FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of IIb or better (see DRUGDEX Strength of Recommendation table below); OR • One major peer reviewed medical journal submitted by the prescriber that presents data

	supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal
For an antineoplastic medication	• American Hospital Formulary Service Drug Information (AHFSDI); OR • National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B (see NCCN Categories of Evidence and Consensus table below); OR • FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of IIb or better (see DRUGDEX Strength of Recommendation table below); OR • Clinical Pharmacology (Gold Standard); OR • One peer-reviewed published medical literature submitted by the prescriber: o American Journal of Medicine o Annals of Internal Medicine o Annals of Oncology o Annals of Surgical Oncology o Biology of Blood and Marrow Transplantation o Blood o Bone Marrow Transplantation o British Journal of Cancer o British Journal of Hematology

	○ British Medical Journal ○ Cancer ○ Clinical Cancer Research ○ Drugs ○ European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology) ○ Gynecologic Oncology ○ International Journal of Radiation, Oncology, Biology, and Physics ○ The Journal of the American Medical Association ○ Journal of Clinical Oncology ○ Journal of the National Cancer Institute ○ Journal of the National Comprehensive Cancer Network (NCCN) ○ Journal of Urology ○ Lancet ○ Lancet Oncology ○ Leukemia ○ The New England Journal of Medicine ○ Radiation Oncology • Wolters Kluwer Lexi-Drugs rated as "Evidence Level A" with a "Strong" recommendation (see Lexi-Drugs Strength of Recommendation table below)

DRUGDEX Strength of Recommendation:

Class	Recommendation	Description

Class I	Recommended	The given test or treatment has been proven useful, and should be performed or administered.
Class IIa	Recommended, In Most Cases	The given test or treatment is generally considered to be useful, and is indicated in most cases.
Class IIb	Recommended, in Some Cases	The given test or treatment may be useful, and is indicated in some, but not most, cases.
Class III	Not Recommended	The given test or treatment is not useful, and should be avoided
Class Indeterminate	Evidence Inconclusive	

NCCN Categories of Evidence and Consensus:

Category	Level of Consensus
1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

Lexi-Drugs: Strength of Recommendation for Inclusion in Lexi-Drugs for Oncology Off-Label Use and Level of Evidence Scale for Oncology Off-Label Use

Strength of Recommendation for Inclusion

Strong (for proposed off-label use)	The evidence persuasively supports the off-label use (ie, Level of Evidence A).
Equivocal (for proposed off-label use)	The evidence to support the off-label use is of uncertain clinical significance (ie, Level of Evidence B, C). Additional studies may be necessary to further define the role of this medication for the off-label use.
Against proposed off-label use	The evidence either advocates against the off-label use or suggests a lack of support for the off-label use (independent of Level of Evidence). Additional studies are necessary to define the role of this medication for the off-label use.

Level of Evidence Scale for Oncology Off-Label Use

A	**Consistent evidence from well-performed randomized, controlled trials or overwhelming evidence of some other form (eg, results of the introduction of penicillin treatment) to support off-label use. Further research is unlikely to change confidence in the estimate of benefit.**
B	**Evidence from randomized, controlled trials with important limitations (eg, inconsistent results, methodologic flaws, indirect, imprecise); or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on confidence in the estimate of benefit and risk and may change the estimate.**
C	**Evidence from observational studies (eg, retrospective case series/reports providing significant impact on patient care); unsystematic clinical experience; or potentially flawed randomized, controlled trials (eg, when limited options exist for condition). Any estimate of effect is uncertain.**
G	**Use has been substantiated by inclusion in at least one evidence-based or consensus-based clinical practice guideline.**

3 . Revision History

Date	Notes
12/8/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129113
Guideline Name	Corlanor (ivabradine)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Corlanor	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

1.1.1 Diagnosis of stable, symptomatic heart failure in sinus rhythm

AND

1.1.2 Both of the following:

- Left ventricular ejection fraction less than or equal to 35%
- Resting heart rate greater than or equal to 70 beats per minute

AND

1.1.3 Prescribed by or in consultation with a cardiologist

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of Inappropriate Sinus Tachycardia

AND

1.2.2 One of the following:

1.2.2.1 Member has symptoms despite use of maximally tolerated beta blocker therapy

OR

1.2.2.2 Member has contraindication to beta blocker use

Product Name: Corlanor	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

1.1.1 Diagnosis of stable, symptomatic heart failure in sinus rhythm

AND

1.1.2 Both of the following:

- Left ventricular ejection fraction less than or equal to 35%
- Resting heart rate greater than or equal to 70 beats per minute

AND

1.1.3 Prescribed by or in consultation with a cardiologist

OR

1.2 BOTH of the following:

1.2.1 Diagnosis of Inappropriate Sinus Tachycardia

AND

1.2.2 One of the following:

1.2.2.1 Member has symptoms despite use of maximally tolerated beta blocker therapy

OR

1.2.2.2 Member has contraindication to beta blocker use

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) must meet initial criteria for coverage

Product Name: Corlanor	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans*
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) must meet initial criteria for coverage

2 . Revision History

Date	Notes
9/8/2023	2024 implementation

Prior Authorization Guideline

Guideline ID	GL-128962
Guideline Name	Corticotropin Gel
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Brand Acthar, Generic Corticotropin	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of infantile spasm with electroencephalogram pattern consistent with hypsarrhythmia

AND

1.1.2 Prescribed by, or in consultation with a Neurologist

AND

1.1.3 Member is less than 2 years of age

OR

1.2 Both of the following:

1.2.1 FDA approved diagnosis with evidence-based supporting literature/guideline

AND

1.2.2 Trial and failure, contraindication, or intolerance to an adequate trial of preferred formulary medications appropriate for the condition

Product Name: Brand Acthar, Generic Corticotropin	
Approval Length	3 Month(s) with partial fill (max 15 days/prescription)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – All plans except IL and MN

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of infantile spasm with electroencephalogram pattern consistent with hypsarrhythmia

AND

1.1.2 Prescribed by, or in consultation with a Neurologist

AND

1.1.3 Member is less than 2 years of age

OR

1.2 Both of the following:

1.2.1 FDA approved diagnosis with evidence-based supporting literature/guideline

AND

1.2.2 Trial and failure, contraindication, or intolerance to an adequate trial of preferred formulary medications appropriate for the condition

Product Name: Brand Acthar, Generic Corticotropin	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - All Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of infantile spasm with electroencephalogram pattern consistent with hypsarrhythmia

AND

1.1.2 Prescribed by, or in consultation with a Neurologist

AND

1.1.3 Member is less than 2 years of age

OR

1.2 Both of the following:

1.2.1 FDA approved diagnosis with evidence-based supporting literature/guideline

AND

1.2.2 Trial and failure, contraindication, or intolerance to an adequate trial of preferred formulary medications appropriate for the condition

AND

2 - Submission of medical records (e.g., chart notes) with documentation of evidence-based rationale for continued use and evidence of member response to therapy from the previous period.

2 . Revision History

Date	Notes
9/7/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-137445
Guideline Name	Cosentyx (secukinumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Cosentyx	
Diagnosis	Plaque Psoriasis
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis with ONE of the following:

- Significant functional disability
- BSA involvement greater than 3%
- Debilitating palmar/plantar psoriasis or other vulnerable areas that are difficult to treat such as nails, hairy/scalp areas, genitals, or intertriginous areas

AND

2 - Member is greater than 6 years old

AND

3 - Trial and failure, contraindication or intolerance to BOTH of the following:

3.1 Topical treatment (e.g., topical corticosteroids, calcipotriene, retinoids, calcineurin inhibitors)

AND

3.2 ONE of the following:

- Certolizumab
- Etanercept
- Adalimumab (biosimilars or Humira)
- Risankizumab
- Ustekinumab
- Guselkumab

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a dermatologist

Product Name: Cosentyx	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis with ONE of the following:

- Significant functional disability
- BSA involvement greater than 3%
- Debilitating palmar/plantar psoriasis or other vulnerable areas that are difficult to treat such as nails, hairy/scalp areas, genitals, or intertriginous areas

AND

2 - Member is greater than 6 years old

AND

3 - Trial and failure, contraindication or intolerance to BOTH of the following:

3.1 Topical treatment (e.g., topical corticosteroids, calcipotriene, retinoids)

AND

3.2 ONE of the following:

- Certolizumab
- Etanercept
- Adalimumab (biosimilars or Humira)
- Risankizumab
- Ustekinumab
- Guselkumab

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a dermatologist

Product Name: Cosentyx	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis

AND

2 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- Actively inflamed joints
- Axial disease
- Active skin, nail, or scalp psoriasis involvement
- Dactylitis
- Enthesitis

AND

3 - Trial and failure or intolerance to a minimum 3 month trial or contraindication to ONE of the following:

- adalimumab
- certolizumab
- etanercept
- upadacitinib
- risankizumab
- guselkumab
- golimumab
- tofacitinib/tofacitinib XR
- ustekinumab

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a Dermatologist or Rheumatologist

Product Name: Cosentyx	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis

AND

2 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- Actively inflamed joints
- Axial disease
- Active skin, nail, or scalp psoriasis involvement
- Dactylitis
- Enthesitis

AND

3 - Trial and failure or intolerance to a minimum 3 month trial or contraindication to ONE of the following:

- adalimumab
- certolizumab
- etanercept
- upadacitinib
- risankizumab
- guselkumab
- golimumab
- tofacitinib/tofacitinib XR
- ustekinumab

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a Dermatologist or Rheumatologist

Product Name: Cosentyx	
Diagnosis	Ankylosing spondylitis (AS)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of Ankylosing spondylitis (AS)

AND

2 - Trial and failure of a 1-month trial of scheduled prescription doses of two different NSAIDs (e.g., naproxen, nabumetone, diclofenac, etc.)

AND

3 - Trial and failure or intolerance to a minimum 3 month trial or contraindication to ONE of the following:

- adalimumab
- certolizumab
- etanercept
- upadacitinib
- golimumab
- tofacitinib/tofacitinib XR

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a Rheumatologist

Product Name: Cosentyx	
Diagnosis	Ankylosing spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Ankylosing spondylitis (AS)

AND

2 - Trial and failure of a 1-month trial of scheduled prescription doses of two different NSAIDs (e.g., naproxen, nabumetone, diclofenac, etc.)

AND

3 - Trial and failure or intolerance to a minimum 3 month trial or contraindication to ONE of the following:

- adalimumab
- certolizumab
- etanercept
- upadacitinib
- golimumab
- tofacitinib/tofacitinib XR

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a Rheumatologist

Product Name: Cosentyx	
Diagnosis	Non-radiographic axial spondyloarthritis (nr-axSpA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of active Non-radiographic axial spondyloarthritis (nr-axSpA)

AND

2 - Trial and failure of a 1-month trial of scheduled prescription doses of two different NSAIDs (e.g., naproxen, nabumetone, diclofenac, etc.)

AND

3 - Trial and failure or intolerance to a minimum 3 month trial or contraindication to ONE of the following:

- certolizumab
- upadacitinib

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a Rheumatologist

Product Name: Cosentyx	
Diagnosis	Non-radiographic axial spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of active Non-radiographic axial spondyloarthritis (nr-axSpA)

AND

2 - Trial and failure of a 1-month trial of scheduled prescription doses of two different NSAIDs (e.g., naproxen, nabumetone, diclofenac, etc.)

AND

3 - Trial and failure or intolerance to a minimum 3 month trial or contraindication to ONE of the following:

- certolizumab
- upadacitinib

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a Rheumatologist

Product Name: Cosentyx	
Diagnosis	Enthesitis-related arthritis (ERA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of Enthesitis-related arthritis (ERA)

AND

2 - Trial and failure, contraindication or intolerance to at least one NSAID (e.g., naproxen, nabumetone, diclofenac, etc.)

AND

3 - Trial and failure, contraindication or intolerance to one DMARD (e.g., sulfasalazine, methotrexate)

AND

4 - Member is greater than 4 years old

AND

3 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

4 - Medication will be self-administered

AND

7 - Prescribed by or in consultation with a Rheumatologist

Product Name: Cosentyx	
Diagnosis	Enthesitis-related arthritis (ERA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Enthesitis-related arthritis (ERA)

AND

2 - Trial and failure, contraindication or intolerance to at least one NSAID (e.g., naproxen, nabumetone, diclofenac, etc.)

AND

3 - Trial and failure, contraindication or intolerance to one DMARD (e.g., sulfasalazine, methotrexate)

AND

4 - Member is greater than 4 years old

AND

5 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication will be self-administered

AND

7 - Prescribed by or in consultation with a Rheumatologist

Product Name: Cosentyx	
Diagnosis	All Indications Listed Above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months member demonstrates a positive clinical response to therapy as evidenced by improvements in functional status related to therapeutic response

Product Name: Cosentyx	
Diagnosis	Plaque psoriasis, AS, PSA, ERA
Approval Length	12 month(s)
Guideline Type	Quantity Exception - IL and MN Plans

Approval Criteria

1 - FDA labeled regimen (based on weight or lack of response to lower doses)

OR

2 - Trial and failure of a 3-month course of standard dosing and the prescriber provides published literature supporting the requested regimen for the person's diagnosis

Product Name: Cosentyx	
Diagnosis	Plaque psoriasis, AS, PSA, ERA
Approval Length	12/31/2039
Guideline Type	Quantity Exception – All Plans except IL and MN Plans

Approval Criteria

1 - FDA labeled regimen (based on weight or lack of response to lower doses)

OR

2 - Trial and failure of a 3-month course of standard dosing and the prescriber provides published literature supporting the requested regimen for the person's diagnosis

2 . Revision History

Date	Notes
12/7/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-137861
Guideline Name	Cystic Fibrosis Transmembrane Receptor (CFTR) Modifiers
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	
P&T Revision Date:	

1 . Criteria

Product Name: Kalydeco, Orkambi, Symdeko, Trikafta	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting ALL of the following:

1.1 Diagnosis of cystic fibrosis (CF)

AND

1.2 Patient has at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene:

- Homozygous F508del CFTR mutation
- Heterozygous F508del CFTR mutation
- Heterozygous CFTR mutation that does not include F508del (Mutation is responsive to the drug as noted in the product labeling)

AND

1.3 Patient has chronic sinopulmonary, gastrointestinal or nutritional abnormalities related to cystic fibrosis (CF) requiring medical treatment

AND

2 - Prescribed by or in consultation with one of the following:

- Pulmonologist
- Specialist in the care of cystic fibrosis (CF)

AND

3 - ONE of the following:

3.1 For members with homozygous F508del CFTR mutation, one of the following:

3.1.1 For Trikafta requests ONLY: Member is 2 years of age or older

OR

3.1.2 For Orkambi requests ONLY, one of the following::

3.1.2.1 Member is between 1 and 2 years of age

OR

3.1.2.2 Both of the following:

- Member is 2 years of age or older
- Submission of medical records (e.g., chart notes) documenting trial and failure to a minimum 6-month trial, contraindication, or intolerance to Trikafta

OR

3.1.3 For Symdeko requests ONLY, all of the following:

- Member is 6 years of age or older
- Submission of medical records (e.g., chart notes) documenting trial and failure to a minimum 6-month trial, contraindication, or intolerance to Trikafta
- Submission of medical records (e.g., chart notes) documenting trial and failure to a minimum 6-month trial, contraindication, or intolerance to Orkambi

OR

3.2 For members with heterozygous F508del CFTR mutation, one of the following:

3.2.1 For Trikafta requests ONLY: Member is 2 years of age or older

OR

3.2.2 For Kalydeco requests ONLY, member is 1 months of age or older

OR

3.2.3 For Symdeko requests ONLY, both of the following:

- Member is 6 years of age or older
- Submission of medical records (e.g., chart notes) documenting trial and failure to a minimum 6-month trial, contraindication, or intolerance to Trikafta

OR

3.3 For members with heterozygous CFTR mutation that does not include F508del (Mutation is responsive to the drug as noted in the product labeling), one of the following:

3.3.1 For Kalydeco requests ONLY, member is 1 months of age or older

OR

3.3.2 For Trikafta requests ONLY, member is 2 years of age or older

OR

3.3.3 For Symdeko requests ONLY, both of the following:

- Member is 6 years of age or older
- Submission of medical records (e.g., chart notes) documenting trial and failure to a minimum 6-month trial, contraindication, or intolerance to Trikafta

Product Name: Kalydeco, Orkambi, Symdeko, Trikafta	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) from the previous 12 months demonstrating positive clinical response to therapy by one of the following:

- FEV1 stabilization or improvement from baseline
- Reduction in the number of pulmonary exacerbations that require antibiotics in the past year
- Improvement in BMI from baseline
- Member-specific description of benefit

AND

2 - Submission of medical records (e.g., chart notes) documenting patient has at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene:

- Homozygous F508del CFTR mutation
- Heterozygous F508del CFTR mutation
- Heterozygous CFTR mutation that does not include F508del (Mutation is responsive to the drug as noted in the product labeling)

AND

3 - ONE of the following:

3.1 For members with homozygous F508del CFTR mutation, one of the following:

3.1.1 For Trikafta requests ONLY: Member is 2 years of age or older

OR

3.1.2 For Orkambi requests ONLY, one of the following:

3.1.2.1 Member is between 1 and 2 years of age

OR

3.1.2.2 Both of the following:

- Member is 2 years of age or older
- Submission of medical records (e.g., chart notes) documenting trial and failure to a minimum 6-month trial, contraindication, or intolerance to Trikafta

OR

3.1.3 For Symdeko requests ONLY, all of the following:

- Member is 6 years of age or older

- Submission of medical records (e.g., chart notes) documenting trial and failure to a minimum 6-month trial, contraindication, or intolerance to Trikafta
- Submission of medical records (e.g., chart notes) documenting trial and failure to a minimum 6-month trial, contraindication, or intolerance to Orkambi

OR

3.2 For members with heterozygous F508del CFTR mutation, one of the following:

3.2.1 For Trikafta requests ONLY: Member is 2 years of age or older

OR

3.2.2 For Kalydeco requests ONLY, member is 1 months of age or older

OR

3.2.3 For Symdeko requests ONLY, both of the following:

- Member is 6 years of age or older
- Submission of medical records (e.g., chart notes) documenting trial and failure to a minimum 6-month trial, contraindication, or intolerance to Trikafta

OR

3.3 For members with heterozygous CFTR mutation that does not include F508del (Mutation is responsive to the drug as noted in the product labeling), one of the following:

3.3.1 For Kalydeco requests ONLY, member is 1 months of age or older

OR

3.3.2 For Trikafta requests ONLY, member is 2 years of age or older

OR

3.3.3 For Symdeko requests ONLY, both of the following:

- Member is 6 years of age or older
- Submission of medical records (e.g., chart notes) documenting trial and failure to a minimum 6-month trial, contraindication, or intolerance to Trikafta

2 . Revision History

Date	Notes
12/15/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-136422
Guideline Name	Diacomit (Stiripentol)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Diacomit	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of Dravet Syndrome

AND

2 - Prescribed by, or in consultation with, a neurologist

AND

3 - Age greater than or equal to 2 years

AND

4 - Used in combination with clobazam and valproate

Product Name: Diacomit	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Diacomit	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of Dravet Syndrome

AND

2 - Prescribed by, or in consultation with, a neurologist

AND **3** - Age greater than or equal to 2 years **AND** **4** - Used in combination with clobazam and valproate

2 . Revision History

Date	Notes
12/8/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129944
Guideline Name	Dificid (Fidaxomicin)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Dificid	
Approval Length	12 month(s) with a fill count = 1
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 Outpatient initiation of treatment

AND

1.2 Relapse or recurrence after a greater than or equal to 10 days treatment course with vancomycin

AND

1.3 One of the following:

1.3.1 Submission of medical records (i.e., PCR positive, toxin assay, or colonoscopy) of recurrent C difficile infection

OR

1.3.2 Submission of medical records (e.g., chart notes) documenting low levels of neutralizing antibodies to C. difficile

OR

2 - Both of the following:

2.1 Continuation of hospital therapy

AND

2.2 Member has been receiving as an inpatient during hospitalization and needs to complete the course of therapy as an outpatient

OR

3 - (Illinois plans only) – the requested drug is being used for the long-term treatment of tick-borne disease

OR

4 - (Minnesota plans only) – Both of the following:

- Member has stage four metastatic cancer

- Requested drug is being used to treat a cancer-related C. difficile infection

2 . Revision History

Date	Notes
10/25/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131134
Guideline Name	Dojolvi (Triheptanoin)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Dojolvi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - ALL Plans

Approval Criteria

1 - Diagnosis of long-chain fatty acid oxidation disorder

AND

2 - Disease confirmed by one of the following:

- elevation of acylcarnitine
- enzyme activity assay below lower limit of normal
- genetic testing showing mutation associated with long-chain fatty acid oxidation disorders

AND

3 - Trial and failure or contraindication to over-the-counter medium-chain fatty acid products for management of long-chain fatty acid oxidation disorder, including submission of medical records (e.g., chart notes) documenting specific adherence intervention deployed by a health care provider

AND

4 - Prescribed by or in consultation with a metabolic disease provider who specializes in management of fatty acid oxidation disorders

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Dojolvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - ALL Plans

Approval Criteria

1 - Diagnosis of long-chain fatty acid oxidation disorder

AND

2 - Disease confirmed by one of the following:

- elevation of acylcarnitine

- enzyme activity assay below lower limit of normal
- genetic testing showing mutation associated with long-chain fatty acid oxidation disorders

AND

3 - Trial and failure or contraindication to over-the-counter medium-chain fatty acid products for management of long-chain fatty acid oxidation disorder, including submission of medical records (e.g., chart notes) documenting specific adherence intervention deployed by a health care provider

AND

4 - Prescribed by or in consultation with a metabolic disease provider who specializes in management of fatty acid oxidation disorders

AND

5 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member has shown improvement with requested drug (e.g., improved cardiac symptoms/function, decreased hospitalizations or urgent care visits, decreased hypoglycemic episodes, etc.)

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
8/20/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-127812
Guideline Name	Dry Eye Disease
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Cequa, Tyrvaya, Xiidra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans
Approval Criteria **1** - Trial and failure of cyclosporine 0.05% eye drops	

Product Name: Cequa, Tyrvaya, Xiidra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Cequa, Tyrvaya, Xiidra	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure of cyclosporine 0.05% eye drops

2 . Revision History

Date	Notes
8/21/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-134628
Guideline Name	Dupixent (dupilumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Dupixent	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria	

1 - Diagnosis of moderate to severe atopic dermatitis based on body surface area (greater than 10%), extent of disability, extent of pruritus, or impact on sleep, quality of life, current use of systemic immunomodulators)

AND

2 - Drug must be self-administered

AND

3 - Prescribed by, or in consultation with, a specialist experienced with the treatment of moderate to severe atopic dermatitis (e.g., Dermatologist, Pediatric Dermatologist, Allergist, Immunologist)

AND

4 - Trial and failure, contraindication, or intolerance with at least TWO of the following:

4.1 Topical corticosteroid (e.g., clobetasol, betamethasone, triamcinolone)

OR

4.2 Topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus)

OR

4.3 Topical phosphodiesterase 4 (PDE-4) inhibitor (e.g., Crisaborole)

OR

4.4 Topical janus kinase (JAK) inhibitor (e.g., ruxolitinib)

OR

4.5 Phototherapy*	
Notes	*If clinic-based phototherapy- record of phototherapy episodes provided. Adherence defined as 3 times per week for one month or if necessary, modified regimen based on required adjustments for tolerability. If home-based phototherapy- provision of data log recording use and dose adjustments as needed for tolerability

Product Name: Dupixent	
Diagnosis	Atopic Dermatitis
Approval Length	12/39/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe atopic dermatitis based on body surface area (greater than 10%), extent of disability, extent of pruritus, or impact on sleep, quality of life, current use of systemic immunomodulators)

AND

2 - Drug must be self-administered

AND

3 - Prescribed by, or in consultation with, a specialist experienced with the treatment of moderate to severe atopic dermatitis (e.g., Dermatologist, Pediatric Dermatologist, Allergist, Immunologist)

AND

4 - Trial and failure, contraindication, or intolerance with at least TWO of the following:

4.1 Topical corticosteroid (e.g., clobetasol, betamethasone, triamcinolone)

OR

4.2 Topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus)

OR

4.3 Topical phosphodiesterase 4 (PDE-4) inhibitor (e.g., Crisaborole)

OR

4.4 Topical janus kinase (JAK) inhibitor (e.g., ruxolitinib)

OR

4.5 Phototherapy*

Notes	*If clinic-based phototherapy- record of phototherapy episodes provided. Adherence defined as 3 times per week for one month or if necessary, modified regimen based on required adjustments for tolerability. If home-based phototherapy- provision of data log recording use and dose adjustments as needed for tolerability

Product Name: Dupixent	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Both of the following

1.1 Diagnosis of eosinophilic asthma

AND

1.2 Submission of medical records (e.g., chart notes) of one of the following:

- Blood eosinophil count of greater than or equal to 150 cells/mm3 (other causes of eosinophilia such as hypereosinophilic syndromes, neoplastic disease, or parasitic disease must be ruled out)
- Oral corticosteroid dependent asthma

AND

2 - Drug must be self-administered

AND

3 - Prescribed by, or in consultation with, an asthma specialist (e.g., Allergist, Immunologist, Pulmonologist)

AND

4 - One of the following:

4.1 Symptoms are not well controlled or poorly controlled despite an adherent (adherent treatment is defined as a medication possession ratio (MPR) greater than or equal to 70% based on the previous 120 days of prescription claims) greater than or equal to 3-month trial of medium to high- dose inhaled corticosteroids in combination with a long-acting bronchodilator or leukotriene modifier

OR

4.2 Patient has intolerance to medium to high dose inhaled corticosteroids in combination with a long-acting bronchodilator or leukotriene modifier (see background for exceptions)

Product Name: Dupixent	
Diagnosis	Severe Asthma

Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Both of the following

1.1 Diagnosis of eosinophilic asthma

AND

1.2 Submission of medical records (e.g., chart notes) of one of the following:

- Blood eosinophil count of greater than or equal to 150 cells/mm3 (other causes of eosinophilia such as hypereosinophilic syndromes, neoplastic disease, or parasitic disease must be ruled out)
- Oral corticosteroid dependent asthma

AND

2 - Drug must be self-administered

AND

3 - Prescribed by, or in consultation with, an asthma specialist (e.g., Allergist, Immunologist, Pulmonologist)

AND

4 - One of the following:

4.1 Symptoms are not well controlled or poorly controlled despite an adherent (adherent treatment is defined as a medication possession ratio (MPR) greater than or equal to 70% based on the previous 120 days of prescription claims) greater than or equal to 3-month trial of medium to high- dose inhaled corticosteroids in combination with a long-acting bronchodilator or leukotriene modifier

OR

4.2 Patient has intolerance to medium to high dose inhaled corticosteroids in combination with a long-acting bronchodilator or leukotriene modifier (see background for exceptions)

Product Name: Dupixent	
Diagnosis	Nasal Polyps
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL or MN Plans Only

Approval Criteria

1 - Diagnosis of chronic rhinosinusitis with nasal polyposis with ALL of the following:

- At least eight weeks of moderate to severe nasal congestion/blockage/obstruction or diminished sense of smell or rhinorrhea
- Documented nasal polyps by direct exam, endoscopy, or sinus CT scan (ex: nasal polyp score five out of eight)
- No chronic or acute infection requiring systemic treatment within two weeks before therapy initiation

AND

2 - Drug must be self-administered

AND

3 - Prescribed by, or in consultation with, a specialist experienced in the treatment of nasal polyps (ex: Otolaryngologist, Allergist)

AND

4 - Trial and failure, contraindication, or intolerance to one of the following:

- Oral corticosteroids for nasal polyps
- Prior surgery for nasal polyps greater than six months ago
- IM corticosteroid injections for polyps with one previous steroid nasal spray
- To greater than 2 nasal steroid sprays (i.e., failed two nasal sprays)

AND

5 - Requested drug will be used in combination with a nasal corticosteroid medication

AND

6 - Requested drug will not be used in combination with other biologics (e.g., benralizumab, mepolizumab, omalizumab, etc.)

Product Name: Dupixent	
Diagnosis	Nasal Polyps
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of chronic rhinosinusitis with nasal polyposis with ALL of the following:

- At least eight weeks of moderate to severe nasal congestion/blockage/obstruction or diminished sense of smell or rhinorrhea
- Documented nasal polyps by direct exam, endoscopy, or sinus CT scan (ex: nasal polyp score five out of eight)
- No chronic or acute infection requiring systemic treatment within two weeks before therapy initiation

AND

2 - Drug must be self-administered

AND

3 - Prescribed by, or in consultation with, a specialist experienced in the treatment of nasal polyps (ex: Otolaryngologist, Allergist)

AND

4 - Trial and failure, contraindication, or intolerance to one of the following:

- Oral corticosteroids for nasal polyps
- Prior surgery for nasal polyps greater than six months ago
- IM corticosteroid injections for polyps with one previous steroid nasal spray
- To greater than 2 nasal steroid sprays (i.e., failed two nasal sprays)

AND

5 - Requested drug will be used in combination with a nasal corticosteroid medication

AND

6 - Requested drug will not be used in combination with other biologics (e.g., benralizumab, mepolizumab, omalizumab, etc.)

Product Name: Dupixent	
Diagnosis	Eosinophilic Esophagitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of eosinophilic esophagitis confirmed by biopsy

AND

2 - Drug must be self-administered

AND

3 - Prescribed by, or in consultation with, a specialist experienced in the treatment of eosinophilic esophagitis (ex: Allergist, Gastroenterologist, Immunologist)

AND

4 - Member is 12 years of age or older

AND

5 - Trial and failure, intolerance, or contraindication to dietary therapy (e.g. elemental or amino acid-based formulary diet or empiric elimination diet that removes common triggers such as milk, wheat, soy, eggs, nuts, and seafood)

AND

6 - Trial and failure, intolerance, or contraindication to proton pump inhibitors (e.g., omeprazole, pantoprazole, lansoprazole)

AND

7 - Requested drug will not be used in combination with other biologics (e.g., benralizumab, mepolizumab, omalizumab, etc.)

Product Name: Dupixent	
Diagnosis	Eosinophilic Esophagitis
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of eosinophilic esophagitis confirmed by biopsy

AND

2 - Drug must be self-administered

AND

3 - Prescribed by, or in consultation with, a specialist experienced in the treatment of eosinophilic esophagitis (ex: Allergist, Gastroenterologist, Immunologist)

AND

4 - Member is 12 years of age or older

AND

5 - Trial and failure, intolerance, or contraindication to dietary therapy (e.g. elemental or amino acid-based formulary diet or empiric elimination diet that removes common triggers such as milk, wheat, soy, eggs, nuts, and seafood)

AND

6 - Trial and failure, intolerance, or contraindication to proton pump inhibitors (e.g., omeprazole, pantoprazole, lansoprazole)

AND

7 - Requested drug will not be used in combination with other biologics (e.g., benralizumab, mepolizumab, omalizumab, etc.)

Product Name: Dupixent	
Diagnosis	Prurigo nodularis (PN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of chronic prurigo nodularis (PN) with all of the following:

- At least 3 months of symptoms
- At least 20 PN lesions in total
- Severe or very severe itch (WI-NRS score ≥ 7)

AND

2 - Drug must be self-administered

AND

3 - Prescribed by, or in consultation with, a Dermatologist

AND

4 - Member is 18 years of age or older

AND

5 - Trial and failure of an optimized regimen of one of the following:

- Phototherapy*
- Moderate to high potency topical corticosteroids, intralesional corticosteroids, systemic corticosteroids
- Systemic immunosuppressive agents (e.g., cyclosporine, methotrexate, azathioprine)
- Immunomodulator agents (e.g., thalidomide, lenalidomide)
- Anticonvulsants (e.g., pregabalin, gabapentin)

Notes	*If clinic-based phototherapy- record of phototherapy episodes provided. Adherence defined as 3 times per week for one month or if necessary, modified regimen based on required adjustments for tolerability. If home-based phototherapy- provision of data log recording use and dose adjustments as need for tolerability

Product Name: Dupixent	
Diagnosis	Prurigo nodularis (PN)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of chronic prurigo nodularis (PN) with all of the following:

- At least 3 months of symptoms
- At least 20 PN lesions in total
- Severe or very severe itch (WI-NRS score ≥ 7)

AND

2 - Drug must be self-administered

AND

3 - Prescribed by, or in consultation with, a Dermatologist

AND

4 - Member is 18 years of age or older

AND

5 - Trial and failure of an optimized regimen of one of the following:

- Phototherapy*
- Moderate to high potency topical corticosteroids, intralesional corticosteroids, systemic corticosteroids
- Systemic immunosuppressive agents (e.g., cyclosporine, methotrexate, azathioprine)
- Immunomodulator agents (e.g., thalidomide, lenalidomide)

- Anticonvulsants (e.g., pregabalin, gabapentin)

Product Name: Dupixent	
Diagnosis	All indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Prescriber submits medical records (e.g., chart notes) of documentation from the previous 12 months of a response to therapy for the treated diagnosis such as one of the following:

- Decreased frequency of use of, or ability to lower the chronic daily dose, of oral corticosteroids to treat/prevent exacerbations
- Decreased frequency of use of unscheduled emergency department/urgent care visits for exacerbations
- Reduction in reported symptoms such as chest tightness, coughing, shortness of breath, or nocturnal awakenings, itching, nasal congestion, etc.
- Sustained (at least six months) improvement in Asthma Control Test (ACT) scores
- Improvement in body surface area affected
- Improvement in nasal polyposis score
- Reduction in dysphagic episodes

AND

2 - Drug must be self-administered

2 . Background

Benefit/Coverage/Program Information
Severe Asthma Exceptions to high dose inhaled corticosteroids in combination with a long-acting bronchodilator or leukotriene modifier. Exceptions based on adverse effects from high dose

ICS or comorbid conditions increasing long-term risks of adverse effects from high dose ICS or oral corticosteroids include:

- Cataracts in patients > 40 years of age
- Glaucoma
- Recurrent Thrush
- Dysphonia
- Growth inhibition, after evaluation by Endocrine Consult
- Diagnosis of osteoporosis, treatment resistant to FDA approved osteoporosis treatment

3 . Revision History

Date	Notes
12/4/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129123
Guideline Name	Empaveli (Pegcetacoplan)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Empaveli	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Confirmed diagnosis of PNH by flow cytometry

AND

2 - Prescribed by, or in consultation with, a Hematologist or Oncologist.

AND

3 - Low hemoglobin (≤ 9 mg/dL with symptoms of anemia), elevated lactate dehydrogenase level (LDH ≥ 1.5 X ULN) and/or number of transfusions in last year

AND

4 - Documentation of the clinical manifestations of disease (e.g., major vascular event, transfusion dependence, renal insufficiency, disabling fatigue and/or other end organ manifestations).

AND

5 - Documentation of receipt of Advisory Committee on Immunization Practices (ACIP) recommended vaccinations at least two weeks prior to therapy initiation as outlined in drug REMS program.

AND

6 - Age greater than or equal to 18

AND

7 - Drug is not being used in combination with another complement inhibitor*

Notes	*Combination of pegcetacoplan with another agent may be considered for circumstances where all three individual complement inhibitors failed to adequately control anemia (eculizumab or ravulizumab) or there are signs of ongoing hemolysis (pegcetacoplan).

Product Name: Empaveli	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Confirmed diagnosis of PNH by flow cytometry

AND

2 - Prescribed by, or in consultation with, a Hematologist or Oncologist.

AND

3 - Low hemoglobin (≤ 9 mg/dL with symptoms of anemia), elevated lactate dehydrogenase level (LDH ≥ 1.5 X ULN) and/or number of transfusions in last year.

AND

4 - Documentation of the clinical manifestations of disease (e.g., major vascular event, transfusion dependence, renal insufficiency, disabling fatigue and/or other end organ manifestations).

AND

5 - Documentation of receipt of Advisory Committee on Immunization Practices (ACIP) recommended vaccinations at least two weeks prior to therapy initiation as outlined in drug REMS program.

AND

6 - Age greater than or equal to 18

AND

7 - Drug is not being used in combination with another complement inhibitor*

AND **8** - Clinical documentation from the past 12 months of improvement or clinical stability, (e.g., improvement in hemoglobin, lactate dehydrogenase level, haptoglobin level and/or number of transfusions in the last year).

Notes	*Combination of pegcetacoplan with another agent may be considered for circumstances where all three individual complement inhibitors failed to adequately control anemia (eculizumab or ravulizumab) or there are signs of ongoing hemolysis (pegcetacoplan).

Product Name: Empaveli	
Approval Length	2 doses/week
Guideline Type	Quantity Limit

Approval Criteria

1 - Documentation of continued hemolysis (LDH levels ≥ 2X ULM) despite an adequate 2-month trial of twice weekly dosing and the prescriber provided an evidence-based rationale for using the requested dose.

2 . Revision History

Date	Notes
9/11/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-134998
Guideline Name	Enbrel (etanercept)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Enbrel	
Diagnosis	Plaque Psoriasis
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans
Approval Criteria	

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - One of the following:

- Significant functional disability
- Body surface area (BSA) involvement of greater than or equal to 3%
- Debilitating palmer/plantar psoriasis or other vulnerable areas that are difficult to treat (e.g. nails, scalp, genitals, or intertriginous areas)

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - Trial and failure, contraindication, or intolerance to topical treatment (e.g. topical corticosteroids, calcipotriene, retinoids)

AND

5 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication will be self-administered

Product Name: Enbrel	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - One of the following:

- Significant functional disability
- Body surface area (BSA) involvement of greater than or equal to 3%
- Debilitating palmer/plantar psoriasis or other vulnerable areas that are difficult to treat (e.g. nails, scalp, genitals, or intertriginous areas)

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - Trial and failure, contraindication, or intolerance to topical treatment (e.g. topical corticosteroids, calcipotriene, retinoids)

AND

5 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication will be self-administered

Product Name: Enbrel	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12/31/2039

Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Enbrel	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Enbrel	
Diagnosis	Juvenile Idiopathic Arthritis (JIA), Moderate to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of one of the following:

- Moderate to severely active rheumatoid arthritis (RA)
- Juvenile idiopathic arthritis (JIA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)*
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

3 - Medication will be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	* Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immu nodeficiency syndromes, bone marrow hyperplasia, leukopenia, throm bocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Enbrel

Diagnosis	Juvenile Idiopathic Arthritis (JIA), Moderate to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of one of the following:

- Moderate to severely active rheumatoid arthritis (RA)
- Juvenile idiopathic arthritis (JIA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)*
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

3 - Medication will be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	* Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immu nodeficiency syndromes, bone marrow hyperplasia, leukopenia, throm bocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Enbrel	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of ankylosing spondylitis (AS)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Enbrel

Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of ankylosing spondylitis (AS)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Enbrel	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Prescriber provides clinical documentation from the previous 12 months of the member's response to therapy including individual improvements in functional status related to therapeutic response

2 . Revision History

Date	Notes
12/4/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131918
Guideline Name	Enspryng (Satralizumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: (Enspryng	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) confirmed by positive serologic test for antiaquaporin-4 (AQP4) receptor antibody

AND

2 - Prescribed by, or in consultation with, a Neurologist or other specialist in NMOSD treatment

AND

3 - History of at least one NMOSD relapse in the last 12 months

AND

4 - Trial and failure, contraindication or intolerance to an adequate trial of at least one of the following: rituximab, mycophenolate or azathioprine

AND

5 - Will not be used in combination with other biologic treatments for NMOSD (i.e. rituximab, inebilizumab, eculizumab)

Product Name: (Enspryng	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug and there is stable disease or improvement in symptoms.

2 . Revision History

Date	Notes
10/31/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129253
Guideline Name	Enzyme Inhibitors for Gaucher Disease
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Miglustat	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of type-1 Gaucher disease

AND

2 - Trial and failure, intolerance, or contraindication to enzyme replacement therapy

Product Name: Generic Miglustat	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Cerdelga	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of type-1 Gaucher disease

AND

2 - Trial and failure, intolerance, or contraindication to enzyme replacement therapy

AND

3 - Have been determined to be CYP2D6 extensive, intermediate, or poor metabolizers by an FDA-approved test

Product Name: Cerdelga	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Generic Miglustat	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of type-1 Gaucher disease

AND

2 - Trial and failure, intolerance, or contraindication to enzyme replacement therapy

Product Name: Cerdelga	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of type-1 Gaucher disease

AND

2 - Trial and failure, intolerance, or contraindication to enzyme replacement therapy

AND **3** - Have been determined to be CYP2D6 extensive, intermediate, or poor metabolizers by an FDA-approved test

2 . Revision History

Date	Notes
10/25/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129740
Guideline Name	Erythropoiesis-Stimulating Agents
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Aranesp, Mircera, Retacrit	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Non-myeloid cancer RECEIVING chemotherapy or within 8 weeks of receiving chemotherapy where the anemia is due to the effect of chemotherapy
- HIV infection, for zidovudine-related anemia
- Severe autoimmune hemolytic anemia
- Myelodysplastic syndrome
- Anemia associated with treatment regimens for Hepatitis C if ribavirin dose reduction does not provide adequate response

- Chronic renal failure with or without dialysis
- Post-transplant anemia
- Religious beliefs prohibiting blood transfusions

AND

2 - Member or family member is self-administering the medication

AND

3 - Submission of medical records (e.g., chart notes) documenting one of the following:

- Hemoglobin (Hgb) < 10 g/dL
- Hematocrit (HCT) < 30%

2 . Revision History

Date	Notes
8/21/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-127846
Guideline Name	Eucrisa (crisaborole)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Eucrisa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure of one of the following:

1.1 Topical steroid (see background for examples)

OR

1.2 Topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus)

Product Name: Eucrisa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Eucrisa	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure of one of the following:

1.1 Topical steroid (see background for examples)

OR

1.2 Topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus)

2 . Background

Benefit/Coverage/Program Information
Examples of topical steroids

alclometasone dipropionate 0.05% cream/ointment, betamethasone dipropionate 0.05% cream/ointment/lotion/gel/spray/pump, betamethasone valerate 0.1% ointment/cream/lotion, betamethasone valerate 0.12% foam, betamethasone/propylene glycol 0.05% cream/lotion/ointment, clobetasol propionate 0.025% cream, clobetasol propionate 0.05% ointment/cream/solution/gel/foam/lotion/spray, clobetasol propionate emollient 0.05% cream/foam, clocortolone pivalate 0.1% cream, desonide 0.05% ointment/lotion/cream/foam/gel, desoximetasone 0.05% gel/cream/ointment, desoximetasone 0.25% cream/ointment/spray, diflorasone diacetate 0.05% ointment/cream, diflorasone diacetate emollient 0.05% cream, fluocinolone acetonide 0.01% solution/cream/oil, fluocinolone acetonide 0.025% ointment/cream, fluocinonide 0.05% cream/ointment/solution/gel, fluocinonide 0.1% cream, fluocinonide emollient 0.05% cream, flurandrenolide 0.025% cream, flurandrenolide 0.05% cream/lotion/ointment, fluticasone propionate 0.005% ointment, fluticasone propionate 0.05% cream/lotion/, halcinonide 0.1% cream/ointment, halobetasol propionate 0.01% lotion, halobetasol propionate 0.05% cream/ointment/lotion/foam, hydrocortisone 1% cream/ointment, hydrocortisone 2% lotion, hydrocortisone 2.5% cream/ointment/solution/lotion, hydrocortisone butyrate 0.1% solution/cream/ointment/lotion, hydrocortisone butyrate emollient 0.1% cream, hydrocortisone probutate 0.1% cream, hydrocortisone valerate 0.2% ointment/cream, mometasone furoate 0.1% cream/ointment/solution, hydrocortisone acetate/aloe vera 2% lotion, prednicarbate 0.1% ointment/cream, triamcinolone acetonide 0.025% cream/ointment/lotion, triamcinolone acetonide 0.05% ointment, triamcinolone acetonide 0.1% cream/ointment/lotion, triamcinolone acetonide 0.147mg/g aerosol, triamcinolone acetonide 0.5% cream/ointment

3 . Revision History

Date	Notes
8/25/2023	New Programs

Prior Authorization Guideline

Guideline ID	GL-131441
Guideline Name	Evrysdi (risdiplam)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Evrysdi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of spinal muscle atrophy (SMA)

AND

2 - Submission of medical records (e.g., chart notes) documenting gene mutation analysis with bi-allelic SMN1 mutations (5q-autosomal recessive point mutation/deletion) phenotype 1,2 or 3.

AND

3 - Prescribed by or in consultation with a Neurologist or other clinician with expertise in management and treatment of neuromuscular disorders

AND

4 - Member does not have advanced SMA (e.g., permanent ventilatory dependence, tracheostomy, complete limb paralysis, etc.)

AND

5 - For members less than or equal to 2 yeas of age established on nusinersen, will not continue nusinersen (Spinraza) post onasemnogene infusion

AND

6 - For members less than or equal to 2 yeas of age established on risdiplam, will not continue risdiplam (Evrysdi) post- onasemnogene infusion

Product Name: Evrysdi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of spinal muscle atrophy (SMA)

AND

2 - Submission of medical records (e.g., chart notes) documenting gene mutation analysis with bi-allelic SMN1 mutations (5q-autosomal recessive point mutation/deletion) phenotype 1,2 or 3.

AND

3 - Prescribed by or in consultation with a Neurologist or other clinician with expertise in management and treatment of neuromuscular disorders

AND

4 - Member does not have advanced SMA (e.g., permanent ventilatory dependence, tracheostomy, complete limb paralysis, etc.)

AND

5 - For members less than or equal to 2 yeas of age established on nusinersen, will not continue nusinersen (Spinraza) post onasemnogene infusion

AND

6 - For members less than or equal to 2 yeas of age established on risdiplam, will not continue risdiplam (Evrysdi) post- onasemnogene infusion

AND

7 - Member is established on therapy

AND

8 - Submission of medical records (e.g., chart notes) documenting both of the following:

8.1 Clinically significant improvement in SMA-related symptoms as evidence by an improvement, stabilization or decreased decline since previous approval

AND

8.2 Specific scale used based on age and motor function and comparison to baseline

2 . Revision History

Date	Notes
10/8/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-132802
Guideline Name	Fasenra (benralizumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Fasenra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria	

1 - Requested medication will be self-administered

AND

2 - Prescribed by or in consultation with one of the following:

- Allergist
- Immunologist
- Pulmonologist

AND

3 - Member is 12 years of age or older

AND

4 - All of the following:

- Diagnosis of eosinophilic asthma
- Blood eosinophil count of ≥ 150 cells/mm3
- All other causes of eosinophilia such as hypereosinophilic syndromes, neoplastic disease, or parasitic disease have been ruled out

AND

5 - One of the following:

5.1 Symptoms are not well controlled or poorly controlled (refer to Table 1 in background section) despite an adherent ‡ ≥ 3-month trial of medium to high-dose inhaled corticosteroids in combination with a long-acting bronchodilator, long-acting muscarinic antagonist, or leukotriene modifier

OR

5.2 Intolerance to medium to high dose inhaled corticosteroids in combination with a long-acting bronchodilator or leukotriene modifier. Exceptions based on adverse effects from medium to high dose ICS or comorbid conditions increasing long-term risks of adverse effects from high dose ICS or oral corticosteroids including at least ONE of the following:

- Cataracts in patients > 40 years of age
- Glaucoma
- Recurrent thrush
- Dysphonia
- Growth inhibition, after evaluation by Endocrine Consult
- Diagnosis of osteoporosis, treatment resistant to FDA approved osteoporosis treatment

Notes	‡Adherent treatment is defined as a medication possession ratio (MPR) ≥ 70% based on the previous 120 days of prescription claims. NOTE: Il-5 inhibitor drugs in combination with omalizumab will be considered on a case-by-case basis if each individual agent with combination high dose ICS/LABA did not control symptoms. Tezepelumab, in combination with other biologics, has not been studied and coverage is not allowed except in extenuating circumstances (applies to both eosinophilic or non-eosinophilic asthma populations). *Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Fasenra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy within the previous 12 months defined by one of the following:

- Decreased frequency of use of, or ability to lower the chronic daily dose, of oral corticosteroids to treat/prevent exacerbations
- Decreased frequency of use of unscheduled emergency department/urgent care visits for exacerbations
- Reduction in reported symptoms such as chest tightness, coughing, shortness of breath, nocturnal awakenings, nasal congestion, obstruction, etc.
- Sustained (at least six months) improvement in Asthma Control Test (ACT) scores

Notes	NOTE: Continuation of case-by case-approved IgE inhibitor and IL-5 i nhibitor, or tezepelumab combination therapy will only be considered if ICS/LABA therapy was also continued AND ther e was reduction in oral steroid dose, exacerbations, or hospitalizations . *Continuation of therapy/coverage criteria will not be applied to person s who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Fasenra	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Requested medication will be self-administered

AND

2 - Prescribed by or in consultation with one of the following:

- Allergist
- Immunologist
- Pulmonologist

AND

3 - Member is 12 years of age or older

AND

4 - All of the following:

- Diagnosis of eosinophilic asthma
- Blood eosinophil count of ≥ 150 cells/mm3

- All other causes of eosinophilia such as hypereosinophilic syndromes, neoplastic disease, or parasitic disease have been ruled out

AND

5 - One of the following:

5.1 Symptoms are not well controlled or poorly controlled (refer to Table 1 in background section) despite an adherent ‡ ≥ 3-month trial of medium to high-dose inhaled corticosteroids in combination with a long-acting bronchodilator, long-acting muscarinic antagonist, or leukotriene modifier

OR

5.2 Intolerance to medium to high dose inhaled corticosteroids in combination with a long-acting bronchodilator or leukotriene modifier. Exceptions based on adverse effects from medium to high dose ICS or comorbid conditions increasing long-term risks of adverse effects from high dose ICS or oral corticosteroids including at least ONE of the following:

- Cataracts in patients > 40 years of age
- Glaucoma
- Recurrent thrush
- Dysphonia
- Growth inhibition, after evaluation by Endocrine Consult
- Diagnosis of osteoporosis, treatment resistant to FDA approved osteoporosis treatment

Notes	‡Adherent treatment is defined as a medication possession ratio (MPR) ≥ 70% based on the previous 120 days of prescription claims. NOTE: Il-5 inhibitor drugs in combination with omalizumab will be considered on a case-by-case basis if each individual agent with combination high dose ICS/LABA did not control symptoms. Tezepelumab, in combination with other biologics, has not been studied and coverage is not allowed except in extenuating circumstances (applies to both eosinophilic or non-eosinophilic asthma populations). *Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

2 . Background

Benefit/Coverage/Program Information

Table 1. Outcome Measure values for uncontrolled asthma

Measure	Not Well Controlled	Very Poorly Controlled
Baseline symptoms (outside of exacerbation)	> 2 days/week	Throughout the day
Nighttime awakening	1-3 times/week	≥ 4 times/week
Interference with normal activity	Some limitation	Extremely limited
Short acting beta agonist use for symptom control	> 2 days/week	Several times per day
FEV1	60-80% predicted or personal best	< 60% predicted or personal best
Asthma exacerbations requiring oral steroids ≥ 2 times in the past year	Yes	Yes
Asthma Control Test (ACT)	16-19	≤ 15

3 . Revision History

Date	Notes
11/1/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-128129
Guideline Name	Febuxostat
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Febuxostat	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting a trial and failure of 3 months of allopurinol 300 mg	

Product Name: Generic Febuxostat	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical notes (e.g. chart notes) from the past 12 months that member is continuing therapy with the requested drug

Product Name: Generic Febuxostat	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a trial and failure of 3 months of allopurinol 300 mg

2 . Revision History

Date	Notes
8/21/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-127842
Guideline Name	Fetzima (levomilnacipran)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Fetzima	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure of at least one preferred serotonin reuptake inhibitor (SSRI):

- citalopram
- escitalopram
- sertraline
- paroxetine

- fluoxetine

AND

2 - Trial and failure of at least one preferred Serotonin Norepinephrine Reuptake inhibitor (SNRI):

- venlafaxine
- duloxetine

Product Name: Fetzima	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Fetzima	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure of at least one preferred serotonin reuptake inhibitor (SSRI):

- citalopram
- escitalopram
- sertraline
- paroxetine
- fluoxetine

AND

2 - Trial and failure of at least one preferred Serotonin Norepinephrine Reuptake inhibitor (SNRI):

- venlafaxine
- duloxetine

2 . Revision History

Date	Notes
8/21/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129617
Guideline Name	Fintepla (Fenfluramine)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Fintepla	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of seizures associated with Dravet syndrome or Lennox-Gastaut syndrome

AND

2 - Prescribed by, or in consultation with, a Neurologist

AND

3 - Previous trial and failure, contraindication or intolerance to an adequate trial of cannabidiol and at least one of the following: topiramate, valproic acid, clobazam or clobazam in combination with stiripentol.

Product Name: Fintepla	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Fintepla	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of seizures associated with Dravet syndrome or Lennox-Gastaut syndrome

AND

2 - Prescribed by, or in consultation with, a Neurologist

AND

3 - Previous trial and failure, contraindication or intolerance to an adequate trial of cannabidiol

and at least one of the following: topiramate, valproic acid, clobazam or clobazam in combination with stiripentol.

2 . Revision History

Date	Notes
10/6/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-127692
Guideline Name	Firdapse, Ruzurgi (amifampridine)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Firdapse	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 Diagnosis of Lambert-Eaton myasthenic syndrome (LEMS)

AND

1.2 Diagnosis confirmed by neurophysiology studies or a positive anti-P/Q type voltage-gated calcium channel antibody test

AND

1.3 Prescribed by or in consult with an expert in the treatment of neuromuscular disorders

OR

2 - Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days), the prescriber must provide submission of medical records (e.g. chart notes) from the previous 12 months regarding the member's response to therapy with improvement or stabilization in muscle weakness compared to baseline

Product Name: Firdapse	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g. chart notes) from the previous 12 months of therapy indicating improvement or stabilization in muscle weakness compared to baseline.

2 . Revision History

Date	Notes
11/3/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-127845
Guideline Name	Fycompa (perampanel)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Fycompa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance to at least TWO preferred anticonvulsants:

- lamotrigine
- levetiracetam
- carbamazepine
- valproate
- oxcarbazepine

- gabapentin
- pregabalin
- topiramate
- phenytoin
- zonisamide
- primidone

Product Name: Fycompa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Fycompa	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance to at least TWO preferred anticonvulsants:

- lamotrigine
- levetiracetam
- carbamazepine
- valproate
- oxcarbazepine
- gabapentin
- pregabalin
- topiramate
- phenytoin
- zonisamide
- primidone

2 . Revision History

Date	Notes
8/21/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129103
Guideline Name	Galafold (Migalastat)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Galafold	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Fabry disease

AND

2 - Submission of medical records (e.g., chart notes) of an amenable galactosidase alpha gene (GLA) variant as noted in the product labeling.

AND

3 - Member does not have severe renal impairment (eGFR

AND

4 - Member is 16 years of age or older

AND

5 - Member will not be using migalastat in combination with enzyme replacement therapy

Product Name: Galafold	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Galafold	
Approval Length	12/31//2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of Fabry disease

AND

2 - Submission of medical records (e.g., chart notes) of an amenable galactosidase alpha gene (GLA) variant as noted in the product labeling.

AND

3 - Member does not have severe renal impairment (eGFR

AND

4 - Member is 16 years of age or older

AND

5 - Member will not be using migalastat in combination with enzyme replacement therapy

2 . Revision History

Date	Notes
9/7/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131937
Guideline Name	Gattex (Teduglutide)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Gattex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of Short Bowel Syndrome

AND

2 - Prescribed by, or in consultation with, a Gastroenterologist

AND

3 - Person dependent on parenteral support

Product Name: Gattex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-All plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months a ≥ 20% reduction in parenteral support requirement from baseline.

Product Name: Gattex	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of Short Bowel Syndrome

AND

2 - Prescribed by, or in consultation with, a Gastroenterologist

AND

3 - Person dependent on parenteral support

2 . Revision History

Date	Notes
10/31/2023	New program

Prior Authorization Guideline

Guideline ID	GL-137502
Guideline Name	Glucagon-like Peptide 1 (GLP-1) Agonist
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Byetta, Bydureon, Trulicity	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN
Approval Criteria **1** - Diagnosis of diabetes mellitus	

Product Name: Byetta, Bydureon, Trulicity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria **1** - Diagnosis of diabetes mellitus

Product Name: Byetta, Bydureon, Trulicity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria **1** - Documentation of positive response to therapy	
Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

2 . Revision History

Date	Notes
12/7/2023	New program

Prior Authorization Guideline

Guideline ID	GL-136601
Guideline Name	GNRH Antagonist
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Myfembree	
Approval Length	2 year(s)
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of heavy menstrual bleeding (menstrual blood loss greater than 80 ml) due to uterine fibroids

AND

1.1.2 Member is premenopausal

AND

1.1.3 Trial and failure, intolerance, or contraindication to two of the following:

- Combined oral contraceptives (e.g., Aubra, Gianvi)
- Levonorgestrel-releasing intrauterine device (IUD, e.g., Mirena)
- Tranexamic acid

OR

1.2 Both of the following:

1.2.1 Diagnosis of moderate to severe pain associated with endometriosis (other than dyspareunia)

AND

1.2.2 Trial and failure (at least 3 months), intolerance, or contraindication to at least two different continuous hormonal contraceptives in combination with prescription-strength nonsteroidal anti-inflammatory (NSAID) drugs

AND

2 - Prescribed by, or in consultation with, an expert in the treatment of Obstetrics and/or Gynecology

Product Name: Myfembree	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of heavy menstrual bleeding (menstrual blood loss greater than 80 ml) due to uterine fibroids

AND

1.1.2 Member is premenopausal

AND

1.1.3 Trial and failure, intolerance, or contraindication to two of the following:

- Combined oral contraceptives (e.g., Aubra, Gianvi)
- Levonorgestrel-releasing intrauterine device (IUD, e.g., Mirena)
- Tranexamic acid

OR

1.2 Both of the following:

1.2.1 Diagnosis of moderate to severe pain associated with endometriosis (other than dyspareunia)

AND

1.2.2 Trial and failure (at least 3 months), intolerance, or contraindication to at least two different continuous hormonal contraceptives in combination with prescription-strength nonsteroidal anti-inflammatory (NSAID) drugs

AND

2 - Prescribed by, or in consultation with, an expert in the treatment of Obstetrics and/or Gynecology

Product Name: Myfembree	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Orilissa	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis (other than dyspareunia)

AND

2 - Prescribed by, or in consultation with, an expert in the treatment of Obstetrics and/or Gynecology

AND

3 - Trial and failure (at least 3 months), intolerance, or contraindication to at least two different continuous hormonal contraceptives in combination with prescription-strength nonsteroidal anti-inflammatory (NSAID) drugs

Product Name: Orilissa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis (other than dyspareunia)

AND

2 - Prescribed by, or in consultation with, an expert in the treatment of Obstetrics and/or Gynecology

AND

3 - Trial and failure (at least 3 months), intolerance, or contraindication to at least two different continuous hormonal contraceptives in combination with prescription-strength nonsteroidal anti-inflammatory (NSAID) drugs

Product Name: Orilissa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
11/20/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131417
Guideline Name	Hemangeol (propranolo solution 4.28 mg/mL)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name: Hemangeol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of proliferating infantile hemangioma requiring systemic therapy.

AND

2 - Therapeutic failure or intolerance to the preferred propranolol solution options at an equivalent dose.

AND

3 - The prescriber provides an evidence-based clinical rationale as to why the Hemangeol product would be expected to produce superior therapeutic results

2 . Revision History

Date	Notes
10/24/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129926
Guideline Name	Hemlibra (Emicizumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Hemlibra	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of congenital hemophilia A

AND

2 - One of the following:

2.1 ALL of the following:

2.1.1 Hemophilia A with inhibitors to Factor VIII

AND

2.1.2 Member requires prophylaxis to prevent or reduce bleeding episodes

AND

2.1.3 One of the following:

- Not used in combination with Immune Tolerance Induction (ITI) therapy
- Member is currently on a bypassing agent (NovoSeven, FEIBA)

OR

2.2 BOTH of the following:

2.2.1 Hemophilia A without inhibitors

AND

2.2.2 One of the following:

- Member requires prophylaxis to prevent or reduce bleeding episodes despite optimal dose/frequency of Factor VIII product
- Member is unable to administer prophylaxis based on individual patient factors (e.g., IV access, home administration, etc.)

AND

3 - Member is followed by a plan approved bleeding disorders program

Product Name: Hemlibra	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL PPO/POS Plans

Approval Criteria

1 - Diagnosis of congenital hemophilia A

AND

2 - One of the following:

2.1 ALL of the following:

2.1.1 Hemophilia A with inhibitors to Factor VIII

AND

2.1.2 Member requires prophylaxis to prevent or reduce bleeding episodes

AND

2.1.3 One of the following:

- Not used in combination with Immune Tolerance Induction (ITI) therapy
- Member is currently on a bypassing agent (NovoSeven, FEIBA)

OR

2.2 BOTH of the following:

2.2.1 Hemophilia A without inhibitors

AND

2.2.2 One of the following:

- Member requires prophylaxis to prevent or reduce bleeding episodes despite optimal dose/frequency of Factor VIII product
- Member is unable to administer prophylaxis based on individual patient factors (e.g., IV access, home administration, etc.)

AND

3 - Member is followed by a specialist in bleeding disorders or a bleeding disorders program

Product Name: Hemlibra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - MN Plans

Approval Criteria

1 - Diagnosis of congenital hemophilia A

AND

2 - One of the following:

2.1 ALL of the following:

2.1.1 Hemophilia A with inhibitors to Factor VIII

AND

2.1.2 Member requires prophylaxis to prevent or reduce bleeding episodes

AND

2.1.3 One of the following:

- Not used in combination with Immune Tolerance Induction (ITI) therapy

- Member is currently on a bypassing agent (NovoSeven, FEIBA)

OR

2.2 BOTH of the following:

2.2.1 Hemophilia A without inhibitors

AND

2.2.2 One of the following:

- Member requires prophylaxis to prevent or reduce bleeding episodes despite optimal dose/frequency of Factor VIII product
- Member is unable to administer prophylaxis based on individual patient factors (e.g., IV access, home administration, etc.)

AND

3 - Member is followed by a plan approved bleeding disorders program

Product Name: Hemlibra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes

8/14/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129749
Guideline Name	Hepatitis C Direct Acting Antivirals
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Brand Epclusa, Mavyret	
Diagnosis	Post-Transplant
Approval Length	12 months with a fill count = 2-3 fills based on drug regimen requested
Guideline Type	Prior Authorization – IL and MN

Approval Criteria

1 - Member is scheduled to undergo, or is status-post heart, lung, kidney or liver transplant

AND

2 - Both of the following:

- HCV antibody (+) donor
- NAT (+) donor

AND

3 - HCV-negative recipients

Notes	*Approval length: Mavyret = 12 weeks, Epclusa = 4 weeks (can extend to 12 weeks if cannot begin on Day 0 or any interruption in treatment) ** Members new to the plan who are established on therapy will have coverage under their drug benefit for the remainder of the current treatment course. Coverage of the drug product will be extended to new members who have already started therapy. Duration of therapy will be determined based on the person's indication and accepted treatment course in labeled and/or guideline supported regimens. Restrictions to specific network pharmacies and participation in medication management programs may apply.

Product Name: Brand Epclusa, Mavyret	
Diagnosis	Post-Transplant
Approval Length	2-3 fills based on drug regimen requested
Guideline Type	Prior Authorization – All Plans except IL and MN

Approval Criteria

1 - Member is scheduled to undergo, or is status-post heart, lung, kidney or liver transplant

AND

2 - Both of the following:

- HCV antibody (+) donor
- NAT (+) donor

AND

3 - HCV-negative recipients

Notes	*Approval length: Mavyret = 12 weeks, Epclusa = 4 weeks (can exten d to 12 weeks if cannot begin on Day 0 or any interruption in treatmen t) ** Members new to the plan who are established on therapy will have coverage under their drug benefit for the remainder of the current treat ment course. Coverage of the drug product will be extended to new m embers who have already started therapy. Duration of therapy will be determined based on the person's indication and accepted treatment course in labeled and/or guideline supported regimens. Restrictions to specific network pharmacies and participation in medication manage ment programs may apply.

Product Name: Non-Preferred Agents: Sovaldi, Viekira Pak, Zepatier	
Diagnosis	Chronic Hepatitis C Virus (HCV)
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL and MN Plans Only

Approval Criteria

1 - Both of the following:

- Diagnosis of chronic hepatitis C infection
- HCV infection > 6 months

AND

2 - Submission of medical records (e.g., chart notes) documenting ALL of the following:

- HCV genotype
- Viral RNA levels measured within the past 3 months prior to initiating therapy
- Age
- Past treatment regimens used or documented treatment naïve status
- Extent of liver disease: non-cirrhotic, compensated cirrhosis (Child-Pugh A), decompensated cirrhosis (ChildPugh B, C)
- Current renal function
- NS5A RAS (if indicated to direct treatment)
- History of liver transplant

- History of kidney transplant
- HIV status and therapy

AND

3 - One of the following:

3.1 Contraindication or intolerance to ALL of the following preferred agents:

- Mavyret (glecaprevir/pibrentasvir)
- Ledipasvir/sofosbuvir (Harvoni brand)
- Sofosbuvir/velpatasvir (Epclusa brand)
- Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

OR

3.2 The requested non-preferred agent will be used in a patient population that cannot be treated with a preferred agent

Notes	*Approval length: As indicated in package labeling or hcvguidelines.org (the shortest appropriate recommended duration will be approved) ** Members new to the plan who are established on therapy will have coverage under their drug benefit for the remainder of the current treatment course. Coverage of the drug product will be extended to new members who have already started therapy. Duration of therapy will be determined based on the person's indication and accepted treatment course in labeled and/or guideline supported regimens. Restrictions to specific network pharmacies and participation in medication management programs may apply.

Product Name: Non-Preferred Agents: Sovaldi, Viekira Pak, Zepatier	
Diagnosis	Chronic Hepatitis C Virus (HCV)
Approval Length	*Approval length: As indicated in package labeling or hcvguidelines.org (the shortest appropriate recommended duration will be approved)
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Both of the following:

- Diagnosis of chronic hepatitis C infection
- HCV infection > 6 months

AND

2 - Submission of medical records (e.g., chart notes) documenting ALL of the following:

- HCV genotype
- Viral RNA levels measured within the past 3 months prior to initiating therapy
- Age
- Past treatment regimens used or documented treatment naïve status
- Extent of liver disease: non-cirrhotic, compensated cirrhosis (Child-Pugh A), decompensated cirrhosis (ChildPugh B, C)
- Current renal function
- NS5A RAS (if indicated to direct treatment)
- History of liver transplant
- History of kidney transplant
- HIV status and therapy

AND

3 - One of the following:

3.1 Contraindication or intolerance to ALL of the following preferred agents:

- Mavyret (glecaprevir/pibrentasvir)
- Ledipasvir/sofosbuvir (Harvoni brand)
- Sofosbuvir/velpatasvir (Epclusa brand)
- Vosevi (sofosbuvir/velpatasvir/voxilaprevir)

OR

3.2 The requested non-preferred agent will be used in a patient population that cannot be treated with a preferred agent

Notes	*Approval length: As indicated in package labeling or hcvguidelines.org (the shortest appropriate recommended duration will be approved) ** Members new to the plan who are established on therapy will have coverage under their drug benefit for the remainder of the current treatment course. Coverage of the drug product will be extended to new members who have already started therapy. Duration of therapy will be determined based on the person's indication and accepted treatment course in labeled and/or guideline supported regimens. Restrictions to

	specific network pharmacies and participation in medication manage ment programs may apply.

Product Name: Preferred Agents: Brand Epclusa, Brand Harvoni 90-400 mg, 45-200mg, Mavyret, Vosevi	
Diagnosis	Chronic Hepatitis C Virus (HCV)
Approval Length	12 month(s)
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Both of the following:

- Diagnosis of chronic hepatitis C infection
- HCV infection > 6 months

AND

2 - Submission of medical records (e.g., chart notes) documenting ALL of the following:

- HCV genotype
- Viral RNA levels measured within the past 3 months prior to initiating therapy
- Age
- Past treatment regimens used or documented treatment naïve status
- Extent of liver disease: non-cirrhotic, compensated cirrhosis (Child-Pugh A), decompensated cirrhosis (ChildPugh B, C)
- Current renal function
- NS5A RAS (if indicated to direct treatment)
- History of liver transplant
- History of kidney transplant
- HIV status and therapy

Notes	*Approval length: As indicated in package labeling or hcvguidelines.or g (the shortest appropriate recommended duration will be approved) ** Members new to the plan who are established on therapy will have coverage under their drug benefit for the remainder of the current treat ment course. Coverage of the drug product will be extended to new m embers who have already started therapy. Duration of therapy will be determined based on the person's indication and accepted treatment course in labeled and/or guideline supported regimens. Restrictions to specific network pharmacies and participation in medication manage ment programs may apply.

Product Name: Preferred Agents: Brand Epclusa, Brand Harvoni 90-400 mg, 45-200mg, Mavyret, Vosevi	
Diagnosis	Chronic Hepatitis C Virus (HCV)
Approval Length	*Approval length: As indicated in package labeling or hcvguidelines.org (the shortest appropriate recommended duration will be approved)
Guideline Type	Prior Authorization-All Plans except IL and MN

Approval Criteria

1 - Both of the following:

- Diagnosis of chronic hepatitis C infection
- HCV infection > 6 months

AND

2 - Submission of medical records (e.g., chart notes) documenting ALL of the following:

- HCV genotype
- Viral RNA levels measured within the past 3 months prior to initiating therapy
- Age
- Past treatment regimens used or documented treatment naïve status
- Extent of liver disease: non-cirrhotic, compensated cirrhosis (Child-Pugh A), decompensated cirrhosis (ChildPugh B, C)
- Current renal function
- NS5A RAS (if indicated to direct treatment)
- History of liver transplant
- History of kidney transplant
- HIV status and therapy

Notes	*Approval length: As indicated in package labeling or hcvguidelines.org (the shortest appropriate recommended duration will be approved) ** Members new to the plan who are established on therapy will have coverage under their drug benefit for the remainder of the current treatment course. Coverage of the drug product will be extended to new members who have already started therapy. Duration of therapy will be determined based on the person's indication and accepted treatment course in labeled and/or guideline supported regimens. Restrictions to specific network pharmacies and participation in medication management programs may apply.

2 . Revision History

Date	Notes
10/27/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129772
Guideline Name	Hereditary Angioedema (HAE) Medications
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who are established on therapy, will have coverage under their drug benefit for the remainder of the current treatment course. Restrictions to specific network pharmacies and participation in medication management programs may apply.

1 . Criteria

Product Name: Berinert, generic icatibant, Ruconest	
Diagnosis	Treatment of Acute Attacks
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans
Approval Criteria	

1 - Diagnosis of Hereditary Angioedema (HAE)

AND

2 - One of the following:

2.1 Low C4 AND low C1 inhibitor level or function

OR

2.2 Both of the following:

- Normal C1 inhibitor level with a family history of HAE
- High dose antihistamines did not control symptoms

AND

3 - Prescribed by or in consultation with an allergist or other provider experienced in the treatment of HAE

AND

4 - All medications that may cause angioedema have been discontinued (e.g., ACE inhibitors, estrogens, ARBs)

AND

5 - Requested medication will not be used in combination with other approved treatments for acute attacks

Product Name: Cinryze	
Diagnosis	Long-Term Prevention/Prophylaxis
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of Hereditary Angioedema (HAE)

AND

2 - One of the following:

- History of ≥ 2 attacks per month
- Symptoms are moderate to severe

AND

3 - One of the following:

3.1 Low C4 AND low C1 inhibitor level or function

OR

3.2 Both of the following:

- Normal C1 inhibitor level with a family history of HAE
- High dose antihistamines did not control symptoms

AND

4 - Prescribed by or in consultation with an allergist or other provider experienced in the treatment of HAE

AND

5 - All medications that may cause angioedema have been discontinued (e.g., ACE inhibitors, estrogens, ARBs)

AND

6 - Requested medication will not be used in combination with other approved HAE prevention treatments

AND

7 - Trial and failure (defined as no reduction in frequency of attacks or severity of attacks), contraindication, or intolerance to BOTH of the following:

- Haegarda
- Takhzyro

AND

8 - One of the following:

- Trial and failure (defined as no reduction in frequency of attacks or severity of attacks), contraindication, or intolerance to Orladeyo
- Member is between 6 and 12 years of age

Product Name: Berinert, generic icatibant, Ruconest	
Diagnosis	Treatment of Acute Attacks
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Hereditary Angioedema (HAE)

AND

2 - One of the following:

2.1 Low C4 AND low C1 inhibitor level or function

OR

2.2 Both of the following:

- Normal C1 inhibitor level with a family history of HAE
- High dose antihistamines did not control symptoms

AND

3 - Prescribed by or in consultation with an allergist or other provider experienced in the treatment of HAE

AND

4 - All medications that may cause angioedema have been discontinued (e.g., ACE inhibitors, estrogens, ARBs)

AND

5 - Requested medication will not be used in combination with other approved treatments for acute attacks

Product Name: Cinryze	
Diagnosis	Long-Term Prevention/Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Hereditary Angioedema (HAE)

AND

2 - One of the following:

- History of ≥ 2 attacks per month
- Symptoms are moderate to severe

AND

3 - One of the following:

3.1 Low C4 AND low C1 inhibitor level or function

OR

3.2 Both of the following:

- Normal C1 inhibitor level with a family history of HAE
- High dose antihistamines did not control symptoms

AND

4 - Prescribed by or in consultation with an allergist or other provider experienced in the treatment of HAE

AND

5 - All medications that may cause angioedema have been discontinued (e.g., ACE inhibitors, estrogens, ARBs)

AND

6 - Requested medication will not be used in combination with other approved HAE prevention treatments

AND

7 - Trial and failure (defined as no reduction in frequency of attacks or severity of attacks), contraindication, or intolerance to BOTH of the following:

- Haegarda
- Takhzyro

AND

8 - One of the following:

- Trial and failure (defined as no reduction in frequency of attacks or severity of attacks), contraindication, or intolerance to Orladeyo
- Member is between 6 and 12 years of age

Product Name: Berinert, generic icatibant, Ruconest, Cinryze	
Diagnosis	All Indications Listed Above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - For members new to plan* (as evidenced by coverage effective date of less than or equal to 90 days)**: Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member has experienced positive clinical response to therapy with the requested drug

OR

2 - For members requesting renewal (reauthorization): Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member has experienced positive clinical response to therapy with the requested drug

Notes	*Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who are established on therapy, will have coverage under their drug benefit for the remainder of the curren t treatment course. Restrictions to specific network pharmacies and p articipation in medication management programs may apply. **Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufact urer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Haegarda, Orladeyo, Takhzyro	
Diagnosis	Long-Term Prevention/Prophylaxis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All Plans Except IL and MN

Approval Criteria

1 - Diagnosis of Hereditary Angioedema (HAE)

AND

2 - One of the following:

- History of ≥ 2 attacks per month
- Symptoms are moderate to severe

AND

3 - One of the following:

3.1 Low C4 AND low C1 inhibitor level or function

OR

3.2 Both of the following:

- Normal C1 inhibitor level with a family history of HAE
- High dose antihistamines did not control symptoms

AND

4 - Prescribed by or in consultation with an allergist or other provider experienced in the treatment of HAE

AND

5 - All medications that may cause angioedema have been discontinued (e.g., ACE inhibitors, estrogens, ARBs)

AND

6 - Requested medication will not be used in combination with other approved HAE prevention treatments

Product Name: Haegarda, Orladeyo, Takhzyro	
Diagnosis	Long Term Prevention/Prophylaxis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - All Plans Except IL and MN

Approval Criteria

1 - For members new to plan* (as evidenced by coverage effective date of less than or equal to 90 days)**: Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member has experienced positive clinical response to therapy with the requested drug

OR

2 - For members requesting renewal (reauthorization), ALL of the following:

2.1 Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member has experienced positive clinical response to therapy with the requested drug

AND

2.2 For Takhzyro and Orladeyo requests ONLY: Submission of medical records (e.g., chart notes) supporting member has experienced no attacks during the preceding 12 months

AND

2.3 For Haegarda requests ONLY: Confirmation there are no weight changes warranting different quantity limits

Notes	Member is new to the plan (as evidenced by coverage effective date o f less than or equal to 90 days) who are established on therapy, will h ave coverage under their drug benefit for the remainder of the current treatment course. Restrictions to specific network pharmacies and par ticipation in medication management programs may apply. **Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufact urer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Haegarda, Orladeyo, Takhzyro	
Diagnosis	Long-Term Prevention/Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans Only

Approval Criteria

1 - Diagnosis of Hereditary Angioedema (HAE)

AND

2 - One of the following:

- History of ≥ 2 attacks per month
- Symptoms are moderate to severe

AND

3 - One of the following:

3.1 Low C4 AND low C1 inhibitor level or function

OR

3.2 Both of the following:

- Normal C1 inhibitor level with a family history of HAE
- High dose antihistamines did not control symptoms

AND

4 - Prescribed by or in consultation with an allergist or other provider experienced in the treatment of HAE

AND

5 - All medications that may cause angioedema have been discontinued (e.g., ACE inhibitors, estrogens, ARBs)

AND

6 - Requested medication will not be used in combination with other approved HAE prevention treatments

Product Name: Haegarda, Orladeyo, Takhzyro	
Diagnosis	Long Term Prevention/Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - For members new to plan* (as evidenced by coverage effective date of less than or equal to 90 days)**: Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member has experienced positive clinical response to therapy with the requested drug

OR

2 - For members requesting renewal (reauthorization), ALL of the following:

2.1 Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member has experienced positive clinical response to therapy with the requested drug

AND

2.2 For Takhzyro and Orladeyo requests ONLY: Submission of medical records (e.g., chart notes) supporting member has experienced no attacks during the preceding 12 months

AND

2.3 For Haegarda requests ONLY: Confirmation there are no weight changes warranting different quantity limits

Notes	Member is new to the plan (as evidenced by coverage effective date o f less than or equal to 90 days) who are established on therapy, will h ave coverage under their drug benefit for the remainder of the current treatment course. Restrictions to specific network pharmacies and par ticipation in medication management programs may apply. **Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufact

	urer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
10/25/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131133
Guideline Name	Hetlioz (tasimelteon)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic tasimelteon, Hetlioz LQ	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Diagnosis of Smith-Magenis syndrome

AND

1.1.2 Trial and failure, contraindication, or intolerance to 3 months of melatonin

OR

1.2 All of the following:

1.2.1 Diagnosis of a non-24-hour sleep-wake disorder

AND

1.2.2 Member is completely blind

AND

1.2.3 Trial and failure, contraindication, or intolerance to 3 months of generic ramelteon

AND

1.2.4 Prescribed by, or in consultation with a sleep specialist

Product Name: Generic tasimelteon, Hetlioz LQ	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Diagnosis of Smith-Magenis syndrome

AND

1.1.2 Trial and failure, contraindication, or intolerance to 3 months of melatonin

OR

1.2 All of the following:

1.2.1 Diagnosis of a non-24-hour sleep-wake disorder

AND

1.2.2 Member is completely blind

AND

1.2.3 Trial and failure, contraindication, or intolerance to 3 months of generic ramelteon

AND

1.2.4 Prescribed by, or in consultation with a sleep specialist

Notes	*Members new to the plan (as evidenced by coverage effective date o f less than or equal to 90 days) must meet the initial criteria for covera ge

Product Name: Generic tasimelteon, Hetlioz LQ	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug	
Notes	*Members new to the plan (as evidenced by coverage effective date o f less than or equal to 90 days) must meet the initial criteria for covera ge

2 . Revision History

Date	Notes
10/6/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129112
Guideline Name	Human Chorionic Gonadotropin (Novarel, Pregnyl equivalents) and Clomiphene (Clomid) Prior Auth
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Clomid	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans*

Approval Criteria

1 - All of the following:

1.1 Diagnosis of hypogonadism not seeking fertility treatment

AND

1.2 Submission of medical records (e.g., chart notes) documenting two low morning testosterone levels (or within 3 hours of waking for shift workers) including the normal ranges for the laboratory

AND

1.3 Submission of medical records (e.g., chart notes) documenting symptoms due to low testosterone other than sexual dysfunction or decreased libido

OR

2 - Submission of medical records (e.g., chart notes) documenting reduction of the uterine lining or fibroid size prior to surgical procedures, unrelated to infertility (e.g., endometriosis, uterine fibroids)

Notes	*Coverage of clomiphene for use in infertility is limited to members wh o have the artificial insemination rider attached to their benefit and coverage is limited to t he duration and cost share amounts as defined in the rider.

Product Name: Clomid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - All of the following:

1.1 Diagnosis of hypogonadism not seeking fertility treatment

AND

1.2 Submission of medical records (e.g., chart notes) documenting two low morning testosterone levels (or within 3 hours of waking for shift workers) including the normal ranges for the laboratory

AND

1.3 Submission of medical records (e.g., chart notes) documenting symptoms due to low testosterone other than sexual dysfunction or decreased libido

OR

2 - Submission of medical records (e.g., chart notes) documenting reduction of the uterine lining or fibroid size prior to surgical procedures, unrelated to infertility (e.g., endometriosis, uterine fibroids)

OR

3 - For Illinois Plans Only : All of the following:

3.1 Member has Quartz plan issued in the state of Illinois

AND

3.2 Infertility coverage as outlined in Illinois Insurance Code 215 ILCS 5/356m

Notes	*Coverage of clomiphene for use in infertility for MN plans is limited to members who have the artificial insemination rider attached to their benefit and coverage is limited to t he duration and cost share amounts as defined in the rider.

Product Name: Clomid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug	
Notes	*Coverage of clomiphene for use in infertility for MN plans is limited to members who have the artificial insemination rider attached to their benefit and coverage is limited to t he duration and cost share amounts as defined in the rider.

Product Name: Human Chorionic Gonadotropin	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans*

Approval Criteria

1 - Diagnosis of hypogonadism not seeking fertility treatment

AND

2 - Submission of medical records (e.g., chart notes) documenting two low morning testosterone levels (or within 3 hours of waking for shift workers) including the normal ranges for the laboratory

AND

3 - Submission of medical records (e.g., chart notes) documenting symptoms due to low testosterone other than sexual dysfunction or decreased libido

AND

4 - Trial and failure, contraindication or intolerance to clomiphene

AND

5 - The drug is being self-administered by the individual and not by a health care professional

Notes	*Coverage of chorionic gonadotropin for the treatment of hypogonadism is limited to the prescription drug benefit and not covered on the medical benefit. Chorionic gonadotropin is covered on the medical benefit without restriction for indications that are not excluded from coverage based by the plan benefits (e.g. treatment of prepuberal cryptorchidism). Diagnoses such as the treatment of infertility are excluded from coverage.

Product Name: Human Chorionic Gonadotropin	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - All of the following must be met:

1.1 Diagnosis of hypogonadism not seeking fertility treatment

AND

1.2 Submission of medical records (e.g., chart notes) documenting two low morning testosterone levels (or within 3 hours of waking for shift workers) including the normal ranges for the laboratory

AND

1.3 Submission of medical records (e.g., chart notes) documenting symptoms due to low testosterone other than sexual dysfunction or decreased libido

AND

1.4 Trial and failure, contraindication or intolerance to clomiphene

AND

1.5 The drug is being self-administered by the individual and not by a health care professional

OR

2 - For Illinois Plans Only : All of the following:

2.1 Member has Quartz plan issued in the state of Illinois

AND

2.2 Infertility coverage as outlined in Illinois Insurance Code 215 ILCS 5/356m

Notes	*Coverage of chorionic gonadotropin for the treatment of hypogonadism is limited to the prescription drug benefit and not covered on the medical benefit. Chorionic gonadotropin is covered on the medical benefit without restriction for indications that are not excluded from coverage based by the plan benefits (e.g. treatment of prepuberal cryptorchidism). Diagnoses such as the treatment of infertility are excluded from coverage. *Members new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) must meet initial criteria for coverage

Product Name: Human Chorionic Gonadotropin	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Notes	*Coverage of chorionic gonadotropin for the treatment of hypogonadism is limited to the prescription drug benefit and not covered on the medical benefit. Chorionic gonadotropin is covered on the medical benefit without restriction for indications that are not excluded from coverage based by the plan benefits (e.g. treatment of prepuberal

	cryptorchidism). Diagnoses such as the treatment of infertility are excl uded from coverage. *Members new to the plan (as evidenced by coverage effective date o f less than or equal to 90 days) must meet initial criteria for coverage

2 . Revision History

Date	Notes
9/8/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-127837
Guideline Name	Hydrocodone ER
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Hydrocodone ER	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure of at least 2 of the following preferred long-acting opioids:

- morphine ERT (generic of MS Contin)
- morphine ERC (generic of Kadian)
- Oxycodone ER (Oxycontin)

OR

2 - For Minnesota Plans step therapy does not apply if member has stage four metastatic cancer and the requested drug is being used to treat cancer-related pain

Product Name: Generic Hydrocodone ER	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Generic Hydrocodone ER	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure of at least 2 of the following preferred long-acting opioids:

- morphine ERT (generic of MS Contin)
- morphine ERC (generic of Kadian)
- Oxycodone ER (Oxycontin)

2 . Revision History

Date	Notes
8/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129635
Guideline Name	Inbrija (Levodopa inhalation powder)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Inbrija	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Prescribed by, or in consultation with, a Neurologist

AND

3 - Current treatment with combination of long-acting and short-acting carbidopa/levodopa

AND

4 - Person experiencing intermittent "off" episodes despite adequate trial with appropriate dosage adjustment with carbidopa/levodopa

Product Name: Inbrija	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Inbrija	
Approval Length	12/31/2039
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of Parkinson's disease

AND

2 - Prescribed by, or in consultation with, a Neurologist

AND

3 - Current treatment with combination of long-acting and short-acting carbidopa/levodopa

AND

4 - Person experiencing intermittent "off" episodes despite adequate trial with appropriate dosage adjustment with carbidopa/levodopa

2 . Revision History

Date	Notes
10/6/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129115
Guideline Name	Increlex (mecasermin)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Increlex	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans*

Approval Criteria

1 - One of the following:

1.1 Diagnosis of one of the following:

- Primary insulin-like growth factor deficiency (IGFD)
- Low insulin-like growth factor-1 (IGF-1) levels
- Growth hormone deletion with neutralizing antibodies to growth hormone

OR

1.2 Submission of medical records (e.g., chart notes) documenting lack of response to growth hormone following therapeutic trial of somatropin (for members with growth hormone deficiency)

AND

2 - Member is less than 18 years of age

AND

3 - Member has confirmed open epiphyses

AND

4 - Prescribed by or in consultation with a pediatric endocrinologist

Notes	*Increlex is not indicated to treat secondary IGFD due to GH deficiency, malnutrition, hypothyroidism or other causes *Increlex is not covered for treatment of idiopathic short stature *Increlex is not a substitute for growth hormone (somatropin)

Product Name: Increlex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - One of the following:

1.1 Diagnosis of one of the following:

- Primary insulin-like growth factor deficiency (IGFD)

- Low insulin-like growth factor-1 (IGF-1) levels
- Growth hormone deletion with neutralizing antibodies to growth hormone

OR

1.2 Submission of medical records (e.g., chart notes) documenting lack of response to growth hormone following therapeutic trial of somatropin (for members with growth hormone deficiency)

AND

2 - Member is less than 18 years of age

AND

3 - Member has confirmed open epiphyses

AND

4 - Prescribed by or in consultation with a pediatric endocrinologist

Notes	*Increlex is not indicated to treat secondary IGFD due to GH deficiency, malnutrition, hypothyroidism or other causes *Increlex is not covered for treatment of idiopathic short stature *Increlex is not a substitute for growth hormone (somatropin)

Product Name: Increlex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - One of the following:

1.1 Diagnosis of one of the following:

- Primary insulin-like growth factor deficiency (IGFD)
- Low insulin-like growth factor-1 (IGF-1) levels
- Growth hormone deletion with neutralizing antibodies to growth hormone

OR

1.2 Submission of medical records (e.g., chart notes) documenting lack of response to growth hormone following therapeutic trial of somatropin (for members with growth hormone deficiency)

AND

2 - Member is less than 18 years of age

AND

3 - Member has confirmed open epiphyses

AND

4 - Prescribed by or in consultation with a pediatric endocrinologist

AND

5 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months, the member remains on therapy

Notes	*Increlex is not indicated to treat secondary IGFD due to GH deficienc y, malnutrition, hypothyroidism or other causes *Increlex is not covered for treatment of idiopathic short stature *Increlex is not a substitute for growth hormone (somatropin)

2 . Revision History

Date	Notes
7/31/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-130583
Guideline Name	Ingrezza (valbenazine)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Ingrezza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria	

1 - Diagnosis of tardive dyskinesia (TD)

AND

2 - Prescribed by or in consultation with one of the following:

- Neurologist
- Psychiatrist
- Specialist in the treatment of TD

AND

3 - One of the following:

3.1 Symptoms persist despite stopping the dopamine receptor blocking drug that caused TD

OR

3.2 Submission of medical records (e.g., chart notes) documenting evidence-based clinical rationale why discontinuation of the drug is not a treatment option for the person based on their diagnosis and previous treatment history

AND

4 - Trial and failure, contraindication, or intolerance to clonazepam

AND

5 - (For patients whose primary symptomology is tardive dystonia ONLY): Trial and failure, contraindication, or intolerance to trihexyphenidyl

Product Name: Ingrezza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Ingrezza	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of tardive dyskinesia (TD)

AND

2 - Prescribed by or in consultation with one of the following:

- Neurologist
- Psychiatrist
- Specialist in the treatment of TD

AND

3 - One of the following:

3.1 Symptoms persist despite stopping the dopamine receptor blocking drug that caused TD

OR

3.2 Submission of medical records (e.g., chart notes) documenting evidence-based clinical rationale why discontinuation of the drug is not a treatment option for the person based on their diagnosis and previous treatment history

AND

4 - Trial and failure, contraindication, or intolerance to clonazepam

AND

5 - (For patients whose primary symptomology is tardive dystonia ONLY): Trial and failure, contraindication, or intolerance to trihexyphenidyl

2 . Revision History

Date	Notes
8/16/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129738
Guideline Name	Inhaled Bronchodilators for Chronic Obstructive Pulmonary Disease
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Stiolto Respimat	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2 - Trial and failure, contraindication or intolerance to use of umeclidinium/vilanterol (Anoro Ellipta)

Product Name: Stiolto Respimat	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Stiolto Respimat	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2 - Trial and failure, contraindication or intolerance to use of umeclidinium/vilanterol (Anoro Ellipta)

2 . Revision History

Date	Notes
10/6/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-143611
Guideline Name	Inhaled Corticosteroid Step therapy
Formulary	• Quartz

Guideline Note:

Effective Date:	4/1/2024
P&T Approval Date:	2/15/2022
P&T Revision Date:	7/18/2023

1 . Criteria

Product Name: Asmanex, Asmanex HFA	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure, intolerance, or contraindication to one of the following:

- an inhaled fluticasone propionate product

- an inhaled fluticasone furoate product

Product Name: Asmanex, Asmanex HFA	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical notes (e.g. chart notes) from the past 12 months that member is continuing therapy with the requested drug

Product Name: Asmanex, Asmanex HFA	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure, intolerance, or contraindication to one of the following:

- an inhaled fluticasone propionate product
- an inhaled fluticasone furoate product

2 . Revision History

Date	Notes
2/28/2024	New Program

Prior Authorization Guideline

Guideline ID	GL-129533
Guideline Name	Injectable Calcitonin Gene-Related Peptide (CGRP) Inhibitors
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Aimovig, Emgality	
Diagnosis	Preventative Treatment of Migraine
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting member has greater than or equal to 4 migraine days per month with headaches that are disabling (e.g., unable to work/attend school, unable to participate in activities of daily living [ADLs], moderate to severe MIDAS score)

AND

2 - Drug must be self-administered

AND

3 - Trial and failure, intolerance, or contraindication to 2 generic preventive migraine medications (e.g., anti-hypertensives, antiepileptics, antidepressants, botulinum toxin)

AND

4 - Drug is not being used in combination with another CGRP inhibitor for the preventative treatment of migraines

Product Name: Aimovig, Emgality	
Diagnosis	Preventative Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting member has greater than or equal to 4 migraine days per month with headaches that are disabling (e.g., unable to work/attend school, unable to participate in activities of daily living [ADLs], moderate to severe MIDAS score)

AND

2 - Drug must be self-administered

AND

3 - Trial and failure, intolerance, or contraindication to 2 generic preventive migraine medications (e.g., anti-hypertensives, antiepileptics, antidepressants, botulinum toxin)

AND

4 - Drug is not being used in combination with another CGRP inhibitor used for the preventative treatment of migraines

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Aimovig, Emgality	
Diagnosis	Preventative Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the previous 12 months the member is showing a response to therapy (e.g., symptom improvement such as decreased frequency or severity of headaches from baseline, reduced cluster headache frequency, improved ability to participate in therapies/ADLs, improved MIDAS score, less acute medication use, fewer ER/UC visits for migraine, ability to return to work/school)

AND

2 - Drug is not being used in combination with another CGRP inhibitor used for the preventative treatment of migraines

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Ajovy	
Diagnosis	Preventative Treatment of Migraine
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting member has greater than or equal to 4 migraine days per month with headaches that are disabling (e.g., unable to work/attend school, unable to participate in activities of daily living [ADLs], moderate to severe MIDAS score)

AND

2 - Drug must be self-administered

AND

3 - Trial and failure, contraindication or intolerance to 2 generic preventive migraine medications (e.g., anti-hypertensives, antiepileptics, antidepressants, botulinum toxin)

AND

4 - Trial and failure, contraindication or intolerance to both of the following:

- Aimovig
- Emgality

AND

5 - Drug is not being used in combination with another CGRP inhibitor for the preventative treatment of migraines

Product Name: Ajovy	
Diagnosis	Preventative Treatment of Migraine

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting member has greater than or equal to 4 migraine days per month with headaches that are disabling (e.g., unable to work/attend school, unable to participate in activities of daily living [ADLs], moderate to severe MIDAS score)

AND

2 - Drug must be self-administered

AND

3 - Trial and failure, contraindication or intolerance to 2 generic preventive migraine medications (e.g., anti-hypertensives, antiepileptics, antidepressants, botulinum toxin)

AND

4 - Trial and failure, contraindication or intolerance to both of the following:

- Aimovig
- Emgality

AND

5 - Drug is not being used in combination with another CGRP inhibitor used for the preventative treatment of migraines

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Ajovy	
Diagnosis	Preventative Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the previous 12 months the member is showing a response to therapy (e.g., symptom improvement such as decreased frequency or severity of headaches from baseline, reduced cluster headache frequency, improved ability to participate in therapies/ADLs, improved MIDAS score, less acute medication use, fewer ER/UC visits for migraine, ability to return to work/school)

AND

2 - Drug is not being used in combination with another CGRP inhibitor used for the preventative treatment of migraines

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Emgality	
Diagnosis	Episodic Cluster Headache
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of cluster headaches that are not rebound headaches due to medication overuse

AND

2 - Drug must be self-administered

AND

3 - Patient is 18 years of age or older

Product Name: Emgality	
Diagnosis	Episodic Cluster Headache
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - Diagnosis of cluster headaches that are not rebound headaches due to medication overuse

AND

2 - Drug must be self-administered

AND

3 - Patient is 18 years of age or older

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Emgality	
Diagnosis	Episodic Cluster Headache
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the previous 12 months the member is showing a response to therapy (e.g., symptom improvement such as decreased frequency or severity of headaches from baseline, reduced cluster headache frequency, improved ability to participate in therapies/ADLs, improved MIDAS score, less acute medication use, fewer ER/UC visits for migraine, ability to return to work/school)

AND

2 - Drug is not being used in combination with another CGRP inhibitor used for the preventative treatment of migraines

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
8/8/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-130130
Guideline Name	Interferons
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Alferon N	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of external genital or perianal warts

AND

2 - Must be self-administered or administered by family member or caretaker

Product Name: Alferon N	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of external genital or perianal warts

AND

2 - Must be self-administered or administered by family member or caretaker

AND

3 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member demonstrates positive clinical response to therapy

Product Name: Actimmune	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Chronic granulomatous disease
- Congenital malignant osteopetrosis

AND

2 - Must be self-administered or administered by family member or caretaker

Product Name: Actimmune	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Chronic granulomatous disease
- Congenital malignant osteopetrosis

AND

2 - Must be self-administered or administered by family member or caretaker

AND

3 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member demonstrates positive clinical response to therapy

2 . Revision History

Date	Notes

8/15/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-130138
Guideline Name	Itraconazole/Onychomycosis
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

For systemic infections only: Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Itraconazole (generic Sporanox)	
Diagnosis	Onychomycosis
Approval Length	4 month(s)
Guideline Type	Prior Authorization – All plans except IL and MN
Approval Criteria	

1 - Diagnosis of fungal or mold infection confirmed by culture or positive KOH test

AND

2 - Submission of medical records (e.g., chart notes) documenting functional disability due to onychomycosis, peripheral vascular disease, diabetes, immunosuppressed or immunocompromised state, or history of recurrent cellulitis

AND

3 - Trial and failure, contraindication, or intolerance to terbinafine therapy

Product Name: Itraconazole (generic Sporanox)	
Diagnosis	Onychomycosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization- IL and MN Plans

Approval Criteria

1 - Diagnosis of fungal or mold infection confirmed by culture or positive KOH test

AND

2 - Submission of medical records (e.g., chart notes) documenting functional disability due to onychomycosis, peripheral vascular disease, diabetes, immunosuppressed or immunocompromised state, or history of recurrent cellulitis

AND

3 - Trial and failure, contraindication, or intolerance to terbinafine therapy

Product Name: Jublia, Kerydin	
Diagnosis	Onychomycosis

Approval Length	6 month(s)
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of fungal or mold infection confirmed by culture or positive KOH test

AND

2 - Submission of medical records (e.g., chart notes) documenting functional disability due to onychomycosis, peripheral vascular disease, diabetes, immunosuppressed or immunocompromised state, or history of recurrent cellulitis

AND

3 - Trial and failure, contraindication, or intolerance to both of the following:

- Oral terbinafine
- Oral itraconazole

Product Name: Jublia, Kerydin	
Diagnosis	Onychomycosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization – IL and MN plans

Approval Criteria

1 - Diagnosis of fungal or mold infection confirmed by culture or positive KOH test

AND

2 - Submission of medical records (e.g., chart notes) documenting functional disability due to onychomycosis, peripheral vascular disease, diabetes, immunosuppressed or immunocompromised state, or history of recurrent cellulitis

AND

3 - Trial and failure, contraindication, or intolerance to both of the following:

- Oral terbinafine
- Oral itraconazole

Product Name: Tolsura	
Diagnosis	Onychomycosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of fungal or mold infection confirmed by culture or positive KOH test

AND

2 - Submission of medical records (e.g., chart notes) documenting functional disability due to onychomycosis, peripheral vascular disease, diabetes, immunosuppressed or immunocompromised state, or history of recurrent cellulitis

AND

3 - Trial and failure, contraindication, or intolerance to use of generic itraconazole (Sporanox equivalent)

Product Name: Tolsura	
Diagnosis	Onychomycosis
Approval Length	6 month(s)
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of fungal or mold infection confirmed by culture or positive KOH test

AND

2 - Submission of medical records (e.g., chart notes) documenting functional disability due to onychomycosis, peripheral vascular disease, diabetes, immunosuppressed or immunocompromised state, or history of recurrent cellulitis

AND

3 - Trial and failure, contraindication, or intolerance to use of generic itraconazole (Sporanox equivalent)

Product Name: Itraconazole (generic Sporanox)	
Diagnosis	Systemic Infections
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Blastomycosis, Histoplasmosis, Aspergillosis or other verified systemic fungal infection susceptible to itraconazole

OR

2 - (Illinois plans only): The drug is being used for the long-term treatment of tick-borne disease

Product Name: Tolsura	
Diagnosis	Systemic Infections

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Diagnosis of Blastomycosis, Histoplasmosis, Aspergillosis or other verified systemic fungal infection susceptible to itraconazole

OR

1.2 (Illinois Plans Only): The drug is being used for the long-term treatment of tick-borne disease

AND

2 - Trial and failure, contraindication, or intolerance to use of generic itraconazole (Sporanox equivalent)

Product Name: Itraconazole (generic Sporanox), Tolsura	
Diagnosis	Systemic Infections
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - New to the plan (within the past 90 days and submission of medical records (e.g., chart notes) documenting that within the past 12 months treatment of the condition is ongoing

OR

2 - BOTH of the following:

2.1 ONE of the following:

- Diagnosis of Blastomycosis, Histoplasmosis, Aspergillosis or other verified systemic fungal infection susceptible to itraconazole
- (Illinois plans only): The drug is being used for the long-term treatment of tick-borne disease

AND

2.2 Submission of medical records (e.g., chart notes) documenting that within the past 12 months treatment of the condition is ongoing

2 . Revision History

Date	Notes
10/5/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-136594
Guideline Name	Juxtapid (lomitapide)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Juxtapid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – All Plans
Approval Criteria	

1 - Diagnosis of homozygous familial hypercholesteremia (HoFH) with one of the following:

- Clinical diagnosis (LDL-C greater than 500 mg/dL with xanthomas or family history of both parents with LDL-C levels greater than 250 mg/dL)
- Genetic verification of HoFH

AND

2 - Prescribed by, or in consultation with, a Cardiologist or other specialist in the treatment of congenital lipid disorders

AND

3 - LDL-C level is greater than 70 mg/dL

AND

4 - Trial and failure, contraindication, or intolerance to a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor unless there is genetic verification of receptor negative (null-null mutation) HoFH

Product Name: Juxtapid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesteremia (HoFH) with one of the following:

- Clinical diagnosis (LDL-C greater than 500 mg/dL with xanthomas or family history of both parents with LDL-C levels greater than 250 mg/dL)
- Genetic verification of HoFH

AND

2 - Prescribed by, or in consultation with, a Cardiologist or other specialist in the treatment of congenital lipid disorders

AND

3 - Submission of medical records (e.g., chart notes) documenting a clinically meaningful (at least 10%) reduction in LDL-C from baseline

Product Name: Juxtapid	
Approval Length	12/31/2039
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesteremia (HoFH) with one of the following:

- Clinical diagnosis (LDL-C greater than 500 mg/dL with xanthomas or family history of both parents with LDL-C levels greater than 250 mg/dL)
- Genetic verification of HoFH

AND

2 - Prescribed by, or in consultation with, a Cardiologist or other specialist in the treatment of congenital lipid disorders

AND

3 - Submission of medical records (e.g., chart notes) documenting a clinically meaningful (at least 10%) reduction in LDL-C from baseline

2 . Revision History

Date	Notes

11/20/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131947
Guideline Name	Jynarque (Tolvaptan)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Jynarque	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of autosomal dominant polycystic kidney disease (ADPKD)

AND

2 - Prescribed by, or on the recommendation of, a Nephrologist or other expert in kidney disease

AND

3 - Age greater than or equal to18 years

AND

4 - Estimated glomerular filtration rate ≥ 25 ml/min

Product Name: Jynarque	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that current laboratory values for liver and kidneys remain within acceptable treatment ranges

2 . Revision History

Date	Notes
10/31/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129742
Guideline Name	Kerendia (finerenone)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Kerendia	
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL and MN Plans Only

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes

AND

2 - Diagnosis is confirmed by one of the following:

- Urine albumin creatinine ratio (UACR) between 30 mg/g and 300 mg/g and estimated glomerular filtration rate (eGFR) of 25 to 60 mL/min
- UACR > 300 mg/g and eGFR of 25 to 75 mL/min

AND

3 - Serum potassium level ≤ 5 mEq/L

AND

4 - Trial and failure of a maximally tolerated dose, contraindication or intolerance to both of the following:

- Ace-inhibitor (ACE-I) or angiotensin receptor blocker (ARB)
- Sodium-glucose cotransporter-2 (SGLT2) drug that has an indication for CKD benefit (e.g., dapagliflozin, canagliflozin, empagliflozin)

AND

5 - UACR remains above 30 mg/g despite use of ACE-I/ARB and SGLT2 (unless contraindicated or not tolerated)

Product Name: Kerendia	
Approval Length	12/31/2039
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes

AND

2 - Diagnosis is confirmed by one of the following:

- Urine albumin creatinine ratio (UACR) between 30 mg/g and 300 mg/g and estimated glomerular filtration rate (eGFR) of 25 to 60 mL/min
- UACR > 300 mg/g and eGFR of 25 to 75 mL/min

AND

3 - Serum potassium level ≤ 5 mEq/L

AND

4 - Trial and failure of a maximally tolerated dose, contraindication or intolerance to both of the following:

- Ace-inhibitor (ACE-I) or angiotensin receptor blocker (ARB)
- Sodium-glucose cotransporter-2 (SGLT2) drug that has an indication for CKD benefit (e.g., dapagliflozin, canagliflozin, empagliflozin)

AND

5 - UACR remains above 30 mg/g despite use of ACE-I/ARB and SGLT2 (unless contraindicated or not tolerated)

Product Name: Kerendia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
10/31/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-132775
Guideline Name	Ketorolac Injection
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Ketorlac Injection	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit - Applies to IL and MN plans only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that the member does not have one of the following:

- reduced kidney function
- history of gastrointestinal ulcers/bleeds

Product Name: Ketorlac Injection	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Quantity Limit - Applies to IL and MN plans only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) from the past 12 months that the member is having a positive response to therapy

Product Name: Ketorlac Injection	
Approval Length	12/31/2039
Guideline Type	Quantity Limit - Applies to all plans except IL and MN

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that the member does not have one of the following:

- reduced kidney function
- history of gastrointestinal ulcers/bleeds

2 . Revision History

Date	Notes
10/31/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131972
Guideline Name	Keveyis (Dichlorphenamide)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Dichlorphenamide	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, or related variants

AND

2 - Age greater than or equal to18

Product Name: Generic Dichlorphenamide	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Generic Dichlorphenamide	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, or related variants

AND

2 - Age greater than or equal to18

2 . Revision History

Date	Notes
10/31/2023	New program

Prior Authorization Guideline

Guideline ID	GL-137218
Guideline Name	Kineret (anakinra)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Kineret	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of one of the following:

- Moderate to severely active rheumatoid arthritis (RA)
- Juvenile idiopathic arthritis (JIA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- Methotrexate (MTX)*
- Leflunomide
- Hydroxychloroquine
- Sulfasalazine

AND

3 - Medication will be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Both of the following:

6.1 Trial and failure, contraindication, or intolerance to TWO of the following:

- Certolizumab
- Etanercept
- Adalimumab (biosimilars or Humira)
- Upadacitinib
- Golimumab
- Tofacitinib/ER

AND

6.2 Trial and failure, contraindication, or intolerance to BOTH of the following:

- Tocilizumab
- Abatacept

Notes	*Absolute contraindications to methotrexate are pregnancy, nursing, a lcoholism, alcoholic liver disease or other chronic liver disease, immun odeficiency syndromes, bone marrow hyperplasia, leukopenia, thromb ocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Kineret	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of one of the following:

- Moderate to severely active rheumatoid arthritis (RA)
- Juvenile idiopathic arthritis (JIA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- Methotrexate (MTX)*
- Leflunomide
- Hydroxychloroquine
- Sulfasalazine

AND

3 - Medication will be self-administered (not in clinic or provider office)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Both of the following:

6.1 Trial and failure, contraindication, or intolerance to TWO of the following:

- Certolizumab
- Etanercept
- Adalimumab (biosimilars or Humira)
- Upadacitinib
- Golimumab
- Tofacitinib/ER

AND

6.2 Trial and failure, contraindication, or intolerance to BOTH of the following:

- Tocilizumab
- Abatacept

Notes	*Absolute contraindications to methotrexate are pregnancy, nursing, a lcoholism, alcoholic liver disease or other chronic liver disease, immun odeficiency syndromes, bone marrow hyperplasia, leukopenia, thromb ocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Kineret	
Diagnosis	Cryopyrin Associated Periodic Syndromes (CAPS)
Approval Length	12/31/2039

Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of cryopyrin associated periodic syndromes (CAPS) including Muckle Wells, neonatal-onset multisystemic inflammatory disorder, familial cold autoinflammatory syndrome, or other periodic syndromes

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Not used in combination with other biologic DMARDs (e.g., canakinumab)

AND

4 - Medication will be self-administered

Product Name: Kineret	
Diagnosis	Cryopyrin Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of cryopyrin associated periodic syndromes (CAPS) including Muckle Wells, neonatal-onset multisystemic inflammatory disorder, familial cold autoinflammatory syndrome, or other periodic syndromes

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Not used in combination with other biologic DMARDs (e.g., canakinumab)

AND

4 - Medication will be self-administered

Product Name: Kineret	
Diagnosis	Systemic Juvenile Arthritis, Adult-Onset Still's Disease
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of systemic juvenile arthritis or adult-onset Still's disease

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Trial and failure, contraindication, or intolerance to ONE of the following for 3 months:

- corticosteroids
- methotrexate
- nonsteroidal anti-inflammatory drugs (NSAIDs)

AND

4 - Not used in combination with other biologic DMARDs (e.g., canakinumab)

AND

5 - Medication will be self-administered

Product Name: Kineret	
Diagnosis	Systemic Juvenile Arthritis, Adult-Onset Still's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of systemic juvenile arthritis or adult-onset Still's disease

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Trial and failure, contraindication, or intolerance to ONE of the following for 3 months:

- corticosteroids
- methotrexate
- nonsteroidal anti-inflammatory drugs (NSAIDs)

AND

4 - Not used in combination with other biologic DMARDs (e.g., canakinumab)

AND **5** - Medication will be self-administered

Product Name: Kineret	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization – IL and MN Plans
Approval Criteria **1** - Prescriber provides clinical documentation from the previous 12 months that describes the member's response as stable disease or improvement seen on therapy	

2 . Revision History

Date	Notes
12/4/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131589
Guideline Name	Kuvan (sapropterin)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Generic sapropterin	
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All plans except IL and MN
Approval Criteria	

1 - Diagnosis of phenylketonuria (PKU)

AND

2 - Used in conjunction with a phenylalanine (Phe) restricted diet

AND

3 - Member is not on concurrent pegvaliase therapy

Product Name: Generic sapropterin	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans Only

Approval Criteria

1 - Diagnosis of phenylketonuria (PKU)

AND

2 - Used in conjunction with a phenylalanine (Phe) restricted diet

AND

3 - Member is not on concurrent pegvaliase therapy

Product Name: Generic sapropterin	
Diagnosis	After 2 month initial fill
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Clinical documentation of a 30% or more reduction in Phe levels from baseline on sapropterin treatment

AND

2 - Used in conjunction with a phenylalanine (Phe) restricted diet

AND

3 - Member will continue to have blood Phe levels measured periodically during treatment

AND

4 - Member is not on concurrent pegvaliase therapy

Product Name: Generic sapropterin	
Diagnosis	Continuation of Coverage
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - All Plans

Approval Criteria

1 - Used in conjunction with a phenylalanine (Phe) restricted diet

AND

2 - Member will continue to have blood Phe levels measured periodically during treatment

AND **3** - Member is not on concurrent pegvaliase therapy

2 . Revision History

Date	Notes
10/27/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131974
Guideline Name	Lescol (Fluvastatin), Lescol XL (Fluvastatin XR)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic: Fluvastatin, Fluvastatin XR	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only
Approval Criteria **1** - Trial and failure, contraindication or intolerance to all generic preferred statins (atorvastatin, lovastatin, pravastatin, rosuvastatin and simvastatin)	

Product Name: Generic: Fluvastatin, Fluvastatin XR	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Generic: Fluvastatin, Fluvastatin XR	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Trial and failure, contraindication or intolerance to all generic preferred statins (atorvastatin, lovastatin, pravastatin, rosuvastatin and simvastatin)

2 . Revision History

Date	Notes
10/31/2023	New program

Prior Authorization Guideline

Guideline ID	GL-136712
Guideline Name	Leukine (Sargramostim)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Leukine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Trial and failure, contraindication, or intolerance to tbo-filgrastim (i.e. Granix)

OR

1.2 Both of the following:

1.2.1 Diagnosis if neuroblastoma

AND

1.2.2 Used in combination with naxitamab (Danyelza)

OR

1.3 Minnesota plans only: The person has stage four metastatic cancer and the requested drug is being used as supportive care for their cancer treatment.

2 . Revision History

Date	Notes
11/27/2023	Criteria updated

Prior Authorization Guideline

Guideline ID	GL-132743
Guideline Name	Leuprolide daily injection
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Leuprolide Injection	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except MN Plans

Approval Criteria

1 - The injections will be self-administered

AND

2 - Use is for a diagnosis other than infertility (e.g.,. prostate cancer, endometriosis, dysmenorrhea, etc.)

Product Name: Leuprolide Injection	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - MN Plans

Approval Criteria

1 - The injections will be self-administered

AND

2 - Use is for a diagnosis other than infertility (e.g.,. prostate cancer, endometriosis, dysmenorrhea, etc.)

Product Name: Leuprolide Injection	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
10/31/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129856
Guideline Name	Levemir (insulin detemir)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Levemir	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Both of the following:

- Member is currently pregnant
- Diagnosis of gestational diabetes

AND

2 - Prescribed by or in consultation with one of the following:

- Endocrinologist
- Diabetes specialist

AND

3 - One of the following:

3.1 Member cannot meet their glycemic goals despite an adequate trial of insulin isophane (NPH) including:

- Dose escalation, unless dose increases cannot be tolerated due to nocturnal hypoglycemia or at least one severe low blood sugar event (requiring assistance from another) or would not be appropriate given the person's self-monitoring blood glucose profile
- Submission of medical records (e.g., chart notes) documenting use of a specific adherence intervention deployed by a health care professional if nonadherence is evident

OR

3.2 Member is intolerant to insulin isophane (NPH)

Product Name: Levemir	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Levemir

Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Both of the following:

- Member is currently pregnant
- Diagnosis of gestational diabetes

AND

2 - Prescribed by or in consultation with one of the following:

- Endocrinologist
- Diabetes specialist

AND

3 - One of the following:

3.1 Member cannot meet their glycemic goals despite adequate trials of insulin isophane (NPH) including:

- Dose escalation, unless dose increases cannot be tolerated due to nocturnal hypoglycemia or at least one severe low blood sugar event (requiring assistance from another) or would not be appropriate given the person's self-monitoring blood glucose profile
- Submission of medical records (e.g., chart notes) documenting use of a specific adherence intervention deployed by a health care provider if nonadherence is evident

OR

3.2 Member is intolerant to insulin isophane (NPH)

2 . Revision History

Date	Notes
10/12/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-135578
Guideline Name	Livmarli (maralixibat)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Livmarli	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Alagille syndrome (ALGS)

AND

2 - Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene

AND

3 - One of the following:

- Total serum bile acid greater than 3x the upper limit of normal (ULN)
- Conjugated bilirubin greater than 1 mg/dL
- Fat soluble vitamin deficiency otherwise unexplainable
- Gamma-glutamyl transpeptidase (GGT) greater than 3x ULN

AND

4 - Member is experiencing moderate to severe cholestatic pruritus

AND

5 - Member has not had a liver transplant or decompensated liver disease

AND

6 - Trial and failure, contraindication or intolerance to TWO of the following medications for pruritis:

- Ursodeoxycholic acid (e.g., Ursodiol)
- Antihistamines (e.g., diphenhydramine, hydroxyzine)
- Rifampin
- Bile acid sequestrants (e.g., Questran, Colestid, Welchol)

AND

7 - Prescribed by or in consultation with one of the following:

- Hepatologist
- Expert in the treatment of cholestasis

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers

	will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies. **For members new to plan (as evidenced by coverage effective date of less than or equal to 90 days) prescriber provides submission of medical records (e.g., chart notes) documenting that from the previous 12 months, member demonstrates an improvement or stabilization in pruritus and the member is tolerating therapy.

Product Name: Livmarli	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months of therapy, member is experiencing improvement or stabilization in pruritus compared to baseline (e.g., change in member reported pruritus, change in sleeping habits due to itch) and the member is tolerating therapy (e.g., does not have chronic diarrhea requiring ongoing intravenous fluids, bile acid reduction)	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies. **For members new to plan (as evidenced by coverage effective date of less than or equal to 90 days) prescriber provides submission of medical records (e.g., chart notes) documenting that from the previous 12 months, member demonstrates an improvement or stabilization in pruritus and the member is tolerating therapy.

2 . Revision History

Date	Notes
10/30/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129857
Guideline Name	Livtencity (maribavir)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Livtencity	
Approval Length	16 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of cytomegalovirus (CMV) infection based on clinical history and laboratory testing

AND

2 - History of stem cell or solid organ transplant

AND

3 - Prescribed by or in consultation with one of the following:

- Hematologist
- Oncologist
- Infectious Disease Specialist
- Transplant Specialist

AND

4 - Submission of medical records (e.g., chart notes) documenting baseline viral load prior to initiating therapy

AND

5 - Trial and failure, contraindication, or intolerance to one of the following:

- Ganciclovir
- Valganciclovir
- Cidofovir
- Foscarnet

Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Livtencity

Approval Length	16 Week(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) supporting treatment response and evidence-based clinical rationale for use beyond 16 weeks of therapy

OR

2 - Members new to coverage (as evidenced by coverage effective date of less than or equal to 90 days) who are established on therapy will have coverage under their drug benefit for the remainder of the current treatment course (to a maximum of 16 weeks)

Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

2 . Revision History

Date	Notes
8/21/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-132812
Guideline Name	Lupkynis (voclosporin)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Lupkynis	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN plans only

Approval Criteria

1 - Diagnosis of biopsy-proven lupus nephritis

AND

2 - Prescribed by or in consultation with one of the following:

- Nephrologist
- Rheumatologist
- specialist in the treatment of lupus nephritis

AND

3 - Trial and failure, contraindication, or intolerance to concurrent use of mycophenolate with corticosteroids

AND

4 - Requested drug will be used in combination with mycophenolate and corticosteroids unless contraindicated or not tolerated

AND

5 - Requested drug will not be used in combination with cyclophosphamide

Product Name: Lupkynis	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of biopsy-proven lupus nephritis

AND

2 - Prescribed by or in consultation with one of the following:

- Nephrologist
- Rheumatologist

- specialist in the treatment of lupus nephritis

AND

3 - Trial and failure, contraindication, or intolerance to concurrent use of mycophenolate with corticosteroids

AND

4 - Requested drug will be used in combination with mycophenolate and corticosteroids unless contraindicated or not tolerated

AND

5 - Requested drug will not be used in combination with cyclophosphamide

Product Name: Lupkynis	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - All plans

Approval Criteria

1 - Patient has demonstrated a positive response to therapy

2 . Revision History

Date	Notes
11/1/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-137862
Guideline Name	Mucosal Protectants
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Mugard, Episil, Oramagicrx	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of grade 3 or 4 mucositis due to chemotherapy and/or radiation (i.e. oral mucositis: severe pain, interferes with oral intake, oral ulceration, difficulty with speech and swallowing)

AND

2 - Both of the following:

2.1 Trial and failure or intolerance to ONE of any moisturizing salivation agents:

- Rinses / Mouthwashes (i.e. OTC sodium/sodium bicarbonate, OTC Biotene, OTC Oasis)
- Gel, Spray (i.e. OTC Biotene, OTC Mouthkote)

AND

2.2 Trial and failure or intolerance to ONE Muco-protectant with or without anesthetic agent [i.e., Mylanta, magic mouthwash (lidocaine/diphenhydramine/Mylanta)]

Product Name: Prothelial, Orafate, Silatrix	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of grade 3 or 4 mucositis due to chemotherapy and/or radiation (i.e. oral mucositis: severe pain, interferes with oral intake, oral ulceration, difficulty with speech and swallowing)

AND

2 - Both of the following:

2.1 Trial and failure or intolerance to ONE of any moisturizing salivation agents:

- Rinses / Mouthwashes (i.e. OTC sodium/sodium bicarbonate, OTC Biotene, OTC Oasis)
- Gel, Spray (i.e. OTC Biotene, OTC Mouthkote)

AND

2.2 Trial and failure or intolerance to ONE Muco-protectant with or without anesthetic agent [i.e., Mylanta, magic mouthwash (lidocaine/diphenhydramine/Mylanta)]

AND **3** - Trial and failure, contraindication or intolerance to ONE bioadhesive gel (i.e., Gelclair, Oramagic Rx, Mugard or Episil)

2 . Revision History

Date	Notes
12/15/2023	Update

Prior Authorization Guideline

Guideline ID	GL-129162
Guideline Name	Multiple Sclerosis
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Avonex, Extavia, Generic dimethyl fumarate, Generic fingolimod, Generic glatiramer acetate, Generic teriflunomide, Glatopa, Plegridy, Rebif	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Diagnosis of one of the following relapsing forms of multiple sclerosis:

- Relapsing-Remitting
- Active secondary progressive

- Relapsing-progressive

OR

1.2 Diagnosis of Clinically Isolated Syndrome (CIS) with a high probability of developing Clinically Definite MS (CDMS) (i.e. greater than or equal to 3 T2 white matter lesions or greater than or equal to 2 GdE lesions on MRI)

AND

2 - Drug will be self-administered at home

AND

3 - Drug will not be used in combination with another disease modifying therapy for multiple sclerosis

AND

4 - Prescribed by or in consultation with a neurologist or other expert in the treatment of multiple sclerosis

Product Name: Avonex, Extavia, Generic dimethyl fumarate, Generic fingolimod, Generic glatiramer acetate, Generic teriflunomide, Glatopa, Plegridy, Rebif	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - One of the following:

1.1 Diagnosis of one of the following relapsing forms of multiple sclerosis:

- Relapsing-Remitting
- Active secondary progressive

- Relapsing-progressive

OR

1.2 Diagnosis of Clinically Isolated Syndrome (CIS) with a high probability of developing Clinically Definite MS (CDMS) (i.e. greater than or equal to 3 T2 white matter lesions or greater than or equal to 2 GdE lesions on MRI)

AND

2 - Drug will be self-administered at home

AND

3 - Drug will not be used in combination with another disease modifying therapy for multiple sclerosis

AND

4 - Prescribed by or in consultation with a neurologist or other expert in the treatment of multiple sclerosis

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Avonex, Extavia, Generic dimethyl fumarate, Generic fingolimod, Generic glatiramer acetate, Generic teriflunomide, Glatopa, Plegridy, Rebif	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) by the treating neurologist documenting that within the past 12 months member has BOTH of the following:

- Relapsing form of multiple sclerosis
- Member is established on therapy

AND

2 - Drug will not be used in combination with another disease modifying therapy for multiple sclerosis

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Kesimpta, Mavenclad	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Diagnosis of one of the following relapsing forms of multiple sclerosis:

- Relapsing-Remitting
- Active secondary progressive
- Relapsing-progressive

OR

1.2 Diagnosis of Clinically Isolated Syndrome (CIS) with a high probability of developing Clinically Definite MS (CDMS) (i.e. greater than or equal to 3 T2 white matter lesions or greater than or equal to 2 GdE lesions on MRI)

AND

2 - Drug will be self-administered at home

AND

3 - Drug will not be used in combination with another disease modifying therapy for multiple sclerosis

AND

4 - One of the following:

4.1 Trial and failure (i.e., acute relapse or new lesion formation) while on one of the following:

- dimethyl fumarate
- fingolimod

OR

4.2 Contraindication, intolerance, or the inability to take BOTH of the following:

- dimethyl fumarate
- fingolimod

AND

5 - Prescribed by or in consultation with a neurologist or other expert in the treatment of multiple sclerosis

Product Name: Kesimpta, Mavenclad	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - One of the following:

1.1 Diagnosis of one of the following relapsing forms of multiple sclerosis:

- Relapsing-Remitting
- Active secondary progressive
- Relapsing-progressive

OR

1.2 Diagnosis of Clinically Isolated Syndrome (CIS) with a high probability of developing Clinically Definite MS (CDMS) (i.e. greater than or equal to 3 T2 white matter lesions or greater than or equal to 2 GdE lesions on MRI)

AND

2 - Drug will be self-administered at home

AND

3 - Drug will not be used in combination with another disease modifying therapy for multiple sclerosis

AND

4 - One of the following:

4.1 Trial and failure (i.e., acute relapse or new lesion formation) while on one of the following:

- dimethyl fumarate
- fingolimod

OR

4.2 Contraindication, intolerance, or the inability to take BOTH of the following:

- dimethyl fumarate

- fingolimod

AND

5 - Prescribed by or in consultation with a neurologist or other expert in the treatment of multiple sclerosis

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Kesimpta, Mavenclad	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) by the treating neurologist documenting that within the past 12 months member has BOTH of the following:

- Relapsing form of multiple sclerosis
- Member is established on therapy

AND

2 - Drug will not be used in combination with another disease modifying therapy for multiple sclerosis

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
10/5/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129645
Guideline Name	Myalept (Metreleptin)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name: Myalept	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of congenital or acquired generalized lipodystrophy

AND

2 - Have experienced metabolic changes (e.g. increased triglycerides or fasting blood glucoses) despite an adequate trial of dietary modification

AND

3 - Failure, intolerance, or contraindication to metformin

AND

4 - Failure, intolerance, or contraindication to at least one statin medication (e.g. atorvastatin, rosuvastatin)

Product Name: Myalept	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Myalept	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of congenital or acquired generalized lipodystrophy

AND

2 - Have experienced metabolic changes (e.g. increased triglycerides or fasting blood glucoses) despite an adequate trial of dietary modification

AND

3 - Failure, intolerance, or contraindication to metformin

AND

4 - Failure, intolerance, or contraindication to at least one statin medication (e.g. atorvastatin, rosuvastatin)

2 . Revision History

Date	Notes
10/6/2023	New program

Prior Authorization Guideline

Guideline ID	GL-127843
Guideline Name	Myrbetriq (mirabegron)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Myrbetriq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure to one of the following:

- trospium
- oxybutynin
- solifenacin
- tolterodine
- darifenacin

- fesoterodine

Product Name: Myrbetriq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Myrbetriq	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All Plans except IL and MN Plans

Approval Criteria

1 - Trial and failure to one of the following:

- trospium
- oxybutynin
- solifenacin
- tolterodine
- darifenacin
- fesoterodine

2 . Revision History

Date	Notes
8/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-135282
Guideline Name	New Indication Administrative Guideline
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Diagnosis	Drugs with a prior authorization requirement for which a guideline is unavailable, OR new FDA-approved indications which are not addressed in the existing drug-specific prior authorization guideline
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Prescribed medication is being used for a Food and Drug Administration (FDA)-approved indication

AND

1.1.2 Both of the following:

1.1.2.1 All components of the FDA approved indication are met (e.g., concomitant use, previous therapy requirements, age limitations, testing requirements, etc.)

AND

1.1.2.2 Prescribed medication will be used at a dose which is within FDA recommendations

OR

1.2 Meets the off-label administrative guideline criteria

AND

2 - (For nonpreferred medications only) Trial and failure or intolerance, or contraindication to at least 1 preferred alternative for the same indication if available

2 . Revision History

Date	Notes
11/27/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-143184
Guideline Name	Non-formulary Exceptions Administrative Guideline
Formulary	• Quartz

Guideline Note:

Effective Date:	2/15/2024

1 . Criteria

Product Name: Non-formulary drugs	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Both of the following:

1.1 One of the following:

1.1.1 Provider attests that it is medically necessary for the individual to receive that specific contraceptive

OR

1.1.2 Both of the following:

1.1.2.1 One of the following:

1.1.2.1.1 Paid claims or submission of medical records (e.g. chart notes) show there have been adequate trials of ALL appropriate therapeutic alternatives and there was (a) inadequate clinical response, (b) inappropriate clinical response, (c) intolerance or (d) allergy to those medications

OR

1.1.2.1.2 An exception to the formulary may be considered when ALL appropriate therapeutic alternatives have not been tried and there is documentation that ALL appropriate therapeutic alternatives will be (a) ineffective, (b) less effective or (c) will result in adverse effects

OR

1.1.2.1.3 An exception to the formulary may be considered when it is a situation that it is not clinically appropriate to have adequate trials of ALL therapeutic alternatives, such as the individual has complex medical conditions, would be subject to prolonged pain, or there is a risk of severe or significant adverse medical outcomes if there is significant delay in treating the condition AND one of the following were tried:

- At least four formulary alternatives in the same drug class as the requested medication
- If there are not four formulary alternatives in the same drug class, at least four formulary alternatives from three different drug classes (if available) when it is appropriate under the standards of acceptable medical practice for the treatment of the diagnosis to trial medications with different mechanisms of action
- No formulary alternative is appropriate to treat the patient's condition

AND

1.1.2.2 When there are prior authorization criteria for the drug class or therapeutic alternatives, an exception to the formulary should take into consideration those criteria and should not be less stringent for the non-formulary drug. An example would be phototherapy for biologics for psoriasis when requesting a non-formulary biologic for psoriasis.

AND

1.2 One of the following:

1.2.1 Requested drug is FDA-approved for the condition being treated

OR

1.2.2 If requested for an off-label indication, the off-label guideline approval criteria have been met.

OR

2 - For Illinois Plans only: Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who are established on nonpreferred therapy, will have coverage under their drug benefit with submission of medical records (e.g., chart notes) documenting symptom improvement or disease stability

2 . Revision History

Date	Notes
2/14/2024	Update Guideline

Prior Authorization Guideline

Guideline ID	GL-131427
Guideline Name	Non-Preferred Topical Steroids
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Trial and failure, contraindication, or intolerance of a preferred topical steroid in comparable potency and/or formulation

Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization-IL and MN Plans Only
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.	
Notes	*Members new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) must meet the initial criteria for coverage

Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN
Approval Criteria **1** - Trial and failure, contraindication, or intolerance of a preferred topical steroid in comparable potency and/or formulation	

2 . Revision History

Date	Notes
10/31/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129167
Guideline Name	Non-Sedating Antihistamine
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Generic desloratadine, Clarinex D (desloratadine/pseudoephedrine)	
Diagnosis	Allergic Rhinitis
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans
Approval Criteria	

1 - Diagnosis of allergic rhinitis

AND

2 - Trial and failure, contraindication, or intolerance to ALL of the following over the counter (OTC) agents:

- Cetirizine
- Fexofenadine
- Levocetirizine
- Loratadine

AND

3 - Trial and failure, contraindication, or intolerance to one nasal steroid* (e.g., fluticasone)

Notes	*Note: The nasal steroid criterion does not apply in the case of predict able situational exposures where nasal steroids would not be the best clinical choice or for children 12 years of age or younger.

Product Name: Generic desloratadine, Clarinex D (desloratadine/pseudoephedrine)	
Diagnosis	Allergic Rhinitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of allergic rhinitis

AND

2 - Trial and failure, contraindication, or intolerance to ALL of the following over the counter (OTC) agents:

- Cetirizine
- Fexofenadine

- Levocetirizine
- Loratadine

AND

3 - Trial and failure, contraindication, or intolerance to one nasal steroid* (e.g., fluticasone)

Notes	*Note: The nasal steroid criterion does not apply in the case of predict able situational exposures where nasal steroids would not be the best clinical choice or for children 12 years of age or younger.

Product Name: Generic desloratadine, Clarinex D (desloratadine/pseudoephedrine)	
Diagnosis	Urticarial Disease
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of urticarial disease

AND

2 - Trial and failure, contraindication, or intolerance to ALL of the following over the counter (OTC) agents:

- Cetirizine
- Fexofenadine
- Levocetirizine
- Loratadine

Product Name: Generic desloratadine, Clarinex D (desloratadine/pseudoephedrine)	
Diagnosis	Urticarial Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of urticarial disease

AND

2 - Trial and failure, contraindication, or intolerance to ALL of the following over the counter (OTC) agents:

- Cetirizine
- Fexofenadine
- Levocetirizine
- Loratadine

Product Name: Generic desloratadine, Clarinex D (desloratadine/pseudoephedrine)	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Prescriber provides clinical documentation from the past 12 months that the member is continuing therapy on the requested drug

2 . Revision History

Date	Notes
9/27/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-132813
Guideline Name	Non-solid Dosage Forms
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Famotidine Suspension 40 mg/5mL, Generic Naproxen Suspension 125 mg/ 5mL, Generic Sevelamer packet, Brand Valsartan solution 4 mg, mL, Atorvaliq, Generic Baclofen solution 5 mg/5mL, Thyquidity, Flolipid, Zonisade, Norliqva, Katerzia, generic esomeprazole gran, Nexium gran, generic lansoprazole ODT, Prilosec Powder, Aspruzyo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN plans only
Approval Criteria **1** - Unable to tolerate solid dose form	

OR

2 - Age is less than 12 years old*

OR

3 - Minnesota Plans Only - Member has stage four metastatic cancer and the requested drug is being used as supportive care to treat symptoms directly related to their cancer or chemotherapy regimen

Notes	*Age edit does not apply to Zonisamide oral suspension because Zonisamide is only approved for age 16 and older.

Product Name: Generic Famotidine Suspension 40 mg/5mL, Generic Naproxen Suspension 125 mg/ 5mL, Generic Sevelamer packet, Brand Valsartan solution 4 mg, mL, Atorvaliq, Generic Baclofen solution 5 mg/5mL, Thyquidity, Flolipid, Zonisade, Norliqva, Katerzia, generic esomeprazole gran, Nexium gran, generic lansoprazole ODT, Prilosec Powder, Aspruzyo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN plans only

Approval Criteria

1 - Clinical documentation from the previous 12 months demonstrating a positive response to therapy

Notes	*Age edit does not apply to Zonisamide oral suspension because Zonisamide is only approved for age 16 and older.

Product Name: Generic Famotidine Suspension 40 mg/5mL, Generic Naproxen Suspension 125 mg/ 5mL, Generic Sevelamer packet, Brand Valsartan solution 4 mg, mL, Atorvaliq, Generic Baclofen solution 5 mg/5mL, Thyquidity, Flolipid, Zonisade, Norliqva, Katerzia, generic esomeprazole gran, Nexium gran, generic lansoprazole ODT, Prilosec Powder, Aspruzyo	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria **1** - Unable to tolerate solid dose form **OR** **2** - Age is less than 12 years old*

Notes	*Age edit does not apply to Zonisamide oral suspension because Zonisamide is only approved for age 16 and older.

2 . Revision History

Date	Notes
11/28/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131403
Guideline Name	Nonpreferred Bowel Preparations
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Clenpiq, Plenvu, Sodium sulfate/Potassium sulfate/Magnesium sulfate	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only
Approval Criteria **1** - Trial and failure, contraindication or intolerance to a preferred bowel preparation	

Product Name: Clenpiq, Plenvu, Sodium sulfate/Potassium sulfate/Magnesium sulfate	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Clenpiq, Plenvu, Sodium sulfate/Potassium sulfate/Magnesium sulfate	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Trial and failure, contraindication or intolerance to a preferred bowel preparation

2 . Revision History

Date	Notes
10/24/2023	New program

Prior Authorization Guideline

Guideline ID	GL-131426
Guideline Name	Nonpreferred insulin
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Apidra, Humalog Mix 50:50	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of diabetes mellitus

AND

2 - Trial and failure, contraindication or intolerance to use of insulin aspart (Novolog, Novolog Mix) including dose adjustments

Product Name: Apidra, Humalog Mix 50:50	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Apidra, Humalog Mix 50:50	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of diabetes mellitus

AND

2 - Trial and failure, contraindication or intolerance to use of insulin aspart (Novolog, Novolog Mix) including dose adjustments

2 . Revision History

Date	Notes
10/9/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131404
Guideline Name	Nonsteroidal Anti-inflammatory (NSAID) Combinations
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Ibuprofen/famotidine, Naproxen/esomeprazole	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of osteoarthritis, rheumatoid arthritis, or other pain-related condition requiring chronic NSAID use

AND

2 - Diagnosis of current or past gastric ulcer

AND

3 - Trial and failure after an adequate trial of the equivalent NSAID and histamine blocker or proton pump inhibitor as separate products

AND

4 - Prescriber supplies published literature to support the requested combination product will produce different clinical results than using the equivalent agents as separate products

OR

5 - For Minnesota Plans Only

5.1 Diagnosis of stage four metastatic cancer and the requested drug is being used to treat cancer-related pain

Product Name: Generic Ibuprofen/famotidine, Naproxen/esomeprazole	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Notes	*Members new to the plan (as evidenced by coverage effective date o f less than or equal to 90 days) must meet the initial criteria for covera ge

Product Name: Generic Ibuprofen/famotidine, Naproxen/esomeprazole	
Approval Length	12/31/2039

Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of osteoarthritis, rheumatoid arthritis, or other pain-related condition requiring chronic NSAID use

AND

2 - Diagnosis of current or past gastric ulcer

AND

3 - Trial and failure after an adequate trial of the equivalent NSAID and histamine blocker or proton pump inhibitor as separate products

AND

4 - Prescriber supplies published literature to support the requested combination product will produce different clinical results than using the equivalent agents as separate products

2 . Revision History

Date	Notes
10/27/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129157
Guideline Name	Northera (droxidopa)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name: Generic Droxidopa*	
Approval Length	See note*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of symptomatic neurogenic orthostatic hypotension caused by primary autonomic failure (Parkinson's disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, or nondiabetic autonomic neuropathy

AND

2 - Prescribed by, or in consultation with, a Neurologist

AND

3 - Trial and failure, contraindication, or intolerance to both midodrine and fludrocortisone

Notes	* 2 months with partial fill (max 15 days/prescription)

Product Name: Generic Droxidopa	
Approval Length	12/31/2039
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Prescriber provides clinical documentation from the previous two months of demonstrated ongoing beneficial response to therapy.

Product Name: Generic Droxidopa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of symptomatic neurogenic orthostatic hypotension caused by primary autonomic failure (Parkinson's disease, multiple system atrophy, and pure autonomic failure), dopamine beta-hydroxylase deficiency, or nondiabetic autonomic neuropathy

AND

2 - Prescribed by, or in consultation with, a Neurologist

AND

3 - Trial and failure, contraindication, or intolerance to both midodrine and fludrocortisone

Product Name: Generic Droxidopa	
Approval Length	12/31/2039
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Prescriber provides clinical documentation from the previous twelve months of demonstrated ongoing beneficial response to therapy.

2 . Revision History

Date	Notes
9/20/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-137266
Guideline Name	Nucala (mepolizumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Nucala	
Diagnosis	Eosinophilic Asthma
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans
Approval Criteria	

1 - Medication must be self-administered

AND

2 - Diagnosis of eosinophilic asthma

AND

3 - Submission of medical records (e.g., chart notes) documenting that the blood eosinophil count is greater than or equal to 150 cells/mm3

AND

4 - Other causes of eosinophilia such as hypereosinophilic syndromes, neoplastic disease, or parasitic disease have been ruled out

AND

5 - One of the following:

5.1 Symptoms are not well controlled or poorly controlled (Table 1) despite adherence* to a greater than or equal to a 3-month trial of medium to high-dose inhaled corticosteroids in combination with a long-acting bronchodilator, long-acting muscarinic antagonist, or leukotriene modifier

OR

5.2 Member has an intolerance to medium to high dose inhaled corticosteroids in combination with a long-acting bronchodilator or leukotriene modifier. Exceptions based on adverse effects from medium to high dose ICS or comorbid conditions increasing long-term risks of adverse effects from high dose ICS or oral corticosteroids include one of the following:

- Cataracts in members older than 40 years of age
- Glaucoma
- Recurrent thrush
- Dysphonia
- Growth inhibition, after consultation with an endocrinologist

- Diagnosis of osteoporosis, whose treatment is resistant to FDA approved osteoporosis treatment

AND

6 - Member is 6 years of age or older

AND

7 - Prescribed by or in consultation with an asthma specialist (i.e., allergist, immunologist, pulmonologist)

Notes	*Adherence to treatment is defined as a medication possession ratio (MPR) greater than or equal to 70%, based on the previous 120 days o f prescription claims **IL-5 inhibitor drugs in combination with omalizumab will be consider ed on a case-by-case basis if each individual agent with combination high dose ICS/LABA did not control symptoms . Tezepelumab, in combination with other biologics, has not been studied and coverage is not allowed except in extenuating circumstances (applies to both eosinophilic or non-eosinophilic asthma populations)

Product Name: Nucala	
Diagnosis	Eosinophilic Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Medication must be self-administered

AND

2 - Diagnosis of eosinophilic asthma

AND

3 - Submission of medical records (e.g., chart notes) documenting that the blood eosinophil count is greater than or equal to 150 cells/mm3

AND

4 - Other causes of eosinophilia such as hypereosinophilic syndromes, neoplastic disease, or parasitic disease have been ruled out

AND

5 - One of the following:

5.1 Symptoms are not well controlled or poorly controlled (Table 1) despite adherence* to a greater than or equal to a 3-month trial of medium to high-dose inhaled corticosteroids in combination with a long-acting bronchodilator, long-acting muscarinic antagonist, or leukotriene modifier

OR

5.2 Member has an intolerance to medium to high dose inhaled corticosteroids in combination with a long-acting bronchodilator or leukotriene modifier. Exceptions based on adverse effects from medium to high dose ICS or comorbid conditions increasing long-term risks of adverse effects from high dose ICS or oral corticosteroids include one of the following:

- Cataracts in members older than 40 years of age
- Glaucoma
- Recurrent thrush
- Dysphonia
- Growth inhibition, after consultation with an endocrinologist
- Diagnosis of osteoporosis, whose treatment is resistant to FDA approved osteoporosis treatment

AND

6 - Member is 6 years of age or older

AND

7 - Prescribed by or in consultation with an asthma specialist (i.e., allergist, immunologist, pulmonologist)

Notes	*Adherence to treatment is defined as a medication possession ratio (MPR) greater than or equal to 70%, based on the previous 120 days o f prescription claims ** IL-5 inhibitor drugs in combination with omalizumab will be consider ed on a case-by-case basis if each individual agent with combination high dose ICS/LABA did not control symptoms . Tezepelumab, in combination with other biologics, has not been studied and coverage is not allowed except in extenuating circumstances (applies to both eosinophilic or non-eosinophilic asthma populations)

Product Name: Nucala	
Diagnosis	Eosinophilic Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member has responded to therapy as evidenced by one of the following:

- Decreased frequency of use of, or ability to lower the chronic daily dose, of oral corticosteroids to treat/prevent exacerbations
- Decreased frequency of use of unscheduled emergency department/urgent care visits for exacerbations
- Reduction in reported symptoms such as chest tightness, coughing, shortness of breath, nocturnal awakenings, nasal congestion, obstruction, etc.
- Sustained (at least six months) improvement in Asthma Control Test (ACT) scores

Notes	**Continuation of case-by case-approved IgE inhibitor and IL-5 inhibit or, or tezepelumab combination therapy will only be considered if ICS/ LABA therapy was also continued AND there was reduction in oral ste roid dose, exacerbations, or hospitalizations

Product Name: Nucala	
Diagnosis	Eosinophilic Granulomatosis with Polyangitis
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Medication must be self-administered

AND

2 - Diagnosis of eosinophilic granulomatosis with polyangitis

AND

3 - Disease is one of the following:

- Relapsed
- Refractory

AND

4 - All of the following:

4.1 Blood eosinophil level greater than or equal to 10% or an absolute eosinophil count greater than 1000 cells/µL with other causes ruled out (i.e. hypereosinophilic syndromes, neoplastic disease, or parasitic disease)

AND

4.2 At least TWO of the following organ systems or features of EGPA disease:

4.2.1 Histopathological evidence of one of the following:

- eosinophilic vasculitis (i.e. bleeding under skin, red rash, petechiae, fibrinoid degeneration, blood clots)

- perivascular eosinophilic infiltration (i.e. inflammatory cells around blood vessels, lichenoid infiltration)
- eosinophil-rich granulomatosis inflammation (i.e. nodules, thick aggregation of histiocytes)

OR

4.2.2 Neuropathy (i.e. mono or polyneuropathy, mononeuritis multiplex)

OR

4.2.3 Pulmonary infiltrates (i.e. asthma, chronic pneumonia, hemoptysis, cough)

OR

4.2.4 Sino-nasal abnormality (i.e. sinusitis, allergic rhinitis, polyposis)

OR

4.2.5 Cardiomyopathy (i.e. heart failure, myocarditis, pericarditis, subendocardial fibrosis)

OR

4.2.6 Glomerulonephritis (i.e. hematuria, red cell casts, proteinuria)

OR

4.2.7 Alveolar hemorrhage (by bronchoalveolar lavage)

OR

4.2.8 Palpable purpura (i.e. skin nodules, urticarial rash, digital ischemia)

OR

4.2.9 Positive antineutrophil cytoplasmic antibody [ANCA]

AND

5 - Member is 18 years of age or older

AND

6 - Trial and failure, intolerance, or contraindication to an adequate 3-month trial of both of the following:

- prednisone
- At least ONE additional immunosuppressive agent (i.e. cyclophosphamide, azathioprine, or methotrexate)

AND

7 - Submission of medical records (e.g., chart notes) documenting baseline disease severity assessment with an objective measure/tool (i.e. chronic oral corticosteroid dose, number of intermittent steroid bursts, Birmingham Vasculitis Activity Score BVAS, number urgent care, emergency room visits or hospitalizations etc.)

AND

8 - Prescribed by, or in consultation with, a provider experienced in the treatment EGPA (i.e. Allergist, Pulmonologist, or Rheumatologist)

Product Name: Nucala	
Diagnosis	Eosinophilic Granulomatosis with Polyangitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Medication must be self-administered

AND

2 - Diagnosis of eosinophilic granulomatosis with polyangitis

AND

3 - Disease is one of the following:

- Relapsed
- Refractory

AND

4 - All of the following:

4.1 Blood eosinophil level greater than or equal to 10% or an absolute eosinophil count greater than 1000 cells/µL with other causes ruled out (i.e. hypereosinophilic syndromes, neoplastic disease, or parasitic disease)

AND

4.2 At least TWO of the following organ systems or features of EGPA disease:

4.2.1 Histopathological evidence of one of the following:

- eosinophilic vasculitis (i.e. bleeding under skin, red rash, petechiae, fibrinoid degeneration, blood clots)
- perivascular eosinophilic infiltration (i.e. inflammatory cells around blood vessels, lichenoid infiltration)
- eosinophil-rich granulomatosis inflammation (i.e. nodules, thick aggregation of histiocytes)

OR

4.2.2 Neuropathy (i.e. mono or polyneuropathy, mononeuritis multiplex)

OR

4.2.3 Pulmonary infiltrates (i.e. asthma, chronic pneumonia, hemoptysis, cough)

OR

4.2.4 Sino-nasal abnormality (i.e. sinusitis, allergic rhinitis, polyposis)

OR

4.2.5 Cardiomyopathy (i.e. heart failure, myocarditis, pericarditis, subendocardial fibrosis)

OR

4.2.6 Glomerulonephritis (i.e. hematuria, red cell casts, proteinuria)

OR

4.2.7 Alveolar hemorrhage (by bronchoalveolar lavage)

OR

4.2.8 Palpable purpura (i.e. skin nodules, urticarial rash, digital ischemia)

OR

4.2.9 Positive antineutrophil cytoplasmic antibody [ANCA]

AND

5 - Member is 18 years of age or older

AND

6 - Trial and failure, intolerance, or contraindication to an adequate 3-month trial of both of the following:

- prednisone
- At least ONE additional immunosuppressive agent (i.e. cyclophosphamide, azathioprine, or methotrexate)

AND

7 - Submission of medical records (e.g., chart notes) documenting baseline disease severity assessment with an objective measure/tool (i.e. chronic oral corticosteroid dose, number of intermittent steroid bursts, Birmingham Vasculitis Activity Score BVAS, number urgent care, emergency room visits or hospitalizations etc.)

AND

8 - Prescribed by, or in consultation with, a provider experienced in the treatment EGPA (i.e. Allergist, Pulmonologist, or Rheumatologist)

Product Name: Nucala	
Diagnosis	Eosinophilic Granulomatosis with Polyangitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12

months the member is showing a response to therapy based upon at least ONE of the following objective measures:

1.1 Birmingham Vasculitis Activity Score (BVAS version 3) improvement from baseline (i.e. a clinically significant score improvement for vasculitis is 16 units or greater)

OR

1.2 Reduction in the total daily dose of prednisolone/prednisone (50-75% reduction in dose from baseline) or reduction in intermittent steroid bursts

OR

1.3 Improvement in the duration of remission or improvement in rate of relapses, urgent care, emergency room visits or hospitalizations

Product Name: Nucala	
Diagnosis	Hypereosinophilic Syndrome
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Medication must be self-administered

AND

2 - Diagnosis of hypereosinophilic syndrome for greater than or equal to 6 months without an identifiable non-hematologic secondary cause (i.e. cancer, imatinib-sensitive conditions, etc.)

AND

3 - Blood eosinophil count of greater than or equal to 1,000 cells/mc on at least two occasions

AND

4 - Trial and failure, contraindication, or intolerance to the use of at least one steroid-sparing preventive treatments for at least 4 weeks (e.g., hydroxyurea, interferon-alfa, cyclosporine, etc.)

AND

5 - Prescribed by or in consultation with one of the following:

- hematologist
- allergist
- other specialist in the treatment of Hypereosinophilic Syndrome

Product Name: Nucala	
Diagnosis	Hypereosinophilic Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Medication must be self-administered

AND

2 - Diagnosis of hypereosinophilic syndrome for greater than or equal to 6 months without an identifiable non-hematologic secondary cause (i.e. cancer, imatinib-sensitive conditions, etc.)

AND

3 - Blood eosinophil count of greater than or equal to 1,000 cells/mc on at least two occasions

AND

4 - Trial and failure, contraindication, or intolerance to the use of at least one steroid-sparing preventive treatments for at least 4 weeks (e.g., hydroxyurea, interferon-alfa, cyclosporine, etc.)

AND

5 - Prescribed by or in consultation with one of the following:

- hematologist
- allergist
- other specialist in the treatment of Hypereosinophilic Syndrome

Product Name: Nucala	
Diagnosis	Hypereosinophilic Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting the member's response to therapy within the past 12 months including individual improvements in functional status

Notes	** Continuation of case-by case-approved IgE inhibitor and IL-5 inhibit or, or tezepelumab combination therapy will only be considered if ICS/ LABA therapy was also continued AND there was reduction in oral ste roid dose, exacerbations, or hospitalizations

Product Name: Nucala	
Diagnosis	Nasal Polyps
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Medication must be self-administered

AND

2 - Diagnosis of chronic rhinosinusitis with nasal polyposis including all of the following:

- At least eight weeks of moderate to severe nasal congestion/blockage/obstruction OR diminished sense of smell or rhinorrhea
- Submission of medical records (e.g., chart notes) documenting nasal polyps by direct exam, endoscopy, or sinus CT scan (i.e. nasal polyp score five out of eight)
- No chronic or acute infection requiring systemic treatment within two weeks before therapy initiation

AND

3 - One of the following:

- Trial and failure, contraindication, or intolerance to oral corticosteroids for nasal polyps
- Prior to surgery for nasal polyps greater than six months ago
- Trial and failure, contraindication, or intolerance to 2 or more nasal steroid sprays (i.e. failed two nasal sprays)
- Trial and failure, contraindication, or intolerance to IM injections for polyps with one previous nasal spray

AND

4 - Will be used in combination with a nasal corticosteroid medication

AND

5 - Will not be used in combination with other biologics (e.g., dupilumab, omalizumab, benralizumab, or reslizumab)

AND

6 - Prescribed by, or in consultation with a specialist experienced in the treatment of nasal polyps (i.e., otolaryngologist, allergist)

Product Name: Nucala	
Diagnosis	Nasal Polyps
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Medication must be self-administered

AND

2 - Diagnosis of chronic rhinosinusitis with nasal polyposis including all of the following:

- At least eight weeks of moderate to severe nasal congestion/blockage/obstruction OR diminished sense of smell or rhinorrhea
- Submission of medical records (e.g., chart notes) documenting nasal polyps by direct exam, endoscopy, or sinus CT scan (i.e. nasal polyp score five out of eight)
- No chronic or acute infection requiring systemic treatment within two weeks before therapy initiation

AND

3 - One of the following:

- Trial and failure, contraindication, or intolerance to oral corticosteroids for nasal polyps
- Prior to surgery for nasal polyps greater than six months ago
- Trial and failure, contraindication, or intolerance to 2 or more nasal steroid sprays (i.e. failed two nasal sprays)
- Trial and failure, contraindication, or intolerance to IM injections for polyps with one previous nasal spray

AND

4 - Will be used in combination with a nasal corticosteroid medication

AND

5 - Will not be used in combination with other biologics (e.g., dupilumab, omalizumab, benralizumab, or reslizumab)

AND

6 - Prescribed by, or in consultation with a specialist experienced in the treatment of nasal polyps (i.e., otolaryngologist, allergist)

Notes	**Continuation of case-by case-approved IgE inhibitor and IL-5 inhibit or, or tezepelumab combination therapy will only be considered if ICS/ LABA therapy was also continued AND there was reduction in oral ste roid dose, exacerbations, or hospitalizations

Product Name: Nucala	
Diagnosis	Nasal Polyps
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status

2 . Background

Benefit/Coverage/Program Information

TABLE 1 - Outcome Measure values for uncontrolled asthma

Measure	Not Well Controlled	Very Poorly Controlled

Baseline symptoms (outside of exacerbation)	Greater than 2 days/week	Throughout the day
Nighttime awakening	1-3 times/week	Greater than or equal to 4 times/week
Interference with normal activity	Some limitation	Extremely limited
Short acting beta agonist use for symptom control	Greater than 2 days/week	Several times per day
FEV1	60-80% predicted or personal best	Less than 60% predicted or personal best
Asthma exacerbations requiring oral steroids greater than or equal to 2 times in the past year	Yes	Yes
Asthma Control Test (ACT)	16 - 19	Less than or equal to 15

3 . Definitions

Definition	Description
Relapsing EGPA	At least one confirmed EGPA relapse while the person was on prednisolone dose of greater than or equal to 7.5 mg (or equivalent) within the past 2 years that required an increase in oral corticosteroid dose, initiation/increased immunosuppressive therapy dose, or hospitalization.
Refractory EGPA	1) Failure to attain remission (BVAS = 0 and oral steroid dose less than or equal to 7.5 mg/day prednisolone or equivalent) within the last 6 months following induction treatment with a standard regimen (e.g., cyclophosphamide, methotrexate, azathioprine, mycophenolate, high dose steroids) administered for at least 3 months OR 2) within 6 months prior to initiation, recurrence of symptoms of EGPA while tapering oral steroids, occurring at any dose level greater than or equal to 7.5 mg/day prednisolone or equivalent.
Failure of an immunosuppressant	Defined as EGPA symptoms are not resolving or flare occurring with a prednisone dose change, hospitalization, OR

	contraindications/clinical inappropriateness to immunosuppressants (i.e., liver disease, fertility etc.).

4 . Revision History

Date	Notes
12/1/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131415
Guideline Name	Nuplazid (Pimavanserin Tartrate)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan who are being treated for Parkinson's disease psychosis and are established on therapy will have coverage under their drug benefit with documentation of symptom improvement or disease stability.

1 . Criteria

Product Name: Nuplazid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only
Approval Criteria **1** - Diagnosis of Parkinson's disease psychosis with documented hallucinations or delusions	

AND

2 - Drug is prescribed by, or in consultation with, a Neurologist

AND

3 - Dose reductions and alterations in scheduling of dopaminergic agents led to increased Parkinson's symptoms

Product Name: Nuplazid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Nuplazid	
Approval Length	12/31/2039
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of Parkinson's disease psychosis with documented hallucinations or delusions

AND

2 - Drug is prescribed by, or in consultation with, a Neurologist

AND

3 - Dose reductions and alterations in scheduling of dopaminergic agents led to increased Parkinson's symptoms

2 . Revision History

Date	Notes
10/9/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129176
Guideline Name	Nuzyra (omadacycline)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Nuzyra	
Approval Length	1 Time Approval
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Member has been receiving drug during hospitalization and needs to complete the course of therapy as an outpatient

OR

1.2 ALL of the following:

1.2.1 Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- Outpatient treatment of bacterial resistant strains
- Report of susceptibilities resistant to preferred alternatives

AND

1.2.2 Prescribed by or in consultation with an Infectious Disease Specialist

Product Name: Nuzyra	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL Plans*

Approval Criteria

1 - One of the following:

1.1 Member has been receiving drug during hospitalization and needs to complete the course of therapy as an outpatient

OR

1.2 ALL of the following:

1.2.1 Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- Outpatient treatment of bacterial resistant strains
- Report of susceptibilities resistant to preferred alternatives

AND

1.2.2 Prescribed by or in consultation with an Infectious Disease Specialist

OR

1.3 The requested FDA approved drug is being used for the long-term treatment of tick-borne disease

Notes	*Members who are established on therapy will have coverage under t heir drug benefit for the remainder of the current treatment course *Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and were not previously approved for c overage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through reauthorization criteria

Product Name: Nuzyra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

AND

2 - Drug is being used for the long-term treatment of tick borne disease

Notes	*Members who are established on therapy will have coverage under t heir drug benefit for the remainder of the current treatment course *Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and were not previously approved for c overage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through reauthorization criteria

Product Name: Nuzyra

Approval Length	12 month(s)
Guideline Type	Prior Authorization - MN Plans*

Approval Criteria

1 - One of the following:

1.1 Member has been receiving drug during hospitalization and needs to complete the course of therapy as an outpatient

OR

1.2 ALL of the following:

1.2.1 Submission of medical records (e.g., chart notes) documenting BOTH of the following:

- Outpatient treatment of bacterial resistant strains
- Report of susceptibilities resistant to preferred alternatives

AND

1.2.2 Prescribed by or in consultation with an Infectious Disease Specialist

Notes	*Members who are established on therapy will have coverage under t heir drug benefit for the remainder of the current treatment course *Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and were not previously approved for c overage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through reauthorization criteria

2 . Revision History

Date	Notes
9/20/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131406
Guideline Name	Ocaliva (obeticholic acid)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name: Ocaliva	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of primary biliary cholangitis

AND

2 - Alkaline phosphatase level > 1.6 times the upper limit of normal (ULN) OR total bilirubin between 1-2 times the ULN

AND

3 - Obeticholic acid will be used in combination with ursodeoxycholic acid (UDCA or ursodiol) OR there is trial and failure, contraindication or intolerance to ursodeoxycholic acid

AND

4 - Person does not have compensated cirrhosis with portal hypertension or a history of decompensated cirrhosis

Product Name: Ocaliva	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Ocaliva	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of primary biliary cholangitis

AND

2 - Alkaline phosphatase level > 1.6 times the upper limit of normal (ULN) OR total bilirubin between 1-2 times the ULN

AND

3 - Obeticholic acid will be used in combination with ursodeoxycholic acid (UDCA or ursodiol) OR there is trial and failure, contraindication or intolerance to ursodeoxycholic acid

AND

4 - Person does not have compensated cirrhosis with portal hypertension or a history of decompensated cirrhosis

2 . Revision History

Date	Notes
10/9/2023	New program

Prior Authorization Guideline

Guideline ID	GL-135255
Guideline Name	Off Label Administrative
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: A drug used for an off-label indication or non-FDA approved indication	
Diagnosis	Off-label indication
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis is supported as a use in American Hospital Formulary Service Drug Information (AHFS DI)

OR

1.2 Diagnosis is supported in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of IIb or better (see DRUGDEX Strength of Recommendation table in Background section)

OR

1.3 Provider submits two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

AND

2 - ONE of the following:

2.1 Trial and failure, contraindication or intolerance to an adequate trial of all formulary and/or over the counter (OTC) alternatives

OR

2.2 (Minnesota plans only) person with stage four metastatic cancer and the requested drug is being used as supportive care to treat symptoms directly related to their cancer or chemotherapy regimen

OR

2.3 (Illinois Plans only) The requested FDA approved drug is being used for the long-term treatment of tick-borne disease

2 . Background

Clinical Practice Guidelines

DRUGDEX Strength of Recommendation

Class	Recommendation	Description
Class I	Recommended	The given test or treatment has been proven useful, and should be performed or administered.
Class IIa	Recommended, In Most Cases	The given test or treatment is generally considered to be useful, and is indicated in most cases.
Class IIb	Recommended, in Some Cases	The given test or treatment may be useful, and is indicated in some, but not most, cases.
Class III	Not Recommended	The given test or treatment is not useful, and should be avoided
Class Indeterminate	Evidence Inconclusive	

NCCN Categories of Evidence and Consensus [A]

Category	Level of Consensus
1	Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
2A	Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

Lexi-Drugs: Strength of Recommendation for Inclusion in Lexi-Drugs for Oncology Off-Label Use and Level of Evidence Scale for Oncology Off-Label Use [5] Strength of Recommendation for Inclusion

Strong (for proposed off-label use)	The evidence persuasively supports the off-label use (ie, Level of Evidence A).

Equivocal (for proposed off-label use)	The evidence to support the off-label use is of uncertain clinical significance (ie, Level of Evidence B, C). Additional studies may be necessary to further define the role of this medication for the off-label use.
Against proposed off-label use	The evidence either advocates against the off-label use or suggests a lack of support for the off-label use (independent of Level of Evidence). Additional studies are necessary to define the role of this medication for the off-label use.

Level of Evidence Scale for Oncology Off-Label Use

A	**Consistent evidence from well-performed randomized, controlled trials or overwhelming evidence of some other form (eg, results of the introduction of penicillin treatment) to support off-label use. Further research is unlikely to change confidence in the estimate of benefit.**
B	**Evidence from randomized, controlled trials with important limitations (eg, inconsistent results, methodologic flaws, indirect, imprecise); or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on confidence in the estimate of benefit and risk and may change the estimate.**
C	**Evidence from observational studies (eg, retrospective case series/reports providing significant impact on patient care); unsystematic clinical experience; or potentially flawed randomized, controlled trials (eg, when limited options exist for condition). Any estimate of effect is uncertain.**
G	**Use has been substantiated by inclusion in at least one evidence-based or consensus-based clinical practice guideline.**

3 . Revision History

Date	Notes
12/8/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-139181
Guideline Name	Omnipod Insulin Delivery System
Formulary	• Quartz

Guideline Note:

Effective Date:	1/19/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Omnipod Dash, Omnipod 5	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Prescribed by or in consultation with an Endocrinologist or other provider with expertise in the management of diabetes (e.g., Certified Diabetic Educator [CDE])

AND

2 - One of the following:

2.1 Diagnosis of type 1 diabetes mellitus or other type of insulin-deficient diabetes

OR

2.2 Both of the following:

2.2.1 Diagnosis of gestational diabetes

AND

2.2.2 Member is on an intensive insulin therapy regimen of at least 3 insulin injections per day with frequent self-adjustments of insulin dose

OR

2.3 All of the following:

2.3.1 Diagnosis of type 2 diabetes mellitus

AND

2.3.2 Evidence of adherence to an intensive insulin therapy regimen with at least three insulin injections per day, requiring frequent self-adjustments of insulin for at least 6 months

AND

2.3.3 At least ONE of the following criteria while on the intensive insulin therapy regimen:

- Hemoglobin A1c greater than 7%

• Recurrent hypoglycemia (less than 70mg/dL) • Dawn phenomenon (recurrent morning FBG greater than 200 mg/dL) • History of severe glycemic excursions • Fluctuations in blood sugar before mealtimes	
Notes	QL = 10 cartridges per 30 days

Product Name: Omnipod Dash, Omnipod 5	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Member has been evaluated within the past 12 months by an Endocrinologist or other diabetes specialist **AND** **2** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the pump	
Notes	QL = 10 cartridges per 30 days

2 . Revision History

Date	Notes
1/18/2024	Update Guideline

Prior Authorization Guideline

Guideline ID	GL-134592
Guideline Name	Opioid Risk Management Program 7 Day Opioid First Fill Exception
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: all opioids, including opioid containing cold products	
Approval Length	14 Day(s)
Guideline Type	DUR - Reject 88: Excd 7DS, review CDC guidelines, use lowest effective dose and shortest duration at start. Submit O/R code.

Approval Criteria

1 - One of the following:

- Long-term care resident
- Receiving hospice, palliative, or other end-of-life care
- Treatment of cancer-related pain or sickle cell-related pain

- Prescriber attests that the current prescription is a continuation of a stable, on-going opioid treatment regimen

2 . Revision History

Date	Notes
11/27/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-134593
Guideline Name	Opioid Risk Management Program: Opioid Concurrent Use Edit
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: all opioids, including opioid containing cold products	
Diagnosis	Opioid Dependency Stopped
Approval Length	12 month(s)
Guideline Type	DUR - Reject 88: Buprenorphine Hx:Call MD,Enter O/R. Co-prescribe Naloxone for safety.

Approval Criteria

1 - Prescriber attests that the person has stopped opioid dependency treatment with a buprenorphine containing drug and is resuming other opioid treatment

Product Name: all opioids, including opioid containing cold products

Diagnosis	Opioid Dependency Continued
Approval Length	1 fill (14 days)
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber attests that the person is continuing opioid dependency treatment with a buprenorphine containing drug but requires acute opioid treatment

2 . Revision History

Date	Notes
11/27/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-134594
Guideline Name	Opioid Risk Management: Opioid dose greater than 120 Morphine Milligram Equivalents (MME)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: all opioids, including opioid containing cold products	
Approval Length	12/31/2039
Guideline Type	DUR - Reject 88: MED 120mg Exceeded; Ttl MME MED <Total calculated cumulative MED >MG TO O/R, ENTER PSS CODE OR MALL HD

Approval Criteria

1 - One of the following:

- Long-term care resident
- Receiving hospice, palliative, or other end of life care
- Treatment of cancer-related pain

- Treatment of sickle cell-related pain

Product Name: all opioids, including opioid containing cold products	
Approval Length	12 month(s)
Guideline Type	DUR - Reject 88: MED 120mg Exceeded; Ttl MME MED <Total calculated cumulative MED >MG TO O/R, ENTER PSS CODE OR MALL HD

Approval Criteria

1 - All of the following:

- Prescriber states the opioid dose requested is medically necessary
- Documentation that the state prescription drug monitoring program (PDMP) site has been checked in the past month
- Documentation of a current pain contract
- Documentation that use of naloxone has been discussed
- Documentation of urine compliance screen in the previous 12 months

Product Name: all opioids, including opioid containing cold products	
Approval Length	14 Day(s)
Guideline Type	DUR - Reject 88: MED 120mg Exceeded; Ttl MME MED <Total calculated cumulative MED >MG TO O/R, ENTER PSS CODE OR MALL HD

Approval Criteria

1 - Person is changing medications and the new medication regimen does not exceed 120 MME

Product Name: all opioids, including opioid containing cold products	
Approval Length	3 month(s)
Guideline Type	DUR - Reject 88: MED 120mg Exceeded; Ttl MME MED <Total calculated cumulative MED >MG TO O/R, ENTER PSS CODE OR MALL HD

Approval Criteria

1 - Member discharged from an inpatient stay after a severe, acute trauma with ALL of the following:

- Prescriber states the opioid dose requested is medically necessary
- Documentation that the state PDMP site has been checked prior to discharge
- Documentation that use of naloxone has been discussed

OR

2 - Both of the following:

2.1 Person has 2 or more fills of greater than 120 MME within the previous 6 months

AND

2.2 Provider attests that continuation of therapy greater than 120 MME is medically necessary

2 . Revision History

Date	Notes
11/27/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-136714
Guideline Name	Opzelura (ruxolitinib)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Opzelura	
Diagnosis	Mild to moderate atopic dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of mild to moderate atopic dermatitis

AND

2 - Trial and failure of or contraindication to topical corticosteroid.

AND

3 - Trial and failure of or contraindication to calcineurin inhibitor (e.g. pimecrolimus, tacrolimus)

AND

4 - Therapy will not be used in combination with other therapeutic biologics (e.g., dupilumab, omalizumab, Upadacitinib)

Product Name: Opzelura	
Diagnosis	Vitiligo
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of nonsegmental vitiligo

AND

2 - Prescribed by, or in consultation with, a Dermatologist

AND

3 - Area being treated does not exceed 10% body surface area (BSA)

AND

4 - Person meets one of the following:

4.1 Trial and failure of or contraindication to a medium-to-high potency topical corticosteroid

OR

4.2 Person is treating vitiligo affecting one of the following areas: face, skin folds, and/or genitalia

OR

4.3 Person has steroid-induced atrophy

OR

4.4 Person has a history of long-term topical steroid use

AND

5 - Therapy will not be used in combination with other therapeutic biologics (e.g., dupilumab, omalizumab, Upadacitinib)

Product Name: Opzelura	
Diagnosis	All diagnoses
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug and with improvement in symptoms (e.g. reduction in body surface area affected, reduced itching, repigmentation.

2 . Revision History

Date	Notes
12/1/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129229
Guideline Name	Oral Calcitonin Gene-Related Peptide (CGRP) Inhibitors
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Nurtec ODT, Ubrelvy	
Diagnosis	Acute Migraine Treatment
Approval Length	12/31/2039
Guideline Type	Prior Authorization- ALL Plans Except IL and MN Plans

Approval Criteria

1 - ONE of the following:

1.1 Trial and failure or intolerance to at least two of the following:

- sumatriptan
- naratriptan
- rizatriptan

- eletriptan
- zolmitriptan
- almotriptan
- frovatriptan

OR

1.2 Both of the following:

1.2.1 Contraindication to triptan use

AND

1.2.2 Trial and failure, contraindication or intolerance to two non-triptan, prescription strength analgesics that are effective for treatment of migraines according to the American Headache Society treatment guidelines (e.g., nonsteroidal anti-inflammatory drugs (NSAIDs), ergotamine derivatives)

Product Name: Nurtec ODT, Ubrelvy	
Diagnosis	Acute Migraine Treatment
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization- IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Trial and failure or intolerance to at least two of the following:

- sumatriptan
- naratriptan
- rizatriptan
- eletriptan
- zolmitriptan
- almotriptan
- frovatriptan

OR

1.2 Both of the following

1.2.1 Contraindication to triptan use

AND

1.2.2 Trial and failure, contraindication or intolerance to two non-triptan, prescription strength analgesics that are effective for treatment of migraines according to the American Headache Society treatment guidelines (e.g., nonsteroidal anti-inflammatory drugs (NSAIDs), ergotamine derivatives)

Product Name: Nurtec ODT, Ubrelvy	
Diagnosis	Acute Migraine Treatment
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization- IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Nurtec ODT, Qulipta	
Diagnosis	Prevention of Migraine
Approval Length	12/31/2039
Guideline Type	Prior Authorization- ALL Plans Except IL and MN Plans

Approval Criteria

1 - Member has greater than or equal to 4 migraine days per month with submission of medical records (e.g., chart notes) documenting that headaches are disabling (e.g., unable to

work/attend school, unable to participate in activities of daily living [ADLs], moderate to severe MIDAS score)

AND

2 - Member is 18 years of age or older

AND

3 - Trial and failure, contraindication or intolerance to two generic preventive migraine medications (e.g., anti-hypertensives, antiepileptics, antidepressants, botulinum toxin)

AND

4 - Trial and failure, contraindication or intolerance to both of the following:

- Aimovig
- Emgality

AND

5 - Drug is not being used in combination with another CGRP inhibitor for the preventative treatment of migraines

Product Name: Nurtec ODT, Qulipta	
Diagnosis	Prevention of Migraine
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization- IL and MN Plans*

Approval Criteria

1 - Member has greater than or equal to 4 migraine days per month with submission of medical records (e.g., chart notes) documenting that headaches are disabling (e.g., unable to

work/attend school, unable to participate in activities of daily living [ADLs], moderate to severe MIDAS score)

AND

2 - Member is 18 years of age or older

AND

3 - Trial and failure, contraindication or intolerance to two generic preventive migraine medications (e.g., anti-hypertensives, antiepileptics, antidepressants, botulinum toxin)

AND

4 - Trial and failure, contraindication or intolerance to both of the following:

- Aimovig
- Emgality

AND

5 - Drug is not being used in combination with another CGRP inhibitor for the preventative treatment of migraines

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and were not previously approved for c overage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through reauthorization criteria

Product Name: Nurtec ODT, Qulipta	
Diagnosis	Prevention of Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization- IL and MN Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member (as evidenced by coverage effective date of less than or equal to 90 days) is showing a response to therapy (e.g., symptom improvement such as decreased frequency or severity of headaches from baseline, reduced cluster headache frequency, improved ability to participate in therapies/ADLs, improved MIDAS score, less acute medication use, fewer ER/UC visits for migraine, ability to return to work/school)

AND

2 - Drug is not being used in combination with another CGRP inhibitor for the preventative treatment of migraines

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and were not previously approved for c overage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through reauthorization criteria

Product Name: Nurtec ODT, Ubrelvy	
Diagnosis	Acute treatment – Quantity Exception
Approval Length	12/31/2039
Therapy Stage	Reauthorization
Guideline Type	Quantity Exception - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that member has 2 or more headaches per week

AND

2 - Patient is on migraine headache prophylaxis treatment

Product Name: Nurtec ODT, Ubrelvy	
Diagnosis	Acute treatment – Quantity Exception
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Quantity Exception - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that member has 2 or more headaches per week

AND

2 - Patient is on migraine headache prophylaxis treatment

2 . Revision History

Date	Notes
10/25/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-137207
Guideline Name	Orencia (abatacept)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Orencia	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Trial and failure, contraindication, or intolerance to TWO of the following:

- Adalimumab
- Etanercept
- Certolizumab
- Golimumab
- Risankizumab
- Upadacitinib
- Guselkumab
- Tofacitinib/Tofacitinib XR
- Ustekinumab

Product Name: Orencia	
Diagnosis	Psoriatic Arthritis (PsA)

Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Trial and failure, contraindication, or intolerance to TWO of the following:

- Adalimumab
- Etanercept
- Certolizumab
- Golimumab
- Risankizumab
- Upadacitinib
- Guselkumab
- Tofacitinib/Tofacitinib XR
- Ustekinumab

Product Name: Orencia	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active rheumatoid arthritis (RA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- Methotrexate (MTX)*
- Leflunomide
- Hydroxychloroquine
- Sulfasalazine

AND

3 - Trial and failure, contraindication, or intolerance to TWO of the following:

- Adalimumab
- Certolizumab
- Etanercept
- Golimumab
- Tofactinib (ER)

- Upadacitinib

AND

4 - Medication will be self-administered (not in clinic or provider office)

AND

5 - Prescribed by or in consultation with a rheumatologist

AND

6 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	* Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immu nodeficiency syndromes, bone marrow hyperplasia, leukopenia, throm bocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Orencia	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active rheumatoid arthritis (RA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- Methotrexate (MTX)*

- Leflunomide
- Hydroxychloroquine
- Sulfasalazine

AND

3 - Trial and failure, contraindication, or intolerance to TWO of the following:

- Adalimumab
- Certolizumab
- Etanercept
- Golimumab
- Tofactinib (ER)
- Upadacitinib

AND

4 - Medication will be self-administered (not in clinic or provider office)

AND

5 - Prescribed by or in consultation with a rheumatologist

AND

6 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Notes	* Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immu nodeficiency syndromes, bone marrow hyperplasia, leukopenia, throm bocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Orencia	
Diagnosis	Juvenile Idiopathic Arthritis (JIA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of juvenile idiopathic arthritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Minimum 3-month trial and failure, contraindication, or intolerance to ONE of the following:

- Methotrexate (MTX)*
- Leflunomide
- Hydroxychloroquine
- Sulfasalazine

AND

4 - Trial and failure, contraindication, or intolerance to TWO of the following:

- Adalimumab
- Etanercept
- Tofacitinib/Tofacitinib XR

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication will be self-administered

Notes	* Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immu

	nodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Orencia	
Diagnosis	Juvenile Idiopathic Arthritis (JIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of juvenile idiopathic arthritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Minimum 3-month trial and failure, contraindication, or intolerance to ONE of the following:

- Methotrexate (MTX)*
- Leflunomide
- Hydroxychloroquine
- Sulfasalazine

AND

4 - Trial and failure, contraindication, or intolerance to TWO of the following:

- Adalimumab
- Etanercept
- Tofacitinib/Tofacitinib XR

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication will be self-administered

Notes	* Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immu nodeficiency syndromes, bone marrow hyperplasia, leukopenia, throm bocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Orencia	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Prescriber provides clinical documentation from the previous 12 months of the member's response to therapy including individual improvements in functional status related to therapeutic response

2 . Revision History

Date	Notes
12/4/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129653
Guideline Name	ORFADIN (Nitisinone), Nityr (Nitisinone)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Orfadin solution, Generic Nitisinone, Brand Nityr	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of hereditary tyrosinemia type I.

AND

2 - Detectable succinylacetone blood or urine levels.

Product Name: Orfadin solution, Generic Nitisinone, Brand Nityr	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Orfadin solution, Generic Nitisinone, Brand Nityr	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of hereditary tyrosinemia type I.

AND

2 - Detectable succinylacetone blood or urine levels.

2 . Revision History

Date	Notes
10/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-137227
Guideline Name	Otezla (apremilast)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Otezla	
Diagnosis	Plaque Psoriasis
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans
Approval Criteria	

1 - Diagnosis of mild to severe plaque psoriasis

AND

2 - Prescribed by or in consultation with a dermatologist

AND

3 - Trial and failure, contraindication, or intolerance to topical treatment (e.g. topical corticosteroids, calcipotriene, retinoids)

AND

4 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Otezla	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of mild to severe plaque psoriasis

AND

2 - Prescribed by or in consultation with a dermatologist

AND

3 - Trial and failure, contraindication, or intolerance to topical treatment (e.g. topical corticosteroids, calcipotriene, retinoids)

AND

4 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Otezla	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Otezla	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Otezla

Diagnosis	Oral Ulcers Associated with Behçet's Disease
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of Behçet's Disease with active oral ulcers

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Otezla	
Diagnosis	Oral Ulcers Associated with Behçet's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Diagnosis of Behçet's Disease with active oral ulcers

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Otezla	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization – IL and MN Plans

Approval Criteria

1 - Prescriber provides clinical documentation from the previous 12 months of the member's response to therapy including individual improvements in functional status related to therapeutic response

2 . Revision History

Date	Notes
12/4/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131477
Guideline Name	Oxazolidinone Antibiotic
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Sivextro	
Approval Length	14 Day (s)*
Guideline Type	Prior Authorization - All Plans except IL and MN
Approval Criteria **1** - One of the following:	

1.1 Submission of medical records (e.g., chart notes, paid claims) supporting use of the drug during the current hospitalization and needs to complete the course of therapy as an outpatient

OR

1.2 All of the following:

1.2.1 Used for outpatient treatment of resistant bacterial strains

AND

1.2.2 Report of susceptibilities documenting resistance to alternatives including linezolid

AND

1.2.3 Prescribed by, or in consultation with, an Infectious Disease specialist

OR

1.3 Both of the following:

1.3.1 Linezolid is the only viable alternative due to resistance

AND

1.3.2 Member is taking serotonergic agents (e.g. SSRI, tricyclic antidepressants, triptans, etc.)

Notes	*Approval duration: Approve for the duration of treatment (usual course 6-14 days, or 14 to 28 days for Vancomycin-resistant enterococcus)

Product Name: Sivextro	
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL Plan and MN Plans

Approval Criteria

1 - One of the following:

1.1 Submission of medical records (e.g., chart notes, paid claims) supporting use of the drug during the current hospitalization and needs to complete the course of therapy as an outpatient

OR

1.2 All of the following:

1.2.1 Used for outpatient treatment of resistant bacterial strains

AND

1.2.2 Report of susceptibilities documenting resistance to alternatives including linezolid

AND

1.2.3 Prescribed by, or in consultation with, an Infectious Disease specialist

OR

1.3 Both of the following:

1.3.1 Linezolid is the only viable alternative due to resistance

AND

1.3.2 Member is taking serotonergic agents (e.g. SSRI, tricyclic antidepressants, triptans, etc.)

OR

1.4 For IL Plans ONLY: The requested drug is being used for the long-term treatment of tick-borne disease

2 . Revision History

Date	Notes
10/6/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-130600
Guideline Name	Oxbryta (voxelotor)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Oxbryta	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Both of the following:

- Diagnosis of sickle cell disease
- Member has persistent anemia requiring transfusion within the past 12 months

AND

2 - Prescribed by or in consultation with one of the following:

- Hematologist
- Specialist with experience in the treatment of sickle cell disease

AND

3 - One of the following:

- Member is stable on hydroxyurea for at least 90 days
- Submission of medical records (e.g., chart notes) documenting trial and failure, contraindication, or intolerance to hydroxyurea

AND

4 - Member's baseline hemoglobin (Hgb) is between 5.5 to 10.5 g/dL prior to use of Oxybryta

AND

5 - Requested medication will not be used in combination with Adakveo (crizanlizumab)

Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Oxbryta	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting from the previous 12 months positive clinical response to therapy as evidenced by one of the following:

- Decreased frequency of sickle cell hospitalizations or urgent care visits
- Decreased frequency of vaso-occlusive crisis
- Reduction in use of pain medications
- Improved quality of life (e.g. decreased pain, fewer missed day of work/school, increase in activities, etc.)
- Reduced need for transfusions

Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

2 . Revision History

Date	Notes
10/6/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-137246
Guideline Name	Oxervate (cenegermin)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Oxervate	
Approval Length	8 Week(s)^
Guideline Type	Prior Authorization

Approval Criteria

1 - Confirmed diagnosis of Stage 2* or Stage 3* Neurotrophic Keratitis

AND

2 - Prescribed by, or in consultation with, an ophthalmologist

AND

3 - Submission of medical records (e.g., chart notes) confirming decreased or loss of corneal sensitivity and corneal epithelium changes

AND

4 - Underlying conditions are being treated, if appropriate (e.g., herpetic eye disease, diabetes, dry eye, multiple sclerosis, etc.)

AND

5 - Failure to improve with conservative management after an adequate trial of one of the following for at least two weeks:

- Ocular lubricants
- Artificial tears

AND

6 - Discontinuation of ophthalmic steroids or avoidance of ophthalmic preservatives

Notes	*Stage 2 (Moderate) = NK exhibits nonhealing persistent epithelial defect (PED); Stage 3 (Severe) = NK exhibits corneal ulceration involving subepithelial (stromal) tissue which may progress to corneal perforation. ^ Maximum coverage is limited to 56 days per lifetime approval. Oxervate is hard-coded with a quantity limit of 56 days of therapy per lifetime. Subsequent request will be reviewed using the off-label guideline

2 . Revision History

Date	Notes
12/6/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129859
Guideline Name	Oxymorphone Hydrochloride
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Oxymorphone Immediate Release (IR), Oxymorphone Extended Release (ER)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL Plan

Approval Criteria

1 - For Oxymorphone IR requests ONLY: Trial and failure, contraindication, or intolerance to two generic immediate-release narcotics

OR

2 - For Oxymorphone ER requests ONLY: Trial and failure, contraindication, or intolerance to BOTH of the following:

- generic extended release morphine
- extended release oxycodone

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Oxymorphone Immediate Release (IR), Oxymorphone Extended Release (ER)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - MN Plan

Approval Criteria

1 - For Oxymorphone IR requests ONLY, One of the following:

1.1 Trial and failure, contraindication, or intolerance to two generic immediate-release narcotics

OR

1.2 Both of the following

- Member has stage four metastatic cancer
- The requested drug is being used to treat cancer-related pain

OR

2 - For Oxymorphone ER requests ONLY, one of the following:

2.1 Trial and failure, contraindication, or intolerance to BOTH of the following:

- generic extended release morphine
- extended release oxycodone

OR

2.2 Both of the following:

- Member has stage four metastatic cancer
- The requested drug is being used to treat cancer-related pain

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Oxymorphone Immediate Release (IR), Oxymorphone Extended Release (ER)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Oxymorphone Immediate Release (IR), Oxymorphone Extended Release (ER)	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - For Oxymorphone IR requests ONLY: Trial and failure, contraindication, or intolerance to two generic immediate-release narcotics

OR

2 - For Oxymorphone ER requests ONLY: Trial and failure, contraindication, or intolerance to BOTH of the following:

- generic extended release morphine
- extended release oxycodone

2 . Revision History

Date	Notes
8/14/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129373
Guideline Name	Palforzia (peanut powder)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Palforzia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - ALL Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting systemic allergic reaction to peanuts (e.g., anaphylaxis, tongue/throat swelling, shortness of breath/wheezing the requires treatment, urticaria, angioedema, hypotension, and/or vomiting that occurs within 1-2 hours after ingestion of peanut)

AND

2 - Submission of medical records (e.g., chart notes) documenting a positive skin prick test (wheal diameter greater than or equal to 3 mm) OR peanut specific IgE (greater than or equal to 0.35 kUA/L) within the past 12 months

AND

3 - Used in conjunction with a peanut-avoidance diet

AND

4 - Patient is 4 years of age or older, to less than or equal to 17 years of age

AND

5 - Prescribed by or in consultation with an allergist/immunologist

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and were not previously approved for c overage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through reauthorization criteria

Product Name: Palforzia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - ALL Plans*

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting one of the following:

- Member has a persistent peanut allergy as documented in an allergy/immunology clinic visit within the past 12 months

• Member has a documented positive skin prick test (wheal diameter greater than or equal to 3 mm) or peanut specific IgE (greater than or equal to 0.35 kUA/L) within the past 12 months **AND** **2** - Used in conjunction with a peanut-avoidance diet **AND** **3** - Prescribed by or in consultation with an allergist/immunologist	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and were not previously approved for c overage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through reauthorization criteria

2 . Revision History

Date	Notes
8/4/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-138053
Guideline Name	Palynziq
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Palynziq (10 and 20 mg dose)	
Approval Length	4 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All plans except IL and MN Plans
Approval Criteria	

1 - Diagnosis of Phenylketonuria (PKU)

AND

2 - Member is 18 years of age or older

AND

3 - Blood phenylalanine (Phe) concentration greater than 600 micromol/L (10 mg/dL) despite both of the following:

- Six months of adherent use of a Phe restricted diet
- Two-month trial and failure, contraindication, or intolerance of sapropterin

AND

4 - Sapropterin must be discontinued prior to start of Palynziq

Product Name: Palynziq (10 and 20 mg dose)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Phenylketonuria (PKU)

AND

2 - Member is 18 years of age or older

AND

3 - Blood phenylalanine (Phe) concentration greater than 600 micromol/L (10 mg/dL) despite both of the following:

- Six months of adherent use of a Phe restricted diet
- Two-month trial and failure, contraindication, or intolerance of sapropterin

AND

4 - Sapropterin must be discontinued prior to start of Palynziq

Product Name: Palynziq (40 mg dose)	
Approval Length	4 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of Phenylketonuria (PKU)

AND

2 - Member is 18 years of age or older

AND

3 - Blood phenylalanine (Phe) concentration greater than 600 micromol/L (10 mg/dL) despite both of the following:

- Six months of adherent use of a Phe restricted diet
- Two-month trial and failure, contraindication, or intolerance of sapropterin

AND

4 - Sapropterin must be discontinued prior to start of Palynziq

AND

5 - One of the following:

- 24-week trial of 20 mg/day dosing and failure to achieve a 20% reduction from baseline in Phe levels
- Phe levels remain greater than 600 micromol/L

Product Name: Palynziq (40 mg dose)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit- IL and MN Plans

Approval Criteria

1 - Diagnosis of Phenylketonuria (PKU)

AND

2 - Member is 18 years of age or older

AND

3 - Blood phenylalanine (Phe) concentration greater than 600 micromol/L (10 mg/dL) despite both of the following:

- Six months of adherent use of a Phe restricted diet
- Two-month trial and failure, contraindication, or intolerance of sapropterin

AND

4 - Sapropterin must be discontinued prior to start of Palynziq

AND

5 - One of the following:

- 24-week trial of 20 mg/day dosing and failure to achieve a 20% reduction from baseline in Phe levels
- Phe levels remain greater than 600 micromol/L

Product Name: Palynziq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Used in conjunction with a Phe restricted diet

AND

2 - Submission of medical records (e.g., chart notes) documenting ONE of the following:

- 20% reduction in Phe levels from baseline
- Phe levels remain greater than 600 micromol/L

AND

3 - Not on concurrent sapropterin

2 . Revision History

Date	Notes
12/20/2023	Update

Prior Authorization Guideline

Guideline ID	GL-137247
Guideline Name	Parathyroid Hormone Analogues for Osteoporosis
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	
P&T Revision Date:	

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Forteo, Teriparatide, Tymlos	
Diagnosis	Osteoporosis in Postmenopausal Women
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Medication will be self-administered or administered by a family member or friend

AND

2 - Will not be used in combination with anti-resorptive therapy or after denosumab therapy

AND

3 - Diagnosis of osteoporosis with a T-score of less than or equal to -2.5 at the femoral neck, total hip, lumbar spine, or 33% (one-third) radius

AND

4 - Very high risk of fracture defined by AT LEAST ONE of the following:

- Recent fracture (e.g. within past 12 months)
- Fracture while on approved osteoporosis therapy
- Multiple fractures
- Fractures while on drugs causing skeletal harm (e.g. long-term glucocorticoid use)
- Very low T-score (less than -3.0)
- High risk for falls
- History of injurious falls

AND

5 - Applies to Forteo and Teriparatide only: Trial and failure, contraindication, or intolerance to abaloparatide

Product Name: Forteo, Teriparatide, Tymlos	
Diagnosis	Osteoporosis in Postmenopausal Women
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Medication will be self-administered or administered by a family member or friend

AND

2 - Will not be used in combination with anti-resorptive therapy or after denosumab therapy

AND

3 - Diagnosis of osteoporosis with a T-score of less than or equal to -2.5 at the femoral neck, total hip, lumbar spine, or 33% (one-third) radius

AND

4 - Very high risk of fracture defined by AT LEAST ONE of the following:

- Recent fracture (e.g. within past 12 months)
- Fracture while on approved osteoporosis therapy
- Multiple fractures
- Fractures while on drugs causing skeletal harm (e.g. long-term glucocorticoid use)
- Very low T-score (less than -3.0)
- High risk for falls
- History of injurious falls

AND

5 - Applies to Forteo and Teriparatide only: Trial and failure, contraindication, or intolerance to abaloparatide

Product Name: Forteo, Teriparatide, Tymlos	
Diagnosis	Osteopenia in Postmenopausal Women
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Medication will be self-administered or administered by a family member or friend

AND

2 - Will not be used in combination with anti-resorptive therapy or after denosumab therapy

AND

3 - Diagnosis of osteopenia with a T-score between -1.0 and -2.5 at the femoral neck, total hip, lumbar spine, or 33% (one-third) radius

AND

4 - 10-year probability of a hip fracture of at least 3% or major osteoporosis-related fracture of at least 20%

AND

5 - Very high risk of fracture defined by AT LEAST ONE of the following:

- Recent fracture (e.g. within past 12 months)
- Fracture while on approved osteoporosis therapy
- Multiple fractures
- Fractures while on drugs causing skeletal harm (e.g. long-term glucocorticoid use)
- Very high FRAX (major osteoporotic fracture > 30%, hip fracture > 4.5%)
- High risk for falls
- History of injurious falls

AND

6 - Applies to Forteo and Teriparatide only: Trial and failure, contraindication, or intolerance to abaloparatide

Product Name: Forteo, Teriparatide, Tymlos	
Diagnosis	Osteopenia in Postmenopausal Women
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Medication will be self-administered or administered by a family member or friend

AND

2 - Will not be used in combination with anti-resorptive therapy or after denosumab therapy

AND

3 - Diagnosis of osteopenia with a T-score between -1.0 and -2.5 at the femoral neck, total hip, lumbar spine, or 33% (one-third) radius

AND

4 - 10-year probability of a hip fracture of at least 3% or major osteoporosis-related fracture of at least 20%

AND

5 - Very high risk of fracture defined by AT LEAST ONE of the following:

- Recent fracture (e.g. within past 12 months)
- Fracture while on approved osteoporosis therapy
- Multiple fractures
- Fractures while on drugs causing skeletal harm (e.g. long-term glucocorticoid use)
- Very high FRAX (major osteoporotic fracture > 30%, hip fracture > 4.5%)
- High risk for falls
- History of injurious falls

AND

6 - Applies to Forteo and Teriparatide only: Trial and failure, contraindication, or intolerance to abaloparatide

Product Name: Forteo, Teriparatide, Tymlos	
Diagnosis	Osteoporosis Due to Prolonged Steroid Use
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Medication will be self-administered or administered by a family member or friend

AND

2 - Will not be used in combination with anti-resorptive therapy or after denosumab therapy

AND

3 - Trial and failure (e.g. low-trauma fractures or decrease in BMD while on alendronate 70 mg per week), contraindication, or intolerance to therapy with at least one bisphosphonate

AND

4 - Applies to Forteo and Teriparatide only: Trial and failure, contraindication, or intolerance to abaloparatide

Product Name: Forteo, Teriparatide, Tymlos	
Diagnosis	Osteoporosis Due to Prolonged Steroid Use
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Medication will be self-administered or administered by a family member or friend

AND

2 - Will not be used in combination with anti-resorptive therapy or after denosumab therapy

AND

3 - Trial and failure (e.g. low-trauma fractures or decrease in BMD while on alendronate 70 mg per week), contraindication, or intolerance to therapy with at least one bisphosphonate

AND

4 - Applies to Forteo and Teriparatide only: Trial and failure, contraindication, or intolerance to abaloparatide

Product Name: Forteo, Teriparatide, Tymlos	
Diagnosis	Primary or Hypogonadal Osteoporosis in Men
Approval Length	24 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Medication will be self-administered or administered by a family member or friend

AND

2 - Will not be used in combination with anti-resorptive therapy or after denosumab therapy

AND

3 - One of the following:

3.1 Trial and failure (e.g. low-trauma fractures or decrease in BMD while on alendronate 70 mg per week), contraindication, or intolerance to therapy with at least one bisphosphonate

OR

3.2 T-score of less than -2.5 and at least one fragility fracture

AND

4 - Applies to Forteo and Teriparatide only: Trial and failure, contraindication, or intolerance to abaloparatide

Product Name: Forteo, Teriparatide, Tymlos	
Diagnosis	Primary or Hypogonadal Osteoporosis in Men
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Medication will be self-administered or administered by a family member or friend

AND

2 - Will not be used in combination with anti-resorptive therapy or after denosumab therapy

AND

3 - One of the following:

3.1 Trial and failure (e.g. low-trauma fractures or decrease in BMD while on alendronate 70 mg per week), contraindication, or intolerance to therapy with at least one bisphosphonate

OR

3.2 T-score of less than -2.5 and at least one fragility fracture

AND

4 - Applies to Forteo and Teriparatide only: Trial and failure, contraindication, or intolerance to abaloparatide

Product Name: Forteo, Teriparatide, Tymlos	
Diagnosis	All Indications
Approval Length	24 Month(s)*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) or who are established on therapy, will have coverage under their drug benefit for the remainder of the current treatment course (up to 24 months total). Restrictions to specific network pharmacies and participation in medication management programs may apply.

Notes	*Maximum coverage is limited to a 24 months per lifetime approval. F orteo, Teriparatide and Tymlos are hard-coded with a quantity limit of 24 months of therapy per lifetime. Subsequent request will be reviewe d using the off-label guideline.

Product Name: Forteo, Teriparatide, Tymlos

Diagnosis	All Indications
Approval Length	12 Month(s)*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) or who are established on therapy, will have coverage under their drug benefit for the remainder of the current treatment course (up to 24 months total). Restrictions to specific network pharmacies and participation in medication management programs may apply.

Notes	*Maximum coverage is limited to 24 months per lifetime approval. Forteo, Teriparatide and Tymlos are hard-coded with a quantity limit of 24 months of therapy per lifetime. Subsequent request will be reviewed using the off-label guideline.

2 . Revision History

Date	Notes
12/6/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129860
Guideline Name	Pegfilgrastim
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Fulphila, Fylnetra, Nyvepria, Stimufend, Udenyca, Ziextenzo	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Trial and failure (e.g., febrile neutropenia, delay in chemotherapy), contraindication, or intolerance to a filgrastim drug product

AND

1.1.2 Trial and failure, contraindication, or intolerance to use of Ziextenzo in the clinic as a clinic administered drug

OR

1.2 Both of the following (Applies to Minnesota Plans ONLY) :

- Member has stage four metastatic cancer
- The requested drug is being used as supportive care for their cancer treatment

Notes	*Pharmacy benefit coverage information (preferred/nonpreferred statu s, restriction, etc) only applies to plans with Quartz pharmacy coverage

2 . Revision History

Date	Notes
10/12/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129861
Guideline Name	Pegylated Interferons
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Pegasys	
Approval Length	Approval Durations: Hepatitis = 48 weeks. Other indications = 12 months
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of one of the following:

- HBeAg positive chronic hepatitis B
- HBeAg negative chronic hepatitis B

AND

1.1.2 Member has compensated liver disease

AND

1.1.3 Evidence of both of the following:

- Viral replication
- Liver inflammation

OR

1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member*

AND

2 - One of the following;

- Medication will be self-administered by member
- Medication will be administered by a family member

Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Pegasys	
Approval Length	Approval Durations: Hepatitis = 48 weeks. Other indications = 12 months
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of one of the following:

- HBeAg positive chronic hepatitis B
- HBeAg negative chronic hepatitis B

AND

1.1.2 Member has compensated liver disease

AND

1.1.3 Evidence of both of the following:

- Viral replication
- Liver inflammation

OR

1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member*

AND

2 - One of the following;

- Medication will be self-administered by member
- Medication will be administered by a family member

AND **3** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months, response to therapy is stable or improvement seen on therapy with evidence-based clinical rationale to support continuing therapy **AND** **4** - Restrictions to specific network pharmacies and participation in medication management programs may apply	
Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

2 . Revision History

Date	Notes
8/14/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129132
Guideline Name	Pradaxa Oral Pellets
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Pradaxa Oral Pellets	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans
Approval Criteria **1** - Trial and failure, contraindication, or intolerance to rivaroxaban suspension	

Product Name: Pradaxa Oral Pellets	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Step Therapy - IL or MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Pradaxa Oral Pellets	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All Plans except IL and MN

Approval Criteria

1 - Trial and failure, contraindication, or intolerance to rivaroxaban suspension

2 . Revision History

Date	Notes
8/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-139113
Guideline Name	Preferred and Unrestricted Insulin Quantity Limit Exception
Formulary	• Quartz

Guideline Note:

Effective Date:	1/17/2024

1 . Criteria

Product Name: Novolin N, Novolin R, Novolin 70/30, Novolog, Novolog 70/30, Humulin R U500, Semglee-yfgn	
Approval Length	12/31/2039
Guideline Type	Quantity Limit - All plans except IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting insulin dosing and directions

AND

2 - Member requires more than 150 units per 30 days or, for U500 pens, more than 100 units per 30 days, or U500 vial, more than 333 units per 30 days based on daily prescribed dosing

Notes	The approval edits for quantity limit exceptions should be rounded up to allow the full trade package size, when necessary (e.g., the requested quantity is 45ml per 30 days and the product is available in 30ml and 100ml, approve to a quantity of 60ml per 30 days, if the guideline criteria has been met).

Product Name: Novolin N, Novolin R, Novolin 70/30, Novolog, Novolog 70/30, Humulin R U500, Semglee-yfgn	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting insulin dosing and directions

AND

2 - Member requires more than 150 units per 30 days or, for U500 pens, more than 100 units per 30 days or, for U500 vial, more than 333 units per 30 days based on daily prescribed dosing

Notes	The approval edits for quantity limit exceptions should be rounded up to allow the full trade package size, when necessary (e.g., the requested quantity is 45ml per 30 days and the product is available in 30ml and 100ml, approve to a quantity of 60ml per 30 days, if the guideline criteria has been met).

Product Name: Novolin N, Novolin R, Novolin 70/30, Novolog, Novolog 70/30, Humulin R U500, Semglee-yfgn	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Quantity Limit - IL and MN Plans

Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug	
Notes	The approval edits for quantity limit exceptions should be rounded up to allow the full trade package size, when necessary (e.g., the requested quantity is 45ml per 30 days and the product is available in 30ml and 100ml, approve to a quantity of 60ml per 30 days, if the guideline criteria has been met).

2 . Revision History

Date	Notes
1/17/2024	Update program

Prior Authorization Guideline

Guideline ID	GL-131588
Guideline Name	Preferred Blood Glucose Test Strips Quantity Limit Exception
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Onetouch Verio, Onetouch Ultra	
Approval Length	12/31/2039
Guideline Type	Quantity Limit - All plans except IL and MN Plans
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting directions and frequency of blood sugar checks indicating member requires more than 200 strips per 30 days	

Product Name: Onetouch Verio, Onetouch Ultra	
Approval Length	12 month(s)
Guideline Type	Quantity Limit - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting directions and frequency of blood sugar checks indicating member requires more than 200 strips per 30 days

2 . Revision History

Date	Notes
10/24/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-135735
Guideline Name	Prevymis (letermovir)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Prevymis	
Approval Length	1 Course up to 200 Days
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Requested drug is being used for cytomegalovirus (CMV) prophylaxis with one of the following:

- Post allogenic hematopoietic stem cell transplant
- Post kidney transplant

AND

2 - Submission of medical records (e.g., chart notes) documenting cytomegalovirus (CMV)-seropositive recipient (R+) or a CMV positive donor (D+)

AND

3 - One of the following:

- Drug is initiated within the first allogenic hematopoietic stem cell transplant: 28 days post-transplant
- Drug is initiated within the first kidney transplant: 7 days post-transplant

AND

4 - Submission of medical records (e.g., chart notes) documenting that member does not have active CMV infection (CMV PCR level over 250 IU/mL) and is not receiving preemptive treatment (e.g., foscarnet)

AND

5 - Prescribed by or in consultation with one of the following:

- hematologist
- oncologist
- infectious disease specialist
- transplant specialist

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who are established on therapy, will ha ve coverage under their drug benefit for the remainder of the current tr eatment course (to a maximum of day 200 post-transplant) ***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufa cturer-sponsored free drug program, provider samples, and/or vouche rs will go through initial criteria, otherwise for continuation of therapy f or new to plan, reauthorization criteria applies

Product Name: Prevymis

Approval Length	12 months with 7 fills
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Requested drug is being used for cytomegalovirus (CMV) prophylaxis with one of the following:

- Post allogenic hematopoietic stem cell transplant
- Post kidney transplant

AND

2 - Submission of medical records (e.g., chart notes) documenting cytomegalovirus (CMV)-seropositive recipient (R+) or a CMV positive donor (D+)

AND

3 - One of the following:

- Drug is initiated within the first allogenic hematopoietic stem cell transplant: 28 days post-transplant
- Drug is initiated within the first kidney transplant: 7 days post-transplant

AND

4 - Submission of medical records (e.g., chart notes) documenting that member does not have active CMV infection (CMV PCR level over 250 IU/mL) and is not receiving preemptive treatment (e.g., foscarnet)

AND

5 - Prescribed by or in consultation with one of the following:

- hematologist
- oncologist

• infectious disease specialist • transplant specialist	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who are established on therapy, will ha ve coverage under their drug benefit for the remainder of the current tr eatment course (to a maximum of day 200 post-transplant) ***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufa cturer-sponsored free drug program, provider samples, and/or vouche rs will go through initial criteria, otherwise for continuation of therapy f or new to plan, reauthorization criteria applies

Product Name: Prevymis	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting evidence-based clinical rationale for using a duration beyond 200 days post-transplant	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who are established on therapy, will ha ve coverage under their drug benefit for the remainder of the current tr eatment course (to a maximum of day 200 post-transplant) ***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufa cturer-sponsored free drug program, provider samples, and/or vouche rs will go through initial criteria, otherwise for continuation of therapy f or new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
11/13/2023	2024 new implementation

Prior Authorization Guideline

Guideline ID	GL-129862
Guideline Name	Pulmonary Arterial Hypertension (PAH) Agents
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Preferred Drugs: Adempas, generic ambrisentan, generic bosentan, Opsumit, generic sildenafil, generic tadalafil, Uptravi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Prescribed by or in consultation with one of the following:

- Cardiologist
- Pulmonologist

Notes	Member new to the plan (as evidenced by coverage effective date of l ess than or equal to 90 days) who initiated therapy using a manufactu rer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Non-Preferred Drugs: Orenitram, Ventavis	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Prescribed by or in consultation with one of the following:

- Cardiologist
- Pulmonologist

AND

3 - Trial and failure, contraindication, or intolerance to inhaled treprostinil (Tyvaso)

Notes	Member new to the plan (as evidenced by coverage effective date of l ess than or equal to 90 days) who initiated therapy using a manufactu rer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Preferred Drugs: Adempas, generic ambrisentan, generic bosentan, Opsumit, generic sildenafil, generic tadalafil, Uptravi; and Non-Preferred Drugs: Orenitram, Ventavis	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug	
Notes	Member new to the plan (as evidenced by coverage effective date of l ess than or equal to 90 days) who initiated therapy using a manufactu rer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Preferred Drugs: Adempas, generic ambrisentan, generic bosentan, Opsumit, generic sildenafil, generic tadalafil, Uptravi	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans
Approval Criteria **1** - Diagnosis of pulmonary arterial hypertension **AND** **2** - Prescribed by or in consultation with one of the following: • Cardiologist • Pulmonologist	
Notes	Member new to the plan (as evidenced by coverage effective date of l ess than or equal to 90 days) who initiated therapy using a manufactu rer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Non-Preferred Drugs: Orenitram, Ventavis	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Prescribed by or in consultation with one of the following:

- Cardiologist
- Pulmonologist

AND

3 - Trial and failure, contraindication, or intolerance to inhaled treprostinil (Tyvaso)

Notes	Member new to the plan (as evidenced by coverage effective date of l ess than or equal to 90 days) who initiated therapy using a manufactu rer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
10/12/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-130133
Guideline Name	Pyrukynd
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Pyrukynd	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of pyruvate kinase deficiency

AND

2 - Prescribed by, or in consultation with, a Hematologist or other expert in treating hemolytic anemia

AND

3 - Hemoglobin less than or equal to 10 mg/dL

AND

4 - Greater than or equal to 1 red blood cell (RBC) transfusion in the past 12 months

AND

5 - Member is 18 years of age or older

Notes	Member new to the plan (as evidenced by coverage effective date of l ess than or equal to 90 days) who initiated therapy using a manufactu rer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Pyrukynd	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of pyruvate kinase deficiency

AND

2 - Prescribed by, or in consultation with, a Hematologist or other expert in treating hemolytic anemia

AND

3 - Hemoglobin less than or equal to 10 mg/dL

AND

4 - Greater than or equal to 1 red blood cell (RBC) transfusion in the past 12 months

AND

5 - Member is 18 years of age or older

Notes	Member new to the plan (as evidenced by coverage effective date of l ess than or equal to 90 days) who initiated therapy using a manufactu rer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Pyrukynd	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pyruvate kinase deficiency

AND

2 - Submission of medical records (e.g., chart notes) documenting that within the past 6 months (for initial starts) or past 12 months the member demonstrates positive clinical response to therapy

Notes	Member new to the plan (as evidenced by coverage effective date of l ess than or equal to 90 days) who initiated therapy using a manufactu rer-sponsored free drug program, provider samples, and/or vouchers

	will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
10/6/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129624
Guideline Name	Qbrexza (Glycopyrronium topical)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Qbrexza	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of axillary hyperhidrosis with clinical documentation of a persistent or chronic cutaneous condition due to excessive sweating (e.g. skin maceration, dermatitis, fungal infections)

AND

2 - Failure of an adequate trial or intolerance to BOTH prescription strength topical aluminum antiperspirants and an oral anticholinergic drug such as glycopyrrolate or oxybutynin

Product Name: Qbrexza	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Qbrexza	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of axillary hyperhidrosis with clinical documentation of a persistent or chronic cutaneous condition due to excessive sweating (e.g. skin maceration, dermatitis, fungal infections)

AND

2 - Failure of an adequate trial or intolerance to BOTH prescription strength topical aluminum antiperspirants and an oral anticholinergic drug such as glycopyrrolate or oxybutynin

2 . Revision History

Date	Notes
10/6/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-134957
Guideline Name	Quantity Limit Exceptions
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Diagnosis	CRITERIA FOR COVERAGE OF QUANTITY EXCEPTIONS (DOSE ≤ MAXIMUM DOSE IN PRESCRIBING INFORMATION) - Titration or loading dose
Approval Length	One Time Fill
Guideline Type	Administrative

Approval Criteria

1 - Request is for a titration or loading dose

Diagnosis	CRITERIA FOR COVERAGE OF QUANTITY EXCEPTIONS (DOSE ≤ MAXIMUM DOSE IN PRESCRIBING INFORMATION)

Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Person is on a dose alternating schedule

OR

2 - For topical applications: person requires a larger quantity to cover a larger surface area

OR

3 - Requested strength/dose is commercially unavailable

OR

4 - If the request is for reauthorization, prescriber submits medical records (e.g., chart notes) of documentation from the previous 12 months that the member is continuing therapy with the requested drug and dosing regimen

Diagnosis	CRITERIA FOR COVERAGE OF QUANTITY EXCEPTIONS (DOSE > MAXIMUM DOSE IN PRESCRIBING INFORMATION)
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Both of the following:

1.1 One of the following:

1.1.1 Higher dose or quantity is supported by clinical research in two articles from major peer reviewed medical journals that present data supporting the proposed higher than maximum doses for the diagnosis provided as generally safe and effective

OR

1.1.2 Higher dose or quantity is supported by American Hospital Formulary Service Drug Information or Micromedex DRUGDEX System

AND

1.2 One of the following

1.2.1 Maximum doses specified under the quantity restriction have been tried for an adequate period of time and been deemed ineffective in the treatment of the member's disease or medical condition

OR

1.2.2 If lower doses have not been tried, there is clinical support (i.e., clinical literature, patient attributes, or characteristics of the drug) that the number of doses available under the quantity restriction will be ineffective in the treatment of the member's disease or medical condition

OR

2 - If the request is for reauthorization, prescriber submits medical records (e.g., chart notes) of documentation from the previous 12 months that the member is continuing therapy with the requested drug and dosing regimen

Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Administrative

Approval Criteria

1 - Prescriber submits medical records (e.g., chart notes) of documentation from the previous 12 months that the member is continuing therapy with the requested drug and dosing regimen

2 . Revision History

Date	Notes
12/5/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129159
Guideline Name	Radicava (Edaravone)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Radicava ORS	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of definite or probable ALS based on El Escorial revised Airlie House diagnostic criteria

AND

2 - Prescribed by, or in consultation with, a Neurologist or other specialist in treating amyotrophic lateral sclerosis (ALS)

AND

3 - Age 20-75

AND

4 - Independent living status (i.e., Japan ALS Severity Classification Grade 1 or 2)

AND

5 - Score of ≥ 2 on all 12 items of the ALS Functional Rating Scale (ALSFRS-R) (assessed and documented within the last 3 months)

AND

6 - FVC % predicted ≥ 80% (assessed and documented within the last 3 months)

AND

7 - Duration of disease from the first symptom of 2 years or less

AND

8 - Current use of riluzole or documented contraindication/intolerance/ lack of therapeutic effect of therapy

Product Name: Radicava ORS	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation that use of the drug has slowed the progression of ALS and function is improved relative to the expected natural course of the disease

2 . Revision History

Date	Notes
9/11/2023	New program

Prior Authorization Guideline

Guideline ID	GL-136613
Guideline Name	Rayos (prednisone DR)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024
P&T Approval Date:	
P&T Revision Date:	

1 . Criteria

Product Name: Rayos	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Therapy-limiting intolerance of immediate-release prednisone despite dose adjustment and/or timing modification

OR

1.1.2 The prescriber provides an evidence-based clinical rationale for why the side effects are not likely to occur with the extended-release formulation

OR

1.2 Minnesota plans only: Member with stage four metastatic cancer and the requested drug is being used as supportive care to treat fatigue related to their cancer diagnosis or chemotherapy regimen

Product Name: Rayos	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Rayos	
Approval Length	12 month(s)
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Therapy-limiting intolerance of immediate-release prednisone despite dose adjustment and/or timing modification

AND **2** - The prescriber provides an evidence-based clinical rationale for why the side effects are not likely to occur with the extended-release formulation

2 . Revision History

Date	Notes
11/21/2023	Update program

Prior Authorization Guideline

Guideline ID	GL-131273
Guideline Name	Relyvrio (sodium phenylbutyrate and taurursodiol)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Relyvrio	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - ALL Plans

Approval Criteria

1 - Diagnosis of definite or probable amyotrophic lateral sclerosis (ALS)

AND

2 - Member is 18 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) documenting Slow vital capacity (SVC) greater than 60%, within the past 3 months

AND

4 - Member has not currently had a tracheostomy or on permanent assisted ventilation

AND

5 - Duration of disease from the first symptom, is of 18 months or less

AND

6 - Member is currently using riluzole or has a documented contraindication/intolerance/or lack of therapeutic effect of therapy

AND

7 - Prescribed by or in consultation with one of the following:

- neurologist
- other specialist in the treatment of ALS

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Relyvrio	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization - ALL Plans
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that the use of the drug has slowed the progression of ALS and function is improved relative to the expected natural course of the disease	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
10/6/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131591
Guideline Name	Repatha (evolocumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Repatha	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of one of the following:

- Heterozygous Familial Hypercholesteremia
- Homozygous Familial Hypercholesterolemia
- Established arteriosclerotic cardiovascular disease (ASCVD)

AND

2 - Submission of medical records (e.g., chart notes) documenting that medication is prescribed by or in consultation with a cardiologist, endocrinologist, or lipidologist

AND

3 - Member has LDL-C greater than or equal to 70 mg/dL while on maximally tolerated statin doses

AND

4 - One of the following:

4.1 All of the following:

4.1.1 Member is statin tolerant and will continue statin treatment in combination with PCSK9

AND

4.1.2 One of the following:

- Adherent treatment with a high potency statin (ex. atorvastatin 40-80 mg daily, rosuvastatin 20-40 mg daily) for a minimum of 8 weeks duration
- Member cannot tolerate high potency statin and adherent treatment with a maximally tolerated dose of any statin for a minimum of 8 weeks duration

OR

4.2 Member is statin intolerant as defined by all of the following:

- Member was unable to tolerate at least two statins with one started at the lowest starting dose
- Statin dose reduction was attempted to resolve symptoms or lab abnormalities (not discontinuation)
- Symptoms or lab abnormalities reversed with statin discontinuation but returned with re-challenge of statins
- Symptoms or lab abnormalities are not due to established predispositions such as drug interactions, significant changes in physical activity, or underlying muscle disease

OR

4.3 Member has a contraindication to statin use such as active liver disease or persistently elevated serum transaminases

Product Name: Repatha	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) within the past 12 month demonstrating a reduction in LDL-C from baseline

AND

2 - Member continues treatment with baseline lipid-lowering therapies

Product Name: Repatha	
Approval Length	12/31/2039
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) within the past 12 month demonstrating a reduction in LDL-C from baseline

AND

2 - Member continues treatment with baseline lipid-lowering therapies

2 . Revision History

Date	Notes
10/8/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131458
Guideline Name	Restricted Diclofenac
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Zipsor, Generic Cambia	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure (with maximized doses) or intolerance of a preferred oral diclofenac

AND

2 - Trial and failure (with maximized doses) or intolerance of another preferred oral nonsteroidal anti-inflammatory drug (NSAID)

Product Name: Diclofenac 2% solution (generic Pennsaid), Diclofenac 1.5% solution, Diclofenac 3% gel	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Both of the following:

1.1 Trial and failure (with maximized doses), contraindication or intolerance to two preferred oral NSAIDs

AND

1.2 Trial and failure of maximized dosing of generic diclofenac 1% gel

OR

2 - (Diclofenac 3% gel only) Used for short-term treatment of actinic keratosis

Product Name: Generic Zipsor, Generic Cambia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Both of the following:

1.1 Trial and failure (with maximized doses) or intolerance of a preferred oral diclofenac

AND

1.2 Trial and failure (with maximized doses) or intolerance of another preferred oral nonsteroidal anti-inflammatory drug (NSAID)

OR

2 - (Minnesota plans only) – Member has stage four metastatic cancer and the requested drug is being used to treat cancer-related pain

Product Name: Diclofenac 2% solution (generic Pennsaid), Diclofenac 1.5% solution, Diclofenac 3% gel	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Both of the following:

1.1 Trial and failure (with maximized doses), contraindication or intolerance to two preferred oral NSAIDs

AND

1.2 Trial and failure of maximized dosing of generic diclofenac 1% gel

OR

2 - (Diclofenac 3% gel only) Used for short-term treatment of actinic keratosis

OR

3 - (Minnesota plans only) – Member has stage four metastatic cancer and the requested drug is being used to treat cancer-related pain

Product Name: Generic Zipsor, Generic Cambia, Diclofenac 2% solution (generic Pennsaid), Diclofenac 1.5% solution, Diclofenac 3% gel	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
10/24/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131503
Guideline Name	Restricted Inhaled Corticosteroid
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Pulmicort Flexhaler, Alvesco, Asmanex	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting trial and failure (e.g., objective change in symptom control such as Asthma Control Test score, nocturnal awakenings, increased rescue inhaler use, etc.) with an equipotent dose as outlined in the Global Initiative for Asthma (GINA) guidelines, intolerance, or contraindication to a preferred fluticasone product (e.g., Arnuity Ellipta or Flovent)

OR

2 - The requested drug is being used as an add-on inhaler to a preferred fluticasone or mometasone maintenance inhaler for patients who need to “step-up” their asthma treatment plan (i.e. go from Green Zone to Yellow Zone, etc.) due to an increase in symptoms

OR

3 - (For Pulmicort only): Submission of medical records (e.g., chart notes) documenting a current pregnancy

Product Name: Pulmicort Flexhaler, Alvesco, Asmanex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting trial and failure (e.g., objective change in symptom control such as Asthma Control Test score, nocturnal awakenings, increased rescue inhaler use, etc.) with an equipotent dose as outlined in the Global Initiative for Asthma (GINA) guidelines, intolerance, or contraindication to a preferred fluticasone product (e.g., Arnuity Ellipta or Flovent)

OR

2 - The requested drug is being used as an add-on inhaler to a preferred fluticasone or mometasone maintenance inhaler for patients who need to “step-up” their asthma treatment plan (i.e. go from Green Zone to Yellow Zone, etc.) due to an increase in symptoms

OR

3 - (For Pulmicort only): Submission of medical records (e.g., chart notes) documenting a current pregnancy

Product Name: Pulmicort Flexhaler, Alvesco, Asmanex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
10/8/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131573
Guideline Name	Restricted Long-acting Morphine Sulfate
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Morphine ER capsules (Kadian and Evinza equivalent)	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans
Approval Criteria **1** - Trial and failure, contraindication or intolerance to an equivalent dose of generic extended release morphine tablets (MS Contin equivalent)	

Product Name: Morphine ER capsules (Kadian and Evinza equivalent)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication or intolerance to an equivalent dose of generic extended-release morphine tablets (MS Contin equivalent)

OR

2 - (Minnesota plans only) – Member has stage four metastatic cancer and the requested drug is being used to treat cancer-related pain

Product Name: Morphine ER capsules (Kadian and Evinza equivalent)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
10/13/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131419
Guideline Name	Restricted Methotrexate Injection
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Rasuvo, Otrexup, Reditrex	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Documented disability that does not allow administration of methotrexate from conventional vials utilizing conventional syringes

AND

2 - The person or a family member/caregiver are self-administering the medication

Product Name: Rasuvo, Otrexup, Reditrex	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Documentation from the past 12 months that the person is continuing therapy with the requested drug

Product Name: Rasuvo, Otrexup, Reditrex	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Documented disability that does not allow administration of methotrexate from conventional vials utilizing conventional syringes

AND

2 - The person or a family member/caregiver are self-administering the medication

2 . Revision History

Date	Notes
10/24/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-137244
Guideline Name	Restricted Minocycline ER
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Brand Coremino, Generic Solodyn, generic minocycline extended release	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Trial and intolerance (clinically significant side effects that limit use) from a preferred minocycline product at equivalent doses

AND

2 - The prescriber provides an evidence-based clinical rationale why a different result would be expected with use of minocycline ER

Product Name: Brand Coremino, Generic Solodyn, generic minocycline extended release	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Brand Coremino, Generic Solodyn, generic minocycline extended release	
Approval Length	One fill
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Trial and intolerance (clinically significant side effects that limit use) from a preferred minocycline product at equivalent doses

AND

2 - The prescriber provides an evidence-based clinical rationale why a different result would be expected with use of minocycline ER

2 . Revision History

Date	Notes
12/6/2023	New program

Prior Authorization Guideline

Guideline ID	GL-134517
Guideline Name	Restricted Non-preferred Medications
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Restricted Non-preferred Drugs Greater than or equal to 5 therapeutic alternatives	
Diagnosis	Illinois Plan ONLY
Approval Length	12
Guideline Type	Administrative

Approval Criteria

1 - Both of the following:

1.1 The requested medication has a diagnosis that is one of the following:

- Food Drug Administration (FDA)-approved indication

- A medically accepted indication that is supported by nationally recognized compendia (see table of Compendia Requirements within the Background Section)

AND

1.2 For drugs with greater than or equal to 5 therapeutic alternatives (in the same drug class or different drug class that treats the same disease as the requested drug) one of the following:

1.2.1 Trial and failure or intolerance, or contraindication to at least 2 preferred alternatives in the same drug class

OR

1.2.2 Trial and failure to at least 2 preferred alternatives from other drug classes that treat the same disease if there are not 2 formulary alternatives in the same drug class and provider attests that it is clinically appropriate treatment of the diagnosis

OR

1.2.3 Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who are established on nonpreferred therapy, will have coverage under their drug benefit with submission of medical records (e.g., chart notes) documenting symptom improvement or disease stability

OR

2 - The requested drug is FDA approved for the treatment of tick-borne disease

Product Name: Restricted Non-preferred Drugs less than 5 therapeutic alternatives	
Diagnosis	Illinois Plan ONLY
Approval Length	12
Guideline Type	Administrative

Approval Criteria

1 - Both of the following:

1.1 The requested medication has a diagnosis that is one of the following:

- Food Drug Administration (FDA)-approved indication
- A medically accepted indication that is supported by nationally recognized compendia (see table of Compendia Requirements within the Background Section)

AND

1.2 For drugs with less than 5 therapeutic alternatives (in the same drug class or different drug class that treats the same disease as the requested drug) one of the following:

1.2.1 Trial and failure or intolerance, or contraindication to at least 1 preferred alternative in the same drug class

OR

1.2.2 Trial and failure to at least 1 preferred alternative from other drug classes that treat the same disease if there are not 1 formulary alternatives in the same drug class and provider attests that it is clinically appropriate treatment of the diagnosis

OR

1.2.3 Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who are established on nonpreferred therapy, will have coverage under their drug benefit with submission of medical records (e.g., chart notes) documenting symptom improvement or disease stability

OR

2 - The requested drug is for the treatment of tick-borne disease

Product Name: Restricted Non-preferred Drugs Greater than or equal to 5 therapeutic alternatives	
Diagnosis	Minnesota Plans ONLY
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Administrative

Approval Criteria

1 - Both of the following:

1.1 The requested medication has a diagnosis that is one of the following:

- Food Drug Administration (FDA)-approved indication
- A medically accepted indication that is supported by nationally recognized compendia (see table of Compendia Requirements within the Background Section)

AND

1.2 For drugs with greater than or equal to 5 therapeutic alternatives (in the same drug class or different drug class that treats the same disease as the requested drug) one of the following:

1.2.1 Trial and failure or intolerance, or contraindication to at least 2 preferred alternatives in the same drug class

OR

1.2.2 Trial and failure to at least 2 preferred alternatives from other drug classes that treat the same disease if there are not 2 formulary alternatives in the same drug class and provider attests that it is clinically appropriate treatment of the diagnosis

OR

1.2.3 Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who are established on nonpreferred therapy, will have coverage under their drug benefit with submission of medical records (e.g., chart notes) documenting symptom improvement or disease stability

OR

2 - Both of the following:

2.1 Provider attests the patient has emotional disturbance or mental illness

AND

2.2 Prescriber submits medical records (e.g., chart notes) that all equivalent drugs in the formulary were considered and it has been determined that the drug prescribed will best treat the person's condition

OR

3 - For continuation of care: the person has been treated for 90 days prior to the change, the medication is working, and the prescriber attests the drug prescribed will best treat the person's condition

OR

4 - The requested drug is for stage four metastatic cancer and prescribed drug is used for cancer related treatment including but not limited to: pain, constipation, nausea, or prevention/treatment of infection

Product Name: Restricted Non-preferred Drugs less than 5 therapeutic alternatives	
Diagnosis	Minnesota Plans ONLY
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Administrative

Approval Criteria

1 - Both of the following:

1.1 The requested medication has a diagnosis that is one of the following:

- Food Drug Administration (FDA)-approved indication
- A medically accepted indication that is supported by nationally recognized compendia (see table of Compendia Requirements within the Background Section)

AND

1.2 For drugs with less than 5 therapeutic alternatives (in the same drug class or different drug class that treats the same disease as the requested drug) one of the following:

1.2.1 Trial and failure or intolerance, or contraindication to at least 1 preferred alternative in the same drug class

OR

1.2.2 Trial and failure to at least 1 preferred alternative from other drug classes that treat the same disease if there are not 1 formulary alternatives in the same drug class and provider attests that it is clinically appropriate treatment of the diagnosis

OR

2 - Both of the following:

2.1 Provider attests the patient has emotional disturbance or mental illness

AND

2.2 Submission of medical records (e.g., chart notes) that all equivalent drugs in the formulary were considered and it has been determined that the drug prescribed will best treat the person's condition

OR

3 - For continuation of care: the person has been treated for 90 days prior to the change, the medication is working, and the prescriber attests the drug prescribed will best treat the person's condition

OR

4 - The requested drug is for stage four metastatic cancer and prescribed drug is used for cancer related treatment including but not limited to: pain, constipation, nausea, or prevention/treatment of infection

Product Name: Restricted Non-preferred Drugs greater than or equal to 5 therapeutic alternatives	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Administrative - All plans except IL and MN

Approval Criteria

1 - The requested medication has a diagnosis that is one of the following:

- Food Drug Administration (FDA)-approved indication
- A medically accepted indication that is supported by nationally recognized compendia (see table of Compendia Requirements within the Background Section)

AND

2 - For drugs with greater than or equal to 5 therapeutic alternatives (in the same drug class or different drug class that treats the same disease as the requested drug) one of the following:

2.1 Trial and failure or intolerance, or contraindication to at least 2 preferred alternatives in the same drug class

OR

2.2 Trial and failure to at least 2 preferred alternatives from other drug classes that treat the same disease if there are not 2 formulary alternatives in the same drug class and provider attests that it is clinically appropriate treatment of the diagnosis

OR

2.3 Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who are established on nonpreferred therapy, will have coverage under their drug benefit with submission of medical records (e.g., chart notes) documenting symptom improvement or disease stability

Product Name: Restricted Non-preferred Drugs less than 5 therapeutic alternatives	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Administrative - All other plans except IL and MN

Approval Criteria

1 - The requested medication has a diagnosis that is one of the following:

- Food Drug Administration (FDA)-approved indication
- A medically accepted indication that is supported by nationally recognized compendia (see table of Compendia Requirements within the Background Section)

AND

2 - For drugs with less than 5 therapeutic alternatives (in the same drug class or different drug class that treats the same disease as the requested drug) one of the following:

2.1 Trial and failure or intolerance, or contraindication to at least 1 preferred alternative in the same drug class

OR

2.2 Trial and failure to at least 1 preferred alternative from other drug classes that treat the same disease if there are not 1 formulary alternatives in the same drug class and provider attests that it is clinically appropriate treatment of the diagnosis

OR

2.3 Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who are established on nonpreferred therapy, will have coverage under their drug benefit with submission of medical records (e.g., chart notes) documenting symptom improvement or disease stability

Product Name: All Indications above	
Diagnosis	All Plans
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Administrative

Approval Criteria

1 - Paid claims or submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
12/7/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131574
Guideline Name	Restricted Nonpreferred Proton Pump Inhibitor (PPI)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic dexlansoprazole	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance to at least THREE of the following preferred PPI alternatives:

- omeprazole
- pantoprazole
- lansoprazole
- rabeprazole tablets

- esomeprazole capsules

Product Name: Generic dexlansoprazole	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL Plan

Approval Criteria

1 - Trial and failure, contraindication, or intolerance to at least THREE of the following preferred PPI alternatives:

- omeprazole
- pantoprazole
- lansoprazole
- rabeprazole tablets
- esomeprazole capsules

Product Name: Generic dexlansoprazole	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - MN Plan

Approval Criteria

1 - Trial and failure, contraindication, or intolerance to at least THREE of the following preferred PPI alternatives:

- omeprazole
- pantoprazole
- lansoprazole
- rabeprazole tablets
- esomeprazole capsules

OR

2 - Diagnosis of stage four metastatic cancer and the requested drug is being used as supportive care to treat symptoms directly related to their cancer or chemotherapy regimen

Product Name: Generic dexlansoprazole	
Diagnosis	Quantity Exception
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Member has extraesophageal symptoms

OR

2 - The requested dosing schedule cannot be met using commercially available dose forms within the quantity limit and the prescriber provides an evidence-based rationale for using a dose outside of the quantity limit

OR

3 - For use in compounded prescriptions where the quantity limit would prevent the pharmacy from being able to make the compounded formulation

Product Name: Generic dexlansoprazole	
Diagnosis	Quantity Exception
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Member has extraesophageal symptoms

OR

2 - The requested dosing schedule cannot be met using commercially available dose forms within the quantity limit and the prescriber provides an evidence-based rationale for using a dose outside of the quantity limit

OR

3 - For use in compounded prescriptions where the quantity limit would prevent the pharmacy from being able to make the compounded formulation

Product Name: Generic dexlansoprazole	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Prescriber provides clinical documentation from the past 12 months that the person is continuing therapy with the requested drug

2 . Revision History

Date	Notes
10/6/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-127882
Guideline Name	Restricted Oral Antipsychotics Step
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Asenapine, Vraylar, Fanapt, Caplyta, Generic Lurasidone, Rexulti	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance of a preferred second-generation antipsychotic (i.e., aripiprazole, olanzapine, risperidone, quetiapine, or ziprasidone).

OR

2 - For Minnesota Plans Only: If requested drug is prescribed for emotional disturbance or mental illness, approve if submission of medical records (e.g., chart notes) documenting that all equivalent drugs in the formulary were considered and it has been determined that the drug prescribed will best treat the member's condition

Product Name: Generic Asenapine, Vraylar, Fanapt, Caplyta, Generic Lurasidone, Rexulti	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

OR

2 - For Minnesota Plans Only - Both of the following for continuation of care (i.e. formulary changes or new member [(as evidenced by coverage effective date of less than or equal to 90 days]):

2.1 The member has been treated with the drug for 90 days prior to the change

AND

2.2 Submission of medical records (e.g., chart notes) of documentation that the drug prescribed will best treat the patient's condition

Product Name: Generic Asenapine, Vraylar, Fanapt, Caplyta, Generic Lurasidone, Rexulti	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance of a preferred second-generation antipsychotic (i.e., aripiprazole, olanzapine, risperidone, quetiapine, or ziprasidone).

Product Name: Generic Aripiprazole ODT	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Both of the following:

1.1 Trial and failure, contraindication, or intolerance of aripiprazole tablets.

AND

1.2 Trial and failure, contraindication, or intolerance of one other preferred antipsychotic (i.e., olanzapine, risperidone, quetiapine, ziprasidone).

OR

2 - For Minnesota Plans Only: If requested drug is prescribed for emotional disturbance or mental illness, approve if submission of medical records (e.g., chart notes) documenting that all equivalent drugs in the formulary were considered and it has been determined that the drug prescribed will best treat the member's condition

Product Name: Generic Aripiprazole ODT	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

OR

2 - For Minnesota Plans Only - Both of the following for continuation of care (i.e. formulary changes or new member [(as evidenced by coverage effective date of less than or equal to 90 days]):

2.1 The member has been treated with the drug for 90 days prior to the change

AND

2.2 Submission of medical records (e.g., chart notes) of documentation that the drug prescribed will best treat the patient's condition

Product Name: Generic Aripiprazole ODT	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All Plans except IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance of aripiprazole tablets.

AND

2 - Trial and failure, contraindication, or intolerance of one other preferred antipsychotic (i.e., olanzapine, risperidone, quetiapine, ziprasidone).

2 . Revision History

Date	Notes
8/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129538
Guideline Name	Restricted Oral Oncology Drug
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Akeega, Alunbrig, Ayvakit, Balversa, Braftovi, Brukinsa, Calquence, Caprelsa, Cometriq, Copiktra, Daurismo, Erleada, Fotivda, Gavreto, Iclusig, Idhifa, Inqovi, Jaypirca, Krazati, Lenvima, Lorbrena, Lumakras, Lytgobi, Mektovi, Nerlynx, Orgovyx, Orserdu, Pemazyre, Qinlock, Rezlidhia, Rydapt, Scemblix, Talzenna, Tepmetko,Tibsovo, Turalio, Vanflyta, Vitrakvi, Vizimpro, Vonjo, Welireg, Xospata, Xpovio,Yonsa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans
Approval Criteria **1** - One of the following:	

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member*

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Akeega, Alunbrig, Ayvakit, Balversa, Braftovi, Brukinsa, Calquence, Caprelsa, Cometriq, Copiktra, Daurismo, Erleada, Fotivda, Gavreto, Iclusig, Idhifa, Inqovi, Jaypirca, Krazati, Lenvima, Lorbrena, Lumakras, Lytgobi, Mektovi, Nerlynx, Orgovyx, Orserdu, Pemazyre, Qinlock, Rezlidhia, Rydapt, Scemblix, Talzenna, Tepmetko,Tibsovo, Turalio, Vanflyta, Vitrakvi, Vizimpro, Vonjo, Welireg, Xospata, Xpovio,Yonsa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member*

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Akeega, Alunbrig, Ayvakit, Balversa, Braftovi, Brukinsa, Calquence, Caprelsa, Cometriq, Copiktra, Daurismo, Erleada, Fotivda, Gavreto, Iclusig, Idhifa, Inqovi, Jaypirca, Krazati, Lenvima, Lorbrena, Lumakras, Lytgobi, Mektovi, Nerlynx, Orgovyx, Orserdu, Pemazyre, Qinlock, Rezlidhia, Rydapt, Scemblix, Talzenna, Tepmetko,Tibsovo, Turalio, Vanflyta, Vitrakvi, Vizimpro, Vonjo, Welireg, Xospata, Xpovio,Yonsa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - MN Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member

OR

1.3 The requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the member in one of the following:*

- United States Pharmacopeia Drug Information
- American Hospital Formulary Service Drug Information
- One article in a major peer-reviewed medical journal that recognizes the safety and efficacy of the requested drug, in the member's specific condition

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Akeega, Alunbrig, Ayvakit, Balversa, Braftovi, Brukinsa, Calquence, Caprelsa, Cometriq, Copiktra, Daurismo, Erleada, Fotivda, Gavreto, Iclusig, Idhifa, Inqovi, Jaypirca, Krazati, Lenvima, Lorbrena, Lumakras, Lytgobi, Mektovi, Nerlynx, Orgovyx, Orserdu, Pemazyre, Qinlock, Rezlidhia, Rydapt, Scemblix, Talzenna, Tepmetko,Tibsovo, Turalio, Vanflyta, Vitrakvi, Vizimpro, Vonjo, Welireg, Xospata, Xpovio,Yonsa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - MN Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member

OR

1.3 The requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the member in one of the following*:

- United States Pharmacopeia Drug Information
- American Hospital Formulary Service Drug Information
- One article in a major peer-reviewed medical journal that recognizes the safety and efficacy of the requested drug, in the member's specific condition

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Akeega, Alunbrig, Ayvakit, Balversa, Braftovi, Brukinsa, Calquence, Caprelsa, Cometriq, Copiktra, Daurismo, Erleada, Fotivda, Gavreto, Iclusig, Idhifa, Inqovi, Jaypirca, Krazati, Lenvima, Lorbrena, Lumakras, Lytgobi, Mektovi, Nerlynx, Orgovyx, Orserdu, Pemazyre, Qinlock, Rezlidhia, Rydapt, Scemblix, Talzenna, Tepmetko,Tibsovo, Turalio, Vanflyta, Vitrakvi, Vizimpro, Vonjo, Welireg, Xospata, Xpovio,Yonsa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member

OR

1.3 The requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the member in one of the following*:

- American Hospital Formulary Service Drug Information
- Thompson Micromedex's Drug Dex
- Elsevier Gold Standard's Clinical Pharmacology
- Two articles in a major peer-reviewed medical journal from the United States or Great Britain that recognizes the safety and efficacy of the requested drug, in the member's specific condition

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Akeega, Alunbrig, Ayvakit, Balversa, Braftovi, Brukinsa, Calquence, Caprelsa, Cometriq, Copiktra, Daurismo, Erleada, Fotivda, Gavreto, Iclusig, Idhifa, Inqovi, Jaypirca, Krazati, Lenvima, Lorbrena, Lumakras, Lytgobi, Mektovi, Nerlynx, Orgovyx, Orserdu, Pemazyre, Qinlock, Rezlidhia, Rydapt, Scemblix, Talzenna, Tepmetko,Tibsovo, Turalio, Vanflyta, Vitrakvi, Vizimpro, Vonjo, Welireg, Xospata, Xpovio,Yonsa	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member

OR

1.3 The requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the member in one of the following*:

- American Hospital Formulary Service Drug Information
- Thompson Micromedex's Drug Dex
- Elsevier Gold Standard's Clinical Pharmacology
- Two articles in a major peer-reviewed medical journal from the United States or Great Britain that recognizes the safety and efficacy of the requested drug, in the member's specific condition

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

2 . Revision History

Date	Notes
10/25/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-141300
Guideline Name	Restricted Oral Oncology Drugs Quartz Specialty Pharmacy Network
Formulary	• Quartz

Guideline Note:

Effective Date:	2/15/2024

1 . Criteria

Product Name: Alecensa, Cotellic, Erivedge, Exkivity, Generic abiraterone, Generic lapatinib, Generic lenalidomide, Gilotrif, Hycamtin, Ibrance, Imbruvica, Kisqali, Kisqali Femara, Koselugo, Lonsurf, Mekinist, Ninlaro, Odomzo, Onureg, Pomalyst, Rozlytrek, Stivarga, Tabrecta, Tafinlar, Tukysa, Venclexta, Verzenio, Zolinza, Zydelig	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member*

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Alecensa, Cotellic, Erivedge, Exkivity, Generic abiraterone, Generic lapatinib, Generic lenalidomide, Gilotrif, Hycamtin, Ibrance, Imbruvica, Kisqali, Kisqali Femara, Koselugo, Lonsurf, Mekinist, Ninlaro, Odomzo, Onureg, Pomalyst, Rozlytrek, Stivarga, Tabrecta, Tafinlar, Tukysa, Venclexta, Verzenio, Zolinza, Zydelig	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member*

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Alecensa, Bosulif, Cabometyx, Cotellic, Erivedge, Exkivity, Generic abiraterone, Generic erlotinib, Generic everolimus, Generic gefitinib, Generic lapatinib, Generic lenalidomide, Generic sorafenib, Generic sunitinib, Gilotrif, Hycamtin, Ibrance, Imbruvica, Inlyta, Inrebic, Jakafi, Kisqali, Kisqali Femara, Koselugo, Lonsurf, Lynparza, Mekinist, Ninlaro, Nubeqa, Odomzo, Onureg, Piqray, Pomalyst, Retevmo, Rozlytrek, Rubraca, Sprycel, Stivarga, Tabrecta, Tafinlar, Tagrisso, Tasigna, Tazverik, Tukysa, Venclexta, Verzenio, Votrient, Xalkori, Xtandi, Zejula, Zelboraf, Zolinza, Zydelig, Zykadia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member

OR

1.3 The requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the member* in one of the following:

- American Hospital Formulary Service Drug Information
- Thompson Micromedex's Drug Dex
- Elsevier Gold Standard's Clinical Pharmacology
- Two articles in peer-reviewed professional medical journals from the United States or Great Britain that recognize the safety and efficacy of the requested drug in the member's specific condition

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Alecensa, Bosulif, Cabometyx, Cotellic, Erivedge, Exkivity, Generic abiraterone, Generic erlotinib, Generic everolimus, Generic gefitinib, Generic lapatinib, Generic lenalidomide, Generic sorafenib, Generic sunitinib, Gilotrif, Hycamtin, Ibrance, Imbruvica, Inlyta, Inrebic, Jakafi, Kisqali, Kisqali Femara, Koselugo, Lonsurf, Lynparza, Mekinist, Ninlaro, Nubeqa, Odomzo, Onureg, Piqray, Pomalyst, Retevmo, Rozlytrek, Rubraca, Sprycel, Stivarga, Tabrecta, Tafinlar, Tagrisso, Tasigna, Tazverik, Tukysa, Venclexta, Verzenio, Votrient, Xalkori, Xtandi, Zejula, Zelboraf, Zolinza, Zydelig, Zykadia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member

OR

1.3 The requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the member* in one of the following:

- American Hospital Formulary Service Drug Information
- Thompson Micromedex's Drug Dex
- Elsevier Gold Standard's Clinical Pharmacology
- Two articles in peer-reviewed professional medical journals from the United States or Great Britain that recognize the safety and efficacy of the requested drug in the member's specific condition

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Alecensa, Cotellic, Erivedge, Exkivity, Generic abiraterone, Generic lapatinib, Generic lenalidomide, Gilotrif, Hycamtin, Ibrance, Imbruvica, Kisqali, Kisqali Femara, Koselugo, Lonsurf, Mekinist, Ninlaro, Odomzo, Onureg, Pomalyst, Rozlytrek, Stivarga, Tabrecta, Tafinlar, Tukysa, Venclexta, Verzenio, Zolinza, Zydelig	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - MN Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member

OR

1.3 The requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the member* in one of the following:

- United States Pharmacopeia Drug Information
- American Hospital Formulary Service Drug Information
- One article in a major peer- reviewed medical journal that recognizes the safety and efficacy of the requested drug in the member's specific condition

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Alecensa, Cotellic, Erivedge, Exkivity, Generic abiraterone, Generic lapatinib, Generic lenalidomide, Gilotrif, Hycamtin, Ibrance, Imbruvica, Kisqali, Kisqali Femara, Koselugo, Lonsurf, Mekinist, Ninlaro, Odomzo, Onureg, Pomalyst, Rozlytrek, Stivarga, Tabrecta, Tafinlar, Tukysa, Venclexta, Verzenio, Zolinza, Zydelig	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - MN Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member

OR

1.3 The requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the member* in one of the following:

- United States Pharmacopeia Drug Information
- American Hospital Formulary Service Drug Information
- One article in a major peer- reviewed medical journal that recognizes the safety and efficacy of the requested drug in the member's specific condition

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

2 . Revision History

Date	Notes

2/14/2024	Update program – Bosulif capsules added to IL criteria

Prior Authorization Guideline

Guideline ID	GL-141303
Guideline Name	Restricted Oral Oncology Drugs Split Fill
Formulary	• Quartz

Guideline Note:

Effective Date:	2/15/2024

1 . Criteria

Product Name: Bosulif, Cabometyx, Generic erlotinib, Generic everolimus, Generic gefitinib, Generic sorafenib, Generic sunitinib, Inlyta, Inrebic, Jakafi, Lynparza, Nubeqa, Piqray, Retevmo, Rubraca, Sprycel, Tagrisso, Tasigna, Tazverik, Votrient, Xalkori, Xtandi, Zejula, Zelboraf, Zykadia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member*

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Bosulif, Cabometyx, Generic erlotinib, Generic everolimus, Generic gefitinib, Generic sorafenib, Generic sunitinib, Inlyta, Inrebic, Jakafi, Lynparza, Nubeqa, Piqray, Retevmo, Rubraca, Sprycel, Sutent, Tagrisso, Tasigna, Tarceva, Tazverik, Votrient, Xalkori, Xtandi, Zejula, Zelboraf, Zykadia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member*

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Bosulif, Cabometyx, Generic erlotinib, Generic everolimus, Generic gefitinib, Generic sorafenib, Generic sunitinib, Inlyta, Inrebic, Jakafi, Lynparza, Nubeqa, Piqray, Retevmo, Rubraca, Sprycel, Tagrisso, Tasigna, Tarceva, Tazverik, Votrient, Xalkori, Xtandi, Zejula, Zelboraf, Zykadia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - MN Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member*

OR

1.3 The requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the member in one of the following:*

- United States Pharmacopeia Drug Information
- American Hospital Formulary Service Drug Information
- One article in a major peer-reviewed medical journal that recognizes the safety and efficacy of the requested drug in the member's specific condition

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

Product Name: Bosulif, Cabometyx, Generic erlotinib, Generic everolimus, Generic gefitinib, Generic sorafenib, Generic sunitinib, Inlyta, Inrebic, Jakafi, Lynparza, Nubeqa, Piqray, Retevmo, Rubraca, Sprycel, Tagrisso, Tasigna, Tarceva, Tazverik, Votrient, Xalkori, Xtandi, Zejula, Zelboraf, Zykadia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - MN Plans

Approval Criteria

1 - One of the following:

1.1 The requested drug is being used alone or in a combination regimen that is FDA-labeled for the treatment of the specific condition the member presents with*

OR

1.2 The requested drug is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) in the specific condition of the member*

OR

1.3 The requested drug is being used alone or in a combination regimen that is recommended for use in the specific condition of the member in one of the following:*

- United States Pharmacopeia Drug Information
- American Hospital Formulary Service Drug Information
- One article in a major peer-reviewed medical journal that recognizes the safety and efficacy of the requested drug in the member's specific condition

AND

2 - Prescribed by or in consultation with one of the following:

- oncologist
- hematologist
- other specialist in the treatment of malignancy

Notes	*Includes any relevant genetic testing, mutations, etc.

2 . Revision History

Date	Notes
2/14/2024	Update program – Bosulif capsules added criteria

Prior Authorization Guideline

Guideline ID	GL-131421
Guideline Name	Restricted Paroxetine
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Paroxetine mesylate	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of vasomotor symptoms due to menopause

AND

2 - Failure of a trial of generic paroxetine (Paxil generic) at an equivalent dose

AND

3 - The prescriber provides an evidence-based clinical rationale for why the requested formulation would provide different results.

Product Name: Paroxetine mesylate	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Paroxetine mesylate	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of vasomotor symptoms due to menopause

AND

2 - Failure of a trial of generic paroxetine (Paxil generic) at an equivalent dose

AND

3 - The prescriber provides an evidence-based clinical rationale for why the requested formulation would provide different results.

2 . Revision History

Date	Notes
10/16/2023	New program

Prior Authorization Guideline

Guideline ID	GL-131422
Guideline Name	Restricted Phosphate Binders
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Velphoro	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD) requiring dialysis

AND

2 - Trial and failure, contraindication, or intolerance to BOTH a sevelamer product (e.g. Renagel, Renvela) and lanthanum (Fosrenol)

Product Name: Velphoro	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Velphoro	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD) requiring dialysis

AND

2 - Trial and failure, contraindication, or intolerance to BOTH a sevelamer product (e.g. Renagel, Renvela) and lanthanum (Fosrenol)

2 . Revision History

Date	Notes
10/9/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-137000
Guideline Name	Restricted Progesterone
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Crinone, Endometrin, progesterone injection	
Diagnosis	Pregnancy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans Only

Approval Criteria

1 - One of the following:

1.1 For members in the 1st trimester of pregnancy, ALL of the following:

- Submission of medical records (e.g., chart notes) documenting member is pregnant

- Prescriber determines that progesterone is to maintain pregnancy
- For Progesterone Injection requests ONLY: The drug is being self-administered

OR

1.2 For members in the 2nd trimester of pregnancy, ALL of the following:

- For Progesterone Injection requests ONLY: The drug is being self-administered
- Submission of medical records (e.g., chart notes) documenting a singleton pregnancy
- Submission of medical records (e.g., chart notes) documenting member has a history of preterm birth

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies *Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Crinone, Endometrin, progesterone injection	
Diagnosis	Pregnancy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans Only

Approval Criteria

1 - One of the following:

1.1 For members in the 1st trimester of pregnancy, ALL of the following:

- Submission of medical records (e.g., chart notes) documenting member is pregnant
- Prescriber determines that progesterone is to maintain pregnancy
- For Progesterone Injection requests ONLY: The drug is being self-administered

OR

1.2 For members in the 2nd trimester of pregnancy, ALL of the following:

- For Progesterone Injection requests ONLY: The drug is being self-administered
- Submission of medical records (e.g., chart notes) documenting a singleton pregnancy
- Submission of medical records (e.g., chart notes) documenting member has a history of preterm birth

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies *Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Crinone, Endometrin, progesterone injection	
Diagnosis	Pregnancy
Approval Length	1st trimester use = 4 months. 2nd trimester use = 6 months.
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - One of the following:

1.1 For members in the 1st trimester of pregnancy, ALL of the following:

- Submission of medical records (e.g., chart notes) documenting member is pregnant
- Prescriber determines that progesterone is to maintain pregnancy
- For Progesterone Injection requests ONLY: The drug is being self-administered

OR

1.2 For members in the 2nd trimester of pregnancy, ALL of the following:

- For Progesterone Injection requests ONLY: The drug is being self-administered
- Submission of medical records (e.g., chart notes) documenting a singleton pregnancy
- Submission of medical records (e.g., chart notes) documenting member has a history of preterm birth

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies *Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Crinone, Endometrin, progesterone injection	
Diagnosis	Pregnancy
Approval Length	1st trimester use = 4 months. 2nd trimester use = 6 months.
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - One of the following:

1.1 For members in the 1st trimester of pregnancy, ALL of the following:

- For Progesterone Injection requests ONLY: The drug is being self-administered
- Submission of medical records (e.g., chart notes) documenting member is pregnant
- Prescriber determines that progesterone is to maintain pregnancy

OR

1.2 For members in the 2nd trimester of pregnancy, ALL of the following:

- For Progesterone Injection requests ONLY: The drug is being self-administered
- Submission of medical records (e.g., chart notes) documenting a singleton pregnancy

• Submission of medical records (e.g., chart notes) documenting member has a history of preterm birth	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies *Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Crinone, Endometrin, progesterone injection	
Diagnosis	Infertility
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL Plan
Approval Criteria **1** - Quartz plan issued in the state of Illinois **AND** **2** - Provider attests patient has infertility coverage as outlined in Illinois Insurance Code 215 ILCS 5/356m	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies *Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Crinone, Endometrin, progesterone injection	
Diagnosis	Infertility
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL Plan
Approval Criteria **1** - Quartz plan issued in the state of Illinois **AND** **2** - Provider attests patient has infertility coverage as outlined in Illinois Insurance Code 215 ILCS 5/356m	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies *Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

2 . Revision History

Date	Notes
11/28/2023	Updated provider attestation verbiage.

Prior Authorization Guideline

Guideline ID	GL-129869
Guideline Name	Restricted Tacrolimus Formulations
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Prograf granule packets	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Member has swallowing impairment or other medical condition that prevents use of solid dose forms

AND

2 - One of the following:

2.1 Trial and failure, contraindication, or intolerance to an adequate trial of an alternative (e.g. sirolimus, cyclosporine)

OR

2.2 Submission of medical records (e.g., chart notes) documenting evidence-based rationale for why the alternatives would not be medically appropriate for the member's condition

Product Name: Astagraf XL, Envarsus XR	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Trial and failure (documented inability to achieve goal trough drug levels despite appropriate dose adjustment and teaching/adherence interventions from a pharmacist and other health care providers) or intolerance of immediate release tacrolimus

Product Name: Prograf granule packets, Astagraf XL, Envarsus XR	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Prograf granule packets	
Approval Length	12/31/2039

Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Member has swallowing impairment or other medical condition that prevents use of solid dose forms

AND

2 - One of the following:

2.1 Trial and failure, contraindication, or intolerance to an adequate trial of an alternative (e.g. sirolimus, cyclosporine)

OR

2.2 Submission of medical records (e.g., chart notes) documenting evidence-based rationale for why the alternatives would not be medically appropriate for the member's condition

Product Name: Astagraf XL, Envarsus XR	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Trial and failure (documented inability to achieve goal trough drug levels despite appropriate dose adjustment and teaching/adherence interventions from a pharmacist and other health care providers) or intolerance of immediate release tacrolimus

2 . Revision History

Date	Notes
10/12/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131450
Guideline Name	Retinoid Products
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Tretinoin, OTC adapalene, Brand Avita	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans
Approval Criteria **1** - Diagnosis of acne or rosacea	

Product Name: Tretinoin, OTC adapalene, Brand Avita	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of acne or rosacea

Product Name: Aklief	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of acne or rosacea

AND

2 - Trial and failure, contraindication, or intolerance to BOTH of the following:

- preferred tretinoin
- adapalene agent

Product Name: Aklief	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of acne or rosacea

AND

2 - Trial and failure, contraindication, or intolerance to BOTH of the following:

- preferred tretinoin
- adapalene agent

Product Name: Prescription adapalene products	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of acne or rosacea

AND

2 - Trial and failure, contraindication, or intolerance to adapalene 0.1% gel

Product Name: Prescription adapalene products	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of acne or rosacea

AND

2 - Trial and failure, contraindication, or intolerance to adapalene 0.1% gel

Product Name: Tazarotene products	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of psoriasis

OR

2 - Both of the following:

2.1 Diagnosis of acne or rosacea

AND

2.2 Trial and failure, contraindication, or intolerance to BOTH of the following:

- preferred tretinoin
- adapalene agent

Product Name: Tazarotene products	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of psoriasis

OR

2 - Both of the following:

2.1 Diagnosis of acne or rosacea

AND

2.2 Trial and failure, contraindication, or intolerance to BOTH of the following:

- preferred tretinoin
- adapalene agent

Product Name: Duobrii	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of psoriasis

AND

2 - Trial and failure, contraindication, or intolerance to one preferred high or super-high potency topical corticosteroid

Product Name: Duobrii	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of psoriasis

AND

2 - Trial and failure, contraindication, or intolerance to one preferred high or super-high potency topical corticosteroid

Product Name: Clindamycin/tretinoin products	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of acne or rosacea

AND

2 - Trial and failure of concurrent use of the individual products (topical clindamycin and preferred tretinoin)

Product Name: Clindamycin/tretinoin products	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of acne or rosacea

AND

2 - Trial and failure of concurrent use of the individual products (topical clindamycin and preferred tretinoin)

Product Name: All Products Listed Above	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
10/31/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129217
Guideline Name	Revcovi (elapegademase)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Revcovi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Diagnosis of adenosine deaminase severe combined immune deficiency (ADA-SCID)

AND

1.2 Prescribed by, or in consultation with, an expert in the treatment of immune deficiencies

Product Name: Revcovi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The prescriber provides recent clinical documentation from the past 6 months of a trough plasma ADA activity ≥ 30 mmol/hr/L and a trough erythrocyte dAXP level below 0.02 mmol/L

2 . Revision History

Date	Notes
8/9/2023	New program

Prior Authorization Guideline

Guideline ID	GL-128187
Guideline Name	Rezurock (belumosudil mesylate)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Rezurock*	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic graft-versus-host disease (chronic GVHD)

AND

2 - Prescribed by or in consultation by a specialist with experience in the treatment of GVHD (e.g.hematologist, oncologist, immunologist, etc.)

AND

3 - The requested is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) for the treatment of chronic GVHD

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and were not previously approved for c overage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through reauthorization criteria

Product Name: Rezurock*	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic graft-versus-host disease (chronic GVHD)

AND

2 - Prescribed by or in consultation by a specialist with experience in the treatment of GVHD (e.g.hematologist, oncologist, immunologist, etc.)

AND

3 - The requested is being used alone or in a combination regimen that has a class 1 or 2 recommendation for use from the National Comprehensive Cancer Network (NCCN) for the treatment of chronic GVHD

AND **4** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and were not previously approved for c overage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through reauthorization criteria

2 . Revision History

Date	Notes
9/7/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-135400
Guideline Name	Rinvoq (upadacitinib)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Rinvoq	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans
Approval Criteria	

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Rinvoq	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Rinvoq	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active rheumatoid arthritis (RA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a minimum duration of a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)*
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

Notes	* Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immu nodeficiency syndromes, bone marrow hyperplasia, leukopenia, throm bocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Rinvoq	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active rheumatoid arthritis (RA)

AND

3 - Submission of medical records (e.g., chart notes) documenting a minimum duration of a 3-month trial and failure, contraindication, or intolerance to ONE of the following:

- methotrexate (MTX)
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

5 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

4 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

Notes	* Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immu nodeficiency syndromes, bone marrow hyperplasia, leukopenia, throm bocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Rinvoq	
Diagnosis	Ankylosing Spondylitis (AS), Non-radiographic axial spondyloarthritis (nr-axSpA)

Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of one of the following:

- Ankylosing spondylitis (AS)
- Active non-radiographic axial spondyloarthritis (nr-axSpA)

AND

2 - For diagnoses of Non-radiographic axial spondyloarthritis (nr-axSpA): Objective signs of inflammation are present (i.e. lab C-reactive protein elevated, imaging scans indicate inflammation) NOTE: Applies to nr-axSpA diagnosis ONLY

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

5 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

6 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Rinvoq	
Diagnosis	Ankylosing Spondylitis (AS), Non-radiographic axial spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of one of the following:

- Ankylosing spondylitis (AS)
- Active non-radiographic axial spondyloarthritis (nr-axSpA)

AND

2 - For diagnoses of Non-radiographic axial spondyloarthritis (nr-axSpA): Objective signs of inflammation are present (i.e. lab C-reactive protein elevated, imaging scans indicate inflammation) NOTE: Applies to nr-axSpA diagnosis ONLY

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

5 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

6 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Rinvoq	
Diagnosis	Moderate to Severely Active Ulcerative Colitis (UC)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active ulcerative colitis (UC)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - Member is considered high-risk based on ONE of the following characteristics:

- Extensive colitis
- Deep ulcers
- Age less than 40 years
- High CRP and ESR
- Steroid-requiring disease
- History of hospitalization
- C. difficile infection
- CMV infection

AND

4 - Trial and failure, contraindication, or intolerance to a short course (2 to 4 weeks) of oral corticosteroids

AND

5 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

6 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Rinvoq	
Diagnosis	Moderate to Severely Active Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active ulcerative colitis (UC)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - Member is considered high-risk based on ONE of the following characteristics:

- Extensive colitis
- Deep ulcers
- Age less than 40 years
- High CRP and ESR
- Steroid-requiring disease
- History of hospitalization

- C. difficile infection
- CMV infection

AND

4 - Trial and failure, contraindication, or intolerance to a short course (2 to 4 weeks) of oral corticosteroids

AND

5 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

6 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Rinvoq	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe atopic dermatitis (AD) based on body surface area (greater than 10%), extent of disability, extent of pruritus, or impact on sleep, quality of life, current use of systemic immunomodulators)

AND

2 - Prescribed by or in consultation with a dermatologist, allergist, or immunologist

AND

3 - Trial and failure, contraindication, or intolerance to ONE of the following:

- Biologics used in AD (e.g., dupilumab, tralokinumab, abrocitinib)
- Other systemic agents (e.g. methotrexate, cyclosporine, azathioprine, etc.)

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Rinvoq	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe atopic dermatitis (AD) based on body surface area (greater than 10%), extent of disability, extent of pruritus, or impact on sleep, quality of life, current use of systemic immunomodulators)

AND

2 - Prescribed by or in consultation with a dermatologist, allergist, or immunologist

AND

3 - Trial and failure, contraindication, or intolerance to ONE of the following:

- Biologics used in AD (e.g., dupilumab, tralokinumab, abrocitinib)
- Other systemic agents (e.g. methotrexate, cyclosporine, azathioprine, etc.)

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Rinvoq	
Diagnosis	Moderate to Severely Active Crohn's Disease (CD)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Crohn's disease (CD)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - One of the following:

3.1 Member is considered high-risk based on ONE of the following characteristics:

- Age less than 30 years at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (e.g., uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy)

OR

3.2 Both of the following:

3.2.1 Member is considered low-risk

AND

3.2.2 One of the following:

- Trial and failure, contraindication, or intolerance to one conventional therapy (e.g., azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)
- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with one conventional therapy
- Demonstrated steroid dependence
- Conventional therapy clinically inappropriate based on location of disease

AND

4 - Member is 18 years of age or older

AND

5 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

6 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Rinvoq	
Diagnosis	Moderate to Severely Active Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Crohn's disease (CD)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - One of the following:

3.1 Member is considered high-risk based on ONE of the following characteristics:

- Age less than 30 years at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (e.g., uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy)

OR

3.2 Both of the following:

3.2.1 Member is considered low-risk

AND

3.2.2 One of the following:

- Trial and failure, contraindication, or intolerance to one conventional therapy (e.g., azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)
- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with one conventional therapy
- Demonstrated steroid dependence
- Conventional therapy clinically inappropriate based on location of disease

AND

4 - Member is 18 years of age or older

AND

5 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

6 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

Product Name: Rinvoq	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Prescriber provides clinical documentation from the previous 12 months of the member's response to therapy including individual improvements in functional status related to therapeutic response

Product Name: Rinvoq	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - One of the following:

1.1 For members with diagnoses of Ulcerative Colitis, ALL of the following:

1.1.1 Failure of a two-month trial of every other week therapy after completion of induction dosing regimen

AND

1.1.2 Based on subtherapeutic drug concentrations and absence (or low levels) of drug antibodies

AND

1.1.3 Provision of published literature supporting efficacy and safety of dosing regimen beyond induction of 8 weeks

OR

1.2 Members requesting early dose escalation (sooner use of higher doses to avoid untoward outcomes related to uncontrolled inflammation), BOTH of the following:

1.2.1 Submission of medical records (e.g., chart notes) documenting clinical details with description of the regimen (SHORT TERM APPROVAL- 3-month approval)

AND

1.2.2 Member has difficult to control inflammation (e.g. biologic experiences with 2 or 3 previous biologic agents, member with perianal disease needing higher trough drug levels, etc.)

2 . Revision History

Date	Notes
12/5/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-128987
Guideline Name	Rytary (Carbidopa/Levodopa)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Rytary	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Have a diagnosis of Parkinson's disease, post-encephalitic parkinsonism, or parkinsonism following intoxication from carbon monoxide or manganese

AND

2 - Prescribed by, or in consultation with, a Neurologist

AND

3 - Have experienced breakthrough symptoms despite titrated treatment with CONCURRENT immediate-release and extended-release carbidopa/levodopa generics

Product Name: Rytary	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Rytary	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - All of the following:

1.1 Have a diagnosis of Parkinson's disease, post-encephalitic parkinsonism, or parkinsonism following intoxication from carbon monoxide or manganese

AND

1.2 Prescribed by, or in consultation with, a Neurologist

AND

1.3 Have experienced breakthrough symptoms despite titrated treatment with CONCURRENT immediate-release and extended-release carbidopa/levodopa generics

OR

2 - Person is new to the plan (within the past 90 days) and submission of medical notes (e.g., chart notes) from the past 12 months that the person is continuing therapy with the requested medication

2 . Revision History

Date	Notes
9/20/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131950
Guideline Name	Samsca (Tolvaptan)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic: Tolvaptan	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of severe hypervolemic or euvolemic hyponatremia (sodium level < 125 mEq/L) OR symptomatic less severe hyponatremia (sodium level 125 mEq/L -134 mEq/L)

AND

2 - Current hospitalization for hyponatremia

AND

3 - Symptoms or low serum sodium levels persist despite supervised fluid restriction and appropriate sodium supplementation

Product Name: Generic: Tolvaptan	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Generic: Tolvaptan	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of severe hypervolemic or euvolemic hyponatremia (sodium level < 125 mEq/L) OR symptomatic less severe hyponatremia (sodium level 125 mEq/L -134 mEq/L)

AND

2 - Current hospitalization for hyponatremia

AND

3 - Symptoms or low serum sodium levels persist despite supervised fluid restriction and appropriate sodium supplementation

2 . Revision History

Date	Notes
10/31/2023	New program

Prior Authorization Guideline

Guideline ID	GL-137190
Guideline Name	Sarafem (Fluoxetine 10 mg Tablet)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Fluoxetine 10 mg Tablet	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Person requires a dose that cannot be met using the preferred fluoxetine capsule formulations (5 or 15 mg per day

AND

2 - An adequate trial of daily dosing at 10 mg and 20 mg capsule did not control symptoms or caused intolerable side effects

Product Name: Fluoxetine 10 mg Tablet	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Fluoxetine 10 mg Tablet	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Person requires a dose that cannot be met using the preferred fluoxetine capsule formulations (5 or 15 mg per day

AND

2 - An adequate trial of daily dosing at 10 mg and 20 mg capsule did not control symptoms or caused intolerable side effects

Product Name: Fluoxetine 10 mg Tablet	
Guideline Type	Quantity limit

Approval Criteria

1 - Doses greater than 15mg (1.5 tablets) per day should be denied. Doses greater than 15mg (1.5 tablets) per day require use of the preferred fluoxetine capsule (ie. fluoxetine 10mg capsule, fluoxetine 20mg capsule, fluoxetine 40mg capsule).

2 . Revision History

Date	Notes
11/30/2023	Update Program

Prior Authorization Guideline

Guideline ID	GL-129647
Guideline Name	Savella (milnacipran)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Savella	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Trial of at least 2 preferred treatment options for fibromyalgia: amitriptyline, cyclobenzaprine, venlafaxine, duloxetine, gabapentin, pregabalin

Product Name: Savella	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Savella	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Trial of at least 2 preferred treatment options for fibromyalgia: amitriptyline, cyclobenzaprine, venlafaxine, duloxetine, gabapentin, pregabalin

2 . Revision History

Date	Notes
10/6/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-128186
Guideline Name	Secuado (asenapine patches)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Secuado	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Trial and failure or intolerance to the sublingual tablet formulation at an equivalent dose

OR

1.2 Person with swallowing impairment or other medical condition that prevents use of solid dose forms

OR

2 - For Minnesota Plans - One of the following:

2.1 When prescribed for emotional disturbance or mental illness, approve if prescriber provides submission of medial records (e.g. chart notes) that all equivalent drugs in the formulary were considered and it has been determined that the drug prescribed will best treat the member's condition

OR

2.2 Both of the following for continuation of care: (i.e. formulary changes or new member [as evidenced by coverage effective date of less than or equal to 90 days]):

2.2.1 Member has been treated with the drug for 90 days prior to the change

AND

2.2.2 Prescriber provides submission of medical records (e.g., chart notes) that the drug prescribed will best treat the member's condition

Product Name: Secuado	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Secuado

Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Trial and failure or intolerance to the sublingual tablet formulation at an equivalent dose

OR

2 - Person with swallowing impairment or other medical condition that prevents use of solid dose forms

2 . Revision History

Date	Notes
9/7/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-127881
Guideline Name	Serotonin Modulating Antidepressants
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Trintellix	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance of at least two preferred antidepressants within the Selective Serotonin Reuptake inhibitor (SSRI) or Serotonin Norepinephrine Reuptake inhibitor (SNRI) drug classes

- citalopram
- escitalopram
- sertraline

- paroxetine
- fluoxetine
- venlafaxine
- duloxetine

Product Name: Trintellix	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Trintellix	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance of at least two preferred antidepressants within the Selective Serotonin Reuptake inhibitor (SSRI) or Serotonin Norepinephrine Reuptake inhibitor (SNRI) drug classes

- citalopram
- escitalopram
- sertraline
- paroxetine
- fluoxetine
- venlafaxine
- duloxetine

2 . Revision History

Date	Notes
8/21/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131411
Guideline Name	Signifor (Pasireotide Diasparte)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Signifor	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of Cushing disease

1.1 Ongoing symptoms despite pituitary surgery or nonsurgical candidate

AND

2 - Age greater than or equal to 18 years

AND

3 - Trial and failure, contraindication, or intolerance to octreotide

OR

4 - Other FDA labeled indications

Product Name: Signifor	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Signifor	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of Cushing disease

1.1 Ongoing symptoms despite pituitary surgery or nonsurgical candidate

AND

2 - Age greater than or equal to 18 years

AND

3 - Trial and failure, contraindication, or intolerance to octreotide

OR

4 - Other FDA labeled indications

2 . Revision History

Date	Notes
10/24/2023	New program

Prior Authorization Guideline

Guideline ID	GL-137422
Guideline Name	Simponi (golimumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Simponi	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans
Approval Criteria	

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

3 - Prescribed by or in consultation with a Dermatologist or Rheumatologist

AND

4 - Not used in combination with other biologic DMARDs (e.g., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Simponi	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a Dermatologist or Rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin/nail/scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Not used in combination with other biologic DMARDs (e.g., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Simponi	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Rheumatoid arthritis (RA)

AND

2 - Prescribed by or in consultation with a Rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- Methotrexate (MTX)*
- Leflunomide
- Hydroxychloroquine
- Sulfasalazine

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (e.g., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Notes	*Absolute contraindications to methotrexate are pregnancy, nursing, a lcoholism, alcoholic liver disease or other chronic liver disease, immun odeficiency syndromes, bone marrow hyperplasia, leukopenia, thromb ocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Simponi	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Rheumatoid arthritis (RA)

AND

2 - Prescribed by or in consultation with a Rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- Methotrexate (MTX)*
- Leflunomide
- Hydroxychloroquine
- Sulfasalazine

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (e.g., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Notes	*Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate.

Product Name: Simponi	
Diagnosis	Ankylosing spondylitis (AS)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of Ankylosing spondylitis (AS)

AND

2 - Prescribed by or in consultation with a Rheumatologist

AND

3 - Trial and failure to a 1-month trial of scheduled prescription doses of two different NSAIDs (e.g., naproxen, nabumetone, diclofenac, etc.)

AND

4 - Medication will not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (e.g., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc)

AND

5 - Medication will be self-administered (not in clinic/provider office)

Product Name: Simponi	
Diagnosis	Ankylosing spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of Ankylosing spondylitis (AS)

AND

2 - Prescribed by or in consultation with a Rheumatologist

AND

3 - Trial and failure to a 1-month trial of scheduled prescription doses of two different NSAIDs (e.g., naproxen, nabumetone, diclofenac, etc.)

AND

4 - Medication will not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (e.g., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc)

AND

5 - Medication will be self-administered (not in clinic/provider office)

Product Name: Simponi	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active ulcerative colitis (UC)

AND

2 - Prescribed by or in consultation with a Gastroenterologist

AND

3 - Trial and failure or contraindication to at least a short course (2-4 weeks) of oral corticosteroids

AND

4 - High-risk individual as evidence by ONE of the following:

- Extensive colitis
- Deep ulcers
- Age less than 40 years
- High C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR)
- Steroid-requiring disease
- History of hospitalization
- C. difficile infection
- CMV infection

AND

5 - Medication will not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (e.g., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc)

AND

6 - Medication will be self-administered (not in clinic/provider office)

Product Name: Simponi	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active ulcerative colitis (UC)

AND

2 - Prescribed by or in consultation with a Gastroenterologist

AND

3 - Trial and failure or contraindication to at least a short course (2-4 weeks) of oral corticosteroids

AND

4 - High-risk individual as evidence by ONE of the following:

- Extensive colitis
- Deep ulcers
- Age less than 40 years
- High C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR)
- Steroid-requiring disease
- History of hospitalization
- C. difficile infection
- CMV infection

AND

5 - Medication will not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (e.g., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc)

AND

6 - Medication will be self-administered (not in clinic/provider office)

Product Name: Simponi

Diagnosis	All Indications Above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member demonstrates positive clinical response to therapy

Product Name: Simponi	
Diagnosis	Ankylosing spondylitis (AS), Moderate to Severely Active Rheumatoid Arthritis, Psoriatic arthritis (PsA)
Approval Length	12/31/2039
Guideline Type	Quantity Exception - All plans except IL and MN Plans

Approval Criteria

1 - Failure of an adherent 3-month trial of standard maintenance dosing with concomitant methotrexate (unless contraindicated or not appropriate for indication being requested)

Product Name: Simponi	
Diagnosis	Ankylosing spondylitis (AS), Moderate to Severely Active Rheumatoid Arthritis, Psoriatic arthritis (PsA)
Approval Length	12 month(s)
Guideline Type	Quantity Exception - IL and MN Plans

Approval Criteria

1 - Failure of an adherent 3-month trial of standard maintenance dosing with concomitant methotrexate (unless contraindicated or not appropriate for indication being requested)

Product Name: Simponi

Diagnosis	Ulcerative Colitis (UC)
Approval Length	12/31/2039
Guideline Type	Quantity Exception - All plans except IL and MN Plans

Approval Criteria

1 - Failure of a two-month trial of monthly therapy after completion of induction dosing regimen

AND

2 - Based on subtherapeutic drug concentrations and absence (or low levels) of drug antibodies

Product Name: Simponi	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Guideline Type	Quantity Exception - IL and MN Plans

Approval Criteria

1 - Failure of a two-month trial of monthly therapy after completion of induction dosing regimen

AND

2 - Based on subtherapeutic drug concentrations and absence (or low levels) of drug antibodies

2 . Revision History

Date	Notes
12/6/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-134612
Guideline Name	Skyrizi (risankizumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Skyrizi	
Diagnosis	Plaque Psoriasis
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans
Approval Criteria	

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - ONE of the following:

- Significant functional disability
- Body surface area (BSA) involvement of greater than or equal to 3%
- Debilitating palmer/plantar psoriasis or other vulnerable areas that are difficult to treat (e.g., nails, scalp, genitals, or intertriginous areas

AND

3 - Trial and failure, contraindication or intolerance to topical treatment (e.g., topical corticosteroids, calcipotriene, retinoids, calcineurin inhibitors, tazarotene)

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a dermatologist

Product Name: Skyrizi	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - ONE of the following:

- Significant functional disability
- Body surface area (BSA) involvement of greater than or equal to 3%
- Debilitating palmer/plantar psoriasis or other vulnerable areas that are difficult to treat (e.g., nails, scalp, genitals, or intertriginous areas

AND

3 - Trial and failure, contraindication or intolerance to topical treatment (e.g., topical corticosteroids, calcipotriene, retinoids, calcineurin inhibitors, tazarotene)

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a dermatologist

Product Name: Skyrizi

Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

2 - Diagnosis of moderate to severely active psoriatic arthritis

AND

1 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- Actively inflamed joints
- Axial disease
- Active skin, nail, or scalp psoriasis involvement
- Dactylitis
- Enthesitis

AND

2 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

3 - Medication will be self-administered

AND

5 - Prescribed by or in consultation with a Dermatologist or Rheumatologist

Product Name: Skyrizi	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

2 - Diagnosis of moderate to severely active psoriatic arthritis

AND

1 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- Actively inflamed joints
- Axial disease
- Active skin, nail, or scalp psoriasis involvement
- Dactylitis
- Enthesitis

AND

2 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

3 - Medication will be self-administered

AND

5 - Prescribed by or in consultation with a Dermatologist or Rheumatologist

Product Name: Skyrizi	
Diagnosis	Crohn's Disease
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Crohn's disease

AND

2 - Member is greater than 18 years of age

AND

3 - ONE of the following:

3.1 Member is a High-risk individual with ONE of the following traits:

- Age less than 30 at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (i.e. uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy, etc.)]

OR

3.2 BOTH of the following

3.2.1 Member is a Low-risk individual

AND

3.2.2 ONE of the following:

- Intolerance or contraindication to 1 conventional therapy (e.g., azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)

- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with 1 conventional therapy
- Demonstrated steroid dependence
- Conventional therapy is clinically inappropriate based on location of disease

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a Gastroenterologist

AND

7 - Prescriber attests patient has been established on therapy with Risankizumab for Crohn's disease through the medical benefit

Product Name: Skyrizi	
Diagnosis	Crohn's Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Crohn's disease

AND

2 - Member is greater than 18 years of age

AND

3 - ONE of the following:

3.1 Member is a High-risk individual with ONE of the following traits:

- Age less than 30 at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (i.e. uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy, etc.)]

OR

3.2 BOTH of the following

3.2.1 Member is a Low-risk individual

AND

3.2.2 ONE of the following:

- Intolerance or contraindication to 1 conventional therapy (e.g., azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)
- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with 1 conventional therapy
- Demonstrated steroid dependence
- Conventional therapy is clinically inappropriate based on location of disease

AND

4 - Therapy must not be used in combination with other biologic disease modifying anti-

rheumatic drug (DMARD) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescribed by or in consultation with a Gastroenterologist

AND

7 - Prescriber attests patient has been established on therapy with Risankizumab for Crohn's disease through the medical benefit

Product Name: Skyrizi	
Diagnosis	All Indications Listed Above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months member demonstrates a positive clinical response to therapy as evidenced by improvements in functional status related to therapeutic response

Product Name: Skyrizi	
Diagnosis	Crohn's Disease
Approval Length	12 month(s)
Guideline Type	Quantity Limit - All Plans

Approval Criteria

1 - Trial and failure of a two-month trial of every 12 week therapy after completion of 3 doses of IV infusion for the induction dosing regimen

AND

2 - Provision of published literature supporting efficacy and safety of dosing regimen

AND

3 - Based on subtherapeutic drug concentrations and absence (or low levels) of drug antibodies (when clinical lab available).

Product Name: Skyrizi	
Diagnosis	Plaque Psoriasis, Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Guideline Type	Quantity Limit - All Plans

Approval Criteria

1 - Trial and failure of an adherent 3-month trial of standard maintenance dosing (every 12 weeks) with concomitant methotrexate (unless contraindicated or not appropriate for indication being requested)

2 . Revision History

Date	Notes
11/30/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129739
Guideline Name	Soliqua (Insulin Glargine/Lixisenatide)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Soliqua	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of insulin dependent type 2 diabetes mellitus with a total basal insulin dose of less than 60 units/day

AND

2 - Prescribed by, or in consultation with, an Endocrinologist or Certified Diabetic Educator

AND

3 - Trial and failure after an adequate trial, intolerance, or contraindication to use of ALL formulary basal insulins (e.g., Semglee-yfgn, insulin degludec) and ALL formulary glucagon-like peptide (GLP) 1 agonists (e.g., Trulicity) in combination

AND

4 - Prescriber supplies published literature to support the requested combination product will produce different clinical results than using the formulary basal insulins and GLP-1 agonists as separate products

Product Name: Soliqua	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Soliqua	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of insulin dependent type 2 diabetes mellitus with a total basal insulin dose of less than 60 units/day

AND

2 - Prescribed by, or in consultation with, an Endocrinologist or Certified Diabetic Educator

AND

3 - Trial and failure after an adequate trial, intolerance, or contraindication to use of ALL formulary basal insulins (e.g., Semglee-yfgn, insulin degludec) and ALL formulary glucagon-like peptide (GLP) 1 agonists (e.g., Trulicity) in combination

AND

4 - Prescriber supplies published literature to support the requested combination product will produce different clinical results than using the formulary basal insulins and GLP-1 agonists as separate products

2 . Revision History

Date	Notes
10/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-132774
Guideline Name	Solosec (secnidazole)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Solosec	
Diagnosis	Bacterial vaginosis
Approval Length	12 month (s) with a fill count = 1
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of bacterial vaginosis

AND

2 - Trial and failure, contraindication, or intolerance to metronidazole (oral or vaginal gel) and clindamycin

Product Name: Solosec	
Diagnosis	Bacterial vaginosis
Approval Length	One time fill
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of bacterial vaginosis

AND

2 - Trial and failure, contraindication, or intolerance to metronidazole (oral or vaginal gel) and clindamycin

Product Name: Solosec	
Diagnosis	trichomoniasis
Approval Length	12 month (s) with a fill count = 1
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of trichomoniasis

AND

2 - Trial and failure, contraindication, or intolerance to a seven day course of one of the following:

- oral metronidazole

- tinidazole

Product Name: Solosec	
Diagnosis	trichomoniasis
Approval Length	One time fill
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of trichomoniasis

AND

2 - Trial and failure, contraindication, or intolerance to a seven day course of one of the following:

- oral metronidazole
- tinidazole

2 . Revision History

Date	Notes
10/31/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-130503
Guideline Name	Somatropin
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Omnitrope	
Diagnosis	Pediatric [less than 18 years of age])
Approval Length	until age 18
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 ALL of the following:

1.1.1 Submission of medical records (e.g., chart notes) documenting radiological evidence of open epiphyses with date completed

AND

1.1.2 Submission of medical records (e.g., chart notes) documenting that the child's growth velocity value is subnormal (age specific growth rate less than the 25th percentile)

AND

1.1.3 Submission of medical records (e.g., chart notes) documenting that the child has delayed bone age (e.g., provide date of completion and the value of bone age)

AND

1.1.4 Submission of medical records (e.g., chart notes) documenting (e.g., provide date and value of test) that the child has subnormal GH response to at least one provocative stimulation test (less than 10 ng/mL)

AND

1.1.5 Member is less than 18 years of age

OR

1.2 Both of the following:

1.2.1 Member is less than 18 years of age

AND

1.2.2 Diagnosis of Turner syndrome

AND

2 - Prescribed by or in consultation with an endocrinologist

Product Name: Omnitrope	
Diagnosis	Pediatric [less than 18 years of age])
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 ALL of the following:

1.1.1 Submission of medical records (e.g., chart notes) documenting radiological evidence of open epiphyses with date completed

AND

1.1.2 Submission of medical records (e.g., chart notes) documenting that the child's growth velocity value is subnormal (age specific growth rate less than the 25th percentile)

AND

1.1.3 Submission of medical records (e.g., chart notes) documenting that the child has delayed bone age (e.g., provide date of completion and the value of bone age)

AND

1.1.4 Submission of medical records (e.g., chart notes) documenting (e.g., provide date and value of test) that the Child has subnormal GH response to at least one provocative stimulation test (less than 10 ng/mL)

AND

1.1.5 Member is less than 18 years of age

OR

1.2 Both of the following:

1.2.1 Member is less than 18 years of age

AND

1.2.2 Diagnosis of Turner syndrome

AND

2 - Prescribed by or in consultation with an endocrinologist

Product Name: Omnitrope	
Diagnosis	Pediatric [less than 18 years of age])
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 ALL of the following:

1.1.1 Submission of medical records (e.g., chart notes) documenting radiological evidence of open epiphyses with date completed

AND

1.1.2 Submission of medical records (e.g., chart notes) documenting that the child's growth velocity value is subnormal (age specific growth rate less than the 25th percentile)

AND

1.1.3 Submission of medical records (e.g., chart notes) documenting that the child has delayed bone age (e.g., provide date of completion and the value of bone age)

AND

1.1.4 Submission of medical records (e.g., chart notes) documenting (e.g., provide date and value of test) that the Child has subnormal GH response to at least one provocative stimulation test (less than 10 ng/mL)

AND

1.1.5 Member is less than 18 years of age

OR

1.2 Both of the following:

1.2.1 Member is less than 18 years of age

AND

1.2.2 Diagnosis of Turner syndrome

AND

2 - Prescribed by or in consultation with an endocrinologist

Product Name: Omnitrope	
Diagnosis	Adult [18 years of age or older])
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization - ALL Plans

Approval Criteria

1 - One of the following:

1.1 ALL of the following:

1.1.1 Member has growth hormone deficiency as a child

AND

1.1.2 Continued low IGF-1 levels or evidence of GH deficiency as noted by stimulation testing

AND

1.1.3 Member is 18 years of age or older

OR

1.2 ALL of the following:

1.2.1 Member is 18 years of age or older

AND

1.2.2 Abnormal structure of the hypothalamus or pituitary gland on MRI as a result of injury, tumor, infection or inflammation

AND

1.2.3 Evidence of GH deficiency as noted by stimulation testing or when the diagnosis is panhypopituitarism

AND

2 - Prescribed by or in consultation with an endocrinologist

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Omnitrope	
Diagnosis	Adult [18 years of age])
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - ALL Plans

Approval Criteria

1 - One of the following:

1.1 ALL of the following:

1.1.1 Member has growth hormone deficiency as a child

AND

1.1.2 Continued low IGF-1 levels or evidence of GH deficiency as noted by stimulation testing

AND

1.1.3 Member is 18 years of age

OR

1.2 ALL of the following:

1.2.1 Member is 18 years of age

AND

1.2.2 Abnormal structure of the hypothalamus or pituitary gland on MRI as a result of injury, tumor, infection or inflammation

AND

1.2.3 Evidence of GH deficiency as noted by stimulation testing or when the diagnosis is panhypopituitarism

AND

2 - Prescribed by or in consultation with an endocrinologist

Product Name: Omnitrope	
Diagnosis	Adult [older than 18 years of age]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - ALL Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is benefitting from drug treatment (i.e., decreased fatigue, increased exercise endurance, age normalized IGF-1 levels, improvements in cholesterol panel, BMD, or body composition) including dates/values if applicable

Product Name: Serostim	
Approval Length	1 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans
Approval Criteria **1** - Diagnosis of AIDS wasting or cachexia **AND** **2** - Member continues on antiviral therapy	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Serostim	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria **1** - Diagnosis of AIDS wasting or cachexia **AND** **2** - Member continues on antiviral therapy	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Serostim	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - ALL Plans
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that member is benefitting from therapy (i.e., weight gain, increased muscle mass)	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Zorbtive	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - ALL Plans
Approval Criteria **1** - Diagnosis of Short Bowel Syndrome **AND** **2** - Member is on a special diet	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Zorbtive	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - ALL Plans

Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months that the member is benefitting from therapy (i.e., improvements in necessary intravenous feeding requirements such as calories required, or volumes infused) including dates/values	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
10/24/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131414
Guideline Name	Somavert (Pegvisomant)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan or who are established on therapy will have coverage under their drug benefit for the remainder of the current treatment course. Restrictions to specific network pharmacies and participation in medication management programs may apply.

1 . Criteria

Product Name: Somavert	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only
Approval Criteria **1** - Person or family member self-administering medication	

AND

2 - Diagnosis of acromegaly

AND

3 - Prescribed by, or in consultation with, an Endocrinologist

AND

4 - Inadequate response to, or not a candidate for, surgical correction

AND

5 - Trial and failure, contraindication, or intolerance to somatostatin therapy

Product Name: Somavert	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Somavert	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Person or family member self-administering medication

AND

2 - Diagnosis of acromegaly

AND

3 - Prescribed by, or in consultation with, an Endocrinologist

AND

4 - Inadequate response to, or not a candidate for, surgical correction

AND

5 - Trial and failure, contraindication, or intolerance to somatostatin therapy

2 . Revision History

Date	Notes
10/10/2023	New program

Prior Authorization Guideline

Guideline ID	GL-143341
Guideline Name	Standalone Personal Continuous Glucose Monitors (CGM)
Formulary	• Quartz

Guideline Note:

Effective Date:	2/23/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Freestyle Libre 2, Freestyle Libre 3	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans
Approval Criteria **1** - Trial and failure or intolerance to a Dexcom product	

Notes	*If patent meets criteria approve all CGM components at NDC list “CG MABBOTT” Persons with insurance coverage of a formulary CGM may upgrade to the newer formulary model upon request (e.g. authorization for Freestyle Libre 2 and requesting Freestyle Libre 3)

Product Name: Freestyle Libre 2, Freestyle Libre 3	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria **1** - Trial and failure or intolerance to a Dexcom product	
Notes	*If patent meets criteria please approve all CGM components at NDC list “CGMABBOTT” Persons with insurance coverage of a formulary CGM may upgrade to the newer formulary model upon request (e.g. authorization for Freestyle Libre 2 and requesting Freestyle Libre 3)

Product Name: Freestyle Libre 2, Freestyle Libre 3	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting regular use of the device (average of at least 5 days per week)	
Notes	*If patent meets criteria please approve all CGM components at NDC list “CGMABBOTT” Persons with insurance coverage of a formulary CGM may upgrade to the newer formulary model upon request (e.g. authorization for Freestyle Libre 2 and requesting Freestyle Libre 3)

2 . Revision History

Date	Notes
2/23/2024	Remove Dexcom from criteria, removal of most requirements for Fre estyle libre

Prior Authorization Guideline

Guideline ID	GL-137462
Guideline Name	State Mandate Reference Document
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Guideline Type	Administrative

Approval Criteria

1 - The following mandates apply to Illinois:

1.1 Effective 1/1/2018, step therapy requirements are deemed met if the provider submits medical records confirming the patient is currently stabilized on the requested medication for the medical condition under consideration.

OR

1.2 Effective 1/1/2019, any clinical criteria component involving a trial/failure requirement are

deemed met if the prescription drug is used to treat the patient's stage four advanced metastatic cancer and treatment is consistent with the U.S. Food and Drug Administration-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer.

OR

1.3 Effective 6/9/2023, all clinical criteria are deemed met for intravenous immunoglobulin (IVIg) therapy when the medication is being used for a diagnosis of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) or pediatric acute onset neuropsychiatric syndrome (PANS).

OR

2 - For Iowa, (effective 1/1/2018), when the provider confirms a patient has previously received either a documented step one prescription drug or submits medical records documenting another prescription drug was received that has the same mechanism of action as the documented step one prescription drug, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event, the patient will not be required to try any other alternatives with the same mechanism of action. Where documented step one prescription drugs are deemed met due to this process, all documented step one prescription drugs with the same mechanism of action will count towards the number of alternatives to be tried/failed. If step through other prescription drugs with a different mechanism of action is still required, the patient must meet the additional criteria. Step therapy requirements are also deemed met if the provider submits medical records confirming that the patient is currently stabilized on the requested medication for the medical condition under consideration. Note: Samples and drugs obtained through coupon cards may not count as sufficient experience with the prescribed medication to be considered stable on the medication.

OR

3 - For Minnesota, (effective 1/1/2020), any clinical criteria component involving a trial/failure requirement are deemed met if the prescription drug is used to treat the patient's stage four advanced metastatic cancer, or an associated condition, and treatment is consistent with the U.S. Food and Drug Administration-approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer.

OR

4 - For Wisconsin, (effective 11/1/2019), any clinical criteria component involving a trial/failure requirement are deemed met when the provider confirms a patient has previously received either a documented step one prescription drug or submits medical records documenting another prescription drug was received that has the same mechanism of action as the documented step one prescription drug, and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event, the patient will not be required to try any other alternatives within the same pharmacological class or with the same mechanism of action. Where documented step one prescription drugs are deemed met due to this process, all documented step one prescription drugs with the same mechanism of action will count towards the number of alternatives to be tried/failed. If step through other prescription drugs with a different mechanism of action is still required, the patient must meet the additional criteria. Any clinical criteria component involving a trial/failure requirement are also deemed met if the provider submits medical records confirming that the patient is currently stabilized on the requested medication for the medical condition under consideration, or if submitted justification and clinical documentation support that the required step one prescription drug is expected to be ineffective.

2 . Background

Benefit/Coverage/Program Information
Background: This document serves as a reference for changes requested to pharmacy utilization management programs based on state mandates. This includes but is not limited to step therapy, prior authorization regulations, supply limits, first line trial duration limitations, and pain therapy/end of life regulations. **Additional Clinical Rules:** • Applicable clinical programs will apply.

3 . Revision History

Date	Notes
12/7/2023	Updated to only include applicable states: MN, IL, IA, WI

Prior Authorization Guideline

Guideline ID	GL-135407
Guideline Name	Stelara (Ustekinumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Stelara SC	
Diagnosis	Plaque Psoriasis
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans
Approval Criteria	

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - ONE of the following:

- Significant functional disability
- Body surface area (BSA) involvement of ≥ 3%
- Debilitating palmer/plantar psoriasis or other vulnerable areas that are difficult to treat (e.g., nails, scalp, genitals, or intertriginous areas

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - Trial and failure, contraindication, or intolerance to topical treatment (e.g. topical corticosteroids, calcipotriene, retinoids)

AND

5 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication will be self-administered

Product Name: Stelara SC	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - ONE of the following:

- Significant functional disability
- Body surface area (BSA) involvement of ≥ 3%
- Debilitating palmer/plantar psoriasis or other vulnerable areas that are difficult to treat (e.g., nails, scalp, genitals, or intertriginous areas

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - Trial and failure, contraindication, or intolerance to topical treatment (e.g. topical corticosteroids, calcipotriene, retinoids)

AND

5 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication will be self-administered

Product Name: Stelara SC	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12/31/2039

Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Stelara SC	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

Product Name: Stelara SC	
Diagnosis	Moderate to Severely Active Crohn's Disease (CD)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Crohn's Disease (CD)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - One of the following:

3.1 Patient is considered high-risk based on at least ONE of the following characteristics:

- Age less than 30 years at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (i.e. uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy, etc.)

OR

3.2 Both of the following:

3.2.1 Patient is considered low-risk

AND

3.2.2 At least ONE of the following:

- Intolerance/contraindication to 1 conventional therapy (ex. azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)
- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with 1 conventional therapy
- Demonstrated steroid dependence
- Conventional therapy clinically inappropriate based on location of disease

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescriber attests patient has been established on therapy with ustekinumab for Crohn's disease through the medical benefit

Product Name: Stelara SC	
Diagnosis	Moderate to Severely Active Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Crohn's Disease (CD)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - One of the following:

3.1 Patient is considered high-risk based on at least ONE of the following characteristics:

- Age less than 30 years at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (i.e. uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy, etc.)

OR

3.2 Both of the following:

3.2.1 Patient is considered low-risk

AND

3.2.2 At least ONE of the following:

- Intolerance/contraindication to 1 conventional therapy (ex. azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)
- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with 1 conventional therapy
- Demonstrated steroid dependence
- Conventional therapy clinically inappropriate based on location of disease

AND

4 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication will be self-administered

AND

6 - Prescriber attests patient has been established on therapy with ustekinumab for Crohn's disease through the medical benefit

Product Name: Stelara SC	
Diagnosis	Moderate to Severely Active Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active ulcerative colitis (UC)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - Patient is considered high-risk based on ONE of the following characteristics:

- Extensive colitis
- Deep ulcers
- Age less than 40 years
- High CRP and ESR
- Steroid-requiring disease
- History of hospitalization
- C. difficile infection
- CMV infection

AND

4 - Trial and failure, contraindication, or intolerance to a short course (2 to 4 weeks) of oral corticosteroids

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication will be self-administered

AND

7 - Prescriber attests patient has been established on therapy with ustekinumab for ulcerative colitis through the medical benefit

Product Name: Stelara SC	
Diagnosis	Moderate to Severely Active Ulcerative Colitis (UC)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active ulcerative colitis (UC)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - Patient is considered high-risk based on ONE of the following characteristics:

- Extensive colitis

- Deep ulcers
- Age less than 40 years
- High CRP and ESR
- Steroid-requiring disease
- History of hospitalization
- C. difficile infection
- CMV infection

AND

4 - Trial and failure, contraindication, or intolerance to a short course (2 to 4 weeks) of oral corticosteroids

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication will be self-administered

AND

7 - Prescriber attests patient has been established on therapy with ustekinumab for ulcerative colitis through the medical benefit

Product Name: Stelara SC	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Prescriber provides clinical documentation from the previous 12 months of the member's response to therapy including individual improvements in functional status related to therapeutic response

Product Name: Stelara SC	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - One of the following:

1.1 For members with diagnoses of Ulcerative Colitis (UC) or Crohn's Disease (CD) requesting reduced interval or increased dose (dose other than 90mg, interval less than every 8 weeks), ALL of the following:

1.1.1 Failure of a two-month trial of every 8-week dosing regimen after completion of induction dosing regimen

AND

1.1.2 Based on subtherapeutic drug concentrations and absence (or low levels) of drug antibodies

AND

1.1.3 Provision of published literature supporting dose increase and/or frequency

OR

1.2 For members with diagnoses of Psoriatic Arthritis (PsA) or Plaque Psoriasis (PP), Failure of an adherent 3-month trial of standard maintenance dosing with concomitant methotrexate (unless contraindicated or not appropriate for indication being requested)

2 . Revision History

Date	Notes
11/30/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-133238
Guideline Name	Strensiq (asfotase alfa)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Strensiq	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of perinatal, infantile, or juvenile-onset hypophosphatasia (HPP) with submission of medical records (e.g., chart notes) of one of the following symptom onset by age 6 months:

1.1 Both of the following:

- Serum alkaline phosphatase (ALP) levels below the age/gender-adjusted normal range
- Elevated tissue non-specific alkaline phosphatase (TNSALP) substrate (e.g. serum pyridoxal 5'-phosphate (PLP) level, serum or urine phosphoethanolamine (PEA) level, or urinary inorganic pyrophosphate level)

OR

1.2 Documentation of TNSALP gene mutation by ALPL genomic DNA testing

AND

2 - Prescribed by or in consultation with an endocrinologist or other specialist in the treatment of inborn errors of metabolism

AND

3 - Submission of medical records (e.g., chart notes) documenting radiographic evidence supporting the diagnosis (e.g. infantile rickets, craniosynotosis, non-traumatic fractures, osteoporosis or low bone mineral content for age, etc.)

Product Name: Strensiq	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) within the past 12 months documenting objective improvements in skeletal quality and labs from baseline such as improvement in respiratory status, improved growth, improved radiographic findings, or decrease in TNSALP substrate levels

2 . Revision History

Date	Notes
9/24/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131364
Guideline Name	Sunosi (solriamfetol)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Sunosi	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans
Approval Criteria **1** - One of the following:	

1.1 Diagnosis of narcolepsy

OR

1.2 Diagnosis of excessive daytime sleepiness in narcolepsy

OR

1.3 All of the following:

- Diagnosis of obstructive sleep apnea (OSA)
- Current or prior treatment of the underlying obstruction (e.g. continuous positive airway pressure [CPAP], mandibular advancement device or surgical intervention, etc.)
- If using CPAP, it will be used concomitantly with solriamfetol

AND

2 - Prescribed by or in consultation with a Sleep Specialist, Neurologist or Psychiatrist

AND

3 - Member is 18 years of age or older

AND

4 - Inadequate clinical response after a 3-month trial and failure, contraindication or intolerance to one other first line alternative (e.g., modafinil, armodafinil)

Product Name: Sunosi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Diagnosis of narcolepsy

OR

1.2 Diagnosis of excessive daytime sleepiness in narcolepsy

OR

1.3 All of the following:

- Diagnosis of obstructive sleep apnea (OSA)
- Current or prior treatment of the underlying obstruction (e.g. continuous positive airway pressure [CPAP], mandibular advancement device or surgical intervention, etc.)
- If using CPAP, it will be used concomitantly with solriamfetol

AND

2 - Prescribed by or in consultation with a Sleep Specialist, Neurologist or Psychiatrist

AND

3 - Member is 18 years of age or older

AND

4 - Inadequate clinical response after a 3-month trial and failure, contraindication or intolerance to one other first line alternative (e.g., modafinil, armodafinil)

Product Name: Sunosi	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
8/23/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129121
Guideline Name	Sympazan (Clobazam)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Sympazan	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Person with a diagnosis of Lennox-Gastaut syndrome with continued seizure activity despite adequate trial and failure, contraindication or intolerance to at least two preferred antiepileptic drugs (e.g., levetiracetam, lamotrigine)

AND

2 - A trial of generic clobazam (tablets and solution) was not tolerated due to physical inability to swallow

Product Name: Sympazan	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Sympazan	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Member with a diagnosis of Lennox-Gastaut syndrome with continued seizure activity despite adequate trial and failure, contraindication or intolerance to at least two preferred antiepileptic drugs (e.g., levetiracetam, lamotrigine)

AND

2 - A trial of generic clobazam (tablets and solution) was not tolerated due to physical inability to swallow

2 . Revision History

Date	Notes
9/11/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129872
Guideline Name	Systemic Lupus Erythematosus (SLE) Treatments
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Benlysta SC	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

- Diagnosis of Systemic Lupus Erythematosus (SLE) with or without lupus nephritis
- Member does not have severe central nervous system lupus

AND

2 - Prescribed by or in consultation with a rheumatologist or other specialist in the treatment of SLE

AND

3 - Trial and failure, contraindication, or intolerance to ALL of the following:

- Hydroxychloroquine
- Nonsteroidal anti-inflammatories (NSAIDs) (e.g., ibuprofen, naproxen)
- A steroid-sparing immunosuppressive (e.g., azathioprine, methotrexate)
- A short course of oral steroids

AND

4 - Medication will not be used in combination with Saphnelo (anifrolumab)

AND

5 - Drug will be self-administered

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies **Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Benlysta SC	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member demonstrates beneficial response from therapy with the requested drug	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies **Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

2 . Revision History

Date	Notes
10/12/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131928
Guideline Name	Tadalafil for Benign Prostate Hyperplasia
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Tadalafil	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only
Approval Criteria **1** - Diagnosis of benign prostatic hyperplasia (BPH)	

Product Name: Generic Tadalafil	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Generic Tadalafil	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of benign prostatic hyperplasia (BPH)

2 . Revision History

Date	Notes
10/31/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-128905
Guideline Name	Tavalisse (Fostamatinib)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Tavalisse	
Approval Length	12/31/2039
Guideline Type	Prior authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of chronic immune thrombocytopenia (ITP)

AND

2 - Member's platelet count < 50,000/mL

AND

3 - Trial and failure of 2 prior ITP therapies (e.g. corticosteroids, rituximab, azathioprine, danazol, splenectomy, or eltrombopag)

AND

4 - Prescribed by, or in consultation with hematology

Product Name: Tavalisse	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of chronic immune thrombocytopenia (ITP)

AND

2 - Member's platelet count < 50,000/mL

AND

3 - Trial and failure of 2 prior ITP therapies (e.g. corticosteroids, rituximab, azathioprine, danazol, splenectomy, or eltrombopag)

AND

4 - Prescribed by, or in consultation with hematology

Product Name: Tavalisse	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization for IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
9/7/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131604
Guideline Name	Tegsedi (inotersen)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Tegsedi	
Diagnosis	Neuropathy due to hereditary transthyretin (hATTR) amyloidosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of neuropathy due to hereditary transthyretin (hATTR) amyloidosis with documentation of TTR gene mutation and biopsy proven amyloid deposits

AND

2 - Prescribed by, or in consultation with, a Neurologist, Cardiologist, or other expert in hereditary transthyretin-mediated amyloidosis (hATTR)

AND

3 - Member is 18 years of age or older

AND

4 - Drug is not being used in combination with another TTR-lowering agent (e.g., patisiran, vutrisiran)

AND

5 - Drug is not being used in combination with a TTR-stabilizing agent (e.g., diflunisal, tafamidis, tafamidis meglumine)

Product Name: Tegsedi	
Diagnosis	Continuation of Coverage if New to Plan
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of neuropathy due to hereditary transthyretin (hATTR) amyloidosis with documentation of TTR gene mutation and biopsy proven amyloid deposits

AND

2 - Prescribed by, or in consultation with, a Neurologist, Cardiologist, or other expert in hereditary transthyretin-mediated amyloidosis (hATTR)

AND

3 - Member is 18 years of age or older

AND

4 - Drug is not being used in combination with another TTR-lowering agent (e.g., patisiran, vutrisiran)

AND

5 - Drug is not being used in combination with a TTR-stabilizing agent (e.g., diflunisal, tafamidis, tafamidis meglumine)

AND

6 - The prescriber must provide clinical documentation of the member's initial response to therapy (e.g. clinical manifestation stability/improvement)

Product Name: Tegsedi	
Diagnosis	Neuropathy due to hereditary transthyretin (hATTR) amyloidosis
Approval Length	12/31/2039
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting response to therapy or documentation of clinical stability for the previous 12 months

Product Name: Tegsedi	
Diagnosis	Neuropathy due to hereditary transthyretin (hATTR) amyloidosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting response to therapy or documentation of clinical stability for the previous 12 months

2 . Revision History

Date	Notes
8/24/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129874
Guideline Name	Testosterone
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Preferred Testosterone Products: generic testosterone 1% gel, generic testosterone 1.6% gel, generic testosterone cypionate, generic testosterone enanthate	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria	

1 - One of the following:

1.1 Diagnosis of gender dysphoria or transsexualism

OR

1.2 Both of the following:

1.2.1 Submission of medical records (e.g., chart notes) demonstrating androgen deficiency** in one of the following diagnoses:

- Primary or secondary hypogonadism
- Mixed hypogonadism

AND

1.2.2 Submission of medical records (e.g., chart notes) documenting symptoms due to low testosterone other than decreased libido and/or other sexual dysfunction

Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage but whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers. **Androgen deficiency is defined as a fasting, morning testosterone level (drawn between 7 and 10 AM or within 3 hours of waking for shift workers) below the lower limit of normal as defined by the laboratory reference range. A single low testosterone is not diagnostic for androgen deficiency and must be confirmed with a second fasting, morning testosterone level.

Product Name: Preferred Testosterone Products: generic testosterone 1% gel, generic testosterone 1.6% gel, generic testosterone cypionate, generic testosterone enanthate	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and established on therapy will have coverage under their drug benefit for the remainder of the current treatment course

Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage but whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers. **Androgen deficiency is defined as a fasting, morning testosterone level (drawn between 7 and 10 AM or within 3 hours of waking for shift workers) below the lower limit of normal as defined by the laboratory reference range. A single low testosterone is not diagnostic for androgen deficiency and must be confirmed with a second fasting, morning testosterone level.

Product Name: Non-Preferred Testosterone Products: Brand Androderm, generic testosterone topical solution	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Diagnosis of gender dysphoria or transsexualism

OR

1.2 Both of the following:

1.2.1 Submission of medical records (e.g., chart notes) demonstrating androgen deficiency** in one of the following diagnoses:

- Primary or secondary hypogonadism
- Mixed hypogonadism

AND

1.2.2 Submission of medical records (e.g., chart notes) documenting symptoms due to low testosterone other than decreased libido and/or other sexual dysfunction

AND

2 - Trial and failure, contraindication, or intolerance to at least one preferred testosterone option (with the same route of administration if available)

Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage but whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers. **Androgen deficiency is defined as a fasting, morning testosterone level (drawn between 7 and 10 AM or within 3 hours of waking for shift workers) below the lower limit of normal as defined by the laboratory reference range. A single low testosterone is not diagnostic for androgen deficiency and must be confirmed with a second fasting, morning testosterone level.

Product Name: Non-Preferred Testosterone Products: Brand Androderm, generic testosterone topical solution	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- Member is new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and established on therapy will have coverage under their drug benefit for the remainder of the current treatment course
- Submission of medical records (e.g., chart notes) documenting intolerance to at least one preferred testosterone formulation

OR

1.2 Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage but whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers. **Androgen deficiency is defined as a fasting, morning testosterone level (drawn between 7 and 10 AM or within 3 hours of waking for shift workers) below the lower limit of normal as defined by the laboratory reference range. A single low testosterone is not diagnostic for androgen deficiency and must be confirmed with a second fasting, morning testosterone level.

Product Name: Preferred Testosterone Products: generic testosterone 1% gel, generic testosterone 1.6% gel, generic testosterone cypionate, generic testosterone enanthate	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Diagnosis of gender dysphoria or transsexualism

OR

1.2 Both of the following:

1.2.1 Submission of medical records (e.g., chart notes) demonstrating androgen deficiency** in one of the following diagnoses:

- Primary or secondary hypogonadism
- Mixed hypogonadism

AND

1.2.2 Submission of medical records (e.g., chart notes) documenting symptoms due to low testosterone other than decreased libido and/or other sexual dysfunction	
Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage but whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers. **Androgen deficiency is defined as a fasting, morning testosterone level (drawn between 7 and 10 AM or within 3 hours of waking for shift workers) below the lower limit of normal as defined by the laboratory reference range. A single low testosterone is not diagnostic for androgen deficiency and must be confirmed with a second fasting, morning testosterone level.

Product Name: Non-Preferred Testosterone Products: Brand Androderm, generic testosterone topical solution	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - One of the following:

1.1 Diagnosis of gender dysphoria or transsexualism

OR

1.2 Both of the following:

1.2.1 Submission of medical records (e.g., chart notes) demonstrating androgen deficiency** in one of the following diagnoses:

- Primary or secondary hypogonadism
- Mixed hypogonadism

AND

1.2.2 Submission of medical records (e.g., chart notes) documenting symptoms due to low testosterone other than decreased libido and/or other sexual dysfunction **AND** **2** - Trial and failure, contraindication, or intolerance to at least one preferred testosterone option (with the same route of administration if available)	
Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage but whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers. **Androgen deficiency is defined as a fasting, morning testosterone level (drawn between 7 and 10 AM or within 3 hours of waking for shift workers) below the lower limit of normal as defined by the laboratory reference range. A single low testosterone is not diagnostic for androgen deficiency and must be confirmed with a second fasting, morning testosterone level.

2 . Revision History

Date	Notes
8/16/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-137010
Guideline Name	Tezspire (tezepelumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Tezspire	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria	

1 - Requested medication will be self-administered

AND

2 - Prescribed by or in consultation with one of the following:

- Allergist
- Immunologist
- Pulmonologist

AND

3 - Member is 12 years of age or older

AND

4 - One of the following:

4.1 Symptoms are not well controlled or poorly controlled (refer to Table 1 in background section) despite an adherent ‡ ≥ 3-month trial of medium to high-dose inhaled corticosteroids in combination with a long-acting bronchodilator, long-acting muscarinic antagonist, or leukotriene modifier

OR

4.2 One of the following:

4.2.1 Member has an intolerance to medium to high dose inhaled corticosteroids (ICS) in combination with long-acting bronchodilator or leukotriene modifier

OR

4.2.2 Member has one or more of the following comorbid conditions that increase long-term risks of adverse effects from high dose ICS or oral corticosteroids:

- Cataracts in patients > 40 years of age
- Glaucoma
- Recurrent thrush

- Dysphonia
- Growth inhibition, after evaluation by endocrine consult
- Diagnosis of osteoporosis, treatment resistant to FDA approved osteoporosis treatment

AND

5 - One of the following:

5.1 All of the following:

5.1.1 Diagnosis of eosinophilic asthma

AND

5.1.2 Submission of medical records (e.g., chart notes) documenting a blood eosinophil count of ≥ 150 cells/mm3

AND

5.1.3 All other causes of eosinophilia such as hypereosinophilic syndromes, neoplastic disease, or parasitic disease have been ruled out

AND

5.1.4 Trial and failure or intolerance to at least two preferred self-administered biologic therapies for eosinophilic asthma (i.e. dupilumab, benralizumab, mepolizumab)

OR

5.2 All of the following:

5.2.1 Diagnosis of moderate-to-severe persistent allergic asthma as defined by Global Initiative for Asthma (GINA) Global Strategy for Asthma Management and Prevention Guidelines (Step 5)

AND

5.2.2 Serum IgE level ≥30 international units/mL

AND

5.2.3 Positive skin tests or in vitro reactivity to common aeroallergens (e.g. dust mites, pet dander, cockroaches, etc.)

AND

5.2.4 Trial and failure or intolerance to at least one preferred self-administered biologic therapy for allergic asthma (i.e. omalizumab)

OR

5.3 All the following:

5.3.1 Diagnosis of severe asthma

AND

5.3.2 One of the following:

- History of ≥ 2 asthma exacerbations requiring systemic corticosteroids within the past 12 months
- One asthma exacerbation requiring hospitalization in the past 12 months

AND

5.3.3 Asthma is non-eosinophilic (example: blood eosinophil counts of

AND

5.3.4 Asthma is non-allergic (example: Serum IgE level

AND

5.3.5 For oral corticosteroid dependent asthma (requiring daily oral steroids): trial and failure or intolerance to at least one preferred self-administered biologic therapy for corticosteroid dependent asthma (i.e. dupilumab)

Notes	‡Adherent treatment is defined as a medication possession ratio (MPR) ≥ 70% based on the previous 120 days of prescription claims. NOTE: Il-5 inhibitor drugs in combination with omalizumab will be considered on a case-by-case basis if each individual agent with combination high dose ICS/LABA did not control symptoms. Tezepelumab, in combination with other biologics, has not been studied and coverage is not allowed except in extenuating circumstances (applies to both eosinophilic or non-eosinophilic asthma populations). *Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Tezspire	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy within the previous 12 months defined by one of the following:

- Decreased frequency of use of, or ability to lower the chronic daily dose, of oral corticosteroids to treat/prevent exacerbations
- Decreased frequency of use of unscheduled emergency department/urgent care visits for exacerbations
- Reduction in reported symptoms such as chest tightness, coughing, shortness of breath, nocturnal awakenings, nasal congestion, obstruction, etc.
- Sustained (at least six months) improvement in Asthma Control Test (ACT) scores

Notes	NOTE: Continuation of case-by case-approved IgE inhibitor and IL-5 i nhibitor, or tezepelumab combination therapy will only be considered if ICS/LABA therapy was also continued AND ther e was reduction in oral steroid dose, exacerbations, or hospitalizations . *Continuation of therapy/coverage criteria will not be applied to person s who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: Tezspire	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Requested medication will be self-administered

AND

2 - Prescribed by or in consultation with one of the following:

- Allergist
- Immunologist
- Pulmonologist

AND

3 - Member is 12 years of age or older

AND

4 - One of the following:

4.1 Symptoms are not well controlled or poorly controlled (refer to Table 1 in background section) despite an adherent ‡ ≥ 3-month trial of medium to high-dose inhaled corticosteroids

in combination with a long-acting bronchodilator, long-acting muscarinic antagonist, or leukotriene modifier

OR

4.2 One of the following:

4.2.1 Member has an intolerance to medium to high dose inhaled corticosteroids (ICS) in combination with long-acting bronchodilator or leukotriene modifier

OR

4.2.2 Member has one or more of the following comorbid conditions that increase long-term risks of adverse effects from high dose ICS or oral corticosteroids:

- Cataracts in patients > 40 years of age
- Glaucoma
- Recurrent thrush
- Dysphonia
- Growth inhibition, after evaluation by Endocrine Consult
- Diagnosis of osteoporosis, treatment resistant to FDA approved osteoporosis treatment

AND

5 - One of the following:

5.1 All of the following:

5.1.1 Diagnosis of eosinophilic asthma

AND

5.1.2 Submission of medical records (e.g., chart notes) documenting a blood eosinophil count of ≥ 150 cells/mm3

AND

5.1.3 All other causes of eosinophilia such as hypereosinophilic syndromes, neoplastic disease, or parasitic disease have been ruled out

AND

5.1.4 Trial and failure or intolerance to at least two preferred self-administered biologic therapies for eosinophilic asthma (i.e. dupilumab, benralizumab, mepolizumab)

OR

5.2 All of the following:

5.2.1 Diagnosis of moderate-to-severe persistent allergic asthma as defined by Global Initiative for Asthma (GINA) Global Strategy for Asthma Management and Prevention Guidelines (Step 5)

AND

5.2.2 Serum IgE level ≥30 international units/mL

AND

5.2.3 Positive skin tests or in vitro reactivity to common aeroallergens (e.g. dust mites, pet dander, cockroaches, etc.)

AND

5.2.4 Trial and failure or intolerance to at least one preferred self-administered biologic therapy for allergic asthma (i.e. omalizumab)

OR

5.3 All the following:

5.3.1 Diagnosis of severe asthma

AND

5.3.2 One of the following:

- History of ≥ 2 asthma exacerbations requiring systemic corticosteroids within the past 12 months
- One asthma exacerbation requiring hospitalization in the past 12 months

AND

5.3.3 Asthma is non-eosinophilic (example: blood eosinophil counts of

AND

5.3.4 Asthma is non-allergic (example: Serum IgE level

AND

5.3.5 For oral corticosteroid dependent asthma (requiring daily oral steroids): trial and failure or intolerance to at least one preferred self-administered biologic therapy for corticosteroid dependent asthma (i.e. dupilumab)

Notes	‡Adherent treatment is defined as a medication possession ratio (MPR) ≥ 70% based on the previous 120 days of prescription claims. NOTE: Il-5 inhibitor drugs in combination with omalizumab will be considered on a case-by-case basis if each individual agent with combination high dose ICS/LABA did not control symptoms. Tezepelumab, in combination with other biologics, has not been studied and coverage is not allowed except in extenuating circumstances (applies to both eosinophilic or non-eosinophilic asthma populations). *Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

2 . Background

Benefit/Coverage/Program Information

Table 1. Outcome Measure values for uncontrolled asthma

Measure	Not Well Controlled	Very Poorly Controlled
Baseline symptoms (outside of exacerbation)	> 2 days/week	Throughout the day
Nighttime awakening	1-3 times/week	≥ 4 times/week
Interference with normal activity	Some limitation	Extremely limited
Short acting beta agonist use for symptom control	> 2 days/week	Several times per day
FEV1	60-80% predicted or personal best	< 60% predicted or personal best
Asthma exacerbations requiring oral steroids ≥ 2 times in the past year	Yes	Yes
Asthma Control Test (ACT)	16-19	≤ 15

3 . Revision History

Date	Notes
12/11/2023	Updated criteria 4.2

Prior Authorization Guideline

Guideline ID	GL-137245
Guideline Name	Thrombopoietin Receptor Agonists
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies.

1 . Criteria

Product Name: Doptelet, Promacta	
Diagnosis	Thrombocytopenia in Patients with Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of chronic ITP with a platelet count less than 50,000/mcL

AND

2 - Prescribed by or in consultation with a hematologist

AND

3 - Trial and failure, contraindication, or intolerance to at least TWO prior ITP therapies (e.g., corticosteroids, rituximab, azathioprine, danazol, or splenectomy)

Product Name: Doptelet	
Diagnosis	Thrombocytopenia in Patients with Chronic Liver Disease (CLD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL and MN Plans Only

Approval Criteria

1 - Diagnosis of liver cirrhosis with a platelet count less than 50,000/mcL

AND

2 - Prescribed by or in consultation with a hematologist or gastroenterologist

AND

3 - Member is scheduled for a procedure with a moderate to high bleeding risk within the next 14 days

Product Name: Doptelet	
Diagnosis	Thrombocytopenia in Patients with Chronic Liver Disease (CLD)
Approval Length	5 Day(s)

Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of liver cirrhosis with a platelet count less than 50,000/mcL

AND

2 - Prescribed by or in consultation with a hematologist or gastroenterologist

AND

3 - Member is scheduled for a procedure with a moderate to high bleeding risk within the next 14 days

Product Name: Mulpleta	
Diagnosis	Thrombocytopenia in Patients with Chronic Liver Disease (CLD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL and MN Plans Only

Approval Criteria

1 - Diagnosis of liver cirrhosis with a platelet count less than 50,000/mcL

AND

2 - Prescribed by or in consultation with a hematologist or gastroenterologist

AND

3 - Member is scheduled for a procedure with a moderate to high bleeding risk within the next 14 days

Product Name: Mulpleta	
Diagnosis	Thrombocytopenia in Patients with Chronic Liver Disease (CLD)
Approval Length	1 Time(s)
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of liver cirrhosis with a platelet count less than 50,000/mcL

AND

2 - Prescribed by or in consultation with a hematologist or gastroenterologist

AND

3 - Member is scheduled for a procedure with a moderate to high bleeding risk within the next 14 days

Product Name: Promacta	
Diagnosis	Chronic Hepatitis C-Associated Thrombocytopenia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C virus (HCV) undergoing treatment with pegylated interferon/ribavirin

AND

2 - Prescribed by or in consultation with a hematologist, gastroenterologist, or infectious disease specialist

AND

3 - Platelet count is less than 75,000/mcL

Product Name: Promacta	
Diagnosis	Aplastic Anemia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe aplastic anemia

AND

2 - Prescribed by or in consultation with a hematologist

AND

3 - Trial and failure, contraindication, or intolerance to at least one immunosuppressive therapy (e.g., glucocorticoids, cyclosporine)

2 . Revision History

Date	Notes
12/6/2023	New program

Prior Authorization Guideline

Guideline ID	GL-131424
Guideline Name	Tiglutik (riluzole)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Tiglutik	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of amyotrophic lateral sclerosis (ALS)

AND

2 - A trial of generic riluzole tablets was not tolerated due to an inability to swallow solid dosage forms

Product Name: Tiglutik	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Tiglutik	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of amyotrophic lateral sclerosis (ALS)

AND

2 - A trial of generic riluzole tablets was not tolerated due to an inability to swallow solid dosage forms

2 . Revision History

Date	Notes
10/10/2023	New program

Prior Authorization Guideline

Guideline ID	GL-136666
Guideline Name	Tobacco Cessation Therapy
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Effective 2/1/2023 these restrictions and quantity limits do not apply to persons with IL plans

1 . Criteria

Product Name: NICOTROL INHALER, NICOTROL NS	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization – MN plans
Approval Criteria **1** - Both of the following:	

1.1 Person requires a smoking cessation product that is designed to alleviate acute cravings and/or replace behavioral activities of smoking

AND

1.2 Trial and failure, contraindication, or intolerance to nicotine gum or nicotine lozenges

OR

2 - Member with stage four metastatic cancer and smoking cessation therapy is supportive care related to their cancer diagnosis

Product Name: NICOTROL INHALER, NICOTROL NS	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization – MN plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: NICOTROL INHALER, NICOTROL NS	
Approval Length	12/31/2039
Guideline Type	Prior Authorization – ALL plans except MN

Approval Criteria

1 - Person requires a smoking cessation product that is designed to alleviate acute cravings and/or replace behavioral activities of smoking

AND

2 - Trial and failure, contraindication, or intolerance to nicotine gum or nicotine lozenges

2 . Revision History

Date	Notes
11/21/2023	Criteria updated

Prior Authorization Guideline

Guideline ID	GL-130574
Guideline Name	Tobramycin for Inhalation
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: generic tobramycin inhalation solution	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans
Approval Criteria	

1 - Diagnosis of cystic fibrosis

AND

2 - Submission of medical records (e.g., chart notes) documenting a current culture positive for, or history of recurrent Pseudomonas aeruginosa lung infections

AND

3 - Requested medication will be used for inhalation only

Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: generic tobramycin inhalation solution	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

Product Name: generic tobramycin inhalation solution	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria **1** - Diagnosis of cystic fibrosis **AND** **2** - Submission of medical records (e.g., chart notes) documenting a current culture positive for, or history of recurrent Pseudomonas aeruginosa lung infections **AND** **3** - Requested medication will be used for inhalation only	
Notes	*Continuation of therapy/coverage criteria will not be applied to persons who were not previously approved for coverage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers.

2 . Revision History

Date	Notes
8/16/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129744
Guideline Name	Tremfya (guselkumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Tremfya	
Diagnosis	Moderate to Severe Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - Patient has one of the following:

- Significant functional disability
- Body surface area (BSA) involvement of greater than 3%
- Debilitating palmar or plantar psoriasis or other vulnerable areas that are difficult to treat such as nails, hairy/scalp areas, genitals, or intertriginous areas

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - Submission of medical records (e.g., chart notes) documenting trial and failure (minimum 4 week trial duration), or contraindication to topical therapy (e.g., topical corticosteroids, calcipotriene, retinoids, calcineurin inhibitor, tazarotene)

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication must be self-administered (not in clinic or provider office)

Product Name: Tremfya	
Diagnosis	Moderate to Severe Plaque Psoriasis
Approval Length	12/31/2039
Guideline Type	Prior AuthorizatioPrior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severe plaque psoriasis

AND

2 - Patient has one of the following:

- Significant functional disability
- Body surface area (BSA) involvement of greater than 3%
- Debilitating palmar or plantar psoriasis or other vulnerable areas that are difficult to treat such as nails, hairy/scalp areas, genitals, or intertriginous areas

AND

3 - Prescribed by or in consultation with a dermatologist

AND

4 - Submission of medical records (e.g., chart notes) documenting trial and failure (minimum 4 week trial duration), or contraindication to topical therapy (e.g., topical corticosteroids, calcipotriene, retinoids, calcineurin inhibitor, tazarotene)

AND

5 - Not used in combination with other biologic DMARDs (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

6 - Medication must be self-administered (not in clinic or provider office)

Product Name: Tremfya	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Symptoms include actively inflamed joints, axial disease, active skin/nail/scalp psoriasis involvement, dactylitis, or enthesitis

AND

3 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

4 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication must be self-administered (not in clinic or provider office)

Product Name: Tremfya	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis (PsA)

AND

2 - Symptoms include actively inflamed joints, axial disease, active skin/nail/scalp psoriasis involvement, dactylitis, or enthesitis

AND

3 - Prescribed by or in consultation with a dermatologist or rheumatologist

AND

4 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Medication must be self-administered (not in clinic or provider office)

Product Name: Tremfya	
Diagnosis	All Indications Listed Above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy within the previous 12 months

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
11/1/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129810
Guideline Name	Tresiba (insulin degludec)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Brand Insulin Degludec U100	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of diabetes mellitus

AND

2 - Prescribed by or in consultation with one of the following:

- Endocrinologist
- Diabetes specialist

AND

3 - One of the following:

3.1 Member cannot meet their glycemic goals despite adequate trials of insulin glargine including:

- Dose escalation, unless dose increases cannot be tolerated due to nocturnal hypoglycemia or at least one severe low blood sugar event (requiring assistance from another) or would not be appropriate given the person's self-monitoring blood glucose profile
- Splitting the dose
- Submission of medical records (e.g., chart notes) documenting use of a specific adherence intervention deployed by a health care provider

OR

3.2 Member is intolerant to insulin glargine

Product Name: Brand Insulin Degludec U200	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of diabetes mellitus

AND

2 - Prescribed by or in consultation with one of the following:

- Endocrinologist

- Diabetes specialist

AND

3 - One of the following:

3.1 Member cannot meet their glycemic goals despite adequate trials of insulin glargine including:

- Dose escalation, unless dose increases cannot be tolerated due to nocturnal hypoglycemia or at least one severe low blood sugar event (requiring assistance from another) or would not be appropriate given the person's self-monitoring blood glucose profile
- Splitting the dose
- Submission of medical records (e.g., chart notes) documenting use of a specific adherence intervention deployed by a health care provider

OR

3.2 Member is intolerant to insulin glargine

AND

4 - Member's daily basal insulin dose is greater than 100 units

Product Name: Brand Insulin Degludec U100 and U200	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Brand Insulin Degludec U100

Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of diabetes mellitus

AND

2 - Prescribed by or in consultation with one of the following:

- Endocrinologist
- Diabetes specialist

AND

3 - One of the following:

3.1 Member cannot meet their glycemic goals despite adequate trials of insulin glargine including:

- Dose escalation, unless dose increases cannot be tolerated due to nocturnal hypoglycemia or at least one severe low blood sugar event (requiring assistance from another) or would not be appropriate given the person's self-monitoring blood glucose profile
- Splitting the dose
- Submission of medical records (e.g., chart notes) documenting use of a specific adherence intervention deployed by a health care provider

OR

3.2 Member is intolerant to insulin glargine

Product Name: Brand Insulin Degludec U200	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of diabetes mellitus

AND

2 - Prescribed by or in consultation with one of the following:

- Endocrinologist
- Diabetes specialist

AND

3 - One of the following:

3.1 Member cannot meet their glycemic goals despite adequate trials of insulin glargine including:

- Dose escalation, unless dose increases cannot be tolerated due to nocturnal hypoglycemia or at least one severe low blood sugar event (requiring assistance from another) or would not be appropriate given the person's self-monitoring blood glucose profile
- Splitting the dose
- Submission of medical records (e.g., chart notes) documenting use of a specific adherence intervention deployed by a health care provider

OR

3.2 Member is intolerant to insulin glargine

AND

4 - Member's daily basal insulin dose is greater than 100 units

2 . Revision History

Date	Notes
10/12/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-127804
Guideline Name	Tudorza Pressair
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Tudorza Pressair	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure, intolerance, or contraindication to both an inhaled tiotropium bromide product and an inhaled umeclidinium product

Product Name: Tudorza Pressair	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical notes (e.g. chart notes) from the past 12 months that member is continuing therapy with the requested drug

Product Name: Tudorza Pressair	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure, intolerance, or contraindication to both an inhaled tiotropium bromide product and an inhaled umeclidinium product

2 . Revision History

Date	Notes
8/21/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-136474
Guideline Name	Vaccines
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Recombivax-HB, Engerix-B, Arexvy, Abrysvo, Boostrix, Prehevbrio, Twinrix, Prevnar 13, Prevnar 20, Vaxneuvance, Pneumovax, Adacel, Boostrix. Tdvax, Tenivac, Shingrix	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Member is 18 years or older*

AND

2 - One of the following: **2.1** The requested vaccination will be used for a Food and Drug Administration (FDA) approved indication **OR** **2.2** The requested vaccination will be used in accordance with Advisory Committee on Immunization Practices (ACIP) recommendation	
Notes	*Vaccines listed above are considered excluded for persons under the age of 18 years. They are covered under the medical benefit

2 . Revision History

Date	Notes
12/5/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129092
Guideline Name	Valtoco (diazepam)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Valtoco	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans

Approval Criteria

1 - Diagnosis of a seizure disorder (epilepsy)

AND

2 - Prescribed by or in consultation with a neurologist or other specialist with experience in the management of epilepsy

AND

3 - Member is between the ages of 6 and 12 years old

AND

4 - Submission of medical records (e.g., chart notes) that support history of frequent episodes of acute seizure activity

Product Name: Valtoco	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of a seizure disorder (epilepsy)

AND

2 - Prescribed by or in consultation with a neurologist or other specialist with experience in the management of epilepsy

AND

3 - Member is between the ages of 6 and 12 years old

AND

4 - Submission of medical records (e.g., chart notes) that support history of frequent episodes of acute seizure activity

Product Name: Valtoco	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
9/7/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129625
Guideline Name	Vascepa (Icosapent Ethyl)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Icosapent Ethyl	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of established cardiovascular disease* OR diabetes mellitus with ≥ 2 additional risk factors for cardiovascular disease**

AND

2 - Prescribed by, or in consultation with, a Cardiologist, Endocrinologist, or other lipid specialist **AND** **3** - Triglycerides ≥ 150 mg/dL **AND** **4** - Using as an adjunct to maximally tolerated statin therapy **OR** **5** - Clinical documentation to support statin intolerance***

Notes	*ASCVD refers to the following conditions: coronary heart disease such as myocardial infarction, angina, coronary artery stenosis >50%; cerebrovascular disease such as transient ischemic attack, ischemic stroke, or carotid artery stenosis > 50%; peripheral artery disease such as claudication; and aortic atherosclerotic disease such as abdominal aortic aneurysm and descending thoracic aneurysm. **Additional risk factors may include: current smoker, family history of premature ASCVD, LDL cholesterol persistently ≥ 160 mg/dL, chronic kidney disease, metabolic syndrome, South Asian ancestry, or other guideline supported risk factors ***Statin intolerance is defined as the inability to tolerate at least 2 statins, with: ♣ one started at the lowest starting dose ♣ statin dose reduction was attempted to resolve symptoms or lab abnormalities (not discontinuation) ♣ symptoms or lab abnormalities reversed with statin discontinuation but returned with re-challenge of statins ♣ symptoms or lab abnormalities are not due to established predispositions such as drug interactions, significant changes in physical activity, or underlying muscle disease

Product Name: Generic Icosapent Ethyl	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Notes	*ASCVD refers to the following conditions: coronary heart disease such as myocardial infarction, angina, coronary artery stenosis >50%; cerebrovascular disease such as transient ischemic attack, ischemic stroke, or carotid artery stenosis > 50%; peripheral artery disease such as claudication; and aortic atherosclerotic disease such as abdominal aortic aneurysm and descending thoracic aneurysm. **Additional risk factors may include: current smoker, family history of premature ASCVD, LDL cholesterol persistently ≥ 160 mg/dL, chronic kidney disease, metabolic syndrome, South Asian ancestry, or other guideline supported risk factors ***Statin intolerance is defined as the inability to tolerate at least 2 statins, with: ♣ one started at the lowest starting dose ♣ statin dose reduction was attempted to resolve symptoms or lab abnormalities (not discontinuation) ♣ symptoms or lab abnormalities reversed with statin discontinuation but returned with re-challenge of statins ♣ symptoms or lab abnormalities are not due to established predispositions such as drug interactions, significant changes in physical activity, or underlying muscle disease

Product Name: Generic Icosapent Ethyl	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of established cardiovascular disease* OR diabetes mellitus with ≥ 2 additional risk factors for cardiovascular disease**

AND **2** - Prescribed by, or in consultation with, a Cardiologist, Endocrinologist, or other lipid specialist **AND** **3** - Triglycerides ≥ 150 mg/dL **AND** **4** - Using as an adjunct to maximally tolerated statin therapy **OR** **5** - Clinical documentation to support statin intolerance***	
Notes	*ASCVD refers to the following conditions: coronary heart disease such as myocardial infarction, angina, coronary artery stenosis >50%; cerebrovascular disease such as transient ischemic attack, ischemic stroke, or carotid artery stenosis > 50%; peripheral artery disease such as claudication; and aortic atherosclerotic disease such as abdominal aortic aneurysm and descending thoracic aneurysm. **Additional risk factors may include: current smoker, family history of premature ASCVD, LDL cholesterol persistently ≥ 160 mg/dL, chronic kidney disease, metabolic syndrome, South Asian ancestry, or other guideline supported risk factors ***Statin intolerance is defined as the inability to tolerate at least 2 statins, with: ♣ one started at the lowest starting dose ♣ statin dose reduction was attempted to resolve symptoms or lab abnormalities (not discontinuation) ♣ symptoms or lab abnormalities reversed with statin discontinuation but returned with re-challenge of statins ♣ symptoms or lab abnormalities are not due to established predispositions such as drug interactions, significant changes in physical activity, or underlying muscle disease

2 . Revision History

Date	Notes
10/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131349
Guideline Name	Vemlidy (tenofovir alafenamide)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Vemlidy	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans
Approval Criteria **1** - Diagnosis of chronic hepatitis B	

AND

2 - One of the following:

- Member has failed entecavir
- Submission of medical records (e.g., chart notes) documenting member has lamivudine resistance

AND

3 - Trial and failure, contraindication, or intolerance to tenofovir disoproxil fumarate

Product Name: Vemlidy	
Approval Length	12 month(s)
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chronic hepatitis B

AND

1.2 One of the following:

- Member has failed entecavir
- Submission of medical records (e.g., chart notes) documenting member has lamivudine resistance

AND

1.3 Trial and failure, contraindication, or intolerance to tenofovir disoproxil fumarate

OR

2 - (Minnesota plans only): Member has stage four metastatic cancer and the requested drug is being used to treat cancer-related hepatitis B infection

Product Name: Vemlidy	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
10/8/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129065
Guideline Name	Verkazia (cyclosporine ophthalmic emulsion 0.1%)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Verkazia	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe vernal keratoconjunctivitis (e.g. visual deficit and/or continuous symptoms)

AND

2 - Positive skin tests or in vitro reactivity to common aeroallergens (e.g. pollen, dust mites, pet dander, cockroaches, etc.)

AND

3 - Continued symptoms despite a two-week trial of an ophthalmic steroid

AND

4 - Trial and failure with first-line treatments including all of the following:

4.1 Lifestyle changes (e.g. cold compresses, trigger avoidance, artificial tears)

AND

4.2 A three-week trial of one of the following, in combination with ophthalmic cyclosporine (0.05 % or 0.09%)

- Topical ophthalmic mast cell stabilizer (e.g., cromolyn sodium, lodoxamide tromethamine, nedocromil sodium)
- Topical dual action mast cell stabilizer/antihistamine (e.g., olopatadine, azelastine hydrochloride, epinastine, ketotifen fumarate)

AND

5 - Prescribed by or in consultation with an ophthalmologist

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and were not previously approved for c overage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through reauthorization criteria

Product Name: Verkazia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization*
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe vernal keratoconjunctivitis (e.g. visual deficit and/or continuous symptoms)

AND

2 - Positive skin tests or in vitro reactivity to common aeroallergens (e.g. pollen, dust mites, pet dander, cockroaches, etc.)

AND

3 - Continued symptoms despite a two-week trial of an ophthalmic steroid

AND

4 - Trial and failure with first-line treatments including all of the following:

4.1 Lifestyle changes (e.g. cold compresses, trigger avoidance, artificial tears)

AND

4.2 A three-week trial of one of the following, in combination with ophthalmic cyclosporine (0.05 % or 0.09%)

- Topical ophthalmic mast cell stabilizer (e.g., cromolyn sodium, lodoxamide tromethamine, nedocromil sodium)
- Topical Dual action mast cell stabilizer/antihistamine (e.g., olopatadine, azelastine hydrochloride, epinastine, ketotifen fumarate)

AND

5 - Prescribed by or in consultation with an ophthalmologist

AND **6** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months, the member has improved while on therapy	
Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) and were not previously approved for c overage whose therapy was initiated using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through reauthorization criteria

2 . Revision History

Date	Notes
7/28/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-141086
Guideline Name	Verquvo (vericiguat)
Formulary	• Quartz

Guideline Note:

Effective Date:	2/3/2024

1 . Criteria

Product Name: Verquvo	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of symptomatic chronic heart failure (HF)

AND

2 - Ejection fraction less than 45%

AND

3 - Hospitalization related to HF in the past 6 months

AND

4 - One of the following:

4.1 Both of the following:

4.1.1 Trial and failure, contraindication or intolerance to one of the following:

- Angiotensin-converting enzyme inhibitor (e.g., enalapril, lisinopril, ramipril)
- Angiotensin II receptor blocker (e.g., candesartan, losartan, valsartan)
- Angiotensin receptor neprilysin inhibitors (e.g., sacubitril/valsartan)

AND

4.1.2 Trial and failure, contraindication or intolerance to beta-blocker (e.g., bisoprolol, carvedilol, metoprolol succinate)

OR

4.2 Trial and failure, contraindication or intolerance to an aldosterone antagonist (e.g., eplerenone, spironolactone)

AND

5 - Prescribed by or in consultation with a cardiologist

Product Name: Verquvo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of symptomatic chronic heart failure (HF)

AND

2 - Ejection fraction less than 45%

AND

3 - Hospitalization related to HF in the past 6 months

AND

4 - One of the following:

4.1 Both of the following:

4.1.1 Trial and failure, contraindication or intolerance to one of the following:

- Angiotensin-converting enzyme inhibitor (e.g., enalapril, lisinopril, ramipril)
- Angiotensin II receptor blocker (e.g., candesartan, losartan, valsartan)
- Angiotensin receptor neprilysin inhibitors (e.g., sacubitril/valsartan)

AND

4.1.2 Trial and failure, contraindication or intolerance to beta-blocker (e.g., bisoprolol, carvedilol, metoprolol succinate)

OR

4.2 Trial and failure, contraindication or intolerance to an aldosterone antagonist (e.g., eplerenone, spironolactone)

AND

5 - Prescribed by or in consultation with a cardiologist

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Verquvo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of symptomatic chronic heart failure (HF)

AND

2 - Ejection fraction less than 45%

AND

3 - Hospitalization related to HF in the past 6 months

AND

4 - One of the following:

4.1 BOTH of the following:

4.1.1 Trial and failure, contraindication or intolerance to one of the following:

- Angiotensin-converting enzyme inhibitor (e.g., enalapril, lisinopril, ramipril)
- Angiotensin II receptor blocker (e.g., candesartan, losartan, valsartan)
- Angiotensin receptor neprilysin inhibitors (e.g., sacubitril/valsartan)

AND

4.1.2 Trial and failure, contraindication or intolerance to beta-blocker (e.g., bisoprolol, carvedilol, metoprolol succinate)

OR

4.2 Trial and failure, contraindication or intolerance to an aldosterone antagonist (e.g., eplerenone, spironolactone)

AND

5 - Prescribed by or in consultation with a cardiologist

AND

6 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member's is stable or an improvement is seen while on therapy with the requested drug

Notes	*Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Revision History

Date	Notes
2/3/2024	Update Program

Prior Authorization Guideline

Guideline ID	GL-130386
Guideline Name	Viagra (sildenafil)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic sildenafil	
Approval Length	12/31/2039
Guideline Type	Quantity Limit - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting the actual number of intercourse events within a 30-day period and the dose required to achieve an erection

AND

2 - Submission of medical records (e.g., chart notes) documenting that the quantity for treatment cannot be met with the commercially available dose forms within the quantity limit*	
Notes	*QTY Limit: MAX 15 doses per 30 days

Product Name: Viagra, Generic sildenafil	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit - IL and MN Plans
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting the actual number of intercourse events within a 30-day period and the dose required to achieve an erection **AND** **2** - Submission of medical records (e.g., chart notes) documenting that the quantity for treatment cannot be met with the commercially available dose forms within the quantity limit*	
Notes	*QTY Limit: MAX 15 doses per 30 days

Product Name: Viagra, Generic sildenafil	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Quantity Limit - IL and MN Plans
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug	

2 . Revision History

Date	Notes
10/6/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129221
Guideline Name	Viberzi (eluxadoline)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Viberzi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Both of the folowing:

1.1 Covered for persons with diarrhea predominant irritable bowel syndrome (IBS)

AND

1.2 Have failed, or been intolerant to, a one-month trial of conventional therapy (such as loperamide or diphenoxylate/atropine)

Product Name: Viberzi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Viberzi	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Both of the following:

1.1 Covered for persons with diarrhea predominant irritable bowel syndrome (IBS)

AND

1.2 Have failed, or been intolerant to, a one-month trial of conventional therapy (such as loperamide or diphenoxylate/atropine)

2 . Revision History

Date	Notes
10/6/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-128134
Guideline Name	Vimpat (lacosamide)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Generic Lacosamide	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance to at least TWO preferred anticonvulsants:

- lamotrigine
- levetiracetam
- carbamazepine
- valproate
- oxcarbazepine

- gabapentin
- pregabalin
- topiramate
- phenytoin
- zonisamide
- primidone

Product Name: Generic Lacosamide	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Generic Lacosamide	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All other plans except IL and MN Plans

Approval Criteria

1 - Trial and failure, contraindication, or intolerance to at least TWO preferred anticonvulsants:

- lamotrigine
- levetiracetam
- carbamazepine
- valproate
- oxcarbazepine
- gabapentin
- pregabalin
- topiramate
- phenytoin
- zonisamide
- primidone

2 . Revision History

Date	Notes
8/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131955
Guideline Name	Vitamin D Analogs
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Brand: Rayaldee, Generic: Doxercalciferol, paricalcitol	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Dose-adjusted trial and failure (unable to achieve parathyroid hormone level goals), contraindication, or intolerance with calcitriol.

Product Name: Brand: Rayaldee, Generic: Doxercalciferol, paricalcitol	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Brand: Rayaldee, Generic: Doxercalciferol, paricalcitol	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Dose-adjusted trial and failure (unable to achieve parathyroid hormone level goals), contraindication, or intolerance with calcitriol.

2 . Revision History

Date	Notes
11/6/2023	New program

Prior Authorization Guideline

Guideline ID	GL-131407
Guideline Name	Vivjoa (Oteseconazole)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Vivjoa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Current diagnosis of vulvovaginal candidiasis with positive KOH test

AND

2 - History of recurrent vulvovaginal candidiasis with ≥ 3 episodes of vulvovaginal candidiasis in the past 12 months

AND

3 - Person is not of reproductive potential (i.e. postmenopausal, permanent infertility, tubal ligation, etc.)

AND

4 - Trial and failure, contraindication, or intolerance of maintenance fluconazole therapy (at least 6 months)

Product Name: Vivjoa	
Approval Length	3 month(s)
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Current diagnosis of vulvovaginal candidiasis with positive KOH test

AND

2 - History of recurrent vulvovaginal candidiasis with ≥ 3 episodes of vulvovaginal candidiasis in the past 12 months

AND

3 - Person is not of reproductive potential (i.e. postmenopausal, permanent infertility, tubal ligation, etc.)

AND

4 - Trial and failure, contraindication, or intolerance of maintenance fluconazole therapy (at least 6 months)

2 . Revision History

Date	Notes
10/24/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-131932
Guideline Name	Vyndaqel, Vyndamax (tafamidis)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: (Vyndaqel, Vyndamax	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM)

AND

2 - Prescribed by, or in consultation with, Cardiology, transthyretin amyloidosis (ATTR) specialist, or medical geneticist

AND

3 - Age ≥ 18

AND

4 - New York Heart Association (NYHA) functional class I, II, or III heart failure

AND

5 - No previous history of heart transplantation or estimated glomerular filtration rate less than 25mL per minute per 1.73m2 of body-surface area

Product Name: (Vyndaqel, Vyndamax	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM)

AND

2 - Prescribed by, or in consultation with, Cardiology, transthyretin amyloidosis (ATTR) specialist, or medical geneticist

AND

3 - Age ≥ 18

AND

4 - New York Heart Association (NYHA) functional class I, II, or III heart failure

AND

5 - No previous history of heart transplantation or estimated glomerular filtration rate less than 25mL per minute per 1.73m2 of body-surface area

AND

6 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

AND

7 - Individual has not progressed to NYHA Class IV heart failure.

2 . Revision History

Date	Notes
10/16/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-127849
Guideline Name	Xcopri (cenobamate)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Xcopri	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Trial and failure of at least two preferred anticonvulsants:

- lamotrigine
- levetiracetam
- carbamazepine
- valproate
- oxcarbazepine

- gabapentin
- pregabalin
- topiramate
- phenytoin
- zonisamide
- primidone

Product Name: Xcopri	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Step Therapy - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

Product Name: Xcopri	
Approval Length	12/31/2039
Guideline Type	Step Therapy - All plans except IL and MN Plans

Approval Criteria

1 - Trial and failure of at least two preferred anticonvulsants:

- lamotrigine
- levetiracetam
- carbamazepine
- valproate
- oxcarbazepine
- gabapentin
- pregabalin
- topiramate
- phenytoin
- zonisamide
- primidone

2 . Revision History

Date	Notes
8/25/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-135582
Guideline Name	Xdemvy
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Xdemvy	
Approval Length	2 month(s)
Guideline Type	Prior Authorization – All plans except IL and MN plans

Approval Criteria

1 - Diagnosis of demodex blepharitis with all of the following:

- Presence of erythema of the upper eyelid margin
- Presence of mites upon examination of eyelashes by light microscopy OR presence of collarettes on slit lamp examination

AND

2 - Member is 18 years of age or older

Product Name: Xdemvy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization- IL and MN plans

Approval Criteria

1 - Diagnosis of demodex blepharitis with all of the following:

- Presence of erythema of the upper eyelid margin
- Presence of mites upon examination of eyelashes by light microscopy OR presence of collarettes on slit lamp examination

AND

2 - Member is 18 years of age or older

Product Name: Xdemvy	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization- IL and MN plans

Approval Criteria

1 - Diagnosis of demodex blepharitis with all of the following:

- Presence of erythema of the upper eyelid margin
- Presence of mites upon examination of eyelashes by light microscopy OR presence of collarettes on slit lamp examination

AND

2 - Member is 18 years of age or older

AND

3 - One of the following:

3.1 At least 11 months has elapsed since previous treatment with lotilaner (Xdemvy)

OR

3.2 Person is established on therapy and has not completed the initial 6 week treatment course

2 . Revision History

Date	Notes
11/6/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-134602
Guideline Name	Xeljanz (tofacitinib)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Moderate to Severely Active Psoriatic Arthritis (PsA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis

AND

2 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

3 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

4 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

5 - Prescribed by or in consultation with one of the following:

- dermatologist
- rheumatologist

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Moderate to Severely Active Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active psoriatic arthritis

AND

2 - Submission of medical records (e.g., chart notes) documenting at least ONE of the following:

- actively inflamed joints
- axial disease
- active skin, nail, or scalp psoriasis involvement
- dactylitis
- enthesitis

AND

3 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

4 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

5 - Prescribed by or in consultation with one of the following:

- dermatologist
- rheumatologist

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	All Diagnoses
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active rheumatoid arthritis (RA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)**
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

3 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

4 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	**Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immu nodeficiency syndromes, bone marrow hyperplasia, leukopenia, throm bocytopenia or significant anemia, or hypersensitivity to methotrexate ***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufa cturer-sponsored free drug program, provider samples, and/or vouche rs will go through initial criteria, otherwise for continuation of therapy f or new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active rheumatoid arthritis (RA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)**
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

2 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

4 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	**Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate ***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Moderate to Severely Active Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)**
- leflunomide
- hydroxychloroquine
- sulfasalazine

AND

3 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

4 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	**Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate. ***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - Submission of medical records (e.g., chart notes) documenting a 3-month trial and failure, intolerance, or contraindication to ONE of the following:

- methotrexate (MTX)**
- leflunomide

- hydroxychloroquine
- sulfasalazine

AND

2 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

4 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	**Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate. ***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status

Notes	**Absolute contraindications to methotrexate are pregnancy, nursing, alcoholism, alcoholic liver disease or other chronic liver disease, immunodeficiency syndromes, bone marrow hyperplasia, leukopenia, thrombocytopenia or significant anemia, or hypersensitivity to methotrexate. ***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of ankylosing spondylitis (AS)

AND

2 - Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

3 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

4 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of ankylosing spondylitis (AS)

AND

2 - Minimum duration of a 1-month trial and failure, contraindication, or intolerance of scheduled prescription doses of TWO different NSAIDs (e.g., naproxen, nabumetone, diclofenac)

AND

3 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

4 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

5 - Prescribed by or in consultation with a rheumatologist

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Moderate to Severely Active Crohn’s Disease (CD)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Crohn’s disease (CD)

AND

2 - One of the following:

2.1 Member is considered high-risk based on at least one of the following characteristics:

- Age less than 30 years at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (e.g., uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy)

OR

2.2 Both of the following:

2.2.1 Member is considered low-risk

AND

2.2.2 One of the following:

- Trial and failure, contraindication, or intolerance to two conventional therapies (e.g., azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)
- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with one conventional therapy
- Demonstrated steroid dependence
- Conventional therapy clinically inappropriate based on location of disease

AND

3 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

4 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

6 - Prescribed by or in consultation with a gastroenterologist

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Moderate to Severely Active Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active Crohn's disease (CD)

AND

2 - One of the following:

2.1 Member is considered high-risk based on at least one of the following characteristics:

- Age less than 30 years at diagnosis
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricturing and/or penetrating behavior
- Fistulizing disease
- Extraintestinal manifestations of inflammation (e.g., uveitis, erythema nodosum, pyoderma gangrenosum, spondyloarthropathy)

OR

2.2 Both of the following:

2.2.1 Member is considered low-risk

AND

2.2.2 One of the following:

- Trial and failure, contraindication, or intolerance to two conventional therapies (e.g., azathioprine, balsalazide, corticosteroids, mesalamine, mercaptopurine, methotrexate, sulfasalazine)
- Inadequate disease control or inability to achieve remission after an adequate trial of 3 months with one conventional therapy
- Demonstrated steroid dependence
- Conventional therapy clinically inappropriate based on location of disease

AND

3 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

4 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

6 - Prescribed by or in consultation with a gastroenterologist

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Moderate to Severely Active Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Moderate to Severely Active Ulcerative Colitis (UC)
Approval Length	12/31/2039
Guideline Type	Prior Authorization - ALL Plans Except IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active ulcerative colitis (UC)

AND

2 - Member is considered high-risk based on at least one of the following characteristics:

- Extensive colitis
- Deep ulcers
- Age less than 40 years
- High CRP and ESR
- Steroid-requiring disease
- History of hospitalization
- C. difficile infection
- CMV infection

AND

3 - Trial and failure, contraindication, or intolerance to a short course (2 to 4 weeks) of oral corticosteroids

AND

4 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

6 - Prescribed by or in consultation with a gastroenterologist

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Moderate to Severely Active Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of moderate to severely active ulcerative colitis (UC)

AND

2 - Member is considered high-risk based on at least one of the following characteristics:

- Extensive colitis
- Deep ulcers
- Age less than 40 years
- High CRP and ESR
- Steroid-requiring disease
- History of hospitalization
- C. difficile infection
- CMV infection

AND

3 - Trial and failure, contraindication, or intolerance to a short course (2 to 4 weeks) of oral corticosteroids

AND

4 - Not used in combination with other biologic disease modifying anti-rheumatic drugs (DMARDs) (i.e., TNF antagonist and IL-12/23, apremilast and TNF antagonist, etc.)

AND

5 - Trial and failure, contraindication, or intolerance to at least one TNF agent (e.g. adalimumab, etanercept, etc.) as per package label

AND

6 - Prescribed by or in consultation with a gastroenterologist

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

Product Name: Xeljanz, Xeljanz ER	
Diagnosis	Moderate to Severely Active Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes), documenting the member's response to therapy within the past 12 months including individual improvements in functional status

Notes	***Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

2 . Definitions

Definition	Description
Inadequate Disease Control of UC/CD:	Worsening of baseline symptoms (i.e. bowel frequency, presence of blood, abdominal pain or tenderness, fever, etc.), extraintestinal manifestations (i.e. fatigue, joint pain, skin rash, and ocular symptoms), laboratory assessment (i.e. Creactive protein (CRP), hemoglobin, ESR white blood count (WBC), albumin, platelets, fecal calprotectin, etc.) and/or recent endoscopy results demonstrating ongoing inflammation
Steroid Dependence:	Demonstrated steroid dependence (defined as equivalent to prednisone 10mg daily for >3 months) with the inability to taper or when tapering of dose leads to loss of symptom control
Inflammatory status: Signs/Symptoms/Labs/Endoscopy for diagnosis	-Bloody diarrhea, weight loss, tenesmus, urgency, abdominal pain, fever, joint swelling/redness, localized abdominal tenderness, anemia, cutaneous signs -CBC, CMP, CRP, ESR, stool cultures, C difficile assay, fecal calprotectin -endoscopy, colonoscopy, sigmoidoscopy
Ulcerative Colitis Disease Severity:	Based on the degree of presentation of the signs and symptoms and change in baseline inflammatory status Moderate disease - more than four stools per day with minimal signs of toxicity, anemia, abdominal pain, low grade fever Severe disease - more than six bloody stools per day, fever, tachycardia, anemia, elevated ESR or CRP
Crohn's Disease Classification:	Stricturing - narrowing of bowel that may cause bowel obstruction; Penetrating - fistulae may form between bowel and other structures; Inflammatory - nonstricturing, nonpenetrating - inflammation without strictures or fistula

3 . Revision History

Date	Notes
12/1/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-129632
Guideline Name	Xenleta (Lefamulin)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Xenleta	
Approval Length	*See Note
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Person has been receiving drug during hospitalization and needs to complete the course of therapy as an outpatient.

OR

2 - Both of the following:

2.1 Outpatient treatment of bacterial resistant strains as ordered by or in consultation with an Infectious Disease Specialist

AND

2.2 Report of susceptibilities documenting resistance to preferred alternatives

OR

3 - (Illinois plans only) – the requested FDA approved drug is being used for the long-term treatment of tick-borne disease.

Notes	Approval Length-12 months Fill Limit- 1 Fill

Product Name: Xenleta	
Approval Length	One fill
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Person has been receiving drug during hospitalization and needs to complete the course of therapy as an outpatient.

OR

2 - Outpatient treatment of bacterial resistant strains as ordered by or in consultation with an Infectious Disease Specialist

AND

3 - Report of susceptibilities documenting resistance to preferred alternatives

2 . Revision History

Date	Notes
10/25/2023	New program

Prior Authorization Guideline

Guideline ID	GL-131938
Guideline Name	Xermelo (telotristat)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Xermelo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of diarrhea secondary to carcinoid syndrome

AND

2 - Age greater than or equal to 18 years

AND

3 - 3-month trial and failure (≥ 4 bowel movements per day) with a somatostatin analog such as octreotide, lanreotide, or pasireotide.

AND

4 - Used in combination with a somatostatin analog

Product Name: Xermelo	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Xermelo	
Approval Length	12/31/2039
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of diarrhea secondary to carcinoid syndrome

AND

2 - Age greater than or equal to 18 years

AND

3 - 3-month trial and failure (≥ 4 bowel movements per day) with a somatostatin analog such as octreotide, lanreotide, or pasireotide.

AND

4 - Used in combination with a somatostatin analog

2 . Revision History

Date	Notes
10/31/2023	New program

Prior Authorization Guideline

Guideline ID	GL-139376
Guideline Name	Xolair (Omalizumab)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/26/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Xolair	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans Only
Approval Criteria	

1 - Diagnosis of moderate-to-severe persistent allergic asthma as defined by Global Initiative for Asthma (GINA) Global Strategy for Asthma Management and Prevention Guidelines (Step 5)

AND

2 - Member is 6 years or older

AND

3 - Serum IgE level ≥ 30 international units/mL

AND

4 - Positive skin tests or in vitro reactivity to common aeroallergens (e.g. dust mites, pet dander, cockroaches)

AND

5 - Member is a non-smoker or smoking cessation therapy has been recommended

AND

6 - One of the following:

6.1 Member has not well controlled or poorly controlled asthma despite episodic use of systemic corticosteroids or at least 3 months of medium to high-dose inhaled corticosteroids (ICS) in combination with long acting beta2 agonist (LABA) or leukotriene modifiers

OR

6.2 Member has one of the following adverse effects from medium to high dose ICS or long-term risks of adverse effects from high dose ICS or oral corticosteroids:

- Cataracts in patients greater than 40 years of age
- Glaucoma

- Recurrent Thrush
- Dysphonia
- Growth inhibition, after evaluation by Endocrine Consult
- Diagnosis of osteoporosis, treatment resistant to FDA approved osteoporosis treatment

AND

7 - Prescriber attestation that the initial six (6) months of therapy must be done in the clinic setting by a healthcare professional

Product Name: Xolair	
Diagnosis	Asthma
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of moderate-to-severe persistent allergic asthma as defined by Global Initiative for Asthma (GINA) Global Strategy for Asthma Management and Prevention Guidelines (Step 5)

AND

2 - Member is 6 years or older

AND

3 - Serum IgE level ≥ 30 international units/mL

AND

4 - Positive skin tests or in vitro reactivity to common aeroallergens (e.g. dust mites, pet dander, cockroaches)

AND

5 - Member is a non-smoker or smoking cessation therapy has been recommended

AND

6 - One of the following:

6.1 Member has not well controlled or poorly controlled asthma despite episodic use of systemic corticosteroids or at least 3 months of medium to high-dose inhaled corticosteroids (ICS) in combination with long acting beta2 agonist (LABA) or leukotriene modifiers

OR

6.2 Member has one of the following adverse effects from medium to high dose ICS or long-term risks of adverse effects from high dose ICS or oral corticosteroids:

- Cataracts in patients greater than 40 years of age
- Glaucoma
- Recurrent Thrush
- Dysphonia
- Growth inhibition, after evaluation by Endocrine Consult
- Diagnosis of osteoporosis, treatment resistant to FDA approved osteoporosis treatment

AND

7 - Prescriber attestation that the initial six (6) months of therapy must be done in the clinic setting by a healthcare professional

Product Name: Xolair	
Diagnosis	Urticaria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans Only

Approval Criteria

1 - Diagnosis of chronic (at least 3 months), refractory urticaria

AND

2 - Member has tried and failed both of the following:

- Scheduled, high dose non-sedating antihistamines
- at least one short course of corticosteroids

AND

3 - Prescriber attestation that the initial six (6) months of therapy must be done in the clinic setting by a healthcare professional

Product Name: Xolair	
Diagnosis	Urticaria
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of chronic (at least 3 months), refractory urticaria

AND

2 - Member has tried and failed both of the following:

- Scheduled, high dose non-sedating antihistamines
- at least one short course of corticosteroids

AND

3 - Prescriber attestation that the initial six (6) months of therapy must be done in the clinic setting by a healthcare professional

Product Name: Xolair	
Diagnosis	Immunotherapy
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescribed by an allergist

AND

2 - Prescriber attestation that the initial six (6) months of therapy must be done in the clinic setting by a healthcare professional

Product Name: Xolair	
Diagnosis	Polyps
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of chronic rhinosinusitis with nasal polyposis

AND

2 - All of the following:

- At least eight weeks of moderate to severe nasal congestion/blockage/obstruction OR diminished sense of smell or rhinorrhea

- Submission of medical records (e.g., chart notes) • Documented nasal polyps by direct exam, endoscopy, or sinus CT scan (i.e., nasal polyp score five out of eight)
- No chronic or acute infection requiring systemic treatment within two weeks before therapy initiation

AND

3 - Prescribed by, or in consultation with, a specialist experienced in the treatment of nasal polyps (e.g., Otolaryngologist, Allergist)

AND

4 - Trial and failure, contraindication, or intolerance to one of the following:

- Greater than or equal to 2 nasal steroid sprays (i.e. failed two nasal sprays)
- IM injections for polyps with one previous nasal spray

AND

5 - Trial and failure, contraindication, or intolerance to one of the following:

- Oral corticosteroids for nasal polyps
- Prior surgery for nasal polyps greater than six months ago

AND

6 - Requested medication will be used in combination with a nasal corticosteroid medication

AND

7 - Requested medication will not used in combination with other biologic therapies (e.g. benralizumab, dupilumab, mepolizumab)

AND

8 - Prescriber attestation that the initial six (6) months of therapy must be done in the clinic setting by a healthcare professional

Product Name: Xolair	
Diagnosis	Polyps
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Diagnosis of chronic rhinosinusitis with nasal polyposis

AND

2 - All of the following:

- At least eight weeks of moderate to severe nasal congestion/blockage/obstruction OR diminished sense of smell or rhinorrhea
- Submission of medical records (e.g., chart notes) • Documented nasal polyps by direct exam, endoscopy, or sinus CT scan (i.e., nasal polyp score five out of eight)
- No chronic or acute infection requiring systemic treatment within two weeks before therapy initiation

AND

3 - Prescribed by, or in consultation with, a specialist experienced in the treatment of nasal polyps (e.g., Otolaryngologist, Allergist)

AND

4 - Trial and failure, contraindication, or intolerance to one of the following:

- Greater than or equal to 2 nasal steroid sprays (i.e. failed two nasal sprays)
- IM injections for polyps with one previous nasal spray

AND

5 - Trial and failure, contraindication, or intolerance to one of the following:

- Oral corticosteroids for nasal polyps
- Prior surgery for nasal polyps greater than six months ago

AND

6 - Requested medication will be used in combination with a nasal corticosteroid medication

AND

7 - Requested medication will not used in combination with other biologic therapies (e.g. benralizumab, dupilumab, mepolizumab)

AND

8 - Prescriber attestation that the initial six (6) months of therapy must be done in the clinic setting by a healthcare professional

Product Name: Xolair	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans Only

Approval Criteria

1 - Submission of medial records documenting a positive clinical response to therapy and improvement in disease state from previous 12 months

AND

2 - Submission of medical records (e.g., chart notes) documenting from the previous 12 months in improvement to one of the following:

- Decreased frequency of corticosteroid use to treat or prevent an exacerbation

- Reductions in symptom exacerbation frequency or intensity
- Decreased frequency of unscheduled clinic, urgent care or emergency department visits due to asthma
- Increase in percent predicted FEV1 from pre-treatment baseline
- Increase in percent predicted FEV1 from pre-treatment baseline
- Reduction use of ICS, leukotriene or beta agonist therapy
- Improvement in nasal polyposis score

2 . Background

Benefit/Coverage/Program Information

Outcome Measure values for uncontrolled asthma

Measure	Not Well Controlled	Very Poorly Controlled
Baseline symptoms (outside of exacerbation)	> 2 days/week	Throughout the day
Nighttime awakening	1-3 times/week	≥ 4 times/week
Interference with normal activity	Some limitation	Extremely limited
Short acting beta agonist use for symptom control	> 2 days/week	Several times per day
FEV1	60-80% predicted or personal best	< 60% predicted or personal best
Asthma exacerbations requiring oral steroids ≥ 2 times in the past year	Yes	Yes
Asthma Control Test (ACT)	16-19	≤ 15

3 . Revision History

Date	Notes
1/26/2024	New Program

Prior Authorization Guideline

Guideline ID	GL-131951
Guideline Name	Xuriden (Uridine triacetate)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Xuriden	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only
Approval Criteria **1** - Diagnosis of hereditary orotic aciduria	

Product Name: Xuriden	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug and that there has been a response to therapy (improvement in hematologic counts and urine orotic acid levels).

Product Name: Xuriden	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of hereditary orotic aciduria

Product Name: Xuriden	
Approval Length	12/31/2039
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug and that there has been a response to therapy (improvement in hematologic counts and urine orotic acid levels).

2 . Revision History

Date	Notes
10/31/2023	New program

Prior Authorization Guideline

Guideline ID	GL-131921
Guideline Name	Xyrem (sodium oxybate)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name: Generic Sodium oxybate	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Diagnosis of cataplexy in narcolepsy or excessive daytime sleepiness in narcolepsy

AND

2 - Trial and failure, contraindication, or intolerance to one preferred narcolepsy medication (e.g. modafinil, armodafinil)

Product Name: Generic Sodium oxybate	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-IL and MN Plans Only

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months documenting an improvement in sleepiness symptoms.

Product Name: Generic Sodium oxybate	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Diagnosis of cataplexy in narcolepsy or excessive daytime sleepiness in narcolepsy

AND

2 - Trial and failure, contraindication, or intolerance to one preferred narcolepsy medication (e.g. modafinil, armodafinil)

Product Name: Generic Sodium oxybate	
Approval Length	12/31/2039
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization-All plans except IL and MN

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months documenting an improvement in sleepiness symptoms.

2 . Revision History

Date	Notes
10/31/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129641
Guideline Name	Zokinvy (Lonafarnib)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Zokinvy	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Hutchinson-Gilford progeria syndrome OR other FDA approved diagnosis

AND

2 - Prescribed by, or in consultation with, a specialist in the treatment of progeria or related-syndromes

Product Name: Zokinvy	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The prescriber must provide clinical documentation from an office visit in the preceding 12 months that use of the drug has slowed the disease progression and function is improved relative to the expected natural course of the disease.

2 . Revision History

Date	Notes
10/6/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-132750
Guideline Name	Zontivity (vorapaxar)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

Note:

Member new to the plan (as evidenced by coverage effective date of less than or equal to 90 days) who initiated therapy using a manufacturer-sponsored free drug program, provider samples, and/or vouchers will go through initial criteria, otherwise for continuation of therapy for new to plan, reauthorization criteria applies

1 . Criteria

Product Name: Zontivity	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN Plans
Approval Criteria **1** - Diagnosis of one of the following:	

- Peripheral Arterial Disease (PAD)
- History of myocardial infarction (MI)

AND

2 - Prescribed by or in consultation with a Cardiologist

AND

3 - Submission of medical records (e.g., chart notes) documenting increased risk of thrombotic cardiovascular events despite being on combination therapy with BOTH aspirin and P2Y12 therapy (e.g., clopidogrel, ticagrelor, or prasugrel)

Product Name: Zontivity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Diagnosis of one of the following:

- Peripheral Arterial Disease (PAD)
- History of myocardial infarction (MI)

AND

2 - Prescribed by or in consultation with a Cardiologist

AND

3 - Submission of medical records (e.g., chart notes) documenting increased risk of thrombotic cardiovascular events despite being on combination therapy with BOTH aspirin and P2Y12 therapy (e.g., clopidogrel, ticagrelor, or prasugrel)

Product Name: Zontivity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
9/7/2023	2024 New Implementation

Prior Authorization Guideline

Guideline ID	GL-131913
Guideline Name	Zoryve (roflumilast cream)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Zoryve	
Approval Length	12/31/2039
Guideline Type	Prior Authorization – All plans except IL and MN plans

Approval Criteria

1 - Diagnosis of psoriasis

AND

2 - 12 years or older

AND

3 - Prescribed by, or in consultation with a dermatologist, or other specialist in the treatment psoriasis

AND

4 - One of the following:

- Trial and failure, contraindication, or intolerance to one preferred high or super-high potency topical corticosteroid (see the formulary at QuartzBenefits.com for a complete listing of options)
- Person has facial or other sensitive area involvement and a trial and failure, contraindication, or intolerance to one preferred non steroid therapy (e.g., calcipotriene, retinoids)

Product Name: Zoryve	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization- Il and MN plans

Approval Criteria

1 - Diagnosis of psoriasis

AND

2 - 12 years or older

AND

3 - Prescribed by, or in consultation with a dermatologist, or other specialist in the treatment psoriasis

AND

4 - One of the following:

- Trial and failure, contraindication, or intolerance to one preferred high or super-high potency topical corticosteroid (see the formulary at QuartzBenefits.com for a complete listing of options)
- Person has facial or other sensitive area involvement and a trial and failure, contraindication, or intolerance to one preferred non steroid therapy (e.g., calcipotriene, retinoids)

Product Name: Zoryve	
Approval Length	12/31/2039
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization- Il and MN plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug

2 . Revision History

Date	Notes
10/31/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-129640
Guideline Name	Ztlido (Lidocaine Patch)
Formulary	• Quartz

Guideline Note:

Effective Date:	1/1/2024

1 . Criteria

Product Name: Ztlido	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Person with a diagnosis of post-herpetic neuralgia

AND

2 - Trial and failure, contraindication or intolerance of an equivalent dose of generic lidocaine 5% transdermal patches

AND

3 - Trial and failure, contraindication or intolerance to at least one other preferred drug with evidence for reducing symptoms of post-herpetic neuralgia symptoms

AND

4 - The prescriber provides an evidence-based clinical rationale for why different results from those seen with generic 5% lidocaine patches would be expected

OR

5 - (Minnesota plans only) – the person has stage four metastatic cancer and the requested drug is being used to treat cancer-related pain

Product Name: Ztlido	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization - IL and MN Plans

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that within the past 12 months the member is continuing therapy with the requested drug.

Product Name: Ztlido	
Approval Length	12/31/2039
Guideline Type	Prior Authorization - All plans except IL and MN

Approval Criteria

1 - Person with a diagnosis of post-herpetic neuralgia

AND

2 - Trial and failure, contraindication or intolerance of an equivalent dose of generic lidocaine 5% transdermal patches

AND

3 - Trial and failure, contraindication or intolerance to at least one other preferred drug with evidence for reducing symptoms of post-herpetic neuralgia symptoms

AND

4 - The prescriber provides an evidence-based clinical rationale for why different results from those seen with generic 5% lidocaine patches would be expected

2 . Revision History

Date	Notes
10/6/2023	New Program