ProCare Rx

JAI MEDICAL SYSTEMS

Contents

Prior Authorization Criteria

GENERIC NAME	ABIRATERONE
LABEL NAME(S)	(ABIRATERONE 250MG TABLET)
Formulary	
Covered Uses	All FDA approved indications: ● Indicated in combination with prednisone for the treatment of patients with metastatic castration-resistant prostate cancer (CRPC) (ICD10-CM C61). ● Indicated in combination with prednisone for the treatment of patients with metastatic high-risk castration-sensitive prostate cancer (CSPC) (ICD10-CM C61).
Required Medical Information	● For the first prescription only: 1. For CRPC: Documentation of metastatic castration-resistant prostate cancer; 2. For CSPC: Documentation of metastatic high-risk castration-sensitive prostate cancer; ● Document concurrent prednisone use.
Max Quantity Per Month	120 TABLETS PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Other Criteria	Refer to package insert for dosage and administration.

GENERIC NAME	ACARBOSE
LABEL NAME(S)	(ACARBOSE 100 MG TABLET | ACARBOSE 25 MG TABLET | ACARBOSE 50 MG TABLET)
Formulary	
Covered Uses	All FDA approved indications: ● Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Required Medical Information	● Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus ○ Failure of maximal doses of one oral sulfonylurea
Max Quantity Per Month	90EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills

Required Information for Previous Trials of Rx	• A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication • Failure is defined as hbA1c ≥7 after trying the medication for at least 60 days
Other Criteria	

GENERIC NAME	ACLIDINIUM BROMIDE
LABEL NAME(S)	(TUDORZA PRESSAIR 400 MCG INHAL)
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the maintenance treatment of patients with chronic obstructive pulmonary disease (COPD)
Required Medical Information	• Diagnosis of COPD and • Must be greater than 18 years of age and • Documented inadequate response or intolerance to Tiotropium
Max Quantity Per Month	1 INHALER PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	ACYCLOVIR SUSPENSION
LABEL NAME(S)	**(ACYCLOVIR 200 MG/5 ML SUSP)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the acute treatment of herpes zoster (shingles) ● Indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes ● Indicated for the treatment of chickenpox (varicella)

Required Medical Information	● Indicated for the acute treatment of herpes zoster (shingles) ○ Patient is >2 years of age and <17 years of age; or ○ Unable to ingest solid dosage form (e.g., capsules) due to dysphagia ● Indicated for the treatment of initial episodes and the management of recurrent episodes of genital herpes ○ Herpes genitalis – for initial episode only; or ○ Oral herpes infection – for immunocompromised patients only ○ Patient is <17 years of age; or ○ Unable to ingest solid dosage form (e.g., capsules) due to dysphagia ● Indicated for the treatment of chickenpox (varicella) ○ Patient is <17 years of age; or ○ Unable to ingest solid dosage form (e.g., capsules) due to dysphagia
Max Quantity Per Month	3000ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Previous Trials of Rx	
Other Criteria	

GENERIC NAME	ACYCLOVIR TOPICAL
LABEL NAME(S)	**(ACYCLOVIR 5% CREAM | ACYCLOVIR 5% OINTMENT)**
Formulary	
Covered Uses	All FDA approved indications: **Cream:** ● Indicated for the treatment of recurrent herpes labialis (cold sores) in immunocompetent adults and adolescents 12 years of age and older **Ointment:** ● Indicated in the management of initial genital herpes and in limited non-life-threatening mucocutaneous HSV infections in immunocompromised patients.
Required Medical Information	• Herpes genitalis – for initial episode only; or • Oral herpes infection – for immunocompromised patients only
Max Quantity Per Month	1.0EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills

Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	ADALIMUMAB
LABEL NAME(S)	(ADALIMUMAB-ADAZ PEN INJCTR 40MG/0.4ML| ADALIMUMAB-ADAZ INJCTR 80MG/0.8ML | ADALIMUMAB-ADAZ SYRINGE 40MG/0.4ML | ADALIMUMAB-ADAZ SYRINGE 20MG/0.2ML | ADALIMUMAB-RYVK (2 PEN) AUTOINJKIT 40MG/0.4ML| HADLIMA (CF) PUSHTOUCH AUTO INJCT 40MG/0.4ML | HADLIMA PUSHTOUCH AUTO INJCT 40MG/0.8ML| HADLIMA 40 MG/0.4 ML SYRINGE | SIMLANDI(CF) AUTOINJECTOR AUTOINJKIT 40MG/0.4ML | SIMLANDI(CF) AUTOINJECTOR AUTOINJKIT 80MG/0.8ML)
Formulary	
Covered Uses	All FDA approved indications: (a) Rheumatoid Arthritis (RA): Reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adult patients with moderately to severely active RA. (ICD10-CM M06.9, ICD-10-CM M05, ICD-10-CM M05.9). (b) Juvenile Idiopathic Arthritis (JIA): Reducing signs and symptoms of moderately to severely active polyarticular JIA in patients 2 years of age and older. (ICD10-CM M08.00). (c) Psoriatic Arthritis (PsA): Reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adult patients with active PsA. (ICD10-CM L40.59, L40.50). (d) Ankylosing Spondylitis (AS): Reducing signs and symptoms in adult patients with active AS. (ICD10-CM M45.9). (e) Crohn's Disease (CD): Treatment of moderately to severely active Crohn's disease in adults and pediatric patients 6 years of age and older. (ICD-10-CM K50.0 - K50.90) (f) Ulcerative Colitis (UC Treatment of moderately to severely active ulcerative colitis in adult patients. (ICD10-CM K51.90). (g) Plaque Psoriasis (PsO): The treatment of adult patients with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate. (ICD10-CM L40.0). (h) Hidradenitis Suppurativa (HS): The treatment of moderate to severe hidradenitis suppurativa in patients 12 years of age and older. (ICD10-CM L73.2). (i) Uveitis (UV): The treatment of non-infectious intermediate, posterior and panuveitis in patients 2 years of age and older. (ICD10-CM: H44.139, H44.11)
Exclusion Criteria	(a) Combination therapy with other biologic agent(s)

Required Medical Information	(a) **First Prescription and every 12 months:** a. The patient had a recent NEGATIVE tuberculosis test, or if positive, has received treatment for latent TB prior to therapy; **and** b. The patient does not have a clinically important active infection (b) **Additional Criteria for RA, JIA, and PsA**: For the **First Prescription Only** a. The patient has failed or is intolerant to one formulary NSAID and b. The patient has failed or is intolerant to one formulary DMARD (c) **Additional Criteria for AS:** For the **First Prescription Only** a. Physician documents that patient failed treatment with at least two NSAIDS for at least three months, except if NSAIDs are contraindicated or if patient has presented toxicity or intolerance. (d) **Additional Criteria for CD and UC:** For the **First Prescription Only** a. The patient has failed or is intolerant to infliximab; or b. The patient has failed or is intolerant to mesalamine or sulfasalazine; and c. The patient has failed or is intolerant to corticosteroids; and d. The patient has failed or is intolerant to an immunomodulator (e.g., methotrexate, 6- mercaptopurine or azathioprine) (e) **Additional Criteria for Ps:** For the **First Prescription Only** a. Document that the patient has an incomplete response or intolerance or contraindicated to one appropriate systemic agent (ex: MTX, cyclosporine, acitretin) or phototherapy or biologic agents. (f) **Additional Criteria for Hs:** For the **First Prescription Only** a. Documentation of evidence failure with the previous treatment including antibiotics, hormonal therapies or oral retinoid at least for 90 days.
Age Restriction	Minimum age for approval determined by FDA approval for each indication
Coverage Duration	(a) One (1) Year
Max Quantity Per Month	8.4EA PER 30 DAYS
Max Refills Per Year	Twelve (12) fills per year.
Required Information for Previous Trials of Rx	• A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication

Other Criteria	(a) Follow package insert instructions for dose modification. (b) Patients treated with ADALIMUMAB are at increased risk of developing serious infections that may lead to hospitalization or death. The physician should be aware and follow up the patient's conditions prior and during treatment. (c) The tuberculosis test should be within 12 months of the request date (d) Provide intended dosing schedule with request, including details of initial dose and maintenance dose (e) **Differences: Humira and biosimilar indications** • **UC**: Humira has pediatric indication for UC: 5 years and older; Simlandi/Hadlima/Adalimumab-adaz only approved for adults • All other indications are the same between biosimilars and Humira (reference product).

GENERIC NAME	AMBRISENTAN
LABEL NAME(S)	**(AMBRISENTAN 10 MG TABLET | AMBRISENTAN 5 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of pulmonary arterial hypertension (PAH) (WHO Group 1) to improve exercise ability and delay clinical worsening & in combination with tadalafil to reduce the risks of disease progression and hospitalization for worsening PAH, and to improve exercise ability
Required Medical Information	○ Documentation of pulmonary arterial hypertension (PAH) (WHO Group 1)
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	ANTIHEMOPHILIC FACTORS
LABEL NAME(S)	**(FEIBA NF 1,000 UNIT (NOMINAL) | FEIBA NF 2,500 UNIT (NOMINAL) | FEIBA NF 500 UNIT (NOMINAL) | RECOMBINATE 1,241-1,800 UNIT V | RECOMBINATE 1,801-2,400 UNIT V | RECOMBINATE 220-400 UNIT VIAL | RECOMBINATE 401-800 UNIT VIAL | RECOMBINATE 801-1,240 UNIT VL | HEMOFIL M 1,000 UNIT NOMINAL | HEMOFIL M 1,700 UNIT NOMINAL | HEMOFIL M 250 UNIT NOMINAL | HEMOFIL M 500 UNIT NOMINAL | KOATE 1,000 UNIT VIAL | KOATE 250 UNIT VIAL | KOATE 500 UNIT VIAL | HUMATE-P 1,200 UNIT VWF:RCO | HUMATE-P 2,400 UNIT VWF:RCO | HUMATE-P 600 UNIT VWF:RCO | THROMBATE III 500 UNIT VIAL)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for use in hemophilia A and B patients with inhibitors for control and prevention of bleeding episodes, perioperative management, routine prophylaxis to prevent or reduce the frequency of bleeding episodes
Required Medical Information	○ Diagnosis of Hemophilia A with inhibitors, OR ○ Diagnosis of Hemophilia B with inhibitors
Max Quantity Per Month	N/A PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	APREPITANT
LABEL NAME(S)	**(APREPITANT 125 MG CAPSULE | APREPITANT 125-80-80 MG PACK | APREPITANT 40 MG CAPSULE | APREPITANT 80 MG CAPSULE)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated in patients 12 years of age and older for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin & nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy (MEC) ● Indicated in adults for the prevention of postoperative nausea and vomiting

Required Medical Information	● Indicated in patients 12 years of age and older for the prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic cancer chemotherapy (HEC) including high-dose cisplatin & nausea and vomiting associated with initial and repeat courses of moderately emetogenic cancer chemotherapy (MEC) ○ Being used for the prevention of chemotherapy-induced nausea and vomiting ● Indicated in adults for the prevention of postoperative nausea and vomiting ○ Being used for the prevention of post-operative nausea and vomiting
Max Quantity Per Month	90EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	AZELASTINE HCL NASAL SPRAY
LABEL NAME(S)	**(AZELASTINE 0.1% (137 MCG) SPRY)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the relief of the symptoms of seasonal allergic rhinitis in patients 6 years of age and older and perennial allergic rhinitis in patients 6 years of age and older
Required Medical Information	○ Patient is > 5 years of age with one of the above diagnoses; and ○ Failure of at least one formulary nasal steroid after a period of at least two months on the maximum dose appropriate and tolerated by the patient
Max Quantity Per Month	40.8ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	BLOOD-GLUCOSE SENSOR [CONTINUOUS GLUCOSE MONITOR (CGM)]
LABEL NAME(S)	**(FREESTYLE LIBRE 3 SENSOR | FREESTYLE LIBRE 10 DAY READER | FREESTYLE LIBRE 14 DAY READER | FREESTYLE LIBRE 2 READER | FREESTYLE LIBRE 10 DAY SENSOR | FREESTYLE LIBRE 14 DAY SENSOR | FREESTYLE LIBRE 2 SENSOR)**
Formulary	
Covered Uses	• For the management of diabetes in members aged 4 years and older with Type 1 and Type 2 diabetes who are using insulin, members with gestational diabetes mellitus, or diabetic members who have problematic hypoglycemic events
Required Medical Information	For the treatment of patients indicated for the management of diabetes in persons aged 4 years and older who meet all of the following initial coverage criteria: 1. The member meets one of the following: a. Diagnosed with Diabetes mellitus (Type I or Type II) and is currently receiving insulin treatment; b. Member has a diagnosis of Gestational Diabetes Mellitus; or c. Member has a history of problematic hypoglycemia with documentation of at least one of the following [as specified in the Policy Specific Documentation Requirements of the LCD-related Policy Article (A52464) from CMS https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52464]: ○ More than one level 2 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple attempts to adjust medications or modify the diabetes treatment plan; or ○ A history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental or physical state requiring third-party assistance for treatment of hypoglycemia; and 2. The treating practitioner has concluded that the member or their caregiver has sufficient training to use the CGM as shown by writing the prescription; and 3. The CGM is prescribed in accordance with its FDA indications for use
Max Quantity Per Month	2 SENSORS PER MONTH SUPPLY (3 SENSORS FOR 10 DAY READER)
Max Refills Per Year	Twelve (12) Refills
Other Criteria	• Renewal request must include information from the practitioner that the member is utilizing the system successfully. • If product is to be used in conjunction with a compatible insulin pump that has already been approved, please include that information with the request. • Approval requested with a Pharmacy PA Form is for pharmacy benefit and is not transferable between pharmacy and DME benefit without a new request. For requests under the DME benefit, please utilize PCP referral and standard authorization form.

	• Requests for any other brands of CGM through the pharmacy benefit must include rationale of why Freestyle CGMs are not appropriate. • Criteria based on instructions from Maryland Medicaid (PT 71-26). Criteria will be updated to align with future updates from Maryland Medicaid.

GENERIC NAME	CALCITONIN,SALMON,SYNTHETIC
LABEL NAME(S)	**(CALCITONIN-SALMON 200 UNITS SP | CALCITONIN-SALMON 400 UNIT/2 M)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of symptomatic Paget's disease of bone in patients with moderate to severe disease characterized by polyostotic involvement with elevated serum alkaline phosphatase and urinary hydroxyproline excretion ● Indicated for the early treatment of hypercalcemic emergencies, along with other appropriate agents, when a rapid decrease in serum calcium is required, until more specific treatment of the underlying disease can be accomplished ● Indicated for the treatment of postmenopausal osteoporosis in women greater than 5 years postmenopause
Required Medical Information	○ Failure of or contraindication to oral bisphosphonate; and ○ One of the following: ▪ Bone density measurement >2.5 standard deviations below the mean for normal, young adults of same gender (T-score < -2.5); or ▪ History of an osteoporotic vertebral fracture; or ▪ Postmenopausal woman with low bone mineral density defined by T-score between -2.0 and -2.5 AND one of the following risks for fracture: a. Thinness or low body mass index (BMI) defined by weight <127lb (57.7kg) or BMI <21kg/m^2 b. History of fragility fracture since menopause c. History of hip fracture in a parent ▪ Diagnosis of Paget's Disease of bone ○ Patients receiving glucocorticoids in daily dosages of >7.5mg prednisone daily AND have bone density measurement > 1 standard deviations below the mean for normal, young adults of same gender (T-score <-1.0)
Max Quantity Per Month	336ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication

Other Criteria	* For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary * If documentation of osteoporosis is available, please submit with PA request

GENERIC NAME	CYANOCOBALAMIN (VITAMIN B-12)
LABEL NAME(S)	**(CYANOCOBALAMIN 10,000 MCG/10 M)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for vitamin B12 deficiencies due to malabsorption which may be associated with the following conditions (Addisonian (pernicious) anemia OR gastrointestinal pathology/dysfunction/surgery/sprue OR small bowel bacteria overgrowth OR total or partial gastrectomy OR fish tapeworm infestation OR malignancy of pancreas or bowel OR folic acid deficiency
Required Medical Information	○ Patients who lack intrinsic factor; or ○ Patients who are on long-term PPI therapy; or ○ Patients with a partial or complete gastrectomy
Max Quantity Per Month	1.38ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	* For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary

GENERIC NAME	CYCLOSPORINE
LABEL NAME(S)	**(RESTASIS 0.05% EYE EMULSION | RESTASIS MULTIDOSE 0.05% EYE)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca
Required Medical Information	• Failure of, intolerance to, contraindication, or previous use to artificial tears, or equivalent
Max Quantity Per Month	6ML PER 30 DAYS

Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	DALFAMPRIDINE
LABEL NAME(S)	**(DALFAMPRIDINE ER 10 MG TABLET) |**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment to improve walking in adult patients with multiple sclerosis (MS)
Required Medical Information	• Diagnosis of multiple sclerosis; and • Prescribed by a neurologist; and • Currently taking a disease modifying drug for multiple sclerosis (Avonex, Aubagio, Betaseron, Copaxone, Extavia, Gilenya, Rebif, Tecfidera or Tysabri)
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	* Renewals will require documented improvement in walking speed (demonstrated improvement in timed 25-foot walk)

GENERIC NAME	DANTROLENE SODIUM
LABEL NAME(S)	**(DANTROLENE SODIUM 100 MG CAP | DANTROLENE SODIUM 25 MG CAP | DANTROLENE SODIUM 50 MG CAP)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated in controlling the manifestations of clinical spasticity resulting from upper motor neuron disorders (e.g., spinal cord injury, stroke, cerebral palsy, or multiple sclerosis) ● Indicated preoperatively to prevent or attenuate the development of signs of malignant hyperthermia in known, or strongly suspect, malignant hyperthermia susceptible patients who require anesthesia and/or surgery

Required Medical Information	● Indicated in controlling the manifestations of clinical spasticity resulting from upper motor neuron disorders (e.g., spinal cord injury, stroke, cerebral palsy, or multiple sclerosis) ○ Demonstrated failure of, or intolerance to, Baclofen ● Indicated preoperatively to prevent or attenuate the development of signs of malignant hyperthermia in known, or strongly suspect, malignant hyperthermia susceptible patients who require anesthesia and/or surgery
Max Quantity Per Month	480EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	DARBEPOETIN ALFA IN POLYSORBATE
LABEL NAME(S)	ARANESP 100 MCG/0.5 ML SYRINGE | ARANESP 10 MCG/0.4 ML SYRINGE | ARANESP 150 MCG/0.3 ML SYRINGE | ARANESP 200 MCG/0.4 ML SYRINGE | ARANESP 25 MCG/0.42 ML SYRING | ARANESP 300 MCG/0.6 ML SYRINGE | ARANESP 40 MCG/0.4 ML SYRINGE | ARANESP 500 MCG/1 ML SYRINGE | ARANESP 60 MCG/0.3 ML SYRINGE | ARANESP 100 MCG/ML VIAL| ARANESP 200 MCG/ML VIAL | ARANESP 25 MCG/ML VIAL | ARANESP 300 MCG/ML VIAL | ARANESP 40 MCG/ML VIAL | ARANESP 60 MCG/ML VIAL
Formulary	
Covered Uses	All FDA approved indications: (a) Indicated for the treatment of anemia due to chronic kidney disease (CKD), including patients on dialysis and patients not on dialysis (b) Indicated for the treatment of anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy
Exclusion Criteria	None

Required Medical Information	(a) Indicated for the treatment of anemia due to chronic kidney disease (CKD), including patients on dialysis and patients not on dialysis 1. Ensure patient's iron stores are adequate (Ferritin > 100 ng/mL and/or Transferrin saturation > 20%) or patient is being treated with iron; and 2. Adequate blood pressure control; and 3. Initiate treatment when hemoglobin is <10g/dL (b) Indicated for the treatment of anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy 1. Ensure patient's iron stores are adequate (Ferritin > 100 ng/mL and/or Transferrin saturation > 20%) or patient is being treated with iron; and 2. Adequate blood pressure control; and 3. Initiate treatment when hemoglobin is <10g/dL; and 4. Anticipated duration of myelosuppressive chemotherapy is ≥ 2 months
Age Restrictions	None
Coverage Duration	One (1) Year
Max Quantity Per Month	QL = 4 ML per 30 day(s).
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	None
Other Criteria	For renewals: (a) Chronic kidney disease patients: (1) With dialysis Hbg <11; or (2) Without dialysis Hbg <10 (b) Anemia due to chemotherapy in cancer patients: (1) Hbg <11

GENERIC NAME	DARIFENACIN
LABEL NAME(S)	**(DARIFENACIN ER 15 MG TABLET | DARIFENACIN ER 7.5 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of overactive bladder with symptoms of urge, urinary incontinence, urgency and frequency.
Required Medical Information	○ Previous trial and failure of oxybutynin

Max Quantity Per Month	30EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	* Renewals will require documented improvement in symptoms of urge, urinary incontinence, urgency and frequency.

GENERIC NAME	DESMOPRESSIN (NONREFRIGERATED)
LABEL NAME(S)	**(DESMOPRESSIN 10 MCG/0.1 ML SPR | DESMOPRESSIN 0.01% SOLUTION | DESMOPRESSIN 1.5 MG/ML (150 MC | DESMOPRESSIN AC 4 MCG/ML AMPUL | DESMOPRESSIN ACETATE 0.1 MG TB | DESMOPRESSIN ACETATE 0.2 MG TB)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated as antidiuretic replacement therapy in the management of central diabetes insipidus and for the management of the temporary polyuria and polydipsia following head trauma or surgery in the pituitary region ● Indicated for the management of primary nocturnal enuresis, Desmopressin acetate tablets may be used alone or as an adjunct to behavioral conditioning or other non-pharmacologic intervention
Required Medical Information	● As antidiuretic replacement therapy in the management of central diabetes insipidus and for the management of the temporary polyuria and polydipsia following head trauma or surgery in the pituitary region: ○ Diagnosis of CCDI ● For the management of primary nocturnal enuresis with Desmopressin acetate tablets: ○ For the treatment of enuresis, age 6 to 18 years; and ○ Failure of behavior modification for 6 months (e.g., alarms, no beverages after 5pm, special diapers, etc)
Max Quantity Per Month	360EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication

Other Criteria	* Renewals for the indication of nocturnal enuresis will require documentation of a retrial of behavior modification

GENERIC NAME	DIMETHYL FUMARATE
LABEL NAME(S)	**(DIMETHYL FUMARATE 30D START PK | DIMETHYL FUMARATE DR 120 MG CP | DIMETHYL FUMARATE DR 240 MG CP)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults
Required Medical Information	○ Prescribed by neurologist, and ○ Not requesting combination of any 2 agents together (e.g., Copaxone, Betaseron, Avonex, Tysabri, Gilenya, Aubagio or Tecfidera)
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	DONEPEZIL HCL
LABEL NAME(S)	**(DONEPEZIL HCL 10 MG TABLET | DONEPEZIL HCL 23 MG TABLET | DONEPEZIL HCL 5 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of dementia of the Alzheimer's type
Required Medical Information	● For the treatment of dementia of the Alzheimer's type ○ Dementia must be confirmed by clinical evaluation
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills

Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	DULAGLUTIDE
LABEL NAME(S)	**(TRULICITY 0.75 MG/0.5 ML PEN | TRULICITY 1.5 MG/0.5 ML PEN | TRULICITY 3 MG/0.5 ML PEN | TRULICITY 4.5 MG/0.5 ML PEN)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated as an adjunct to diet and exercise to improve glycemic control in adults and pediatric patients 10 years of age and older with type 2 diabetes mellitus ● Indicated to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with type 2 diabetes mellitus who have established cardiovascular disease or multiple cardiovascular risk factors.
Required Medical Information	For First Prescription Only: ● Diagnosis of type II diabetes mellitus; and ● Must have tried **at least 2 antidiabetic** agents such as metformin, sulfonylureas, thiazolidinedione or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications.
Max Quantity Per Month	6.63ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	• A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication • Failure is defined as hbA1c ≥7 after trying the medication for at least 60 days
Other Criteria	

GENERIC NAME	DUPILUMAB
LABEL NAME(S)	**(DUPIXENT 100 MG/0.67 ML SYRING | DUPIXENT 200 MG/1.14 ML PEN | DUPIXENT 200 MG/1.14 ML SYRING | DUPIXENT 300 MG/2 ML PEN | DUPIXENT 300 MG/2 ML SYRINGE)**

Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of adult and pediatric patients aged 6 months and older with moderate-to-severe AD whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable ● Indicated as an add-on maintenance treatment of adult and pediatric patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma ● Indicated as an add-on maintenance treatment in adult patients and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) ● Indicated for the treatment of adult and pediatric patients aged one (1) year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE) ● Indicated for the treatment of adult patients with prurigo nodularis (PN) ● Indicated as an add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype ● Chronic Spontaneous Urticaria for the treatment of adult and pediatric patients aged 12 years and older with chronic spontaneous urticaria (CSU) who remain symptomatic despite H1 antihistamine treatment. ● Bullous Pemphigoid for the treatment of adult patients with bullous pemphigoid (BP).
Required Medical Information	● Indicated for the treatment of adult and pediatric patients aged 6 months and older with moderate-to-severe AD whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable ○ Previous treatment, or intolerance of, TCS; and ○ Previous treatment, or intolerance of, TCI ● Indicated for an add-on maintenance treatment of adult and pediatric patients aged 6 years and older with moderate-to-severe asthma characterized by an eosinophilic phenotype or with oral corticosteroid dependent asthma ○ Previous treatment, or intolerance, with Xolair; and ○ Patients must be reevaluated after 6 months ● Indicated for an add-on maintenance treatment in adult and pediatric patients aged 12 years and older with inadequately controlled chronic rhinosinusitis with nasal polyposis (CRSwNP) ○ Previous treatment, or intolerance, with Xolair; and ○ Previous treatment, or intolerance, with oral corticosteroid ● Indicated for the treatment of adult and pediatric patients aged one (1) year and older, weighing at least 15 kg, with eosinophilic esophagitis (EoE) ○ Confirmed diagnosis with endoscopic esophageal biopsy showing the presence of eosinophils (≥15 eosinophils per high-power field); and ○ Previous treatment with proton-pump inhibitor (PPI); and ○ Previous treatment with oral corticosteroid; and ○ Attestation of dietary modifications (e.g., avoidance of food allergen triggers) ● Indicated for the treatment of adult patients with prurigo nodularis (PN)

	○ Previous treatment, or intolerance of TCS; and ○ Previous treatment, or intolerance of TCI ● Indicated as an add-on maintenance treatment of adult patients with inadequately controlled chronic obstructive pulmonary disease (COPD) and an eosinophilic phenotype ○ Document diagnosis of severe COPD with exacerbations (requiring treatment with either systemic corticosteroids and/or antibiotics) within the last year ○ Document concurrent use of standard of care therapy (e.g., LABA+LAMA+ICS triple therapy) ○ Document blood eosinophil count (BEC) ≥300 cells/µL within the past 6 months ● For Chronic Spontaneous Urticaria (CSU) ○ For the first prescription only: i. Diagnosis of chronic spontaneous urticaria (ICD-10-CM: L50.1) ii. Failure, inadequate response, intolerance, or contraindication to H1 antihistamines: e.g., cetirizine, loratadine, fexofenadine, levocetirizine, etc. ● For Bullous Pemphigoid (BP) ○ For the first prescription only: i. Diagnosis of bullous pemphigoid (ICD-10-CM:L12.0) ii. Previous inadequate response, intolerance, or contraindication to standard treatments such as: Systemic corticosteroids (e.g., prednisone), Topical corticosteroids (e.g., clobetasol), OR immunosuppressive agents (e.g., azathioprine, mycophenolate
Renewal Criteria	Renewal Criteria: ● For moderate-to-severe Atopic Dermatitis, Chronic Spontaneous Urticaria, Bullous Pemphigoid renewal also requires: ○ Documented improvement while on therapy ● For moderate-to-severe Asthma, renewal also requires documentation of clinical response as evidenced by ONE of the following: ○ Reduction in asthma exacerbation (worsening of symptoms) from baseline ○ Decreased use of rescue medications ○ Increase in percent predicted FEV1 (amount of air you can forcefully exhale) from pretreatment baseline ○ Reduction in severity or frequency of asthma-related symptoms such as less wheezing, shortness of breath, coughing, etc. ● For Chronic Rhinosinusitis with Nasal Polyposis, renewal also requires: ○ o Document clinical benefit compared to baseline (such as improvements in nasal congestion, sense of smell, or size of polyps)
Max Quantity Per Month	8.85ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills

Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other important information	● Provide intended dosing schedule with request, including details of initial dose and maintenance dose ● Submit requests for renewal on a Continuation of Therapy Form

GENERIC NAME	ELBASVIR/GRAZOPREVIR
LABEL NAME(S)	**(ZEPATIER 50-100 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of chronic HCV genotype 1 or 4 infection in adult and pediatric patients 12 years of age and older or weighing at least 30 kg
Required Medical Information	○ Documentation of chronic infection (>180 days) ○ Genotypes 1 and 4 ○ Must follow the clinical criteria as set by the Maryland Department of Health Special Hepatitis C PA request forms, treatment plan, length of treatment, and clinical documentation to be attached with the request. Full criteria can be obtained on our website's pharmacy information page https://jaimedicalsystems.com/providers/pharmacy/ For retreatment requests: Please also include information about the previous treatment (length of treatment and regimen received, treatment response, genotype and viral load results pre-and post-treatment, etc), as requested in the clinical criteria
Max Quantity Per Month	28EA PER 28 DAYS
Refill Limits	THREE (3) FILLS PER COURSE OF TREATMENT
Required Information for Previous Trials of Rx	For retreatment requests: Please also include information about the previous treatment (length of treatment and regimen received, treatment response, genotype and viral load results pre-and post-treatment, etc), as requested in the clinical criteria
Other Criteria	

GENERIC NAME	EMPAGLIFLOZIN/LINAGLIPTIN
LABEL NAME(S)	**(GLYXAMBI 10 MG-5 MG TABLET | GLYXAMBI 25 MG-5 MG TABLET)**
Formulary	

Covered Uses	All FDA approved indications: ● Indicated for the adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Required Medical Information	○ For use when an SGLT2 and a DPP-4 Inhibitor is appropriate
Max Quantity Per Month	30EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	• A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication • Failure is defined as hbA1c ≥7 after trying the medication for at least 60 days
Other Criteria	

GENERIC NAME	ENTACAPONE
LABEL NAME(S)	**(ENTACAPONE 200 MG TABLET | ENTACAPONE 200 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the adjunct to levodopa and carbidopa to treat end-of-dose "wearing-off" in patients with Parkinson's disease
Required Medical Information	○ Diagnosis of Parkinson's disease; and ○ Patient is receiving concomitant levodopa/carbidopa therapy
Max Quantity Per Month	240EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	EPOETIN ALFA
LABEL NAME(S)	**(EPOGEN 10,000 UNITS/ML VIAL | EPOGEN 2,000 UNITS/ML VIAL | EPOGEN 20,000 UNITS/2 ML VIAL | EPOGEN 20,000 UNITS/ML VIAL | EPOGEN 3,000 UNITS/ML VIAL | EPOGEN 4,000 UNITS/ML VIAL)**
Formulary	

Covered Uses	All FDA approved indications: ● Indicated for the treatment of anemia due to chronic kidney disease (CKD), including patients on dialysis and not on dialysis to decrease the need for red blood cell (RBC) transfusion ● Indicated for the treatment of anemia due to zidovudine administered at ≤ 4200 mg/week in patients with HIV-infection with endogenous serum erythropoietin levels of ≤ 500 mUnits/mL ● Indicated for the treatment of anemia in patients with non-myeloid malignancies where anemia is due to the effect of concomitant myelosuppressive chemotherapy, and upon initiation, there is a minimum of two additional months of planned chemotherapy ● Indicated to reduce the need for allogeneic RBC transfusions among patients with perioperative hemoglobin > 10 to ≤ 13 g/dL who are at high risk for perioperative blood loss from elective, noncardiac, nonvascular surgery
Required Medical Information	● **For all indications**: ○ Patient's iron stores are adequate (Ferritin ≥100 mcg/mL and/or Transferrin saturation ≥20%) or patient is being treated with iron; and ○ Adequate blood pressure control ● **Extra criteria for anemia due to CKD:** ○ Initiate treatment when hemoglobin is <10 g/dL (3-month approval) ● **Extra criteria for anemia due to zidovudine:** ○ Initiate treatment when hemoglobin is <10 g/dL ● **Extra criteria for anemia due to concomitant myelosuppressive chemotherapy:** ○ Initiate treatment only if hemoglobin <10 g/dL and anticipated duration of myelosuppressive chemotherapy is ≥2 months ● **Extra criteria for reducing the need for allogeneic RBC transfusions among patients with perioperative hemoglobin > 10 to ≤ 13 g/dL who are at high risk for perioperative blood loss from elective, noncardiac, nonvascular surgery:** ○ Patient's pre-operative Hgb >10 to ≤13 g/dL (14-day approval)
Max Quantity Per Month	N/A PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	For renewals: • Anemia in patients with CKD: (a) With dialysis Hbg <11 or (b) Without dialysis Hbg <10 • Anemia due to chemotherapy in cancer patients: Hbg <11 • Anemia due to zidovudine in HIV-infected patients: Hbg <11

GENERIC NAME	ETANERCEPT
LABEL NAME(S)	**(ENBREL 25 MG KIT | ENBREL 25 MG/0.5 ML SYRINGE | ENBREL 25 MG/0.5 ML VIAL | ENBREL 50 MG/ML MINI CARTRIDGE | ENBREL 50 MG/ML SURECLICK | ENBREL 50 MG/ML SYRINGE)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active rheumatoid arthritis (RA) ● Indicated for reducing signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis (JIA) in patients ages 2 and older ● Indicated for reducing signs and symptoms, inhibiting the progression of structural damage of active arthritis, and improving physical function in patients with psoriatic arthritis (PsA) ● Indicated for reducing signs and symptoms in patients with active ankylosing spondylitis (AS) ● Indicated for the treatment of patients 4 years or older with chronic moderate to severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy ● Indicated for the treatment of active juvenile psoriatic arthritis (JPsA) in pediatric patients 2 years of age and older
Required Medical Information	● **For all indications listed above:** ○ The patient had a recent NEGATIVE tuberculosis test, or if positive, has received treatment for latent TB prior to Enbrel therapy; and ○ The patient does not have a clinically important active infection ● **Additional criteria for moderately to severely active rheumatoid arthritis (RA):** ○ The patient has failed or is intolerant to one formulary NSAID and ○ The patient has failed or is intolerant to one formulary DMARD ● **Additional criteria for Plaque Psoriasis**: ○ Involvement of > 10% body surface area (BSA) ● **Additional criteria for active juvenile psoriatic arthritis (JPsA) in pediatric patients 2 years of age and older** ○ The patient has failed or is intolerant to one formulary DMARD
Max Quantity Per Month	9.15ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	• A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication

Other Criteria	• Provide intended dosing schedule with request, including details of initial dose and maintenance dose • The tuberculosis test should be within 12 months of the request date • Submit requests for renewal on a Continuation of Therapy Form

GENERIC NAME	EVOLOCUMAB
LABEL NAME(S)	**(REPATHA 140 MG/ML SURECLICK | REPATHA 140 MG/ML SYRINGE | REPATHA 420 MG/3.5 ML PUSHTRON)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the established cardiovascular disease (CVD) to reduce the risk of myocardial infarction, stroke, and coronary revascularization ● Indicated for the adjunct to diet, alone or in combination with other low-density lipoprotein cholesterol (LDL-C)-lowering therapies, in adults with primary hyperlipidemia, including heterozygous familial hypercholesterolemia (HeFH), to reduce LDL-C ● Indicated for the adjunct to diet and other LDL-C-lowering therapies in pediatric patients aged 10 years and older with HeFH, to reduce LDL-C ● Indicated for the adjunct to other LDL-C-lowering therapies in adults and pediatric patients aged 10 years and older with homozygous familial hypercholesterolemia (HoFH), to reduce LDL-C
Required Medical Information	○ positive clinical response ○ Comprehensive counseling regarding diet ○ Not used in combination with another type 9 (PCSK9) INHIBITOR
Max Quantity Per Month	4.41ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	EZETIMIBE/SIMVASTATIN
LABEL NAME(S)	**(EZETIMIBE-SIMVASTATIN 10-10 MG | EZETIMIBE-SIMVASTATIN 10-10 MG | EZETIMIBE-SIMVASTATIN 10-20 MG | EZETIMIBE-SIMVASTATIN 10-20 MG | EZETIMIBE-SIMVASTATIN 10-40 MG | EZETIMIBE-SIMVASTATIN 10-40 MG | EZETIMIBE-SIMVASTATIN 10-80 MG)**
Formulary	

Covered Uses	All FDA approved indications: • As an adjunct to diet to reduce elevated low density lipoprotein cholesterol (LDL-C): ○ In adults with primary hyperlipidemia. ○ In adults and pediatric patients aged 10 years and older with heterozygous familial hypercholesterolemia (HeFH). • As an adjunct to other LDL-C-lowering therapies to reduce elevated LDL-C in adults with homozygous familial hypercholesterolemia (HoFH).
Required Medical Information	○ Failure of generic fenofibrate 48, 54, 154, or 160 mg after a period of at least two months on the maximum dose appropriate and tolerated by the patient
Max Quantity Per Month	30EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	FENTANYL PATCH
LABEL NAME(S)	**(FENTANYL 100 MCG/HR PATCH | FENTANYL 12 MCG/HR PATCH | FENTANYL 25 MCG/HR PATCH | FENTANYL 37.5 MCG/HR PATCH | FENTANYL 50 MCG/HR PATCH | FENTANYL 62.5 MCG/HR PATCH | FENTANYL 75 MCG/HR PATCH | FENTANYL 87.5 MCG/HR PATCH)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate
Required Medical Information	○ Diagnosis of persistent, moderate to severe chronic or cancer- related pain requiring continuous, around-the-clock opioid administration for an extended period of time; and ○ Patient unable to take medications by mouth; or ○ Failure of or intolerance/contraindication to a long-acting oral opiate (narcotic) medication (controlled-release morphine, oxycodone, or oxymorphone) ○ Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/
Max Quantity Per Month	53.88EA PER 30 DAYS

Max Refills Per Year	Not Applicable – Approval must be renewed every 6 months
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	Approval must be renewed every 6 months

GENERIC NAME	FILGRASTIM-AYOW
LABEL NAME(S)	**(RELEUKO 300 MCG/0.5 ML SYRINGE | RELEUKO 480 MCG/0.8 ML SYRINGE | RELEUKO 300 MCG/ML VIAL | RELEUKO 480 MCG/1.6 ML VIAL)**
Formulary	
Covered Uses	All FDA approved indications: (a) Decrease the incidence of infection, as manifested by febrile neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anti- cancer drugs associated with a significant incidence of severe neutropenia with fever. (b) Reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia (AML). (c) Reduce the duration of neutropenia and neutropenia-related clinical sequelae, e.g., febrile neutropenia, in patients with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT). (d) Mobilize autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis. (e) Reduce the incidence and duration of sequelae of severe neutropenia, (e.g., fever, infections, oropharyngeal ulcers) in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. (f) Increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome).
Exclusion Criteria	None
Required Medical Information	Document one of the following: (a) Patient with nonmyeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a significant incidence of severe neutropenia with fever; or (b) Patient has undergone induction or consolidation chemotherapy treatment for acute myeloid leukemia (AML); or (c) Patient with nonmyeloid malignancies undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT); or (d) Is for mobilizing autologous hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis; or (e) Diagnosis of severe neutropenia with an absolute neutrophil count (ANC) < 1,000; or

	(f) ANC nadir of <1,000 neutrophils to previous chemotherapy. Once this has been documented, approval will be given for prophylaxis for all future chemo cycles; or (g) Is for increasing survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome)
Max Quantity Per Month	None
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	None
Other Criteria	(a) For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary. (b) Please indicate estimated duration of therapy

GENERIC NAME	FINGOLIMOD
LABEL NAME(S)	**FINGOLIMOD 0.5 MG CAPSULE**
Formulary	
Covered Uses	All FDA approved indications: ● Treatment of patients with relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in patients 10 years of age and older (ICD-10-CM G35).
Required Medical Information	● Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Gilenya, Aubagio or Tecfidera. ● Prescribed by Neurologist ● Not to be given in patients with cardiac arrhythmias requiring anti-arrhythmic treatment with Class Ia or Class III anti-arrhythmic drugs.
Max Quantity Per Month	30EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication to that medication
	● Follow Package insert instructions for dosage and administration. ● Fingolimod use is contraindicated in the following: recent myocardial infarction, unstable angina, stroke, transient ischemic attack, decompensated heart failure with hospitalization, or Class III/IV heart failure; history of Mobitz Type II 2nd degree or 3rd degree AV block or sick sinus syndrome, unless patient has a

Other Criteria	pacemaker; baseline QTc interval ≥ 500 msec; patients with cardiac arrhythmias requiring anti-arrhythmic treatment with Class Ia or Class III anti-arrhythmic drugs; patients who had a hypersensitivity reaction to fingolimod or any of the excipients in Fingolimod (observed reactions include rash, urticaria and angioedema upon treatment initiation.) ● The physician must be aware and follow up in the patient's conditions. ● Because it takes approximately 2 months to eliminate fingolimod from the body, women of childbearing potential should use effective contraception to avoid pregnancy during and for 2 months after stopping GILENYA treatment. The physician should be aware and follow up on the patient's pregnancy status.

GENERIC NAME	FLUCONAZOLE
LABEL NAME(S)	**(FLUCONAZOLE 10 MG/ML SUSP | FLUCONAZOLE 100 MG TABLET | FLUCONAZOLE 150 MG TABLET | FLUCONAZOLE 200 MG TABLET | FLUCONAZOLE 40 MG/ML SUSP | FLUCONAZOLE 50 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of vaginal candidiasis (vaginal yeast infections due to Candida) ● Indicated for the treatment of oropharyngeal and esophageal candidiasis. (In open noncomparative studies of relatively small numbers of patients, fluconazole tablets were also effective for the treatment of Candida urinary tract infections, peritonitis, and systemic Candida infections including candidemia, disseminated candidiasis, and pneumonia.) ● Indicated for the treatment of cryptococcal meningitis
Required Medical Information	○ Any of the above diagnoses; except ○ For the diagnosis of oropharyngeal candidiasis, failure of nystatin therapy; and ○ For the diagnosis of vaginal candidiasis, patients who are immunocompromised and/or have recurrent or refractory infections
Max Quantity Per Month	600ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	No PA needed for up to two (2) 150mg tablets to be dispensed per month

GENERIC NAME	FLUTICASONE PROPION/SALMETEROL
LABEL NAME(S)	**(FLUTICASONE-SALMETEROL 100-50 | FLUTICASONE-SALMETEROL 113-14 | FLUTICASONE-SALMETEROL 115-21 | FLUTICASONE-SALMETEROL 230-21 | FLUTICASONE-SALMETEROL 232-14 | FLUTICASONE-SALMETEROL 250-50 | FLUTICASONE-SALMETEROL 45-21 | FLUTICASONE-SALMETEROL 500-50 | FLUTICASONE-SALMETEROL 55-14 | WIXELA 100-50 INHUB | WIXELA 250-50 INHUB | WIXELA 500-50 INHUB)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the twice-daily treatment of asthma in patients aged 4 years and older ● Indicated for the twice-daily maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema
Required Medical Information	● For the twice-daily treatment of asthma in patients aged 4 years and older ○ Documentation of diagnosis ○ The patient must be reevaluated after 6 months ● Indicated for the twice-daily maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema ○ Currently on, but not controlled by a LAMA; and ○ The patient must be reevaluated after 6 months
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	For members currently with an approved prior authorization for Fluticasone-Salmeterol, claims will process as long as the member has filled the medication within the last 4 months. No yearly renewal will be needed for compliant members. Prior authorization will be required for members new to the plan, new to therapy, or with no claim history of the medication within the last 4 months. Once approved, 90-day supplies are allowed.

GENERIC NAME	FLUTICASONE FUROATE/UMECLIDINIUM BROMIDE/VILANTEROL TRIFENATATE
LABEL NAME(S)	**(TRELEGY ELLIPTA 100-62.5-25 | TRELEGY ELLIPTA 200-62.5-25)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the maintenance treatment of patients with chronic obstructive pulmonary disease (COPD) ● Indicated for the maintenance treatment of asthma in patients aged 18 years and older
Required Medical Information	● For the maintenance treatment of patients with chronic obstructive pulmonary disease (COPD) ○ Currently on, but not adequately controlled by two (2) or more inhaled medium to high dose LABA+ICS; and ○ Currently on, but not adequately controlled by an inhaled LAMA or LAMA+LABA ○ Patients must be reevaluated after 6 months ● For the maintenance treatment of asthma in patients aged 18 years and older ○ Currently on, but not adequately controlled by two (2) or more inhaled medium to high dose LABA+ICS; and ○ Patients must be reevaluated after 6 months
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication to that medication
Other Criteria	

GENERIC NAME	FREMANEZUMAB-VFRM
LABEL NAME(S)	**(AJOVY 225 MG/1.5 ML AUTOINJECT, AJOVY 225 MG/1.5 ML SYRINGE)**
Formulary	
Covered Uses	All FDA approved indications: ● For the preventive treatment of migraine in adults. (ICD-10-CM G43.019, G43.119, G43.719, G43.919) ● For the preventive treatment of episodic migraine in pediatric patients who are 6 to 17 years of age and who weigh 45 kg or more. (ICD-10-CM G43.019, G43.119, G43.719, G43.919)

Required Medical Information	For the first prescription only: ● Preventive treatment of migraine: ○ Document evidence of 4 or more migraine days per month AND ○ Document failure or intolerance to at least one (1) medication used for migraine prophylaxis, after at least 3 months of use (e.g., beta blocker [propranolol, metoprolol or atenolol], previous use of a CGRP), AND ○ Document no concurrent use of another CGRP indicated for migraine prophylaxis. ● Preventive treatment of episodic migraine in pediatric patients ○ Document evidence of patient's weight ○ Document evidence of 4 or more migraine days per month AND ○ Document failure or intolerance to at least one (1) medication used for migraine prophylaxis, after at least 3 months of use (e.g., beta blocker [propranolol, metoprolol or atenolol], previous use of a CGRP), AND ○ Document no concurrent use of another CGRP indicated for migraine prophylaxis.
Age Restriction	Age 6 years or older (may vary depending on diagnosis)
Other Criteria	Refer to the package insert for dosage and administration.

GENERIC NAME	GALANTAMINE HBR
LABEL NAME(S)	**(GALANTAMINE ER 16 MG CAPSULE | GALANTAMINE ER 24 MG CAPSULE | GALANTAMINE ER 8 MG CAPSULE | GALANTAMINE HBR 12 MG TABLET | GALANTAMINE HBR 4 MG TABLET | GALANTAMINE HBR 8 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of mild to moderate dementia of the Alzheimer's type
Required Medical Information	○ Confirmation of diagnosis by clinical evaluation
Max Quantity Per Month	90EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	GALCANEZUMAB-GNLM
LABEL NAME(S)	**EMGALITY 120 MG/ML PEN, EMGALITY 120 MG/ML SYRINGE EMGALITY 300 MG DOSE (100 MG/ML) SYRINGE, EMGALITY 100 MG/ML SYRINGE**
Formulary	
Covered Uses	All FDA approved indications: ● For the preventive treatment of migraine in adults. (ICD-10-CM G43.019, G43.119, G43.719, G43.919) ● For the treatment of episodic cluster headache. (ICD-10-CM G44.019)
Required Medical Information	For the first prescription only: ● Preventive treatment of migraine: ○ Document evidence of 4 or more migraine days per month AND ○ Document failure or intolerance to at least one (1) medication used for migraine prophylaxis, after at least 3 months of use (e.g., beta blocker [propranolol, metoprolol or atenolol], previous use of a CGRP), AND ○ Document no concurrent use of another CGRP indicated for migraine prophylaxis. ● For the treatment of Episodic Cluster Headache: ○ Physician documentation of at least two cluster periods lasting between 2 weeks and 3 months.
Other Criteria	● Refer to the package insert for dosage and administration.

GENERIC NAME	GATIFLOXACIN
LABEL NAME(S)	**(GATIFLOXACIN 0.5% EYE DROPS)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of bacterial conjunctivitis caused by susceptible strains of the following organisms: Aerobic gram-positive bacteria (Staphylococcus aureus, Staphylococcus epidermidis, Streptococcus mitis group, Streptococcus oralis, and Streptococcus pneumoniae) and Aerobic gram-negative bacteria (Haemophilus influenzae)
Required Medical Information	○ Failure of, contraindication to, or intolerance to ciprofloxacin ophthalmic formulation
Max Quantity Per Month	24ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication

Other Criteria	

GENERIC NAME	GLATIRAMER ACETATE
LABEL NAME(S)	**(GLATIRAMER 20 MG/ML SYRINGE | GLATIRAMER 40 MG/ML SYRINGE)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults
Required Medical Information	○ Prescribed by neurologist; and ○ Not requesting combination therapy of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera
Max Quantity Per Month	30ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	GLECAPREVIR/PIBRENTASVIR
LABEL NAME(S)	**(MAVYRET 100-40 MG TABLET)**
Formulary	
Covered Uses	Certain FDA approved indications: ● Indicated for the treatment of adult and pediatric patients 3 years and older with chronic HCV genotype (GT) 1, 2, 3, 4, 5 or 6 infection without cirrhosis or with compensated cirrhosis (Child-Pugh A) ● Indicated for the treatment of adult and pediatric patients 3 years and older with HCV genotype 1 infection, who previously have been treated with a regimen containing an HCV NS5A inhibitor or an NS3/4A protease inhibitor, but not both

Required Medical Information	○ Documentation of chronic infection (>180 days) ○ Genotypes 1, 2, 3, 4, 5, and 6 ○ Must follow the clinical criteria as set by the Maryland Department of Health Special Hepatitis C PA request forms, treatment plan, length of treatment, and clinical documentation to be attached with the request. Full criteria can be obtained on our website's pharmacy information page https://jaimedicalsystems.com/providers/pharmacy/ For retreatment requests: Please also include information about the previous treatment (length of treatment and regimen received, treatment response, genotype and viral load results pre-and post-treatment, etc), as requested in the clinical criteria
Max Quantity Per Month	84EA PER 28 DAYS
Max Refills Per Year	One (1) refill per standard course of treatment; up to three (3) refills in special populations (as described in the clinical criteria)
Other Criteria	For retreatment requests: Please also include information about the previous treatment (length of treatment and regimen received, treatment response, genotype and viral load results pre-and post-treatment, etc), as requested in the clinical criteria

GENERIC NAME	INTERFERON ALFA-2B, RECOMB.
LABEL NAME(S)	**(INTRON A 10 MILLION UNITS VIAL | INTRON A 18 MILLION UNIT/3 ML | INTRON A 18 MILLION UNITS VIAL | INTRON A 25 MILLION UNIT/2.5 M | INTRON A 50 MILLION UNITS VIAL)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of patients 18 years of age or older with hairy cell leukemia ● Indicated as adjuvant to surgical treatment in patients 18 years of age or older with malignant melanoma who are free of disease but at high risk for systemic recurrence, within 56 days of surgery ● Indicated for the initial treatment of clinically aggressive follicular Non-Hodgkin's Lymphoma in conjunction with anthracycline-containing combination chemotherapy in patients 18 years of age or older ● Indicated for intralesional treatment of selected patients 18 years of age or older with condylomata acuminata involving external surfaces of the genital and perianal areas ● Indicated for the treatment of selected patients 18 years of age or older with AIDS-Related Kaposi's Sarcoma ● Indicated for the treatment of chronic hepatitis C in patients 18 years of age or older with compensated liver disease who have a history of blood or blood-

	product exposure and/or are HCV antibody positive • Indicated for the treatment of chronic hepatitis B in patients 1 year of age or older with compensated liver disease
Required Medical Information	• Documentation of an FDA approved diagnosis (listed above)
Max Quantity Per Month	N/A PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	* For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

GENERIC NAME	INTERFERON ALFA-N3
LABEL NAME(S)	**(ALFERON N 5 MILLION UNITS VIAL)**
Formulary	
Covered Uses	All FDA approved indications: • Indicated for the intralesional treatment of refractory or recurring external condylomata acuminata in patients 18 years of age or older
Required Medical Information	• Indicated for the intralesional treatment of refractory or recurring external condylomata acuminata in patients 18 years of age or older
Max Quantity Per Month	0.45ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	INTERFERON BETA-1A
LABEL NAME(S)	**(AVONEX 30 MCG/0.5 ML SYRINGE | AVONEX PEN 30 MCG/0.5 ML | AVONEX PEN 30 MCG/0.5 ML KIT | AVONEX PREFILLED SYR 30 MCG KI | AVONEX 30 MCG VIAL KIT | REBIF 22 MCG/0.5 ML SYRINGE | REBIF 44 MCG/0.5 ML SYRINGE | REBIF REBIDOSE 22 MCG/0.5 ML | REBIF REBIDOSE 44 MCG/0.5 ML | REBIF REBIDOSE TITRATION PACK | REBIF TITRATION PACK | BETASERON 0.3 MG KIT)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults
Required Medical Information	○ Prescribed by neurologist; and ○ If patient has a history of or is currently being treated for severe psychiatric disorders, suicidal ideation or severe depression, this condition is well controlled; and ○ Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera
Max Quantity Per Month	6.78ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	* For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

GENERIC NAME	ITRACONAZOLE
LABEL NAME(S)	**(ITRACONAZOLE 10 MG/ML SOLUTION | ITRACONAZOLE 100 MG CAPSULE)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of the following fungal infections in immunocompromised and non-immunocompromised patients (Blastomycosis, pulmonary and extrapulmonary AND Histoplasmosis, including chronic cavitary pulmonary disease and disseminated, non- meningeal histoplasmosis, AND Aspergillosis, pulmonary and extrapulmonary, in patients who are intolerant of or who are refractory to amphotericin B therapy)

Covered Uses (Continued)	● Indicated for the treatment of the following fungal infections in non-immunocompromised patients (Onychomycosis of the toenail, with or without fingernail involvement, due to dermatophytes (tinea unguium) AND Onychomycosis of the fingernail due to fingernail due to dermatophytes (tinea unguium)
Required Medical Information	○ Any of the above diagnoses
Max Quantity Per Month	240EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	IXEKIZUMAB
LABEL NAME(S)	**(TALTZ 80 MG/ML AUTOINJECTOR | TALTZ 80 MG/ML AUTOINJECTOR (2 | TALTZ 80 MG/ML AUTOINJECTOR (3 | TALTZ 80 MG/ML SYRINGE | TALTZ 80 MG/ML SYRINGE (2-PK) | TALTZ 80 MG/ML SYRINGE (3-PK))**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the patients aged 6 years or older with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy ● Indicated for the treatment of adults with active psoriatic arthritis ● Indicated for the treatment of adults with active ankylosing spondylitis ● Indicated for the treatment of adults with active non-radiographic axial spondyloarthritis with objective signs of inflammation
Required Medical Information	○ First Prescription and every 12 months – a recent NEGATIVE tuberculosis test, or if positive, has received treatment for latent TB prior to treatment. ○ Previous treatment, or intolerance of, with Enbrel; and ○ Previous treatment, or intolerance of, with Adalimumab
Max Quantity Per Month	2.22ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	• A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication

Other Criteria	• Provide intended dosing schedule with request, including details of initial dose and maintenance dose • The tuberculosis test should be within 12 months of the request date • Submit requests for renewal on a Continuation of Therapy Form

GENERIC NAME	LACTOSE-REDUCED FOOD / NUTRITIONAL SUPPLEMENTS
LABEL NAME(S)	**(BOOST BREEZE LIQUID | BOOST CALORIE SMART LIQUID | BOOST HIGH PROTEIN LIQUID | BOOST LIQUID | BOOST PLUS ENERGY DRINK | ENSURE LIQUID | ENSURE POWDER | BOOST PUDDING | BOOST KID ESSENTIALS-FIBER LIQ | BOOST KID ESSENTIALS LIQUID | BOOST KID ESSENTIALS LIQUID | PEDIASURE 1.5 LIQUID | PEDIASURE ENTERAL LIQUID | PEDIASURE GROW-GAIN LIQUID | PEDIASURE GROW-GAIN POWDER | PEDIASURE LIQUID | BOOST HIGH PROTEIN POWDER)**
Formulary	
Covered Uses	All FDA approved indications: ● Used for nutritional supplementation
Required Medical Information	○ Patient must have enteral access via one of the following: nasogastric (NG) tube, nasoduodenal (ND) tube, nasojejunal (NJ) tube, percutaneous endoscopic gastrostomy (PEG) or percutaneous endoscopic jejunostomy (PEJ)
Max Quantity Per Month	N/A PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	To obtain nutritional supplements (e.g., Ensure or Pediasure) for members without enteral access, please follow the DME Prior Authorization process. For assistance accessing the DME process, please contact Customer Service at 1-888-524-1999.

GENERIC NAME	LANSOPRAZOLE, ORALLY DISINTEGRATING
LABEL NAME(S)	**(LANSOPRAZOLE ODT 15 MG TABLET | LANSOPRAZOLE ODT 30 MG TABLET)**
Formulary	

Covered Uses	All FDA approved indications: ● Indicated in adults for short-term treatment (for four weeks) for healing and symptom relief of active duodenal ulcer ● Indicated in adults for the treatment of patients with H. pylori infection and duodenal ulcer disease (active or one year history of a duodenal ulcer) to eradicate H. pylori. Eradication of H. pylori has been shown to reduce the risk of duodenal ulcer rec ● Indicated in adults to maintain healing of duodenal ulcers ● Indicated in adults for short-term treatment (up to eight weeks) for healing and symptom relief of active benign gastric ulcer ● Indicated in adults for the treatment of NSAID-associated gastric ulcer in patients who continue NSAID use ● Indicated in adults for reducing the risk of NSAID-associated gastric ulcers in patients with a history of a documented gastric ulcer who require the use of an NSAID ● Indicated for short-term treatment in adults and pediatric patients 12 to 17 years of age (up to eight weeks) and pediatric patients one to 11 years of age (up to 12 weeks) for the treatment of heartburn and other symptoms associated with GERD ● Indicated for short-term treatment in adults and pediatric patients 12 to 17 years of age (up to eight weeks) and pediatric patients one to 11 years of age (up to 12 weeks) for healing and symptom relief of all grades of erosive esophagitis (EE) ● Indicated in adults to maintain healing of erosive esophagitis (EE) ● Indicated in adults for the long-term treatment of pathological hypersecretory conditions, including Zollinger-Ellison syndrome
Required Medical Information	○ Unable to ingest a solid dosage form (e.g. oral tablet or capsule) due to one of the following ▪ Age ▪ Oral/motor difficulties ▪ Dysphagia ▪ Patient utilizes a feeding tube for medication administration
Max Quantity Per Month	90EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	LEDIPASVIR/SOFOSBUVIR
LABEL NAME(S)	**(LEDIPASVIR-SOFOSBUVIR 90-400 MG TABLET)**

Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of chronic hepatitis C virus (HCV) in adults and pediatric patients 3 years of age and older with Genotype 1, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis OR genotype 1 infection with decompensated cirrhosis, in combination with ribavirin OR genotype 1 or 4 infection who are liver transplant recipients without cirrhosis or with compensated cirrhosis, in combination with ribavirin
Required Medical Information	○ Generic tablet only (requests for other formulations must include medical necessity rationale) ○ Documentation of chronic infection (>180 days) ○ Genotypes 1, 4, 5, and 6 ○ Must follow the clinical criteria as set by the Maryland Department of Health Special Hepatitis C PA request forms, treatment plan, length of treatment, and clinical documentation to be attached with the request. Full criteria can be obtained on our website's pharmacy information page https://jaimedicalsystems.com/providers/pharmacy/ For retreatment requests: Please also include information about the previous treatment (length of treatment and regimen received, treatment response, genotype and viral load results pre-and post-treatment, etc), as requested in the clinical criteria
Max Quantity Per Month	28EA PER 28DAYS
Refill Limits	ONE (1) OR TWO (2) REFILLS PER STANDARD COURSE OF TREATMENT; UP TO FIVE (5) REFILLS IN SPECIAL POPULATIONS (AS DESCRIBED IN THE CLINICAL CRITERIA)
Other Criteria	• Please report SVR lab results from at least 12 weeks post treatment completion or patient discontinuation of treatment • For retreatment requests: Please also include information about the previous treatment (length of treatment and regimen received, treatment response, genotype and viral load results pre-and post-treatment, etc), as requested in the clinical criteria

GENERIC NAME	LEUPROLIDE ACETATE
LABEL NAME(S)	**(ELIGARD 7.5 MG SYRINGE KIT |ELIGARD 22.5 MG SYRINGE KIT | ELIGARD 30 MG SYRINGE KIT |ELIGARD 45 MG SYRINGE KIT)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of advanced prostatic cancer

Exclusion Criteria	When leuprolide acetate or medroxyprogesterone are used for the treatment of adult males with certain diagnosed behavioral disorders, these two drugs are not covered under the MCO and will be paid fee-for-service, but will require preauthorization (PA) through the University of Maryland School of Pharmacy CAMP program at 410-706-3431 (Please see Maryland Medicaid Mental Health Formulary)
Required Medical Information	○ Diagnosis of advanced prostate cancer
Coverage Duration	One (1) year
Max Quantity	Eligard 7.5 mg for 1-month administration, 22.5 mg for 3-month administration,30 mg for 4-month administration, and 45 mg for 6-month administration
Max Refills Per Year	Twelve (12) Refills
Other Criteria	(a) Administration frequency depends on the product being dispensed. Note: This agent is ordinarily administered at the physician's office. For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary

GENERIC NAME	LEUPROLIDE ACETATE
LABEL NAME(S)	**(LUPRON DEPOT 11.25 MG 3MO KIT | LUPRON DEPOT 22.5 MG 3MO KIT | LUPRON DEPOT 3.75 MG KIT | LUPRON DEPOT 45 MG 6MO KIT | LUPRON DEPOT 7.5 MG KIT | LUPRON DEPOT-4 MONTH KIT)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of advanced prostatic cancer ● Indicated for management of endometriosis, including pain relief and reduction of endometriotic lesions ● Indicated for the preoperative hematologic improvement of women with anemia caused by fibroids for whom three months of hormonal suppression is deemed necessary ● Indicated for the treatment of pediatric patients with central precocious puberty (CPP) Under Maryland's Medicaid Gender-Affirming Treatment Services Program: ● For medical treatment of transgender care
Exclusion Criteria	When leuprolide acetate or medroxyprogesterone are used for the treatment of adult males with certain diagnosed behavioral disorders, these two drugs are not covered under the MCO and will be paid fee-for-service, but will require preauthorization (PA) through the University of Maryland School of Pharmacy CAMP program at 410-706-3431 (Please see Maryland Medicaid Mental Health Formulary)

Required Medical Information	1. Diagnosis of advanced prostate cancer or fibroids; OR 2. Diagnosis of endometriosis: • failure of NSAIDS and oral contraceptives or endometriosis diagnosed by laparoscopy; OR 3. Diagnosis of pediatric patients with central precocious puberty (CPP): ▪ First Prescription Only - Diagnosis of precocious puberty: (a) Positive pubertal response to a GnRH stimulation test. (b) Girl: document of secondary sexual characteristics earlier than 8 years of age. (c) Boy: document of secondary sexual characteristics earlier than 9 years of age. (d) Bone age advanced one year beyond the chronological age ● For Gender Affirming Treatment ○ For all requests for gender affirming care, please refer to the Gender-Affirming Treatment Services Under the Maryland Medicaid Program document (for a copy of the criteria see our website at https://jaimedicalsystems.com/providers/pharmacy/.) Please ensure that all necessary documentation required under the criteria is included to show consent for treatment and medical necessity (documentation requirements may vary depending on patient age, type of treatment requested, and specialty of requesting provider).
Coverage Duration	Duration of approval depends on diagnosis for use and requested length of treatment
Max Quantity Per Month	Approved amount per month depends on product being requested
Max Refills Per Year	Number of refills per year may vary based on product being requested
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	• Note: This agent is ordinarily administered at the physician's office. For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary • For more information on transgender care, refer to the Gender-Affirming Treatment Services documentation under the Maryland Medicaid Program or on the MCO website at https://jaimedicalsystems.com/providers/pharmacy/

GENERIC NAME	LIDOCAINE
LABEL NAME(S)	**(LIDOCAINE 5% PATCH)**
Formulary	

Covered Uses	All FDA approved indications: ● Indicated for the relief of pain associated with post-herpetic neuralgia
Required Medical Information	○ Skin application site is intact, and ○ For the relief of pain associated with post-herpetic neuralgia; and ○ Failure, adverse reaction, or contraindication to two prescription analgesics, including formulary lidocaine topical cream or gel.
Max Quantity Per Month	90EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	LIRAGLUTIDE
LABEL NAME(S)	**(VICTOZA 2-PAK 18 MG/3 ML PEN | VICTOZA 3-PAK 18 MG/3 ML PEN)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated as an adjunct to diet and exercise to improve glycemic control in patients 10 years and older with type 2 diabetes mellitus ● To reduce the risk of major adverse cardiovascular events in adults with type II diabetes mellitus and established cardiovascular disease.
Required Medical Information	For First Prescription Only; (a) Diagnosis of type 2 diabetes; **and** (b) Failure or intolerance to sulfonylureas and/or metformin at optimal dosing. (Failure defined as Hemoglobin A1c ≥ 7.0)
Max Quantity Per Month	9ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	• A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication • Failure is defined as hbA1c ≥7 after trying the medication for at least 60 days
Other Criteria	

GENERIC NAME	LUBIPROSTONE
LABEL NAME(S)	**(LUBIPROSTONE 24 MCG CAPSULE | LUBIPROSTONE 24 MCG CAPSULE | LUBIPROSTONE 8 MCG CAPSULE | LUBIPROSTONE 8 MCG CAPSULE)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of chronic idiopathic constipation (CIC) in adults ● Indicated for the treatment of opioid-induced constipation (OIC) in adult patients with chronic non-cancer pain, including patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation. ● Indicated for the treatment of irritable bowel syndrome with constipation (IBS-C) in women at least 18 years old
Required Medical Information	○ Must have a diagnosis of either chronic idiopathic constipation, irritable bowel syndrome, or opioid-induced constipation; and ○ Failure of Miralax, Senna-S, and/or lactulose
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	MEMANTINE HCL
LABEL NAME(S)	**(MEMANTINE 5-10 MG TITRATION PK | MEMANTINE HCL 10 MG TABLET | MEMANTINE HCL 2 MG/ML SOLUTION | MEMANTINE HCL 5 MG TABLET | MEMANTINE HCL ER 14 MG CAPSULE | MEMANTINE HCL ER 21 MG CAPSULE | MEMANTINE HCL ER 28 MG CAPSULE | MEMANTINE HCL ER 7 MG CAPSULE)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of moderate to severe dementia of the Alzheimer's type
Required Medical Information	● For the treatment of moderate to severe dementia of the Alzheimer's type ○ Dementia must be confirmed by clinical evaluation; and ○ Documented dementia is either moderate or severe
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills

Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	METHADONE HCL
LABEL NAME(S)	**(METHADONE 10 MG/5 ML SOLUTION | METHADONE 10 MG/ML ORAL CONC | METHADONE 40 MG TABLET DISPR | METHADONE 5 MG/5 ML SOLUTION | METHADONE HCL 10 MG TABLET | METHADONE HCL 5 MG TABLET)**
Formulary	
Covered Uses	● Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatment options are inadequate
Exclusion Criteria	The following indications are covered by Maryland Medicaid under Substance Use Disorder Services and are not covered under the MCO Pharmacy Benefit ● Indicated for detoxification treatment of opioid addiction (heroin or other morphine-like drugs) ● Indicated for maintenance treatment of opioid addiction (heroin or other morphine-like drugs), in conjunction with appropriate social and medical services
Required Medical Information	● Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatment options are inadequate ○ Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/.
Max Quantity Per Month	90EA PER 30 DAYS
Max Refills Per Year	Not Applicable – Approval must be renewed every 6 months
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	Approval must be renewed every 6 months

GENERIC NAME	METRONIDAZOLE
LABEL NAME(S)	**(METRONIDAZOLE VAGINAL 0.75% GL)**
Formulary	

Covered Uses	All FDA approved indications: ● Indicated in the treatment of bacterial vaginosis (formerly referred to as Haemophilus vaginitis, Gardnerella vaginitis, nonspecific vaginitis, Corynebacterium vaginitis, or anaerobic vaginosis)
Required Medical Information	For the treatment of bacterial vaginosis: ○ Pregnancy; or ○ Intolerance to oral metronidazole
Max Quantity Per Month	420G PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	MILNACIPRAN HCL
LABEL NAME(S)	**(SAVELLA 100 MG TABLET | SAVELLA 12.5 MG TABLET | SAVELLA 25 MG TABLET | SAVELLA 50 MG TABLET | SAVELLA TITRATION PACK)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the management of fibromyalgia
Required Medical Information	○ Diagnosis of fibromyalgia; and ○ Documented failure or contraindication to: ▪ Pain relievers (e.g. Tramadol); or ▪ Muscle Relaxants (e.g. cyclobenzaprine, Baclofen)
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	MIRABEGRON
LABEL NAME(S)	**(MYRBETRIQ ER 25 MG TABLET | MYRBETRIQ ER 25 MG TABLET | MYRBETRIQ ER 50 MG TABLET | MYRBETRIQ ER 50 MG TABLET | MYRBETRIQ ER 8 MG/ML SUSP | MYRBETRIQ ER 8 MG/ML SUSP)**

Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of OAB in adult patients with symptoms of urge urinary incontinence, urgency, and urinary frequency ● Indicated for the treatment of NDO in pediatric patients aged 3 years and older
Required Medical Information	● For the treatment of OAB in adult patients with symptoms of urge urinary incontinence, urgency, and urinary frequency ○ Failure of Oxybutynin ● For the treatment of NDO in pediatric patients aged 3 years and older ○ Failure of Oxybutynin ○ Age 3 years and older and weighing 35kg or more (NDO)
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	MORPHINE SULFATE EXTENDED RELEASE
LABEL NAME(S)	**(MORPHINE SULF ER 100 MG TABLET | MORPHINE SULF ER 15 MG TABLET | MORPHINE SULF ER 200 MG TABLET | MORPHINE SULF ER 30 MG TABLET | MORPHINE SULF ER 60 MG TABLET | MORPHINE SULFATE ER 10 MG CAP | MORPHINE SULFATE ER 100 MG CAP | MORPHINE SULFATE ER 20 MG CAP | MORPHINE SULFATE ER 30 MG CAP | MORPHINE SULFATE ER 40 MG CAP | MORPHINE SULFATE ER 50 MG CAP | MORPHINE SULFATE ER 60 MG CAP | MORPHINE SULFATE ER 80 MG CAP)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate
Required Medical Information	● For the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate ○ Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy

Max Quantity Per Month	540EA PER 30 DAYS
Max Refills Per Year	Not Applicable – Approval must be renewed every 6 months
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	Approval must be renewed every 6 months

GENERIC NAME	MOXIFLOXACIN HCL
LABEL NAME(S)	**(MOXIFLOXACIN HCL 400 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of adults (≥ 18 years of age) with infections caused by susceptible strains of the designated microorganisms for: ○ acute bacterial sinusitis caused by Streptococcus pneumoniae, Haemophilus influenzae, or Moraxella catarrhalis. ○ acute bacterial exacerbation of chronic bronchitis caused by Streptococcus pneumoniae, Haemophilus influenzae, Haemophilus parainfluenzae, Klebsiella pneumoniae, Staphylococcus aureus, or Moraxella catarrhalis ○ community acquired pneumonia caused by Streptococcus pneumoniae (including multi-drug resistant strains), Haemophilus influenzae, Moraxella catarrhalis, Staphylococcus aureus, Klebsiella pneumoniae, Mycoplasma pneumoniae, or Chlamydia pneumoniae ○ uncomplicated skin and skin structure infections caused by Staphylococcus aureus or Streptococcus pyogenes ○ complicated intra-abdominal infections including polymicrobial infections such as abscess caused by susceptible isolates of Escherichia coli, Bacteroides fragilis, Streptococcus anginosus, Streptococcus constellatus, Enterococcus faecalis, Proteus mirabilis, Clostridium perfringens, Bacteroides thetaiotaomicron, or Peptostreptococcus species ○ complicated skin and skin structure infections caused by methicillin-susceptible Staphylococcus aureus, Escherichia coli, Klebsiella pneumoniae or Enterobacter cloacae
Required Medical Information	• In patients ≥18 years of age with any of the above listed indications when: ○ Cultures show sensitivity to Avelox® only; or ○ Patient discharged on Avelox® from the hospital and needs to complete regimen on an outpatient basis
Max Quantity Per Month	30EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills

Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	NAFARELIN ACETATE
LABEL NAME(S)	**(SYNAREL 2 MG/ML NASAL SPRAY)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for treatment of central precocious puberty (CPP) (gonadotropin-dependent precocious puberty) in children of both sexes ● Indicated for management of endometriosis, including pain relief and reduction of endometriotic lesions Other indication: ● For medical treatment of transgender care
Exclusion Criteria	
Required Medical Information	● For treatment of central precocious puberty (CPP) (gonadotropin- dependent precocious puberty) in children of both sexes ○ Diagnosis of central precocious puberty ● For management of endometriosis, including pain relief and reduction of endometriotic lesions ○ For the diagnosis of endometriosis in patients > 18 years of age, failure of NSAIDs and oral contraceptives, or endometriosis diagnosed by laparoscopy ● For Gender Affirming Treatment For all requests for gender affirming care, please refer to the Gender-Affirming Treatment Services Under the Maryland Medicaid Program document (for a copy of the criteria see our website at https://jaimedicalsystems.com/providers/pharmacy/.) Please ensure that all necessary documentation required under the criteria is included to show consent for treatment and medical necessity (documentation requirements may vary depending on patient age, type of treatment requested, and specialty of requesting provider).
Coverage Duration	
Max Quantity Per Month	15.99ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication

Other Criteria	For more information on transgender care, refer to the Gender-Affirming Treatment Services documentation under the Maryland Medicaid Program or on the MCO website at https://jaimedicalsystems.com/providers/pharmacy/

GENERIC NAME	OCTREOTIDE ACETATE
LABEL NAME(S)	**(OCTREOTIDE 1,000 MCG/5 ML VIAL | OCTREOTIDE 5,000 MCG/5 ML VIAL | OCTREOTIDE ACET 100 MCG/ML AMP | OCTREOTIDE ACET 100 MCG/ML SYR | OCTREOTIDE ACET 50 MCG/ML SYR | OCTREOTIDE ACET 50 MCG/ML VIAL | OCTREOTIDE ACET 500 MCG/ML SYR | OCTREOTIDE ACET 500 MCG/ML VL)**
Formulary	
Covered Uses	All FDA approved indications: • Indicated to reduce blood levels of growth hormone (GH) and insulin growth factor-1 (IGF-1; somatomedin C) in acromegaly patients who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses • Indicated for the symptomatic treatment of patients with metastatic carcinoid tumors where it suppresses or inhibits the severe diarrhea and flushing episodes associated with the disease • Indicated for the treatment of the profuse watery diarrhea associated with VIP-secreting tumors
Required Medical Information	○ Any of the above diagnoses; and ○ For the diagnosis of acromegaly, the patient has had an inadequate response to, or cannot be treated with surgical resection, pituitary irradiation and bromocriptine at maximally tolerated doses
Max Quantity Per Month	90ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	For injectable medications administered by a healthcare professional, please refer to the “Specialty Medication Guidelines” in the beginning of this formulary.

GENERIC NAME	OLODATEROL HCL
LABEL NAME(S)	**(STRIVERDI RESPIMAT INHAL SPRAY)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema

Required Medical Information	○ Currently on, but not controlled by a LAMA; and ○ The patient must be reevaluated after 6 months
Max Quantity Per Month	8.58G PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication to that medication
Other Criteria	

GENERIC NAME	OMALIZUMAB
LABEL NAME(S)	**(XOLAIR 150 MG/1.2 ML POWDER VL | XOLAIR 150 MG/ML SYRINGE | XOLAIR 75 MG/0.5 ML SYRINGE)**
Formulary	
Covered Uses	All FDA approved indications: ● Treatment of moderate to severe persistent asthma in patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids. ICD-10-CM J45.40, ICD-10-CM J45.50 ● Treatment of adult patients, as an add-on maintenance treatment, chronic rhinosinusitis with nasal polyposis (CRSwNP). (ICD-10-CM J333.9) ● Treatment of adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment with chronic spontaneous urticaria (CSU). (ICD-10-CM L50.1) ● IgE-mediated food allergy in adult and pediatric patients aged 1 year and older for the reduction of allergic reactions (Type I), including anaphylaxis, that may occur with accidental exposure to one or more foods. To be used in conjunction with food allergen avoidance (ICD-10-CM Z91.01, Z91.02, Z91.18, T78.0)
Exclusion Criteria	
Required Medical Information	**(a) For pediatric patients 6 years and older with asthma** i. Documentation of baseline (pre-omalizumab treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 1300 IU/mL ii. Documentation of positive skin test or in vitro reactivity to a perennial aeroallergen iii. Previous treatment, or intolerance of, with two (2) or more inhaled medium to high dose LABA+ICS for more than sixty (60) days; **and** iv. Patients must be reevaluated after 6 months **(b) For adult patients with asthma** i. Documentation of baseline (pre-omalizumab treatment) serum total IgE

	level greater than or equal to 30 IU/mL and less than or equal to 1300 IU/mL ii. Documentation of positive skin test or in vitro reactivity to a perennial aeroallergen iii. Previous treatment, or intolerance of, with LAMA+LABA+ICS for more than sixty (60) days; **and** iv. Patients must be reevaluated after 6 months **(c) For adult patients with CRSwNP** i. Previous treatment, or intolerance of, with two (2) or more intranasal corticosteroid for more than ninety (90) days; **and** ii. Previous treatment, or intolerance of, with oral corticosteroid **(d) For pediatric patients 12 years and older with CSU** i. Previous treatment with two (2) H1-antihistamines for more than sixty (60) days within the past ninety (90) days **(e) IgE-mediated food allergy** i. First Prescription Only: (1) Documentation of patient's diagnosis ii. Documentation of baseline (pre-omalizumab treatment) serum total IgE level greater than or equal to 30 IU/mL and less than or equal to 1300 IU/mL iii. Documentation of patient's weight
Age Restriction	
Coverage Duration	
Max Quantity Per Month	5.52ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	• Submit requests for renewal on a Continuation of Therapy Form

GENERIC NAME	OXYCODONE HCL EXTENDED RELEASE
LABEL NAME(S)	**(OXYCODONE HCL ER 10 MG TABLET | OXYCODONE HCL ER 15 MG TABLET | OXYCODONE HCL ER 20 MG TABLET | OXYCODONE HCL ER 30 MG TABLET | OXYCODONE HCL ER 40 MG TABLET | OXYCODONE HCL ER 60 MG TABLET | OXYCODONE HCL ER 80 MG TABLET | OXYCONTIN ER 10 MG TABLET | OXYCONTIN ER 15 MG TABLET | OXYCONTIN ER 20 MG TABLET | OXYCONTIN ER 30 MG TABLET | OXYCONTIN ER 40 MG TABLET | OXYCONTIN ER 60 MG TABLET | OXYCONTIN ER 80 MG TABLET)**
Formulary	

Covered Uses	All FDA approved indications: ● Indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate in adults and opioid-tolerant pediatric patients 11 years of age and older who are already receiving and tolerate a minimum daily opioid dose of at least 20 mg oxycodone orally or its equivalent
Required Medical Information	○ Persistent, moderate to severe chronic pain or cancer-related pain that requires around-theclock analgesia for an extended period of time; and ○ For chronic pain, failure, intolerance, or contraindication to at least 2 short-acting formulary narcotic analgesics and controlled-release morphine (MS Contin, others). For cancer pain, failure intolerance, or contraindication to controlled-release morphine (MS Contin, others). ○ Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/
Max Quantity Per Month	240EA PER 30 DAYS
Max Refills Per Year	Not Applicable – Approval must be renewed every 6 months
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	Approval must be renewed every 6 months.

GENERIC NAME	PEGFILGRASTIM-PBBK
LABEL NAME(S)	**FYLNETRA 6 MG/0.6 ML SYRINGE**
Formulary	
Covered Uses	All FDA approved indications: • To decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. • Increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome).
Exclusion Criteria	None
Required Medical Information	Document one of the following: (a) Patients with nonmyeloid malignancies receiving myelosuppressive anti- cancer drugs associated with a significant incidence of severe neutropenia with fever (b) ANC nadir of < 1,000 neutrophils to previous chemotherapy. Once this has been documented, approval will be given for prophylaxis for all future chemo cycles. (c) Patient acutely exposed to myelosuppressive doses of radiation (Hematopoietic Subsyndrome of Acute Radiation Syndrome)

Coverage Duration	One (1) Year
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	None
Other Criteria	(a) For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary. (b) Please indicate estimated duration of therapy

GENERIC NAME	PEGINTERFERON ALFA-2A
LABEL NAME(S)	**(PEGASYS 180 MCG/0.5 ML SYRINGE | PEGASYS 180 MCG/ML VIAL | PEGASYS PROCLICK 135 MCG/0.5 M | PEGASYS PROCLICK 180 MCG/0.5)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of adults with chronic hepatitis C (CHC) and compensated liver disease in combination therapy with other hepatitis C virus drugs for adults with compensated liver disease ● in combination with ribavirin for pediatric patients 5 years of age and older with compensated liver disease ● Indicated for the treatment of adults with HBeAg-positive and HBeAg- negative chronic hepatitis B (CHB) infection who have compensated liver disease and evidence of viral replication and liver inflammation ● non-cirrhotic pediatric patients 3 years of age and older with HBeAg-positive CHB with evidence of viral replication and elevations in serum alanine aminotransferase (ALT)
Required Medical Information	● For Chronic Hepatitis C (In combination with other medication) ○ Diagnosis as indicated above including any applicable labs and/or tests ○ Clinically documented chronic Hepatitis C with detectable HCV RNA levels > 50 IU/mL ○ Age ≥ 3 years ○ Liver biopsy (unless contraindicated) indicates some fibrosis and inflammatory necrosis ○ If HIV-positive, patient is clinically stable ● For Chronic Hepatitis B: ○ Documented HBeAg -positive or -negative chronic Hepatitis B ○ Compensated liver disease ○ Evidence of viral replication ○ Evidence of liver inflammation ○ Not contraindicated

Max Quantity Per Month	4.41ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	PENTOXIFYLLINE
LABEL NAME(S)	**(PENTOXIFYLLINE ER 400 MG TAB)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of patients with intermittent claudication on the basis of chronic occlusive arterial disease of the limbs
Required Medical Information	● For the treatment of patients with intermittent claudication on the basis of chronic occlusive arterial disease of the limbs ○ Pain on walking or ABI < 0.8; or ○ Diabetic foot ulcer; or ○ Gangrene; or ○ Risk of, or existing, amputation
Max Quantity Per Month	90EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	PIMECROLIMUS
LABEL NAME(S)	**(PIMECROLIMUS 1% CREAM)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of mild to moderate atopic dermatitis in non-immunocompromised adults and children 2 years of age and older, who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable

Required Medical Information	○ Documented failure of optimal dosing/adequate duration; or ○ Intolerance or contraindication to at least one formulary topical corticosteroid; and ○ Diagnosis of mild to moderate atopic dermatitis; and ○ Using for short-term and non-continuous treatment.
Max Quantity Per Month	1EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	RALOXIFENE HCL
LABEL NAME(S)	**(RALOXIFENE HCL 60 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment and prevention of osteoporosis in postmenopausal women ● Indicated for the reduction in risk of invasive breast cancer in postmenopausal women with osteoporosis ● Indicated for the reduction in risk of invasive breast cancer in postmenopausal women at high risk for invasive breast cancer
Required Medical Information	● For the treatment and prevention of osteoporosis in postmenopausal women ○ Personal or family history of breast cancer; or ○ Intolerable side effects to at least one formulary estrogen. ● For the reduction in risk of invasive breast cancer in postmenopausal women with osteoporosis ○ Personal or family history of breast cancer; or ○ Intolerable side effects to at least one formulary estrogen. ● For the reduction in risk of invasive breast cancer in postmenopausal women at high risk for invasive breast cancer ○ Personal or family history of breast cancer; or ○ Intolerable side effects to at least one formulary estrogen.
Max Quantity Per Month	30EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication

Other Criteria	

GENERIC NAME	REPAGLINIDE
LABEL NAME(S)	**(REPAGLINIDE 0.5 MG TABLET | REPAGLINIDE 1 MG TABLET | REPAGLINIDE 2 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus
Required Medical Information	○ Diagnosis of Type 2 diabetes mellitus ○ Contraindication to metformin, a sulfonylurea, OR a preferred DPP-4 Inhibitor ○ Has not achieved adequate glycemic control on at least ONE of the following: • Metformin (alone or in combination) • A Sulfonylurea (alone or in combination) • A formulary DPP-4 inhibitor
Max Quantity Per Month	960EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	RIBAVIRIN
LABEL NAME(S)	**(RIBAVIRIN 200 MG CAPSULE | RIBAVIRIN 200 MG TABLET | RIBAVIRIN 6 GM INHALATION VIAL)**
Formulary	

Covered Uses	All FDA approved indications: ● **Capsule:** ○ Indicated for the treatment of chronic hepatitis C (CHC) in patients 3 years of age or older with compensated liver disease in combination with interferon alfa-2b (pegylated and nonpegylated) ● **Tablets:** ○ Indicated for the treatment of chronic hepatitis C (CHC) virus infection in combination with peginterferon alfa-2a in patients 5 years of age and older with compensated liver disease not previously treated with interferon alpha, and in adult CHC patients coinfected with HIV. ● **Inhalation solution:** ○ Indicated for the treatment of hospitalized infants and young children with severe lower respiratory tract infections due to RSV.
Required Medical Information	● Indicated for the treatment of chronic hepatitis C (CHC) in patients 3 years of age or older with compensated liver disease in combination with interferon alfa-2b (pegylated and nonpegylated) ○ Diagnosis of chronic Hepatitis C; and ○ Patient is receiving concomitant recombinant interferon alfa-2a or alfa-2b therapy or other Direct-Acting Antivirals
Max Quantity Per Month	30EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	RIFAXIMIN
LABEL NAME(S)	**(XIFAXAN 550 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the reduction in risk of overt hepatic encephalopathy (HE) recurrence in adults ● Indicated for the treatment of irritable bowel syndrome with diarrhea (IBS- D) in adults

Required Medical Information	● For the reduction in risk of overt hepatic encephalopathy (HE) recurrence in adults ○ Failure of, intolerance to, contraindication, or previous use to lactulose at maximally tolerated doses ● For the treatment of irritable bowel syndrome with diarrhea (IBS-D in adults ○ Failure of, intolerance to, contraindication, or previous use to loperamide ○ For renewals: the patient has a ten (10) or more week treatment- free period
Max Quantity Per Month	90EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	For the treatment of irritable bowel syndrome with diarrhea, max retreatment of two (2) times

GENERIC NAME	RILUZOLE
LABEL NAME(S)	**(RILUZOLE 50 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of amyotrophic lateral sclerosis (ALS)
Required Medical Information	● Indicated for the treatment of amyotrophic lateral sclerosis (ALS) ○ diagnosis of ALS
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	RISANKIZUMAB-RZAA
LABEL NAME(S)	**(SKYRIZI 150 MG/ML PEN | SKYRIZI 150 MG/ML SYRINGE | SKYRIZI 180 MG/1.2 ML ON-BODY | SKYRIZI 360 MG/2.4 ML ON-BODY | SKYRIZI 600 MG/10 ML VIAL)**
Formulary	

Covered Uses	FDA approved indications: ● Indicated for the treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy ● Indicated for the treatment of active psoriatic arthritis in adults ● For other indications see criteria for preferred Stelara Biosimilar, Yesintek
Required Medical Information	• **For all diagnoses:** ○ First Prescription and every 12 months – a recent NEGATIVE tuberculosis test, or if positive, has received treatment for latent TB prior to treatment. ● **Additional criteria for the treatment of moderate-to-severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy** ○ Previous treatment, or intolerance of, with Taltz ● **Additional criteria for the treatment of active psoriatic arthritis in adults** ○ Previous treatment, or intolerance of, with Taltz • For medical necessity requests for other indications, please include why preferred IL-23 inhibitor, Yesintek (PA required) is not appropriate.
Max Quantity Per Month	1 pen or syringe per fill
Max Refills Per Year	Number of refills per year varies by treatment schedule
Required Information for Previous Trials of Rx	• A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	• Provide intended dosing schedule with request, including details of initial dose and maintenance dose • The tuberculosis test should be within 12 months of the request date • Submit requests for renewal on a Continuation of Therapy Form • The recommended dosage for Plaque Psoriasis and Psoriatic Arthritis is 150 mg administered by subcutaneous injection at Week 0, Week 4, and every 12 weeks thereafter.

GENERIC NAME	RIVASTIGMINE
LABEL NAME(S)	**(RIVASTIGMINE 13.3 MG/24HR PTCH | RIVASTIGMINE 4.6 MG/24HR PATCH | RIVASTIGMINE 9.5 MG/24HR PATCH | RIVASTIGMINE 1.5 MG CAPSULE | RIVASTIGMINE 3 MG CAPSULE | RIVASTIGMINE 4.5 MG CAPSULE | RIVASTIGMINE 6 MG CAPSULE)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the mild-to-moderate dementia of the Alzheimer's type (AD) ● Indicated for the mild-to-moderate dementia associated with Parkinson's disease (PD)

Required Medical Information	● Indicated for the mild-to-moderate dementia of the Alzheimer's type (AD) ○ Confirmation by clinical evaluation ● Indicated for the mild-to-moderate dementia associated with Parkinson's disease (PD) ○ Confirmation by clinical evaluation
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	RIZATRIPTAN BENZOATE
LABEL NAME(S)	**(RIZATRIPTAN 10 MG TABLET | RIZATRIPTAN 5 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the acute treatment of migraine with or without aura in adults and in pediatric patients 6 to 17 years of age
Required Medical Information	● Indicated for the acute treatment of migraine with or without aura in adults and in pediatric patients 6 to 17 years of age ○ Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID's, ergotamine, or combination analgesic); or ○ Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., betablockers, calcium channel blockers; and ○ Patient is not currently using ergotamine or another 5-HT1 Receptor Agonist
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	ROPINIROLE HCL
LABEL NAME(S)	**(ROPINIROLE HCL 0.25 MG TABLET | ROPINIROLE HCL 0.5 MG TABLET | ROPINIROLE HCL 1 MG TABLET | ROPINIROLE HCL 2 MG TABLET | ROPINIROLE HCL 3 MG TABLET | ROPINIROLE HCL 4 MG TABLET | ROPINIROLE HCL 5 MG TABLET | ROPINIROLE HCL ER 2 MG TABLET | ROPINIROLE HCL ER 4 MG TABLET | ROPINIROLE HCL ER 6 MG TABLET | ROPINIROLE HCL ER 8 MG TABLET | ROPINIROLE HCL ER 12 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of Parkinson's disease (PD) ● Indicated for the moderate-to-severe primary restless leg syndrome
Required Medical Information	● Indicated for the treatment of Parkinson's disease (PD) ○ Diagnosis of idiopathic Parkinson's disease ● Indicated for the moderate-to-severe primary restless leg syndrome ○ Diagnosis of Restless Leg Syndrome and normal iron stores (serum ferritin and/or iron binding saturation)
Max Quantity Per Month	90 EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	SALMETEROL XINAFOATE
LABEL NAME(S)	**(SEREVENT DISKUS 50 MCG)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of asthma in patients aged 4 years and older with an ICS ● Indicated for the prevention of exercise-induced bronchospasm (EIB) in patients aged 4 years and older ● Indicated for the treatment of bronchospasm associated with chronic obstructive pulmonary disease (COPD)

Required Medical Information	● Indicated for the treatment of asthma in patients aged 4 years and older with an ICS ○ Currently on, but not controlled by an inhaled corticosteroid; and ○ Patients must be reevaluated after 6 months ● Indicated for the prevention of exercise-induced bronchospasm (EIB) in patients aged 4 years and older ○ Currently on, but not controlled by an inhaled corticosteroid; and ○ Patients must be reevaluated after 6 months ● Indicated for the treatment of bronchospasm associated with chronic obstructive pulmonary disease (COPD) ○ Currently on, but not controlled by a LAMA; and ○ Patients must be reevaluated after 6 months
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication to that medication
Other Criteria	

PA Description	SEMAGLUTIDE
LABEL NAME(S)	**(OZEMPIC PEN INJECTOR 0.25MG OR 0.5MG/DOSE (2MG/3ML) | OZEMPIC PEN INJECTOR 1MG/DOSE (4MG/3ML) | OZEMPIC PEN INJECTOR 2MG/DOSE (8MG/3ML))**
Covered Uses	All FDA approved indications: • Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus • Indicated to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with type 2 diabetes mellitus who have established cardiovascular disease. • Indicated to reduce the risk of sustained eGFR decline, end-stage kidney disease, and cardiovascular death in adults with type 2 diabetes mellitus and chronic kidney disease.
Exclusion Criteria	• Use for weight loss is not covered (anti-obesity medications are excluded under the HealthChoice program); • Co-administration with any other GLP-1 receptor agonist products is not covered; • Use that is not in accordance with FDA-approved prescribing information for the product is not covered

Required Medical Information	For First Prescription Only: • Diagnosis of type II diabetes mellitus; and • Must have tried at least 2 antidiabetic agents such as metformin, sulfonylureas, thiazolidinedione or insulin and not achieved adequate glycemic control despite treatment or intolerant to other antidiabetic medications.
Max Quantity Per Month	One 3mL pen per 28 days (the initial 0.25/0.5mg dose pen should be filled as a 42-day supply)
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	• A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication • Failure is defined as hbA1c ≥7 after trying the medication for at least 60 days

PA Description	SEMAGLUTIDE
LABEL NAME(S)	**(WEGOVY INJECTION 0.25 MG/0.5ML, 0.5MG/0.5ML, 1 MG/0.5ML, 1.7 MG/0.75ML, 2.4 MG/0.75ML | WEGOVY TABLETS 1.5MG, 4MG, 9MG. 25MG)**
Covered Uses	Only the following FDA approved indications (other uses remain excluded with other weight loss medications): ● To reduce the risk of (MACE) Major Adverse Cardiovascular Events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke), in combination with a reduced calorie diet and increased physical activity, for adults with established cardiovascular disease (ASCVD) who are either obese or overweight ● Treatment of non-cirrhotic metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH), with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) in adults
Exclusion Criteria	(a) Use for weight loss NOT in conjunction with one of the covered uses listed above; or (b) Co-administration with any other GLP-1 receptor agonist products. (c) Use that is not in accordance with prescribing information (d) Any other indication-specific exclusions as described in the Required Medical Information below

Required Medical Information	For Initial Approval: Wegovy will be considered for coverage when all of the criteria below are met, confirmed with supporting medical documentation. **Criteria for MACE (tablets or injectable):** (a) Member age is 18 years or older; AND (b) Prescribed by or in consultation with a cardiologist; AND (c) Member is overweight/obese with a recent BMI (based on accurate height and weight within the past 90 days) greater than or equal to 27kg/m2; AND (d) Member has established and documented atherosclerotic cardiovascular disease (ASCVD) as evidenced by one or more of the following: 1. Prior myocardial infarction; AND/OR 2. Prior stroke (ischemic or hemorrhagic stroke); AND/OR 3. Symptomatic peripheral arterial disease (PAD) as evidenced by: a. Intermittent claudication with ankle-brachial index (ABI) less than 0.85 (at rest); OR b. Peripheral arterial revascularization procedure; OR c. Amputation due to atherosclerotic disease; AND (e) Prescriber attests that medication is prescribed in accordance with prescribing information, including screening for any black box warnings and all contraindications. **Criteria for non-cirrhotic MASH (injectable only:** (a) Member age is 18 years or older; AND (b) Prescribed by or in consultation with a gastroenterologist or hepatologist; AND (c) The member has noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis): ● Diagnosis of noncirrhotic MASH with liver fibrosis stage F2 or F3, confirmed by liver biopsy or one of the noninvasive testing methods in the list below, from within the past 180 days; AND (d) Absence of concurrent use of another medication(s) indicated for noncirrhotic MASH; AND (e) Prescriber attests that medication is prescribed in accordance with prescribing information, including screening for any black box warnings and all contraindications; AND (f) Patients will be excluded from treatment when: 1. There are documented causes of chronic liver disease other than non-alcoholic fatty liver disease (NAFLD) 2. Presence of liver cirrhosis or a history of decompensated liver diseases 3. History of liver transplantation or current/prior hepatocellular carcinoma 4. Excessive alcohol consumption (20 gm per day for female; 30 gm per day for male)
Age Restriction	Age 18 or older
Max Quantity Per Month	Four (4) pens/28 days, any strength; 30 tablets / 30 days

<table>
<tr><td>Coverage Duration</td><td>4 months for initial approval and 6 months for subsequent renewals</td></tr>
<tr><td>Accepted Fibrosis Testing</td><td>Noninvasive methods for the determination of fibrosis in MASLD
Numerous noninvasive methodologies have been developed to determine the degree of fibrosis in patients with Metabolic dysfunction-associated steatotic liver disease (MASLD). These methodologies employ either the use of biomarkers or the evaluation of liver stiffness to make a determination regarding the degree of liver fibrosis. Below is a list of acceptable noninvasive testing (as identified by Maryland Medicaid) to determine if a patient meets the criteria for approval of Wegovy for this indication. Wegovy is labeled for the treatment of patients with metabolic dysfunction-associated steatohepatitis (MASH) who have a fibrosis score of F2-F3.
<table>
<tr><th>Noninvasive test</th><th>CPT Code</th><th>Score comparable to F2-F3 fibrosis</th></tr>
<tr><td colspan="3">Imaging-Based Fibrosis Tests</td></tr>
<tr><td>Transient elastography</td><td>91200</td><td>8 kPa to 15 kPa</td></tr>
<tr><td>Shear wave elastography (pSWE)</td><td>76981</td><td>1.2 m/s to 2 m/s</td></tr>
<tr><td>Magnetic resonance elastography (MRE)</td><td>76391</td><td>3.4 kPa to 6.7 kPa</td></tr>
<tr><td colspan="3">Blood-Based Fibrosis Tests</td></tr>
<tr><td>ELF</td><td>81517</td><td>7.7 to 9.8</td></tr>
<tr><td>Fibrotest</td><td>81596</td><td>0.32 to 0.48</td></tr>
<tr><td>Fibrotic NASH Index (FNI)*</td><td>N/A</td><td>0.10 to 0.33</td></tr>
<tr><td>MACK-3*</td><td>N/A</td><td>0.135 to 0.549</td></tr>
</table>
* CPT code is not available, but FNI or MACK-3 score may be submitted to fulfill the diagnostic requirement for the clinical criteria.</td></tr>
<tr><td>Renewal Criteria</td><td>All criteria in the initial approval must continue to be met.</td></tr>
<tr><td>Criteria Updates</td><td>Criteria for Wegovy will be updated to align with the criteria from Maryland Medicaid as further updates are reported to the MCO.</td></tr>
<tr><td>Other Criteria</td><td>(a) Refer to package insert information for black box warning and contraindications.
(b) Current BMI, height, and weight measurements must be included with the request for renewal to show that treatment is effective;
(c) Renewal requests will NOT be authorized if the member's BMI is less than or equal to 24 or if treatment is not proving effective.</td></tr>
</table>

GENERIC NAME	SEVELAMER CARBONATE POWDER
LABEL NAME(S)	**(SEVELAMER CARBONATE POWDER, FOR ORAL SUSPENSION - 0.8GM PACKET | 2.4GM PACKET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the control of serum phosphorus in adults and children 6 years of age and older with chronic kidney disease on dialysis.

Required Medical Information	Document unable to ingest a solid dosage form (e.g., oral tablet or capsule) due to one of the following: • Age • Oral/motor difficulties • Dysphagia • Patient utilizes a feeding tube for medication administration
Max Quantity Per Month	6 PACKETS/DAY (180 PACKETS/30 DAYS)
Max Refills Per Year	Twelve (12) Refills
Other Information	Sevelamer Carbonate 800mg tablet on formulary without prior authorization

GENERIC NAME	SILDENAFIL CITRATE
LABEL NAME(S)	**(SILDENAFIL 20 MG TABLET | SILDENAFIL ORAL SUSPENSION FOR RECONSTITUTION 10 MG/ML**
Formulary	
Covered Uses	• Indicated for the treatment in adults and pediatric patients 1 to 17 years old of pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group I) in adults to improve exercise ability and delay clinical worsening
Exclusion Criteria	Products for Erectile Dysfunction are excluded from the HealthChoice Program
Required Medical Information	• For the treatment of PAH; and • Current utilization of nitrates is contraindicated; and • Age limit of 2 years and younger for the solution
Max Quantity Per Month	360EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Other Criteria	

GENERIC NAME	SIMVASTATIN (80MG TABLET ONLY)
LABEL NAME(S)	**(SIMVASTATIN 80 MG TABLET)**
Formulary	

Covered Uses	All FDA approved indications: ● Indicated for the reduce the risk of total mortality by reducing risk of coronary heart disease death, non-fatal myocardial infarction and stroke, and the need for coronary and non-coronary revascularization procedures in adults with established coronary heart disease, cerebrovascular disease, peripheral vascular disease, and/or diabetes, who are at high risk of coronary heart disease events ● Indicated for the adjunct to diet to reduce low-density lipoprotein cholesterol (LDL-C) ● Indicated for the adjunct to other LDL-C-lowering therapies to reduce LDL-C in adults with homozygous familial hypercholesterolemia (HoFH) ● Indicated for the adjunct to diet for the treatment of adults with primary dysbetalipoproteinemia and/or hypertriglyceridemia
Required Medical Information	• Age ≤ 65 years • Male gender (female gender predisposed to myopathy including rhabdomyolysis) • Controlled hypothyroidism • Normal renal function
Max Quantity Per Month	15EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	SOFOSBUVIR/VELPATASVIR
LABEL NAME(S)	**(SOFOSBUVIR-VELPATASVIR 400-100 TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of adults and pediatric patients 3 years of age and older with chronic hepatitis C virus (HCV) genotype 1, 2, 3, 4, 5, or 6 infection without cirrhosis or with compensated cirrhosis OR with decompensated cirrhosis for use in combination with ribavirin

Required Medical Information	○ Generic tablets only (requests for other formulations must include medical necessity rationale) ○ Genotypes 1, 2, 3, 4, 5 and 6 ○ Documentation of chronic infection (>180 days) ○ Must follow the clinical criteria as set by the Maryland Department of Health Special Hepatitis C PA request forms, treatment plan, length of treatment, and clinical documentation to be attached with the request. Full criteria can be obtained on our website's pharmacy information page https://jaimedicalsystems.com/providers/pharmacy/ For retreatment requests: Please also include information about the previous treatment (length of treatment and regimen received, treatment response, genotype and viral load results pre-and post-treatment, etc), as requested in the clinical criteria
Max Quantity Per Month	28EA PER 28 DAYS
Refill Limits	TWO (2) REFILLS PER STANDARD COURSE OF TREATMENT; UP TO FIVE (5) REFILLS IN SPECIAL POPULATIONS (AS DESCRIBED IN THE CLINICAL CRITERIA)
Other Criteria	• Please report SVR lab results from at least 12 weeks post treatment completion or patient discontinuation of treatment • For retreatment requests: Please also include information about the previous treatment (length of treatment and regimen received, treatment response, genotype and viral load results pre-and post-treatment, etc), as requested in the clinical criteria

GENERIC NAME	SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR
LABEL NAME(S)	**(VOSEVI 400-100-100 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of adult patients with chronic hepatitis C virus (HCV) infection without cirrhosis or with compensated cirrhosis (Child-Pugh A) who have genotype 1, 2, 3, 4, 5, or 6 infection and have previously been treated with an HCV regimen containing an NS5A inhibitor OR genotype 1a or 3 infection and have previously been treated with an HCV regimen containing sofosbuvir without an NS5A inhibitor

Required Medical Information	○ For retreatment only ○ Documentation of chronic infection (>180 days) ○ Must follow the clinical criteria as set by the Maryland Department of Health Special Hepatitis C PA request forms, treatment plan, length of treatment, and clinical documentation to be attached with the request. Full criteria can be obtained on our website's pharmacy information page https://jaimedicalsystems.com/providers/pharmacy/ ○ Include information about the previous treatment (length of treatment and regimen received, treatment response, genotype and viral load results pre- and post-treatment, etc), as requested in the clinical criteria
Max Quantity Per Month	28EA PER 28 DAYS
Refill Limits	TWO (2) REFILLS PER STANDARD COURSE OF TREATMENT
Other Criteria	Please report SVR lab results from at least 12 weeks post treatment completion or patient discontinuation of treatment

GENERIC NAME	SOMATROPIN
LABEL NAME(S)	**(HUMATROPE 12 MG CARTRIDGE | HUMATROPE 24 MG CARTRIDGE | HUMATROPE 5 MG VIAL | HUMATROPE 6 MG CARTRIDGE)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the growth failure due to inadequate secretion of endogenous growth hormone (GH) ● Indicated for the short stature associated with Turner syndrome ● Indicated for the Idiopathic Short Stature (ISS), height standard deviation score (SDS) less than or equal to <-2.25, and associated with growth rates unlikely to permit attainment of adult height in the normal range ● Indicated for the short stature or growth failure in short stature homeoboxcontaining gene (SHOX) deficiency ● Indicated for the short stature born small for gestational age (SGA) with no catch-up growth by 2 years to 4 years of age ● Indicated for the replacement of endogenous GH in adults with GH deficiency.
Required Medical Information	**For the growth failure due to inadequate secretion of endogenous growth hormone (GH):** ○ Patient with open epiphyses (as confirmed by radiograph of wrist and hand) who has not reached final height; and ○ Medication prescribed by an endocrinologist; and ○ Patient meets one of the following criteria: ▪ Growth Hormone Deficiency (GHD) with diagnosis confirmed by one of the following: i. Severe short stature defined as patient's height at > 2 SD below the population mean

	ii. Patient's height > 1.5 SD below the midparental height (average of mother's and father's heights) iii. Patient's height > 2 SD below the mean and a 1-year height velocity more than 1 SD below the mean for chronologic age or (in children 2 years of age or older) a 1-year decrease of more than 0.5 SD in height iv. In the absence of short stature, a 1-year height velocity more than 2 SD below the mean or a 2-year height velocity more than 1.5 SD below the mean (may occur in GHD manifesting during infancy or in organic, acquired GHD) v. Signs indicative of an intracranial lesion vi. Signs of multiple pituitary hormone deficiencies vii. Neonatal symptoms and signs of GHD **For the short stature associated with Turner syndrome:** o Document height below the 5th percentile of normal growth curve, and o Medication prescribed by an endocrinologist **For the Idiopathic Short Stature (ISS):** o Document height standard deviation score (SDS) less than or equal to -2.25, and associated with growth rates unlikely to permit attainment of adult height in the normal range and, o Medication prescribed by an endocrinologist **For the short stature or growth failure in short stature homeobox-containing gene (SHOX) deficiency:** o Document gene (SHOX) deficiency, and o Height more than two standard deviations below the mean for age and gender, and o Medication prescribed by an endocrinologist; **For the short stature born small for gestational age (SGA) with no catch-up growth by 2 years to 4 years of age:** o The patient has a documented birth weight and/or length that is more than two standard deviations (SD) below the mean for gestational age; and, o At 24 months of age, the patient failed to manifest catch-up growth evidenced by a height more than two standard deviations (SD) below the mean for age and sex, and o Medication prescribed by an endocrinologist **For the replacement of endogenous GH in adults with GH deficiency.** o Document irreversible hypothalamic/pituitary structural lesions or ablation (e.g., pituitary tumor, pituitary damage from surgery, hypothalamic disease, radiation, pituitary damage from trauma) OR GH deficiency diagnosed during childhood OR Defect in GH synthesis. o Medication prescribed by an endocrinologist
Max Quantity Per Month	N/A PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills

Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	● Include copy of any test results done to confirm diagnosis and for ongoing patient monitoring, when applicable ● To continue therapy, requests will be reviewed every six months. ● For injectable medications administered by a healthcare professional, please refer to the "Specialty Medication Guidelines" in the beginning of this formulary.

GENERIC NAME	SUCCIMER
LABEL NAME(S)	**(CHEMET 100 MG CAPSULE)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of lead poisoning in pediatric patients with blood lead levels above 45 mcg/dL
Required Medical Information	● Indicated for the treatment of lead poisoning in pediatric patients with blood lead levels above 45 mcg/dL ○ Diagnosis of lead poisoning with blood levels > 45mcg/dl; and ○ Child is hospitalized; or ○ Child was started on the medication in the hospital and needs to continue upon discharge.
Max Quantity Per Month	N/A PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	Unlabeled uses: Succimer may be beneficial in the treatment of other heavy metal poisonings

GENERIC NAME	TACROLIMUS TOPICAL
LABEL NAME(S)	**(TACROLIMUS 0.03% OINTMENT | TACROLIMUS 0.1% OINTMENT)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of moderate to severe atopic dermatitis in non-immunocompromised adults and children who have failed to respond adequately to other topical prescription treatments for atopic dermatitis, or when those treatments are not advisable, as second-line therapy

Required Medical Information	○ Patient must be non-immunocompromised and ○ Must be at least 2 years of age or older for the 0.03% strength; or ○ 16 years of age or older for 0.1% strength and ○ Diagnosis of atopic dermatitis ○ Documented failure of 2 different topical corticosteroids of medium
Max Quantity Per Month	1EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	TERIFLUNOMIDE
LABEL NAME(S)	**(AUBAGIO 14 MG TABLET | AUBAGIO 7 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults
Required Medical Information	○ Prescribed by neurologist; and ○ Not requesting combination of any 2 agents together: Copaxone, Betaseron, Avonex, Tysabri, Rebif, Gilenya, Aubagio, or Tecfidera.
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	TESTOSTERONE
LABEL NAME(S)	**(TESTOSTERONE 1.62% (2.5 G) PKT | TESTOSTERONE 1.62% GEL PUMP | TESTOSTERONE 1.62% (1.25 G) PKT | TESTOSTERONE 1% (25 MG/2.5 G) | TESTOSTERONE 10 MG GEL PUMP | TESTOSTERONE 12.5 MG/1.25 GRAM | TESTOSTERONE 30 MG/1.5 ML PUMP | TESTOSTERONE 50 MG/5 GRAM GEL | TESTOSTERONE 50 MG/5 GRAM PKT | TESTOSTERON CYP 1,000 MG/10 ML | TESTOSTERONE CYP 200 MG/ML)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the replacement therapy in males for conditions associated with a deficiency or absence of endogenous testosterone such as primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (congenital or acquired) Other indication: ● For medical treatment of transgender care
Exclusion Criteria	
Required Medical Information	● Indicated for the replacement therapy in males for conditions associated with a deficiency or absence of endogenous testosterone such as primary hypogonadism (congenital or acquired) or hypogonadotropic hypogonadism (congenital or acquired) ○ Must be prescribed by an Endocrinologist or Urologist ○ The patient has documented low testosterone concentration ● For Gender Affirming Treatment ○ For all requests for gender affirming care, please refer to the Gender-Affirming Treatment Services Under the Maryland Medicaid Program document (for a copy of the criteria see our website at https://jaimedicalsystems.com/providers/pharmacy/.) Please ensure that all necessary documentation required under the criteria is included to show consent for treatment and medical necessity (documentation requirements may vary depending on patient age, type of treatment requested, and specialty of requesting provider).
Age Restriction	
Coverage Duration	
Max Quantity Per Month	9.24ML PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication

Other Criteria	● Renewal: The patient has documented therapeutic concentration to confirm response ● For more information on transgender care, refer to the Gender-Affirming Treatment Services documentation under the Maryland Medicaid Program or on the MCO website at https://jaimedicalsystems.com/providers/pharmacy/

GENERIC NAME	THROMBIN
LABEL NAME(S)	**(THROMBIN-JMI NAS SP SYR 5000 UNIT | THROMBIN-JMI SPRAY 20000 UNIT | THROMBIN-JMI SPRAY SYRN 20000 UNIT, 5000 UNIT | THROMBIN-JMI VIAL 5000 UNIT, 20000 UNIT)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated to aid hemostasis whenever oozing blood and minor bleeding from capillaries and small venules is accessible and control of bleeding by standard surgical techniques (such as suture, ligature, or cautery) is ineffective or impractical.
Required Medical Information	○ Diagnosis of a bleeding disorder
Max Quantity Per Month	N/A PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	TIRZEPATIDE INJECTIONS
LABEL NAME(S)	**(ZEPBOUND 2.5MG/0.5ML PEN | ZEPBOUND 5MG/0.5ML PEN | ZEPBOUND 7.5MG/0.5ML PEN | ZEPBOUND 10MG/0.5ML PEN | ZEPBOUND 12.5MG/0.5ML PEN | ZEPBOUND 15MG/0.5ML PEN)**
Formulary	
Covered Uses	(a) Treatment of moderate to severe obstructive sleep apnea (OSA) in adults with obesity.
Exclusion Criteria	(a) Use for weight loss when not being used to treat moderate to severe OSA in adults (anti-obesity medications are excluded under the HealthChoice program); (b) Use in patients with type 2 diabetes (other GLP-1 products on formulary for treatment of diabetes); (c) Co-administration with any other GLP-1 receptor agonist products; (d) Use that is not in accordance with FDA-approved prescribing information for the product.

Required Medical Information	All of the following: (a) Prescribed by or in consultation with a sleep specialist, pulmonologist, or other provider experienced in treating OSA; (b) Moderate to severe OSA as diagnosed by polysomnography with an apneahypopnea index (AHI) ≥ 15 events per hour; (c) BMI ≥ 30 kg/m2; (d) Provide current height and weight measurements (within the last 90 days) (e) Patient meets FDA-approved prescribing information clinical parameters for use (i.e. no contraindications, appropriate screening and monitoring have been completed); (f) If the patient has a diagnosis of Type 2 Diabetes Mellitus (T2DM), they must use a GLP-1 receptor agonist indicated for T2DM; (g) Will not be used concurrently with other tirzepatide-containing products or GLP-1 receptor agonists.
Age Restriction	(a) Only for patients 18 years of age and older
Prescriber Restriction	(a) Prescribed by or in consultation with a sleep specialist, pulmonologist, or other provider experienced in treating OSA.
Quantity Limitations	(a) Four (4) pens/28 days, any strength
Coverage Duration	(a) Six (6) months for initial approval and subsequent renewals
Other Criteria	(a) Prescriber attestation of continued clinical benefit and subsequent evaluation and monitoring performed; (b) Current BMI, height, and weight measurements must be included with the request for renewal; (c) Renewal requests will NOT be authorized if the member's BMI is < 30 kg/m2; (d) Therapy beyond 12 months will require repeat documentation confirming moderate to severe OSA and annually thereafter.

GENERIC NAME	TRAMADOL HCL EXTENDED RELEASE
LABEL NAME(S)	**(TRAMADOL HCL ER 100 MG TABLET | TRAMADOL HCL ER 200 MG TABLET | TRAMADOL HCL ER 300 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate
Required Medical Information	○ For patients who have a contraindication or failure of tramadol regular release tablets ○ Completion of Opioid Prior Authorization/Attestation Form required, available at http://www.jaimedicalsystems.com/providers/pharmacy/
Max Quantity Per Month	90EA PER 30 DAYS
Max Refills Per Year	Maximum 6 fills (5 refills) in 6 months

Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	Approval must be renewed every 6 months

GENERIC NAME	UMECLIDINIUM BRM/VILANTEROL TR
LABEL NAME(S)	**(ANORO ELLIPTA 62.5-25 MCG INH)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of patients with chronic obstructive pulmonary disease (COPD)
Required Medical Information	○ Currently on, but not controlled by a LAMA; and ○ The patient must be reevaluated after 6 months
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	UPADACITINIB
LABEL NAME(S)	**(RINVOQ ER 15 MG TABLET | RINVOQ ER 30 MG TABLET | RINVOQ ER 45 MG TABLET | RINVOQ LQ 1 MG/ML SOLUTION)**
Formulary	
Covered Uses	All FDA approved indications: (a) **Rinvoq:** Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with rheumatoid arthritis (RA). (b) **Rinvoq/RinvoqLQ**: Treatment of adult and pediatric patients 2 years of age and older, who have had an inadequate response or intolerance to one or more TNF blockers, with active psoriatic arthritis (PsA). (c) **Rinvoq** Treatment of pediatric patients 12 years and older, who have had an inadequate response or intolerance to other systemic drug products, including biologics, with active atopic dermatitis (AD). (d) **Rinvoq** Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with active ulcerative colitis (UC).

Covered Uses (continued)	(e) **Rinvoq** Treatment of adults with moderately to severely active Crohn's disease (CD) who have had an inadequate response or intolerance to one or more TNF blockers. (f) **Rinvoq** Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with active ankylosing spondylitis (AS). (g) **Rinvoq** Treatment of adult patients, who have had an inadequate response or intolerance to one or more TNF blockers, with active non-radiographic axial spondyloarthritis (nr-axSpA). (h) **Rinvoq/RinvoqLQ**: For the treatment of patients 2 years of age and older with active polyarticular juvenile idiopathic arthritis (PJIA) who have had an inadequate response or intolerance to one or more TNF blockers. (i) **Rinvoq** Treatment of adults with giant cell arteritis
Exclusion Criteria	Combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine
Required Medical Information	(a) First Prescription and every 12 months: i. The patient had a recent NEGATIVE tuberculosis test, or if positive, has received treatment for latent TB prior to treatment. ii. The patient had a NEGATIVE hepatitis B and C viral screening; and (b) For adult patients with RA i. Previous treatment, or intolerance of Enbrel for more than sixty (60) days; and ii. Previous treatment, or intolerance of formulary Humira biosimilar for more than sixty (60) days (c) For adult patients with PsA i. Previous treatment, or intolerance of Enbrel for more than sixty (60) days; and ii. Previous treatment, or intolerance of formulary Humira biosimilar for more than sixty (60) days; and iii. Previous treatment, or intolerance of Taltz for more than sixty (60) days (d) For pediatric patients 2 years of age and older with PsA i. Previous treatment, or intolerance of Enbrel for more than sixty (60) days; and ii. Previous treatment, or intolerance of formulary Humira biosimilar for more than sixty (60) days; (e) For patients 2 years of age and older with PJIA i. Previous treatment, or intolerance of Enbrel for more than sixty (60) days; and ii. Previous treatment, or intolerance of formulary Humira biosimilar for more than sixty (60) days (f) For patients 12 years and older with AD i. Previous treatment, or intolerance of Dupixent for more than sixty (60) days (g) For adult patients with UC/CD i. Previous treatment, or intolerance of formulary Humira biosimilar for more than sixty (60) days (h) For adult patients with AS and nr-asSpA i. Previous treatment, or intolerance of Taltz for more than sixty (60) days (i) For adult patients with GCA i. Previous treatment, or intolerance of systemic corticosteroids (e.g., prednisone) for more than sixty (60) days; and ii. Previous treatment, or intolerance of Actemra (tocilizumab) for more than sixty (60) days

<table>
<tr><td>Age Restriction</td><td>Minimum age for approval varies to align with FDA approved indications listed earlier in the criteria</td></tr>
<tr><td>Coverage Duration</td><td>Six (6) months</td></tr>
<tr><td>Max Quantity Per Month</td><td>Limits may be higher for induction dose for some diagnoses, in accordance with package insert information; please include explanation if intent is to exceed 1 tablet per day for maintenance dosing
30 or 60 EA PER 30 DAYS
360 ML PER 30 DAYS</td></tr>
<tr><td>Max Refills Per Year</td><td>Twelve (12) Refills</td></tr>
<tr><td>Required Information for Previous Trials of Rx</td><td>A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication for that medication</td></tr>
<tr><td>Other Criteria</td><td>Submit requests for renewal on a Continuation of Therapy Form
Provide intended dosing schedule with request, including details of initial dose and maintenance dose
The tuberculosis test should be within 12 months of the request date
Table. RINVOQ/RINVOQ LQ Dosage for Pediatric Patients 2 Years to Less Than 18 Years of Age with Psoriatic Arthritis and Patients 2 years and older with pJIA<table><tr><th>Patient Weight</th><th>RINVOQ LQ</th><th>RINVOQ</th></tr><tr><td>10 kg to less than 20 kg</td><td>3 mg (3 mL oral solution) twice daily</td><td>Not recommended</td></tr><tr><td>20 kg to less than 30 kg</td><td>4 mg (4 mL oral solution) twice daily</td><td>Not recommended</td></tr><tr><td>30 kg and greater</td><td>6 mg (6 mL oral solution) twice daily</td><td>15 mg (one 15 mg tablet) once daily</td></tr></table></td></tr>
</table>

GENERIC NAME	USTEKINUMAB-KFCE
LABEL NAME(S)	**(YESINTEK 45 MG/0.5 ML SYRINGE | YESINTEK 90 MG/ML SYRINGE)**
Formulary	
Covered Uses	All FDA approved indications: • Indicated for the treatment of adults and pediatric patients 6 years of age and older with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy. • Indicated for the treatment of adults and pediatric patients 6 years of age and older with active psoriatic arthritis • Indicated for the treatment of adult patients with moderately to severely active Crohn's disease • Indicated for the treatment of adult patients with moderately to severely active ulcerative colitis.

Required Medical Information	• For first prescription for Plaque Psoriasis or Psoriatic Arthritis: ○ Patient's age is 6 years or older. ○ A NEGATIVE tuberculosis test, or if positive, has received treatment for latent TB prior to treatment. ○ Previous treatment failure, intolerance, or contraindication to at least a Tumor necrosis factor (TNF) inhibitor (e.g. etanercept, adalimumab) • For first prescription for Crohn's Disease or Ulcerative Colitis: ○ A NEGATIVE tuberculosis test, or if positive, has received treatment for latent TB prior to treatment. ○ Previous treatment failure, intolerance, or contraindication to at least a Tumor necrosis factor (TNF) inhibitor (e.g. adalimumab, infliximab) or documented corticosteroid-refractoriness or dependency.
Max Quantity Per Month	1 prefilled syringe (45 mg/05 ML or 90 mg/1ML)
Max Refills Per Year	Six (6) Refills
Renewal Criteria	• Submit requests for renewal on a Continuation of Therapy Form • IV infusion for initial dose should be requested through medical benefit with PCP referral and Authorization form the UM Department on a Standard Auth Form

GENERIC NAME	VALACYCLOVIR HYDROCHLORIDE
LABEL NAME(S)	**VALACYCLOVIR HCL 1 GRAM TABLET | VALACYCLOVIR HCL 500 MG TABLET**
Covered Uses	All FDA approved indications: (a) Adult Patients a. Treatment of cold sores (herpes labialis). (ICD 10 CM B00.1) b. Genital Herpes (ICD 10 CM A60. 0) i. Treatment in immunocompetent patients (initial or recurrent episode) ii. Suppression in immunocompetent or HIV-1−infected patients iii. Reduction of transmission of genital herpes in immunocompetent adults. c. Treatment of herpes zoster (shingles) in immunocompetent adults. (ICD 10 CM B02) (b) Pediatric Patients a. Treatment of cold sores (herpes labialis) in pediatric patients aged greater than or equal to 12 years. (ICD 10 CM B00.1) b. Treatment of chickenpox in immunocompetent pediatric patients aged 2 to less than 18 years. (ICD 10 CM B01) Limitations of Use: The efficacy and safety of VALACYCLOVIR have not been established in immunocompromised patients other than for the suppression of genital herpes in HIV-1−infected patients.
Exclusion Criteria	Hypersensitivity to valacyclovir (e.g., anaphylaxis), acyclovir, or any component of the formulation.

Required Medical Information	(a) Adult Patients a. For management of cold sores (herpes labialis), Genital Herpes, or herpes zoster (shingles) i. Document trial, failure, or contraindication to acyclovir or document rationale supporting acyclovir is not inappropriate. (b) Pediatric Patients a. Treatment of cold sores (herpes labialis) in pediatric patients aged greater than or equal to 12 years. (ICD 10 CM B00.1) i. Document trial, failure, or contraindication to acyclovir or document rationale supporting acyclovir is not inappropriate b. Treatment of chickenpox in immunocompetent pediatric patients aged 2 to less than 18 years. (ICD 10 CM B01) i. Document trial, failure, or contraindication to acyclovir or document rationale supporting acyclovir is not inappropriate
Age Restriction	(a) Treatment of cold sores (herpes labialis) in pediatric patients aged greater than or equal to 12 years. (b) Treatment of chickenpox in immunocompetent pediatric patients aged 2 to less than 18 years.
Coverage Duration	Per indication
Max Quantity Per Month	
Max Refills Per Year	
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication for that medication
Other Criteria	(a) Refer to package insert information for dosage and administration. (b) Guidelines suggest **not administering antiviral therapy for healthy children ≤12 years.** Varicella is typically a self-limited disease in this population. Although acyclovir may modestly reduce the duration and severity of symptoms, these benefits must be weighed against the adverse effects (including rare but potentially serious adverse effects), cost, and potential transmission of infection during the office visit to obtain the prescription. https://www.cdc.gov/chickenpox/hcp/clinical-overview/

GENERIC NAME	VALSARTAN
LABEL NAME(S)	**(VALSARTAN 160 MG TABLET | VALSARTAN 320 MG TABLET | VALSARTAN 40 MG TABLET | VALSARTAN 80 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of hypertension, to lower blood pressure in adults and pediatric patients six years of age and older ● Indicated for the reduction of hospitalization for heart failure in adult patients with heart failure (NYHA class II-IV) ● Indicated to reduce the risk of cardiovascular mortality in clinically stable adult patients with left ventricular failure or left ventricular dysfunction following myocardial infarction
Required Medical Information	○ Failure or contraindication of 2 formulary ARBs (Irbesartan, Losartan)
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	VALSARTAN/HYDROCHLOROTHIAZIDE
LABEL NAME(S)	**(VALSARTAN-HYDROCHLOROTHIAZIDE TABLET 160-12.5MG, 160-25MG, 320-12.5MG, 320-25MG, 80MG-12.5MG)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the treatment of hypertension, to lower blood pressure in adults and pediatric patients six years of age and older ● Indicated for the reduction of hospitalization for heart failure in adult patients with heart failure (NYHA class II-IV) ● Indicated to reduce the risk of cardiovascular mortality in clinically stable adult patients with left ventricular failure or left ventricular dysfunction following myocardial infarction
Required Medical Information	○ Failure or contraindication of 2 formulary ARB-Hydrochlorothiazide combinations (Irbesartan- Hydrochlorothiazide, Losartan-Hydrochlorothiazide)

Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for Previous Trials of Rx	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Other Criteria	

GENERIC NAME	ZOLMITRIPTAN
LABEL NAME(S)	**(ZOLMITRIPTAN 2.5 MG TABLET | ZOLMITRIPTAN 5 MG TABLET)**
Formulary	
Covered Uses	All FDA approved indications: ● Indicated for the acute treatment of migraine with or without aura in adults
Required Medical Information	● Indicated for the acute treatment of migraine with or without aura in adults ○ Failure of, intolerance to, or contraindication to one traditional formulary agent (NSAID, ergotamine, or combination analgesic); or ○ Unsuccessful concurrent or previous use of migraine prophylaxis medications (e.g., betablockers, calcium channel blockers); and ○ Patient is not currently using ergotamine or another 5-HT1 Receptor Agonist
Max Quantity Per Month	60EA PER 30 DAYS
Max Refills Per Year	Twelve (12) Refills
Required Information for	A trial, or failure, of a medication is defined by a minimum sixty (60) day trial, UNLESS there is a contraindication that medication
Previous Trials of Rx	
Other Criteria	