



Clinical Policy Governance Committee Charter

Last Revised: September 1, 2023

Clinical Policy Governance Committee Charter

COMMITTEE NAME: Clinical Policy Governance Committee (CPGC)

REPORTS TO COMMITTEE: Quality Enterprise Committee (QEC)

CHAIRPERSON(S):

Chair: VP, Clinical Policy

Co-Chair: VP, Behavioral Health

CPGC MEETING FACILITATORS: Clinical Policy Administrative Staff

CLINICAL POLICY GOVERNANCE OVERSIGHT:

The EVP & Chief Medical Officer of Medical Affairs provides executive oversight of the Enterprise function of the Clinical Policy Governance Team and Committee.

SCOPE OF CLINICAL POLICY GOVERNANCE COMMITTEE:

CareSource Clinical Policy Governance Committee (CPGC) is the official governing body charged with the approval of new or revised clinical policies that relate to medical necessity determinations. The CPGC is responsible for determining whether the proposed clinical policy is clearly defined, is clinically evidence-based, assures a high level of member safety and quality of care, and articulates a business value. The CPGC reports up through the Quality Enterprise Committee (QEC) which then reports to the CareSource Board of Directors.

In addition, the New Medical Technology Subcommittee as part of the CPGC, will evaluate new or emerging technologies. The Subcommittee will conduct a quality & safety assessment of the proposed technology. Recommendations from this group will follow the current workflow of CPGC.

PROCESS DESCRIPTION:

The Clinical Policy Governance Committee utilizes a robust, multidisciplinary approval process that encompasses internal business units, existing systems/tools, combination of internal analytics, industry standards and operational best practices for all lines of business.

RESPONSIBILITIES:

The primary objectives and responsibilities of the Clinical Policy Governance Committee (CPGC) members are:

- Voting members must actively participate and have full understanding of the policies to be presented prior to each meeting.
- Attend bi-weekly meetings for oversight of all financial analytic analysis and final approval of policies presented to the Clinical Policy Governance Committee.
- Review and vote for final approval on all the following:
 - New clinical policies
 - Revision of existing clinical policies
 - Annual reviews

- Approval for archiving of existing clinical policies

VOTING OUTCOMES:

- Committee Meeting Approval:
 - A quorum must be present for the meeting to occur. A quorum is defined as 50% of voting members plus 1. See below.
 - For policies to be approved and implemented, they must have a majority approval from the Committee.
- Electronic voting via email:
 - Utilized when policies have already been viewed by the Clinical Policy Governance Committee but were tabled for revisions.
 - Annual revisions that had minimal to no revisions from previous year
 - Archiving of current policies
 - Administrative revisions that do not impact the policy substance and intent
 - Oversight of vendor policies, when applicable

MEMBERSHIP:

The Clinical Policy Governance Committee is the official body charged with issuing final approval of Clinical policies.

Each core voting member will assign a backup to perform in their role as it relates to the CareSource Clinical Policy Governance Committee voting and decision making.

VOTING MEMBERS
VP, Clinical Policy
VP, Medical Services – Behavioral Health
SVP, Executive Medical Director
Clinical Operations Market Leaders
VP, Market Chief Medical Officers/Market Medical Directors
VP, Configuration
VP, Medical Affairs
SVP, Clinical Operations
AVP, Benefits Coding & Support
Director/Manager, Utilization Management
Director, Grievance and Appeals
Director, Payment Integrity
Director, Pharmacy
Enterprise Dental Medical Director
Enterprise UM Medical Directors
Program Integrity
Clinical Appeals
Medical Director – Behavioral Health
Manager, Product Management Marketplace
Medical Director

ADDITIONAL SUBJECT MATTER EXPERTS (NON-VOTING MEMBERS)

** Medical Directors and other subject matter experts (SME) are pulled in based on specialty on an ad hoc basis to review and provide input for all applicable policies. SME input is taken into consideration during the development process, but they are NOT voting members. The list below includes the most frequently used SMEs but is not an all-inclusive list. **

Regulatory (All applicable Markets/Lines of business)
Audit & Recovery (Claims)
Clinical Utilization Analytics
Legal
Member Benefits
Provider Operations (Health Partner Reps)
Consumer Experience
Policy Writers
President, Market
Medical Director
Senior Manager, Product Lifecycle and Operations

DOCUMENT REVISION HISTORY:

DATE	DESCRIPTION OF CHANGE	AUTHOR
9/1/2023	UPDATED VOTING MEMBERS	DR. HAMILTON, S DALTON, J SCHEIDWEILER
3/1/2023	UPDATED VOTING MEMBERS	DR. M GREGG, S DALTON, J SCHEIDWEILER
01/05/2023	UPDATED VOTING MEMBERS	J SCHEIDWEILER
12/20/2022	UPDATED VOTING MEMBERS	J SCHEIDWEILER
9/14/2022	UPDATED VOTING MEMBERS	J SCHEIDWEILER
8/11/2022	UPDATED VOTING MEMBERS, FORMATTING	S. DALTON, J. SCHEIDWEILER
3/30/2022	UPDATE VOTING MEMBERS AND QUORUM REQUIREMENTS	DR. M GREGG, S. DALTON, J SCHEIDWEILER
03/15/2021	UPDATE VOTING MEMBERS	DR. M GREGG, S. DALTON, A. GROSZKO
01/20/2021	UPDATE DESCRIPTION OF CLINICAL POLICY GOVERNANCE OVERSIGHT AND VOTING MEMBERS	DR. M GREGG, S. DALTON, A. GROSZKO
08/03/2020	REMOVED NAMES OF CHAIRPERSONS. UPDATED NAMES OF AUTHORS. UPDATED LANGUAGE OF SCOPE. UPDATED FORMAT.	DR. M GREGG, S. DALTON, A. GROSZKO
12/2019	REMOVED NAMES FROM VOTING MEMBERS TABLE AND RESTRUCTURED FORMAT	A. COLLINS, A. MCADAMS
09/2019	REVISION OF CHARTER – ADDED VOTING OUTCOMES SECTION AND UPDATED THE VOTING MEMBERS	Q. KLINE, A. COLLINS, M. GREGG, AND A. MCADAMS
06/2019	REVISION OF VOTING MEMBERS AND DOCUMENT FORMAT	Q. KLINE, A. COLLINS, A. MCADAMS
04/2019	REVISION OF CHARTER	Q. KLINE, A. COLLINS, A. MCADAMS
08/2018	ADD BEHAVIORAL HEALTH VOTING MEMBERS	S. LUCHT
05/2018	REVISION OF CHARTER	S. LUCHT
12/2017	CHARTER REVISION TO INCLUDE TWICE A MONTH MEETING FREQUENCY; OUT OF SCOPE 'ADDED VALUE;' TITLE CHANGES TO VOTING AND ALTERNATE VOTING MEMBERS	S. LUCHT
12/2016	CHARTER REVISION TO INCLUDE MATERNAL HEALTH; CHANGE OF PAYMENT POLICY WRITER TO REIMBURSEMENT POLICY WRITER	S. LUCHT
12/2015	CHARTER REVISION TO INCLUDE PRIMARY AND ALTERNATE VOTING MEMBERS	S. LUCHT
12/2014	CHARTER REVISION TO INCLUDE PHARMACY FOR UNIVERSAL CHARTER	S. LUCHT
10/2014	CHARTER REVISION TO REPORTING STRUCTURE AND VOTING/NON-VOTING MEMBERSHIP	S. LUCHT
03/2014	USE OF NEW TEMPLATE	S. LUCHT

CHARTER AUTHOR(S):

Dr. Glenn Hamilton
 Susan Dalton
 Jessica Scheidweiler

APPENDIX:

VOTING MEMBERSHIP AS OF FEBRUARY 2023		
Role	Voting Member	Delegate
Chair		
VP, Clinical Policy	Dr. Glenn Hamilton	Dr. Christina Weston
Co-Chair		
VP, Medical Services – Behavioral Health	Dr. Christina Weston	Dr. Rachel Cash
SVP, Executive Medical Director	Dr. Gisele Goff	Dr. Hamilton
Clinical Operations Market Leaders	Ariel Esteves Betsy Tener Claire Rodehaver Jennifer Cagiano Sherry Spehr	Angela Mutko Dr. Cameual Wright Timia DelPrete-Brown Dr. Michael Wilson Dr. Lawrence Griffin
Market Medical Directors	Dr. Seema Csukas (GA) Dr. Larry Griffin (KY/WV/NC) Dr. Cameual Wright (IN) Dr. Michael Wilson (AR) Dr. Jerome Chelliah (OH)	Dr. Minh Nguyen Sherry Spehr Betsy Tener Jennifer Cagiano Claire Rodehaver
VP, Configuration	Satendra Shukla	Delegate needed
SVP, Clinical Operations	Lisa Lagana	Amy Cleveland
AVP, Benefits Coding & Support	Sue Palcis	Laura Pittman
Utilization Management	Deronda Honig Rachel Green Charity O'Connor Rebecca DePaulitte	Amanda Christensen Heather Hunter/Susan Angelo Lee Smith/Andrea Cessna Deronda Honig
Director, Grievance and Appeals	Celeste Acuna	Kelly Winters
Director, Payment Integrity	Norman Reid	Stephanie Deaton/ Lereca Venable
Director, Pharmacy	Kelani Condon	Andrea Enterline
Enterprise Dental Medical Director	Dr. Clarence Thomas	Dr. Daniel Jolly
Enterprise Medical Directors	Dr. Christopher Johnson Dr. David Choi Dr. Paul Rubinton	Dr. Paul Rubinton Dr. David Choi
Medical Director	Dr. Jada Armstrong Dr. Melissa Skibo	Dr. Melissa Skibo Dr. Jada Armstrong
Program Integrity	Karen Smiley	Brandy Artz
Clinical Appeals	Dr. Cathryn Caton Dr. Michael Adolph	Dr. David Koehler
Medical Director – Behavioral Health	Dr. Rachel Cash	Dr. Christina Weston
Manager, Product Management Marketplace	Phoung Nguyen	Lori Frazier

Evidentiary Standards for Factors

APPLIED BEHAVIOR ANALYSIS	2
BREAST CANCER INDEX® (BCI) FOR MANAGING BREAST CANCER TREATMENT	3
BREAST RECONSTRUCTION SURGERY.....	3
BREAST REDUCTION	4
EPIDURAL STEROID INJECTIONS.....	4
FACET JOINT INTERVENTIONS.....	5
FRACTION FLOW RESERVE FOR COMPUTER TOMOGRAPHY (FFRCT)	5
GENDER DYSPHORIA SERVICES (GENDER AFFIRMING SURGERY)	6
GENETIC TESTING AND COUNSELING.....	7
HYPERTHERMIC INTRAPERITONEAL CHEMOTHERAPY	8
HYPOGLOSSAL NERVE STIMULATION FOR THE TREATMENT OF OBSTRUCTIVE SLEEP APNEA.....	8
INHALED NITRIC OXIDE	8
INSULIN INFUSION PUMP	9
INTRAOSSEOUS BASIVERTEBRAL NERVE ABLATION	10
MECHANICAL STRETCHING DEVICES	10
MYOELETRIC LOWER EXTREMITY PROSTHETIC TECHNOLOGY	10
NEGATIVE PRESSURE WOUND THERAPY	11
NEONATAL DISCHARGE CRITERIA.....	11
NON-EMERGENCY FACILITY TO FACILITY TRANSFERS	11
NUTRITIONAL FOODS, FORMULA, SUPPLEMENTS	11
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PERIPHERAL NERVE BLOCKS FOR TREATMENT OF PAIN.....	12
PERIPHERAL NERVE STIMULATORS FOR TREATMENT OF PAIN	12
PERORAL ENDOSCOPIC MYOTOMY (POEM)	13
PERSONAL EMERGENCY RESPONSE SYSTEMS.....	13
POSITIVE AIRWAY PRESSURE DEVICES FOR PULMONARY DISORDERS.....	13
PROACT ADJUSTABLE CONTINENCE THERAPY	13
RADIOFREQUENCY AND MICROWAVE ABLATION OF TUMORS.....	14

RESIDENTIAL TREATMENT SERVICES	14
SACROILIAC JOINT PROCEDURES.....	14
SUD OPIOID TREATMENT PROGRAMS.....	14
STANDING FRAMES	15
TRANSCRANIAL MAGNETIC STIMULATION	15
TMJ AND RELATED SERVICES	16
TRIGGER POINT INJECTIONS	16

***Reference is uploaded onto SP site in Documents folder.**

****Any reference containing a doi can be pulled from Google Scholar. Copy/paste doi into search engine.**

Applied Behavior Analysis

Clinical Safety/Efficacy

1. MCG Health 27th ed. Clinical Guideline: B-806-T. **p. 2-3.**
 - a. Comprehensive ABA - duration, intensity: most -guidelines and evidence reviews suggest at least 15 hours per week over 1 to 4 years, depending on the scope of the intervention (comprehensive or focused) and the child's response to treatment. Systematic reviews and meta-analyses of studies of early intervention ABA found a mean treatment intensity range of 12 to 45 hours per week, and treatment duration ranged from 4 to 48 months.
 - b. Focused ABA - duration, intensity: recommends these services be provided for up to 8 hours of treatment per month, and indicates that for patients with the most severe symptoms (eg, severe aggressive behavior that poses a risk of harm to self or others), an additional 8 hours per month may be indicated; focused ABA should be provided for 6 months, with a recommendation that a longer duration of therapy should be considered only if there has been meaningful progress toward treatment goals, or if new problem behaviors have developed during the initial course of treatment
2. American Academy of Pediatrics- Autism Initiatives
 - The Council on Children with Disabilities Autism Subcommittee provides evidence-based guidance specific to caring for children and youth with autism spectrum disorder (ASD) and facilitates the translation of same into education, practice, policy and advocacy for pediatricians, caregivers, and the public. www.aap.org
3. American Psychiatric Association – website provides links for new research for treatment, individualized treatments and specific deficits for treatment efficacy
4. ****CMS** - Shaw KA, Bilder DA, McArthur D, et al. Early identification of autism spectrum disorder among children aged 4 years — autism and developmental disabilities monitoring network, 11 sites, United States. MMWR Surveill Summ 2023;72(No. SS-1):1–15/**4**. doi:10.15585/mmwr.ss7201a1
5. Weissman L. Autism spectrum disorders in children and adolescents: behavioral and educational interventions. ***UpToDate. p. 6-8.** Updated April 27, 2022. www.uptodate.com; Includes links to society guidelines:

- American Academy of Pediatrics (3)
- American Academy of Neurology
- American College of Medical Genetics and Genomics
- Centers for Disease Control and Prevention
 - Autism Case Training-Classroom Based Curriculum
 - Screening and Diagnosis for Healthcare Providers
 - Guidelines and Recommendations
 - Research
- US Preventive Services Task Force

State Regs

GEORGIA

GA CODE ANN. §§

- 33-24-59.10. Coverage for Autism.
- 37-2-1. Declaration of Purpose.

Breast Cancer Index® (BCI) for Managing Breast Cancer Treatment

Clinical Safety/Efficacy

- LCD -MoIDX: Breast Cancer Index (BCI) Gene Expression Test. Medicaid Coverage Database; 2019. LCD ID L37913. Revised February 23, 2023. **p. 4-5.**
- Molecular Test Assessment: Breast Cancer Index (BioTheragnostics Inc.) for Lymph Node-Negative Patients. Hayes; 2020. **p. 3, 6, 13-14.**
- Molecular Test Assessment: Breast Cancer Index (BioTheragnostics Inc.) for Lymph Node-Positive (1-3) Patients. Hayes; 2020. **p. 5-6, 12-13.**

Breast Reconstruction Surgery

Clinical Safety/Efficacy

- Lee BT, Agarwak JP, Ascherman JA, et al. Evidence-based clinical practice guideline: autologous breast reconstruction with DIEP or Pedicled TRAM abdominal flaps. *Plastic Reconstr Surg.* 2017;140(5):651e-664e/**662e**. doi:10.1097/PRS.0000000000003768
- National Comprehensive Cancer Network (NCCN). NCCN® practice guidelines in oncology. Breast Cancer. Version 4.2022
- *Performance and Practice Guidelines for Breast-Conserving Surgery/Partial Mastectomy.* The American Society of Breast Surgeons; 2018.
- *Performance and Practice Guidelines for Mastectomy.* The American Society of Breast Surgeons; 2018.
- Sabel MS. Breast-conserving therapy. UpToDate. **p. 2-9.** Updated September 11, 2023. www.uptodate.com
- Nahabedian M. Overview of breast reconstruction. UpToDate. **p. 7-13.** Updated May 24, 2023. Includes copies of Society Guidelines
 1. International multidisciplinary expert panel consensus on breast reconstruction and radiotherapy (2019)
 2. Enhanced Recovery After Surgery (ERAS) Society: Recommendations from consensus review of optimal perioperative care in breast reconstruction (2017)
 3. American Society of Breast Surgeons (ASBrS): Official statements
 4. American Society of Breast Surgeons (ASBrS): Timeliness of Care

Duration of Service

- Nahabedian M. Overview of breast reconstruction. UpToDate. **p. 25-26**. Updated May 24, 2023.

Regulatory

- Required Coverage for Reconstructive Surgery Following Mastectomies, 29 U.S.C. § 1185(b) (2023).

Breast Reduction

Clinical Safety/Efficacy

- American Society of Plastic Surgeons evidence-based clinical practice guideline revision: reduction mammoplasty. *Plastic Reconstr Surg*. 2022;149(3):**392e-409e/395e-397e**. doi:10.1097/PRS.00000000000008860
- MCG Care Guidelines for Reduction Mammoplasty: A-0274. MCG Health. 26th ed. 2022.
- Braunstein GD, Anawalt BD. Management of gynecomastia. UpToDate. Updated May 10, 2021. **p. 2-3,6**. www.uptodate.com
- Hansen J, Chang S. Overview of breast reduction. UpToDate. **p. 2-5**. Updated April 19, 2023. www.uptodate.com

Duration of Service

- American Society of Plastic Surgeons evidence-based clinical practice guideline revision: reduction mammoplasty. *Plastic Reconstr Surg*. 2022;149(3):**392e-409e/396e-97e**. doi:10.1097/PRS.00000000000008860
- Braunstein GD, Anawalt BD. Management of gynecomastia. UpToDate. Updated May 10, 2021. **p. 3**. www.uptodate.com
- Hansen J, Chang S. Overview of breast reduction. UpToDate. **p. 9**. Updated April 19, 2023. www.uptodate.com

Regulatory

- Required Coverage for Reconstructive Surgery Following Mastectomies, 29 U.S.C. § 1185(b) (2023).

Epidural Steroid Injections

Clinical Safety/Efficacy

- Chou R. Subacute and chronic low back pain: nonsurgical interventional treatment. UpToDate. **p.4-5**. Updated June 10, 2021.
The best evidence for benefit comes from trials for patients with radiculopathy due to a herniated disc, which demonstrate short-term, but not long-term, benefit.
 - Includes copies of Society Guidelines
 - American Society of Regional Anesthesia and Pain Medicine (ASRA), European Society of Regional Anaesthesia and Pain Therapy (ESRA), American Academy of Pain Medicine (AAPM), International Neuromodulation Society (INS), North American Neuromodulation Society (NANS), and World Institute of Pain (WIP): Guidelines on interventional spine and pain procedures in patients on antiplatelet and anticoagulant medications, 2nd edition (2018).
 - North American Spine Society (NASS): Guidelines
 - American College of Radiology (ACR): ACR Appropriateness Criteria on inflammatory back pain – Known or suspected axial spondyloarthritis (2021)

- ACR: ACR Appropriateness Criteria on low back pain (2021)
- American Physical Therapy Association (APTA): Clinical practice guidelines for interventions for the management of acute and chronic low back pain, revision (2021)
- Helm S, Harmon PC, Noe C, et al. Transforaminal epidural steroid injections: a systematic review and meta-analysis of efficacy and safety. *Pain Phys*. 2021;24:S209-S232/**s216-227**.
- Manchikanti L, Knezevic NN, Navani A, et al. Epidural Interventions in the management of chronic spinal pain: American Society of Interventional Pain Physicians (ASIPP) comprehensive evidence-based guidelines. *Pain Physician*. 2021 Jan;24(S1):S27-S208/**s156-161**.
- Chou R, Hashimoto R, Friedly J, et al. Epidural Corticosteroid Injections for Radiculopathy and Spinal stenosis: a systematic review and meta-analysis. *Ann Int Med*. 2015;163(5):373-381/**375-378**. doi:10.7326/M15-0934

Duration of Service

- Chou R. Subacute and chronic low back pain: nonsurgical interventional treatment. UpToDate. **p.5**. Updated June 10, 2021.
- Helm S, Harmon PC, Noe C, et al. Transforaminal epidural steroid injections: a systematic review and meta-analysis of efficacy and safety. *Pain Phys*. 2021;24:S209-S232/**s216-227**.
- Manchikanti L, Knezevic NN, Navani A, et al. Epidural Interventions in the management of chronic spinal pain: American Society of Interventional Pain Physicians (ASIPP) comprehensive evidence-based guidelines. *Pain Physician*. 2021 Jan;24(S1):S27-S208/**s162**.

Facet Joint Interventions

Clinical Safety/Efficacy

- Hurley RW, Adams MCB, Barad M, et al. Consensus practice guidelines on interventions for cervical spine (facet) joint pain from a multispecialty international working group. *Reg Anesth Pain Med*. 2022;47(1):3-59/**8-10,13-14,24**. doi:10.1136/rapm-2021-103031
- Le DT, Alem N. *Facet Joint Injection*. In: StatPearls. StatPearls Publishing; 2022:2,4.
- Manchikanti L, Kaye AD, Soin A, et al. Comprehensive evidence-based guidelines for facet joint interventions in the management of chronic spinal pain: American Society of Interventional Pain Physicians (ASIPP) guidelines facet joint interventions 2020 guidelines. *Pain Physician*. 2020;23(3S):S1-S127/**s18-20,s26,s50,s93-94,s101**.

Duration of Service

Manchikanti L, Kaye AD, Soin A, et al. Comprehensive evidence-based guidelines for facet joint interventions in the management of chronic spinal pain: American Society of Interventional Pain Physicians (ASIPP) guidelines facet joint interventions 2020 guidelines. *Pain Physician*. 2020;23(3S):S1-S127/**s102**.

Fraction Flow Reserve for Computer Tomography (FFRct)

Clinical Safety/Efficacy

- Nours F, Budde RPJ, Fairbairn TA, et al. Temporal changes in FFRct guided management of coronary artery disease - lessons from the ADVANCE Registry. *J Cardio CT*. 2021;15:48-55,**51-52**. doi:10.1016/j.jcct.2020.04.011
- Health Technology Assessment: Noninvasive Computer Fractional Flow Reserve from Computed Tomography (FFRCT) for Diagnosis of Coronary Artery Disease. Hayes Inc; 2020:**5,14**.

Duration of Care

- Health Technology Assessment: Noninvasive Computer Fractional Flow Reserve from Computed Tomography (FFRCT) for Diagnosis of Coronary Artery Disease. Hayes Inc; 2020:**58**.

Cost

- Health Technology Assessment: Noninvasive Computer Fractional Flow Reserve from Computed Tomography (FFRCT) for Diagnosis of Coronary Artery Disease. Hayes Inc; 2020:**58**.

Gender Dysphoria Services (Gender Affirming Surgery)

Cost

- *Report: Sex Reassignment Surgery for the Treatment of Gender Dysphoria*. Hayes Inc; 2018:**112**. Updated July 27, 2022.

Clinical Safety/Efficacy;

- *MCG Health 27th ed. Clinical Guidelines: GG-FMMF; policy – only 18 and over
- American Society of Addiction Medicine
- American Psychological Association. Guidelines for psychological practice with transgender and gender nonconforming people. *Amer Psych*. 2015;70(9): 832-864.
- American Academy of Child & Adolescent Psychiatry
- *World Professional Association for Transgender Health. (8th Edition 2022). Standards of care for the health of transsexual, transgender and gender nonconforming people.
- UpToDate:
 1. *Transgender surgery: female to male; updated January 24, 2023; includes link for guidelines from the following:
 - Society for Adolescent Health and Medicine
 - American Academy of Pediatrics
 - American College of Obstetrician and Gynecologists
 - Endocrine Society (ES) and Pediatric Endocrine Society (PES)
 - Pediatric Endocrine Society
 - American College of Physicians
 - American Geriatrics Society
 - American Psychological Association
 - American Society for Reproductive Medicine
 2. *Transgender surgery: male to female; updated January 24, 2023; includes links for guidelines from above (female to male)
- *Report: Sex Reassignment Surgery for the Treatment of Gender Dysphoria*. Hayes Inc; 2018:**18-19, 110-111, 114-118**. Updated July 27, 2022. Includes position statements from the following:
 - The Endocrine Society
 - American Academy of Child and Adolescent Psychiatry (AACAP)
 - American College of Obstetricians and Gynecologists (ACOG)
 - American College of Pediatricians
 - American Psychiatric Association
 - American Psychological Association
 - World Professional Association for Transgender Health (WPATH)
 - Society for Adolescent Health and Medicine

Duration of Service

- *MCG Health 27th ed. Clinical Guidelines: GG-FMMF; policy – only 18 and over

- *Report: Sex Reassignment Surgery for the Treatment of Gender Dysphoria*. Hayes Inc; 2018:**110**. Updated July 27, 2022.

State Law Regarding Clinical Safety & Efficacy:

GA

- Prohibition on certain therapies and procedures for treatment of gender dysphoria in minors; regulations; exceptions; accountability, GA CODE ANN.§ 43-34-15.
- Treatment of minors for gender dysphoria; penalty for violations, GA CODE ANN. § 31-7-3.5.

Genetic Testing and Counseling

Cost

Kohlmann W, Slavotinek A. Genetic testing. UpToDate. Updated October 7, 2022. p. **15,24-25**

Clinical Safety and/or Efficacy

- *MCG, 26th ed – multiple guidelines for genetic medicine and genetic counseling. Uploaded pdf with screenshot of first pages in MCG. Policy is specific that MCG criteria will be followed for particular occurrence.
- National Center for Biotechnology Information (NCBI). Genetic Testing Registry (GTR) National Library of Medicine. The GTR provides a central location for voluntary submission of genetic test information by providers. The scope includes the test's purpose, methodology, validity, evidence of the test's usefulness, and laboratory contacts and credentials. The overarching goal of the GTR is to advance the public health and research into the genetic basis of health and disease.
- National Human Genome Research Institute. (2019 August 15). Coverage and Reimbursement of Genetic Tests. National Institutes of Health. Provides information on reports created by policy and scientific experts seeking to advise Federal agencies on how to reimburse for genetic tests, including the following:
 - Coverage and Reimbursement of Genetic Tests and Services (HHS Secretary's Advisory Committee on Genetics, Health, and Society)
 - An Evidence Framework for Genetic Testing (National Academies of Sciences, Engineering, and Medicine)
 - Federal law, Genetic Information Nondiscrimination Act (GINA)
 - NHGRI's Genome Statute and Legislation Database to search for laws state-by-state.
- UpToDate:
 - *Kohlmann W, Slavotinek A. Genetic testing. UpToDate. Updated October 7, 2022. p. **16,23**.
 - *Raby B, Kohlmann W. Genetic counseling: family history interpretation and risk assessment. UpToDate. January 31, 2022. p. **3,8,15-18**. Provides online tools for resources for location of counselors, etc, including:
 - The National Society of Genetic Counselors (NSGC has a locator tool for counselors according to geographical location and area of specialization.
 - The American College of Medical Genetics and Genomics (ACMG) has a searchable database for clinics that provide genetic counseling.
 - The National Cancer Institute (NCI) has a searchable directory for counselors with expertise in cancer syndromes.
 - The March of Dimes will provide information about services through contact with its local chapters.
 - Genomic Medicine Service (GMS) is available through many of the Veteran's Administration medical centers and provides genetic evaluation primarily by telehealth for individuals.

Federal/State Regs

- National Human Genome Research Institute. Regulation of Genetic Tests. National Institutes of Health. Updated February 2, 2022.

Hyperthermic Intraperitoneal Chemotherapy

Clinical Safety/Efficacy

- Auer RC, Sivajohanathan D, Biagi J, et al. Indications for hyperthermic intraperitoneal chemotherapy with cytoreductive surgery: a clinical practice guideline. *Curr Oncol*. 2020;27(3):146-154. doi:10.3747/co.27.6033. **p. 149-152.**
- Yap DRY, Wong JSM, Tan QX, et al. Effect of HIPEC on peritoneal recurrence in peritoneal metastasis treated with cytoreductive surgery: a systematic review. *Front Oncol*. 2021;11:1-12. doi:10.3389/fonc.2021.795390. **p. 2, 8-10.**
- Health Technology Assessment: Hyperthermic Intraperitoneal Chemotherapy for Peritoneal Carcinomatosis Resulting from Ovarian Cancer. Hayes; 2019. **p 2-4, 9, 11, 47.**
- Health Technology Assessment: Hyperthermic Intraperitoneal Chemotherapy for Peritoneal Carcinomatosis Resulting from Peritoneal Mesothelioma. Hayes; 2019. **p 2-3, 9, 44, 46**
- Health Technology Assessment: Hyperthermic Intraperitoneal Chemotherapy for Sarcoma with Peritoneal Involvement. Hayes; 2019. **p 2-3.**
- Aziz MB, Napoli RD. *Hyperthermic Intraperitoneal Chemotherapy*. Stat Pearls Publishing; 2023. **p. 1-4, 7.**

Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea

Clinical Safety/Efficacy

- American Academy of Otolaryngology-Head and Neck Surgery. Position Statement: Hypoglossal Nerve Stimulation for Treatment of Obstructive Sleep Apnea (OSA). (2021 April 22). <https://www.entnet.org/>
- L38307: *Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea*. US Centers for Medicare and Medicaid Services. April 1, 2020. Revised March 2, 2023. **p. 4-5.** www.cms.gov
- Tietjens JR, Claman D, Kezirian EJ, et al. Obstructive sleep apnea in cardiovascular disease: a review of the literature and proposed multidisciplinary clinical management strategy. *J Am Heart Assoc*. 2019;8(1). **p. 5.** doi:10.1161/JAHA.118.010440.

Inhaled Nitric Oxide

Clinical Safety/Efficacy

- UpToDate:
 1. Stark, A, Eichenwalk E. Bronchopulmonary Dysplasia (BPD): prevention. UpToDate. Updated October 28, 2022. **p. 5.** Contains guideline links for the following:
 - American Thoracic Society
 - American Academy of Pediatrics
 - American Heart Association and ATS
 - National Institutes of Health
 2. Hendrick H, Adzick S. Congenital diaphragmatic hernia in the neonate. UpToDate. Updated July 19, 2023. **p. 5.** Contains guideline links for the following:
 - American College of Radiology

- American Society of Hematology
- Pediatric Pulmonary Hypertension Network
- Pediatric Cardiac Intensive Care Society
- American Heart Association (AHA)/American Thoracic Society (ATS)
- American Thoracic Society
- Canadian Congenital Diaphragmatic Hernia Collaborative; Puligandla P, Skarsgard E, et al. Diagnosis and management of congenital diaphragmatic hernia: a clinical practice guideline. *CMAJ*. 2018;190(4):E103-E112/**e108**. doi:10.1503/cmaj.170206
- Karam O, Gebistorf F, Wetterslev J, et al. The effect of inhaled nitric oxide in acute respiratory distress syndrome in children and adults: a Cochrane Systematic Review with trial sequential analysis. *Anaesthesia*. 2017;72(1):106-117. **p.106** doi:10.1111/anae.13628
- Kumar P, Committee on Fetus and Newborn. Clinical report: use of inhaled nitric oxide in preterm infants. *Am Acad Pediatr*. 2014;133(1):164-170/**168**. doi:10.1542/peds.2013-3444
- Tal A, Greenberg D, Av-Gay Y, et al. Nitric oxide inhalations in bronchiolitis: a pilot, randomized, double-blinded, controlled trial. *Pediatr Pulmonol*. 2018;53(1):95-102. doi:10.1002/ppul.23905

Insulin Infusion Pump

Clinical Safety/Efficacy

- American Diabetes Association Professional Practice Committee. Pharmacologic approaches to glycemic treatment: standards of medical care in diabetes-2022. *Diabetes Care*. 2022;45(Suppl 1):s125-143/**s126**. doi:10.2337/dc22-S009
- Handelsman Y, Bloomgarden ZT, Grunberger G, et al. American Association of Clinical Endocrinologists and American College of Endocrinology - clinical practice guidelines for developing a diabetes mellitus comprehensive care plan - 2015. *Endocr Pract*. 2015;21(Suppl 1):1-87/**14,22**. doi:10.4158/EP15672.GL
- Levitsky L, Misra M. Overview of the management of type 1 diabetes mellitus in children and adolescents. UpToDate. Updated January 5, 2023. www.uptodate.com
Contains guidelines from the following:
 - Endocrine Society (ES): Clinical practice guideline for the management of individuals with diabetes at high risk for hypoglycemia (2022)
 - International Society for Pediatric and Adolescent (ISPAD): Clinical practice consensus guidelines (2022): Assessment and management of hypoglycemia in children and adolescents with diabetes
 - Kidney Disease: Improving Global Outcomes (KDIGO): Clinical practice guideline for diabetes management in chronic kidney disease (2022)
 - American Diabetes Association (ADA): Standards of care in diabetes (2023)
 - AACE/ACE: Consensus statement on insulin pump management (2014)
- Levitsky L, Misra M. Insulin therapy for children and adolescents with type 1 diabetes mellitus. UpToDate. Updated October 10, 2022. **p. 13-17, 20**. Accessed March 21, 2023. www.uptodate.com
- Weinstock RS. Management of blood glucose in adults with type 1 diabetes mellitus. UpToDate. Updated January 10, 2023. **p. 8-10,15**. Accessed March 21, 2023. www.uptodate.com
Contains guidelines from the following:

- World Health Organization (WHO): Guidelines on second-and third-line medicines and type of insulin for the control of blood glucose levels in non-pregnant adults with diabetes mellitus (2018)
- ES: Clinical practice guideline on diabetes technology – Continuous subcutaneous insulin infusion therapy and continuous glucose monitoring in adults (2016)
- IDF: Global guideline for type 2 diabetes (2012)
- American Diabetes Association (ADA): Standards of care in diabetes (2023)
- ADA and EASD: A consensus report on the management of type 1 diabetes in adults (2021)
- American Association of Clinical Endocrinologists (AACE): Clinical practice guideline – The use of advanced technology in management of persons with diabetes mellitus (2021)
- EASD and ADA: Joint statement on insulin pump risks and benefits – A clinical appraisal of pump safety standards, adverse event reporting, and research needs (2015)
- Wexler DJ. Overview of general medical care in nonpregnant adults with diabetes mellitus. Updated February 2, 2023. UpToDate. Accessed March 21, 2023. uptodate.com

Intraosseus Basivertebral Nerve Ablation

Clinical Safety/Efficacy

- Evolving evidence review: Intraosseus Nerve Ablation System (Relevant Medsystems Inc.) for treatment of adults with low back pain. Hayes, Inc; 2022. Updated June 23, 2023. **p. 30-33**
- Lorio M, Clerk-Lamallice O, Beall DP, et al. International Society for the Advancement of Spine Surgery Guideline-intraosseous ablation of the basivertebral nerve for the relief of chronic low back pain. *Int J Spine Surg*. 2020;14(1):18-25/**20,22-23**. doi:10.14444/7002
- North American Spine Society. *Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis and Treatment of Low Back Pain*. 2020. **p. 161,**
- US Food and Drug Administration, 510(k) approval.

Mechanical Stretching Devices

Clinical Safety/Efficacy

- Harvey LA, Katalinic OM, Herbert RD, et al. Stretch for the treatment and prevention of contractures (review). *Cochrane Datab System Rev*. 2017;1:1-167. doi:10.1002/14651858.CD007455.pub3. p. 2-3, 34.
- Mechanical Stretching Devices for Treatment of Joint Contractures of the Extremities. Hayes; 2018. p 7-8.
- Dynamic Joint Extension and Flexion Devices: A-0882. MCG Health. 27th ed. 2023. p. 1-3.

Myoelectric Lower Extremity Prosthetic Technology

Clinical Safety/Efficacy

- *Local Coverage Determination: Lower Limb Prostheses*. US Centers for Medicare and Medicaid Services. LCD ID L33787. October 1, 2015. Revised January 1, 2020. **p. 5-6** www.cms.gov
- *Health Technology Assessment: Lower Limb Prosthetic Workgroup Consensus Document*. Centers for Medicare & Medicaid Services; 2017:**10-11,16**.

Negative Pressure Wound Therapy

Clinical Safety/Efficacy

- Bobkiewicz A, Studniarek A, Drews M, Banasiewicz, T. Negative pressure wound therapy with instillation (NPWTi): Current status, recommendations and perspectives in the context of modern wound therapy. *Negative Pressure Wound Ther J*. 2016;3(1):S2-S19/1.
- Gestring M. Negative pressure wound therapy. UpToDate. Updated November 16, 2022. **p.5-7**. www.uptodate.com
- Webster J, Liu Z, Norman G, et al. Negative pressure wound therapy for surgical wounds healing by primary closure. *Cochran Database Syst Rev* 2022;4:CD009261. **p. 2-3**. doi:10.1002/14651858.CD009261.pub7

Duration of Service

Gestring M. Negative pressure wound therapy. UpToDate. Updated November 16, 2022. **p.2**. www.uptodate.com

Neonatal Discharge Criteria

Clinical Safety/Efficacy

- Jeffries AL; Canadian Paediatric Society, Fetus and Newborn Committee. Going home: facilitating discharge of the preterm infant. *Paediatr Child Health*. 2014;19(1):31-34. **p. 31-33**.
- Policy statement: hospital discharge of the high-risk neonate. *Am Acad Pediatr*. 2008; 122(5):1119-1125. **p. 1123**.
- Smith VC, Stewart J. Discharge planning for high-risk newborns. UpToDate. Updated April 10, 2023. **p. 2-7, 17-18**.

Non-Emergency Facility to Facility Transfers

Clinical Safety/Efficacy

- American College of Emergency Physicians. Appropriate Interfacility Patient Transfer. Revised January 2022. **p. 2**.
- Discharges and Transfers, 42 C.F.R. § 412.4 (2022).
 - (b) Acute care transfers.
- Heaton J, Kohn MD. *EMS Inter-Facility Transport*. StatPearls Publishing; 2023. p 2-3.
- Kulshrestha A, Singh J. Inter-hospital and intra-hospital patient transfer: recent concepts. *Indian J Anaesth*. 2016;60:451-457. **p. 451-52**.

Nutritional Foods, Formula, Supplements

Nutritional Supplements

Clinical Safety/Efficacy

- **Cederholm T, et al. ESPEN guidelines on definitions and terminology of clinical nutrition. *Clin Nutr*. 2017;36(1):49-64. Doi:10.1016/j.clnu.2016.09.004
- Dipasquale V, Ventimiglia M, Gramaglia SMC, et al. Health-related quality of life and home enteral nutrition in children with neurological impairment: report from a multicenter survey. *Nutrients*. 2019;11(12):2968.
- Druyan ME, Compher C, Boullata JI, et al. Clinical Guidelines for the Use of Parenteral and Enteral Nutrition in Adult and Pediatric Patients: applying the GRADE system to development of A.S.P.E.N. clinical guidelines. *J Parenter Enteral Nutr*. 2012;36(1):77-80.

- Marchand V, Motil KJ. NASPGHAN Committee on Nutrition. Nutrition support for neurologically impaired children: a clinical report of the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition. *J Pediatr Gastroenterol Nutr.* 2006;43(1):123-135. doi:10.1097/01.mpg.0000228124.93841.ea
- Wanden-Berghe C, et al. Complications associated with enteral nutrition: CAFANE study. *Nutrients.* 2019;11(9):2041. doi:10.3390/nu11092041

Duration of Service

- Cederholm T, et al. ESPEN guidelines on definitions and terminology of clinical nutrition. *Clin Nutr.* 2017;36(1):49-64/**56-60**. Doi:10.1016/j.clnu.2016.09.004
- Marchand V, Motil KJ. NASPGHAN Committee on Nutrition. Nutrition support for neurologically impaired children: a clinical report of the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition. *J Pediatr Gastroenterol Nutr.* 2006;43(1):123-135/**130**.
- Wanden-Berghe C, et al. Complications associated with enteral nutrition: CAFANE study. *Nutrients.* 2019;11(9):2041/**6-10**. doi:10.3390/nu11092041

Partial Hospitalization

Partial Hospitalization - Mental Health & SUD Administrative Policies, MP Only

Duration of Care

- Partial Hospital Behavioral Health Level of Care: B-901-PHP, B-902-PHP. MCG Health. 27th ed. www.careweb.careguidelines.com
- Mee-Lee D, Shulman G, Fishman M, Gastfriend D, Miller, E. *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* 3rd ed. The Change Companies; 2013.

Peripheral Nerve Blocks for Treatment of Pain

Clinical Safety/Efficacy

- Ailani J, Burch RC, Robbins MS; American Headache Society. The American Headache Society consensus statement: update on integrating new migraine treatments into clinical practice. *Headache.* 2021;61(7):1021-1039. doi:10.1111/head.14153.
- Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC clinical practice guideline for prescribing opioids for pain. *MMWR Recomm Rep.* 2022;71(No. RR-3):1-95. doi:10.15585.mmwr.rr7103a1

Peripheral Nerve Stimulators for Treatment of Pain

Clinical Safety/Efficacy

- Health Technology Assessment: Percutaneous Peripheral Nerve Stimulation for Treatment of Chronic Pain. Hayes; 2022. **p. 4-5, 8, 10.**
- Evidence Analysis Research Brief: Peripheral Nerve Stimulation for Treatment of Chronic Pain. Hayes; 2021. **p. 4.**
- Evolving Evidence Review: SPRINT PNS System for Chronic Pain. Hayes; 2021. **p. 6, 8.**

Peroral Endoscopic Myotomy (POEM)

Clinical Safety/Efficacy

- Vaezi MF, Pandolfino JE, Yadlapati RH, Greer KB, Kavitt RT. ACG clinical guidelines: diagnosis and management of achalasia. *Am J Gastroenterol*. 2020;115(9):1393-1411. **p. 12-13.**
- Health Technology Assessment: Peroral Endoscopic Myotomy for Treatment of Esophageal Achalasia. Hayes; 2019. **p. 3-7, 9, 11-14, 19-20, 55-57.**
- LCD: Peroral Endoscopic Myotomy. Medicare Coverage Database; 2021. LCD ID L38747. **p. 3, 9-10.**

Personal Emergency Response Systems

Clinical Safety/Efficacy

- Lachal F, Tchalla AE, Cardinaud N, et al. Effectiveness of light paths coupled with personal emergency response systems in preventing functional decline among the elderly. *SAGE Open Med*. 2016;4:1-8. **p. 2, 5-6.**
- The personal emergency response system as a technology innovation in primary health care services: an integrative review. *J Med Internet Res*. 2016;18(7):e187. **p. 2, 4, 6-7, 10, 12.**

Positive Airway Pressure Devices for Pulmonary Disorders

Clinical Safety/Efficacy

- Bi-level Positive Airway Pressure (BPAP) Device: A-0994 (AC). MCG Health. 25th ed. 2021. **p.1-3, 5.** www.careweb.careguidelines.com.
- Continuous Positive Airway Pressure (CPAP) Device: A-0431. MCG Health. 25th ed. 2021. **p. 1-2.** www.careweb.careguidelines.com
- Patil SP, Ayappa IA, Caples SM, et al. Treatment of adult obstructive sleep apnea with positive airway pressure: an American Academy of Sleep Medicine clinical practice guideline. *J Clin Sleep Med*. 2019;15(2):335-343. doi:10.5664/jcsm.7640

Duration of Service

- Patil SP, Ayappa IA, Caples SM, et al. Treatment of adult obstructive sleep apnea with positive airway pressure: an American Academy of Sleep Medicine clinical practice guideline. *J Clin Sleep Med*. 2019;15(2):335-343/**336-37**,. doi:10.5664/jcsm.7640

ProAct Adjustable Continence Therapy

Clinical Safety/Efficacy

- Angulo JC, Schonburg S, Giammo A, et al. Systematic review and meta-analysis comparing Adjustable Transobtrurator Male System (ATOMS) and Adjustable Continence Therapy (ProACT) for male stress incontinence. *PlosOne*. 2019;14(12):1-22,**5,16.** doi:10.1371/journal.pone.0225762
- Health Technology Assessment: ProACT Adjustable Continence Therapy (Uromedica) for Treatment of Post-Surgical Urinary Incontinence in Men. Hayes Inc; 2020:**4,11,14-15,19.**

Radiofrequency and Microwave Ablation of Tumors

Clinical Safety/Efficacy

- Genshaft SJ, Suh RD, Abtin F, et al. Society of Interventional Radiology quality improvement standards on percutaneous ablation of non-small cell lung cancer and metastatic disease to the lungs. *J Vasc Interv Radiol*. 2021;32:1242.e1-.e10/**e3,e6-7**. doi:10.1016/j.jvir.2021.04.027
- Radiofrequency Ablation of Tumor: A-0718 (AC). MCG Health. 26th ed. **p.1-2, 5-6**. www.careweb.guidelines.com
- Wang N, Xu J, Wang G, et al. Safety and efficacy of microwave ablation for lung cancer adjacent to the interlobar fissure. *Thorac Cancer*. 2022;13:2557-2565/**2563**. doi:10.1111/1759-7714.14589.

Residential Treatment Services

Residential Treatment Services: Mental Health & SUD - Administrative policies,

Clinical Safety/Efficacy

Residential behavior health level of care: 901,902,903,907. MCG Health. 27th ed.
www.careweb.careguidelines.com

Sacroiliac Joint Procedures

Clinical Safety/Efficacy

- Chou R, et al. Nonpharmacologic therapies for low back pain: a systematic review for an American College of Physicians Clinical Practice Guideline. *Ann Intern Med*. 2017;166(7):493-505. doi:10.7326/M16-2459
- Chou R. Subacute and chronic low back pain: nonsurgical interventional treatment. UpToDate. Updated June 10, 2021. **p. 9**. www.uptodate.com
Contains the following guidelines:
 - North American Spine Society (NASS): Guidelines
 - ACR: ACR Appropriateness Criteria on low back pain (2021)
 - American Physical Therapy Association (APTA): Clinical practice guidelines for interventions for the management of acute and chronic low back pain, revision (2021)
 - American Society of Interventional Pain Physicians (ASIPP): Comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain, update (2013)
- Manchikanti L, et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. *Pain Phys*. 2013 Apr;16(2 Suppl):S49-S283/**s59,132-141, s203**.

Duration of Care

- Manchikanti L, et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. *Pain Phys*. 2013 Apr;16(2 Suppl):S49-S283/**s203**.

SUD Opioid Treatment Programs

Opioid Use Disorder Medication Treatment Providers - Administrative Policy

Clinical Safety/Efficacy

- *The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update*. American Society of Addiction Medicine; 2020.

- National Institute on Drug Abuse. *Principles of Drug Addiction Treatment: A Research-Based Guide Opioid Addiction*. 3rd ed. National Institutes of Health; 2014. Updated 2018. www.nida.nih.gov
- Substance Abuse and Mental Health Services Administration. Certification of Opioid Treatment Programs (OTPs). (January 27, 2023). Retrieved February 27, 2023 from www.samhsa.gov.

Federal Regulations

- Medication Assisted Treatment for Opioid Use Disorders, 42 C.F.R. §§ 8.1-.655 (2023).
- Federal Opioid Treatment Standards, 42 C.F.R. § 8.12 (2023).

Standing Frames

Clinical Safety/Efficacy

- Activities of daily living. In: *StatPearls*. StatPearls Publishing; 2023;**1,4**. Updated June 26, 2023. www.ncbi.nlm.nih.gov.
- Standing Frame: A-0996. MCG Health. 26th ed. 2022.
- **Paleg G, Livingstone R. Systematic review and clinical recommendations for dosage of supported home-based standing programs for adults with stroke, spinal cord injury and other neurological conditions. *BMC Musculoskelet Disord*. 2015;16:358. p. **2,12-13**. doi:10.1186/s12891-015-0813-x
- **Paleg GS, Smith BA, Glickman LB. Systematic review and evidence-based clinical recommendations for dosing of pediatric supported standing programs. *Pediatr Phys Ther*. 2013;25(3):232-247/**242-244**. doi:10.1097/PEP.0b013e318299d5e7

Duration of Service

- Paleg G, Livingstone R. Systematic review and clinical recommendations for dosage of supported home-based standing programs for adults with stroke, spinal cord injury and other neurological conditions. *BMC Musculoskelet Disord*. 2015;16:358. p. **2,12-13**. doi:10.1186/s12891-015-0813-x
- Paleg GS, Smith BA, Glickman LB. Systematic review and evidence-based clinical recommendations for dosing of pediatric supported standing programs. *Pediatr Phys Ther*. 2013;25(3):232-247;**242-244**. doi:10.1097/PEP.0b013e318299d5e7

Regulatory

GEORGIA

Durable Medical Equipment, GA. COMP. R. & REGS. R. 560-12-2-.30 (2012).

Transcranial Magnetic Stimulation

Duration of Service

- Holtzheimer PE. Unipolar depression in adults: indications, efficacy, and safety of transcranial magnetic stimulation (TMS). UpToDate. p. **6-13**. Updated February 15, 2023. www.uptodate.com

Clinical Safety/Efficacy

- Holtzheimer PE. Unipolar major depression: Administering transcranial magnetic stimulation (TMS). UpToDate. p. **1-3**. Updated February 2, 2023. www.uptodate.com
 - Is better tolerated than ECT; does not require general anesthesia and induction of seizures.
 - **Indications for transcranial magnetic stimulation (TMS)** – Patients with unipolar major depression who do not respond to standard treatment with pharmacotherapy and psychotherapy are candidates for noninvasive neuromodulation procedures, including repetitive TMS
- Holtzheimer PE. Unipolar depression in adults: indications, efficacy, and safety of transcranial magnetic stimulation (TMS). UpToDate. Updated February 15, 2023. www.uptodate.com

- Use of repetitive TMS for treatment-resistant/refractory depression is consistent with treatment guidelines from the American Psychiatric Association, Canadian Network for Mood and Anxiety Treatments, British Association for Psychopharmacology, and the Royal Australian and New Zealand College of Psychiatrists.
- Based upon randomized trials, multiple reviews have consistently concluded that repetitive transcranial magnetic stimulation (TMS) can be efficacious and is generally safe for patients with treatment-resistant unipolar major depression. *Includes copies of Society Guidelines*
 - International Neuromodulation Society and North American Neuromodulation Society (INS-NANS): Expert consensus panel review and recommendation for transcranial magnetic stimulation for pain, headache, and comorbid depression (2020).
 - American Psychiatric Association (APA): Consensus recommendations for the clinical application of repetitive transcranial magnetic stimulation (rTMS) in the treatment of depression (2018)
- Transcranial Magnetic Stimulation (B-801-T). MCG Health; 2023. 27th Ed. www.careweb.careguidelines.com
- Perera T, George MS, Grammer G, Janicak PG, Pascual-Leone A, Wirecki TS. The Clinical TMS Society Consensus Review and Treatment Recommendations for TMS Therapy for Major Depressive Disorder. *Brain Stimul.* 2016;9(3):336-346. doi:10.1016/j.brs.2016.03.010

TMJ and Related Services

Temporomandibular Joint Disorder or Dysfunction (TMJD/TMD) Craniomandibular Jaw Disorder/Non-Surgical Treatment

Clinical Safety/Efficacy

- American Society of Temporomandibular Joint Surgeons. Guidelines for diagnosis and management of disorders involving the temporomandibular joint and related musculoskeletal structures. *Cranio.* 2003;21(1):68-76.
- MCG Care Guidelines for Temporomandibular Joint Disorder: A-0492; A-0521; A-0522; A-0523. MCG Health. 26th ed. 2022. **p. 1-2.**

Duration of Service

Guidelines for Diagnosis and Management of Disorders Involving the Tempromandibular Joint and Related Musculoskeletal Structures. American Society of Tempromandibular Joint Surgeons; 2001. **p.3-4**

Trigger Point Injections

Clinical Safety/Efficacy

- Chou R. Subacute and chronic low back pain: nonsurgical interventional treatment. UpToDate. **p. 8.** Updated June 10, 2021. Includes copies of Society Guidelines
 1. American Society of Regional Anesthesia and Pain Medicine (ASRA), European Society of Regional Anesthesia and Pain Therapy (ESRA), American Academy of Pain Medicine (AAPM), International Neuromodulation Society (INS), North American Neuromodulation Society (NANS), and World Institute of Pain (WIP): Guidelines on interventional spine and pain procedures in patients on antiplatelet and anticoagulant medications, 2nd edition (2018).
 2. North American Spine Society (NASS): Guidelines
 3. American College of Radiology (ACR): ACR Appropriateness Criteria on inflammatory back pain – Known or suspected axial spondylarthritis (2021)
 4. ACR: ACR Appropriateness Criteria on low back pain (2021)
 5. American Physical Therapy Association (APTA): Clinical practice guidelines for interventions for the management of acute and chronic low back pain, revision (2021)

- Isaac Z. Management of non-radicular neck pain in adults. UpToDate. **p.16**. Updated November 16, 2021. www.uptodate.com. Includes copies of Society Guidelines
 1. ACR: ACR Appropriateness Criteria on cervical neck pain or cervical radiculopathy (2018)
 2. American Society of Interventional Pain Physicians (ASIPP): An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain – Introduction and general considerations (2013)
 3. ASIPP: An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain – Guidance and recommendations (2013)
 4. American Society of Anesthesiologists (ASA) and American Society of Regional Anesthesia and Pain Medicine (ASRA): Practice guidelines for chronic pain management (2010)
 5. North American Spine Society (NASS): Clinical guidelines for diagnosis and treatment of cervical radiculopathy from degenerative disorders (2010)
- Staal JB, et al. Injection therapy for subacute and chronic low back pain:an updated Cochrane review. *Spine*. 2009;34(1):49-59/**55-57**. doi:10.1097/BRS.0b013e3181909558
- American Society of Anesthesiologists Task Force on Chronic Pain Management. Practice guidelines for chronic pain management. *Anesthesiology*. 2010;112(4):810-833/**819**. doi:10.1097/ALN.0b013e3181c43103

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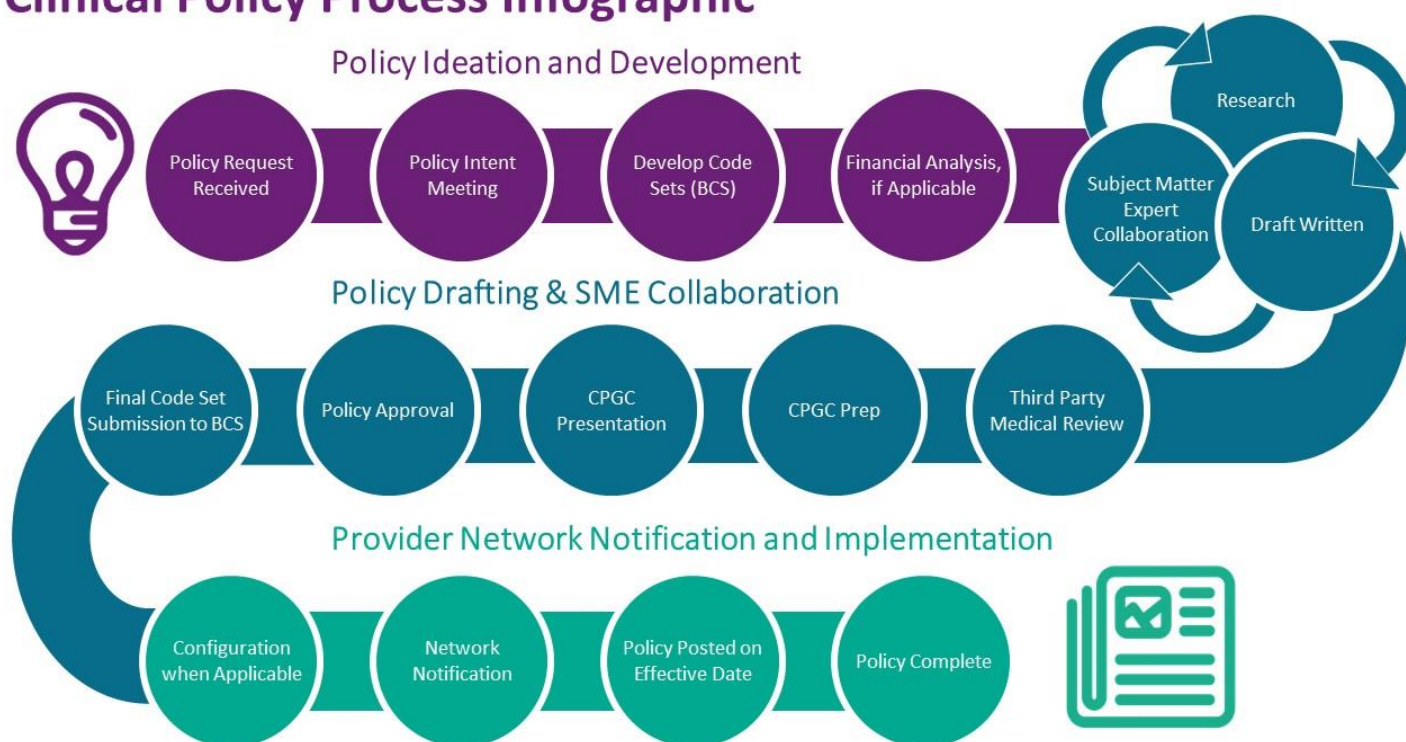


Medical and Clinical Policy Writer Standard Operating Procedures Catalog

The Clinical Policy and Oversight department has developed an infographic for their policy ideation, creation and implementation process and have correlating SOPs for each step of the process as noted in this catalog.

Standard Operating Procedures (SOPs) are written documents that are used by specific departments detailing specific actions to take to complete a task or process. The purpose of this SOP catalog is to improve efficiency, increase productivity and quality, and provide consistent policy products to our stakeholders and business owners.

Clinical Policy Process Infographic






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Medical and Clinical Policy Writer
Standard Operating Procedures Catalog

STANDARD OPERATING PROCEDURE (SOP)		
Attachments	Creation Date	Step One: New Policy Intake Submission and Creation
<input type="checkbox"/> Yes <input type="checkbox"/> No	12/12/2018	

A. DESCRIPTION / PURPOSE

The purpose is to standardize the process for creating a new policy (Medical, Reimbursement, and Administrative), including the policy intake process for the Business Owner/Requestor. Skip this step if you are not a Business Owner of a policy.

B. DEFINITIONS

- **General Feedback Request** – This request type is for access issues, submit feedback to the policy team and general information submissions.
- **New Policy Request** – Intake request for the ideation of a new policy.
- **Policy Types** – The Clinical Policy and Oversight Team manages three main types of policies, which serve different functions for CareSource:
 - **Administrative** – Policies written which have no medical criteria or reimbursement information. This policy addresses the company stance on how we operate concerning a specific topic.
 - **Medical** – Policies written with medical criteria including current evidence-based research, best practices, clinical studies, etc. which will determine the criteria the member must meet in order for the provider to provide a service. NO reimbursement (coding/language) or administrative language.
 - **Reimbursement** – No medical criteria or administrative language. This policy addresses a topic in what must be met from a provider regarding billing/claims criteria. Final code sets may not necessarily be listed in the policy. It is the responsibility of the provider to ensure their coders are submitting the correct codes for the correct procedure/diagnosis in order to receive reimbursement.
- **Revision of Existing Policy Request** – Intake request to initiate the review of an existing policy. This request can be before annual review or a break/fix if there is an issue with the current policy.

I. Business Owner - Filling out a request to create a new policy:

-
- The screenshot shows the 'New Document' dialog box with the following options:
- Word Document (highlighted with a red rectangle)
 - HTML Document
 - Excel Spreadsheet
 - PowerPoint Presentation
 - Upload a File
- The 'Cancel' button is located at the bottom right of the dialog box. In the background, the left sidebar of the application is visible, with the 'Recent' menu item highlighted by a red rectangle.

- Title**

Document Owner ⓘ

Vitullo, Kathleen (Medical/Clinical Policy Writer) _____

Template ⓘ

Clinical Policy Intake _____

Version Number

1

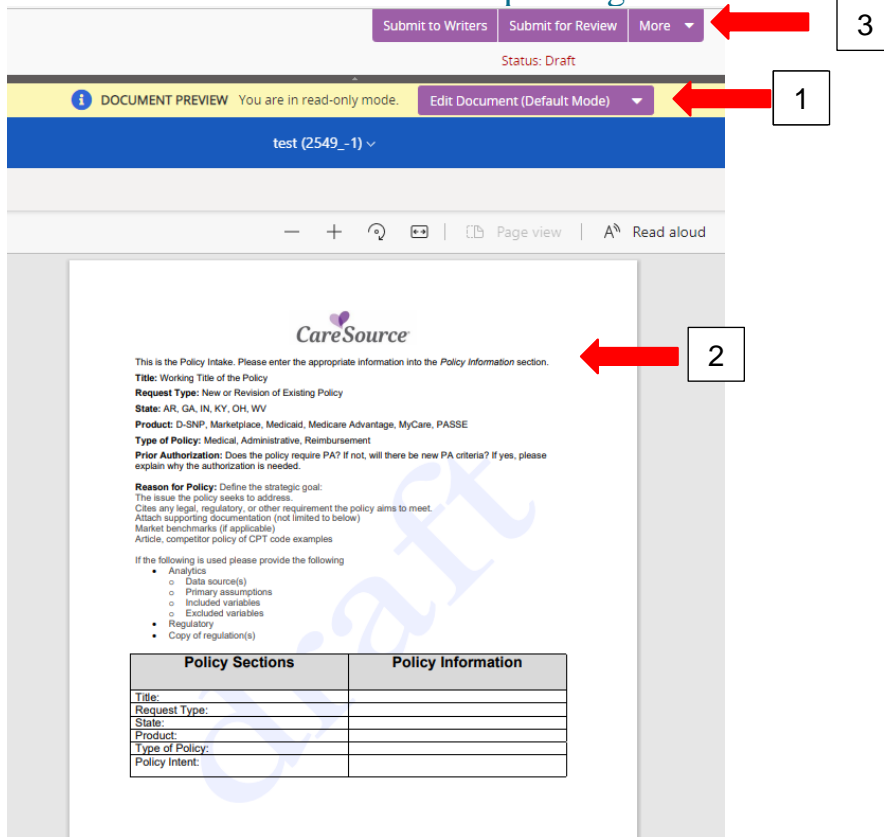
Publication Date ⓘ ⚠

Publish as soon as approved. _____

End Date (Optional) ⓘ

- 4

Medical and Clinical Policy Writer Standard Operating Procedures Catalog



Submit to Writers Submit for Review More

Status: Draft

DOCUMENT PREVIEW You are in read-only mode. Edit Document (Default Mode)

test (2549_-1)

Page view Read aloud

CareSource

This is the Policy Intake. Please enter the appropriate information into the Policy information section.

Title: Working Title of the Policy

Request Type: New or Revision of Existing Policy

State: AR, GA, IN, KY, OH, WV

Product: D-SNP, Marketplace, Medicaid, Medicare Advantage, MyCare, PASSE

Type of Policy: Medical, Administrative, Reimbursement

Prior Authorization: Does the policy require PA? If not, will there be new PA criteria? If yes, please explain why the authorization is needed.

Reason for Policy: Define the strategic goal.
The issue the policy seeks to address.
Cites any legal, regulatory, or other requirement the policy aims to meet.
Attach supporting documentation (not limited to below)
Market benchmarks (if applicable)
Article, competitor policy of CPT code examples

If the following is used please provide the following

- Analytics
 - Data source(s)
 - Primary assumptions
 - Included variables
 - Excluded variables
- Regulatory
- Copy of regulation(s)

Policy Sections	Policy Information
Title:	
Request Type:	
State:	
Product:	
Type of Policy:	
Policy Intent:	

- The Administrator needs to check the Enterprise site's unfiled documents in the Browse function for policy intakes.
- The Administrator selects an intake and declines the approval.
- The Administrator can then assign the policy to a Policy Writer through Properties Wizard. (note: writer will need to change template).


D. REVIEW / REVISION HISTORY

Tracking history commenced January 2011			
Review	Revision	Date	Description of Changes
<input type="checkbox"/>	<input type="checkbox"/>	12/12/2018	Service Now Ticket process changed
<input type="checkbox"/>	<input type="checkbox"/>	12/27/2018	Updated SharePoint site screenshot, separated first step in policy process into its own policy
<input type="checkbox"/>	<input type="checkbox"/>	5/9/2019	Updated screenshots and verbiage
<input type="checkbox"/>	<input type="checkbox"/>	3/6/2020	Updated screenshots and verbiage
<input type="checkbox"/>	<input type="checkbox"/>	05/01/2020	Updated format and process
<input type="checkbox"/>	<input type="checkbox"/>	12/07/2020	Removed: Pricing for Reimbursement; General Feedback; Prior Authorization Explanation; Define Policy Statement; Regulatory Impact; Claims Impact; State Complaint; Is This a Covered Benefit in Your Market; Policy Impact section; Definitions; Medical Codes; System Automation. Redesign of Supporting

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			Documents Pending with SharePoint Administrator. <i>Revision Type</i> : pending redesign with SharePoint Administrator—removed <i>Break/Fix</i> .
<input checked="" type="checkbox"/>	<input type="checkbox"/>	03/25/2021	Updated Screenshots
<input type="checkbox"/>	<input checked="" type="checkbox"/>	11/24/2021	Updated steps to incorporate PT
<input type="checkbox"/>	<input checked="" type="checkbox"/>	03/02/2023	Updated process.

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STANDARD OPERATING PROCEDURE (SOP)		
Attachments	Creation Date	Step Two: Policy Triage - Policy Intent and Direction Collaboration
<input type="checkbox"/> Yes <input type="checkbox"/> No	05/01/2020	

A. DESCRIPTION / PURPOSE

The purpose is to standardize the process in which the policy writer establishes the intent and purpose of the policy for both annual/periodic reviews of policies and new policies.

B. DEFINITIONS


C. PROCEDURE

- I. A New Policy is requested and assigned to Policy Writer OR an existing policy will appear in the assigned Policy Writer's Tasks queue in Policy Tech.
- II. For new policy:
 - A. A meeting will be scheduled by the policy writer to discuss the need and intent of the policy and should include the following attendees:
 - a. The policy writer;
 - b. Dr. Gregg;
 - c. Business Requestor;
 - d. Susan Dalton (optional); and
 - e. Any other relevant individuals identified by Dr. Gregg.
 - B. Prior to Intent Meeting, perform some preliminary research to better understand the potential policy topic. Identify any important questions you need the group to discuss/answer.
 - C. At the Intent Meeting, RECORD the meeting, and use the [Intent Meeting Cheat Sheet](#) to help outline the policy.
 - D. Schedule any necessary follow-up meetings, and identify any deliverables. Receive consent from attendees on who should review policy during draft phase.
 - E. Bring policy topic to BCS Monday meeting to determine if a Service Now Ticket is needed (see Step Three).
- III. For existing policy, proceed to Step Two A.

D. REVIEW / REVISION HISTORY

Tracking history commenced January 2011			
Review	Revision	Date	Description of Changes
<input type="checkbox"/>	<input checked="" type="checkbox"/>	12/1/2020	Updated to a new process that includes intent meetings.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	07/12/2021	Updated to remove financial analytics.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	03/02/2023	Updated process to reflect current practice

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STANDARD OPERATING PROCEDURE (SOP)		
Attachments	Creation Date	Step Two A: Annual/Periodic Policy Review
<input type="checkbox"/> Yes <input type="checkbox"/> No	03/15/2022	

A. DESCRIPTION / PURPOSE

The purpose is to describe the standardized process of performing an annual or periodic review of a policy. The process is performed at the very least cyclically for Administrative and Reimbursement policies every 1 year to 3 years, and annually for Medical policies to maintain National Committee for Quality Assurance (NCQA) accreditation.

B. DEFINITIONS

- Agency for Healthcare Research and Quality (AHRQ) – an agency within the United States Department of Health and Human Services (HHS) to enhance the quality, appropriateness, and effectiveness of health care services and access to care by conducting and supporting research, demonstration projects, and evaluations; developing guidelines; and disseminating information on health care services and delivery systems.
- CAHPS – Overseen by AHRQ, a set of surveys that ask patients to report on their health care experiences, focusing on aspects of healthcare quality that patients find important
- National Committee for Quality Assurance (NCQA) – An independent 501(c)(3) nonprofit organization that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. NCQA operates on a formula of measure, analyze, and improve and aims to build consensus across the health care industry by working with policymakers, employers, doctors, patients, and health plans. Health plans seek accreditation and measure performance through the administration and submission of the Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.
- HEDIS – maintained by NCQA, is designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks, it also measures performance in health care where improvements can make a meaningful difference in people's lives.
- Out-of-Cycle – Review performed at a time frame irrespective of the policy's effective date or NCQA requirements to address a specific issue within a policy.

C. PROCEDURE

I. Policy Review

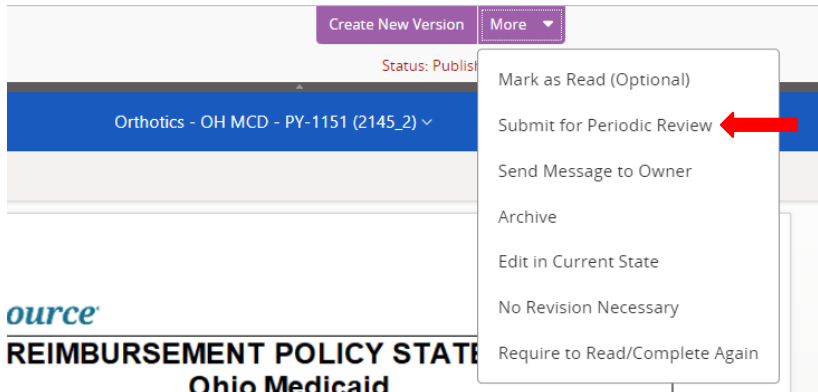
A. Annual/Periodic Review:

1. A task will be created in Policy Tech, and automatically route to the assigned Medical/Clinical Policy Writer. Task generation is automatically set up to occur six months after the last review date.
 - a. Administrative or Reimbursement policies: For internal compliance, the policy must be reviewed and published every 18 months.
 - b. Medical policies: For NCQA requirements, the policy must be reviewed and published every year.
2. Policy writer determines if an intent meeting is needed (significant changes/issues encountered over the previous year). If an intent meeting is desired, go back to Step Two. If an intent meeting is not desired, go to Step Three (NOTE: an intent meeting is rarely needed for an existing policy).

B. Out-of-cycle review:

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1. An Administrator in Policy Tech must locate the specific policy(ies) and submit for periodic review OR a writer can Create New Version.




2. Policy writer determines if an intent meeting is needed; if a meeting is desired, go to Step 2. If an intent meeting is not needed to discuss the issues driving the out-of-cycle review, go to Step 3.

D. REVIEW / REVISION HISTORY

Tracking history commenced January 2011			
Review	Revision	Date	Description of Changes
<input type="checkbox"/>	<input type="checkbox"/>	03/15/2022	Updated process to include policy tech
<input type="checkbox"/>	<input type="checkbox"/>		
<input type="checkbox"/>	<input type="checkbox"/>		

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STANDARD OPERATING PROCEDURE (SOP)		
Attachments	Creation Date	
<input type="checkbox"/> Yes <input type="checkbox"/> No	12/27/2018	Step Three: Initial Code Sets

A. DESCRIPTION / PURPOSE

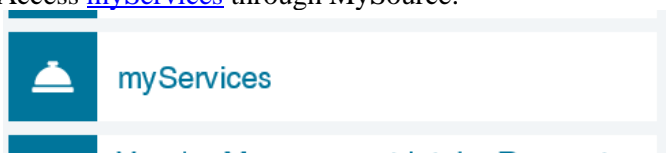
The purpose is to standardize the process in which the policy writers submit and receive initial code sets from the member benefits team.

B. DEFINITIONS

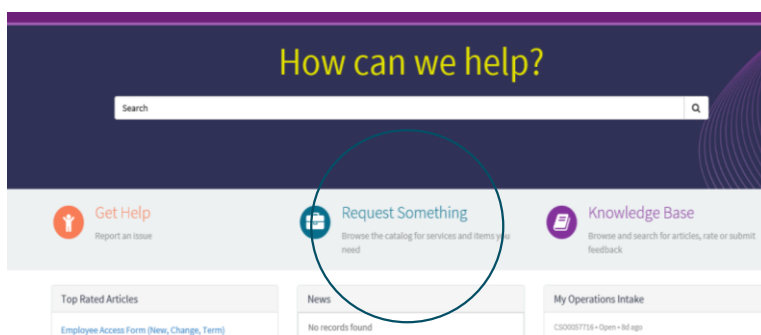
- **ServiceNow** - is a software platform that supports IT service management and automates common business processes. This software as a service (SaaS) platform contains a number of modular applications that can vary by instance and user.
- **Team Foundation Server** (commonly abbreviated to **TFS board**) - is a Microsoft product that provides source code management, reporting, requirements management, project management (for both agile software development and waterfall teams), automated builds, lab management, testing, and release management capabilities.

C. PROCEDURE

- I. Once a policy's intent has been established (or if an annual review), bring policy topic to *Review of Policies for BCS* Monday meeting. Provide brief description of policy's purpose (1 sentence), and ask if an initial code ticket is required. If no, move to next step. If yes:
 - A. Access [myServices](#) through MySource.

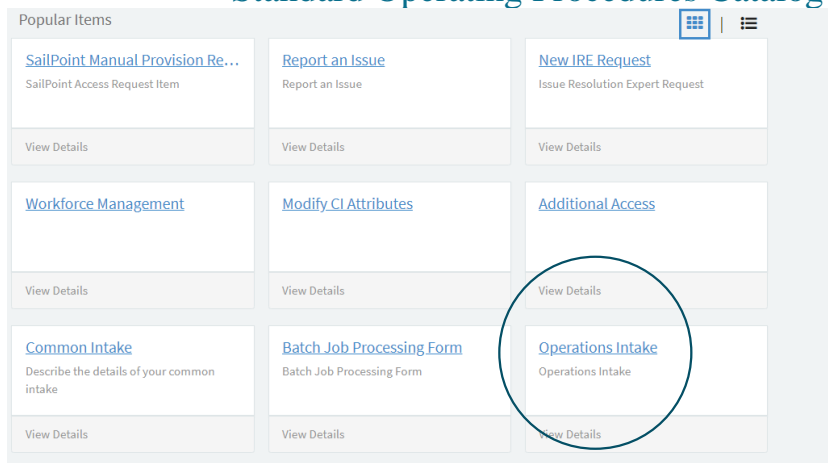


1. Select *Request Something*



2. Select *Operations Intake*.

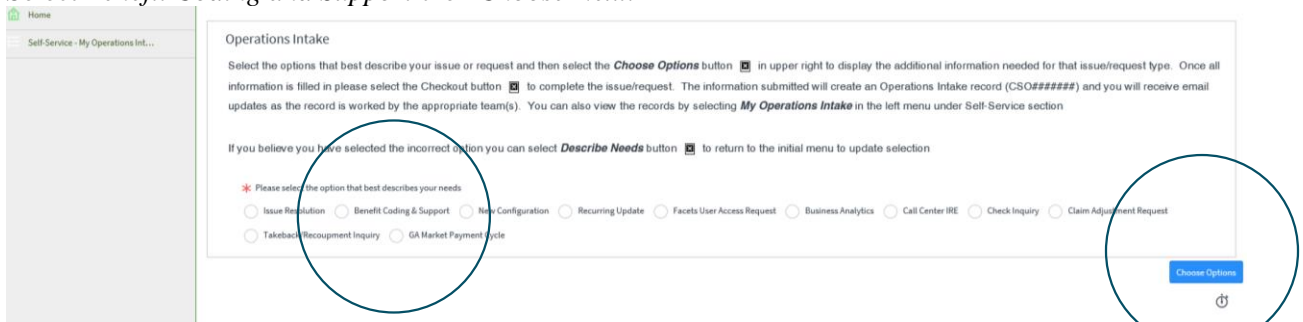
Medical and Clinical Policy Writer Standard Operating Procedures Catalog



Popular Items

SailPoint Manual Provision Re... SailPoint Access Request Item View Details	Report an Issue Report an Issue View Details	New IRE Request Issue Resolution Expert Request View Details
Workforce Management View Details	Modify CI Attributes View Details	Additional Access View Details
Common Intake Describe the details of your common intake View Details	Batch Job Processing Form Batch Job Processing Form View Details	Operations Intake Operations Intake View Details

3. Select *Benefit Coding and Support* then *Choose Next*.



Home

Self-Service - My Operations Intake

Operations Intake


Select the options that best describe your issue or request and then select the **Choose Options** button in upper right to display the additional information needed for that issue/request type. Once all information is filled in please select the **Checkout** button to complete the issue/request. The information submitted will create an Operations Intake record (CSO#####) and you will receive email updates as the record is worked by the appropriate team(s). You can also view the records by selecting **My Operations Intake** in the left menu under Self-Service section.

If you believe you have selected the incorrect option you can select **Describe Needs** button to return to the initial menu to update selection.

Please select the option that best describes your needs:

☐ Issue Resolution
 ☐ **Benefit Coding & Support**
☐ New Configuration
 ☐ Recurring Update
 ☐ Facets User Access Request
 ☐ Business Analytics
 ☐ Call Center IRE
 ☐ Check Inquiry
 ☐ Claim Adjustment Request
 ☐ Takeback/Recoupment Inquiry
 ☐ GA Market Payment Cycle

Choose Options

4. Hit dropdown arrow on the Benefit Coding & Support item
5. Complete request form:
 - a. The Requested For field will auto populate your name
 - b. The cost center or cost center manager will also auto populate
 - c. Select *Clinical Policy Code Sets* under options that best fits your issue or request.
 - d. Select *Initial Code Set (for new policy) OR Policy-Annual Review Initial (for existing policy)* under secondary option that best fits your request
 - e. Type in Policy title
 - f. Type in policy number(s)
 - g. Input all relevant Policy Tech web addresses
 - h. Select what market and product the request impacts or benefits
 - i. Select *Corporate* for submitting Market
 - j. Type in any additional helpful information for the team in the problem and purpose for request (e.g., *Request: Initial Code Set Breast Imaging OH MCD MM-0011*)
 - k. Type **NA** in the requested date for claims analysis
 1. Select the desired complete date through the  icon (typically **30 days**)
 - m. Type your name and select when it populates
 - n. Select: *Next*
 - o. *Select Submit.*
6. After submitting the ticket, the Policy Writer will receive a Notification/IT Service Desk email with the Submitting Issue Request number: **CSO 0000000** indicating the issue will be researched and routed to the correct department for completion. Be sure to add this to a OneNote file for the policy.

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IT Service Desk <caresource@service-now.com> | Nurrenbrock, Kara S.



IT Service Desk <caresource@service-now.com>

Nurrenbrock, Kara S.

New Member Benefits Request CSO0042298

Retention Policy CareSource_Deleted Items (2 weeks)

Expires 5/15/2020

This item will expire in 13 days. To keep this item longer apply a different Retention Policy.

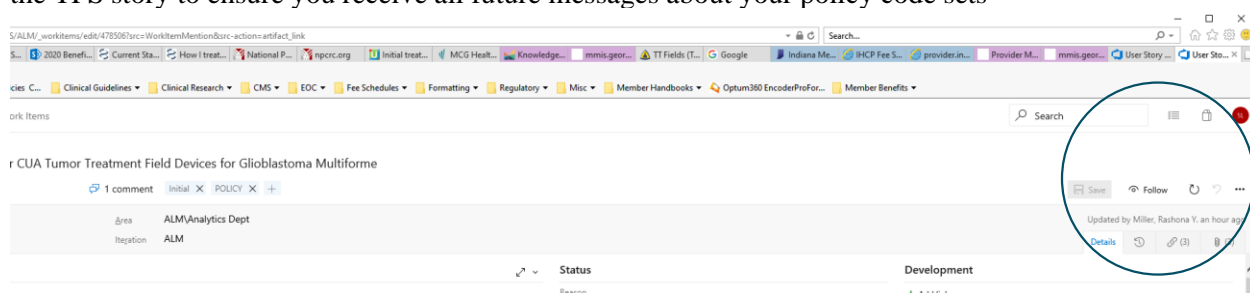
Thank you for submitting operations intake [CSO0042298](#). Your request has been sent to the appropriate Member Benefits and Predictive Health team for review.

Thank you for your time

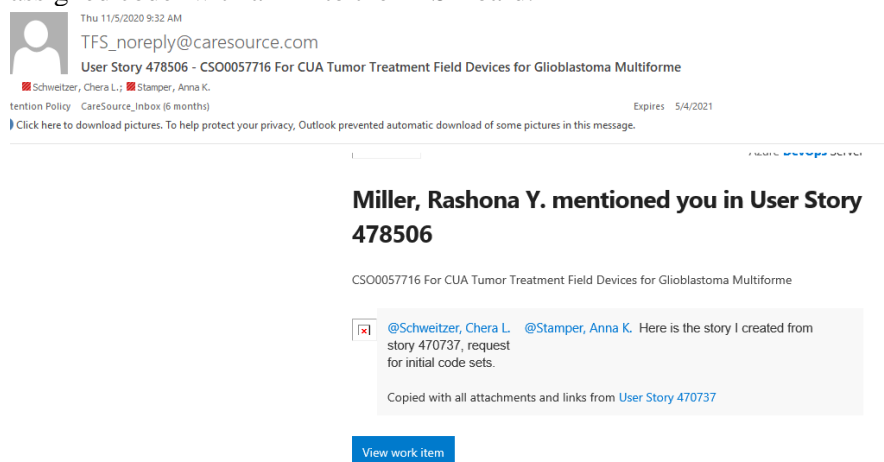
[Unsubscribe](#) | [Notification Preferences](#)

Ref:MSG9155691

- You should also receive an email that your *Operations Intake* has been added to the TFS board and assigned a **TFS story number** (i.e. 412129), select the story associated with your CSO#. You can “Follow” each work item you are “tagged in” by clicking the *Follow* icon in the upper right hand side of the TFS story to ensure you receive all future messages about your policy code sets

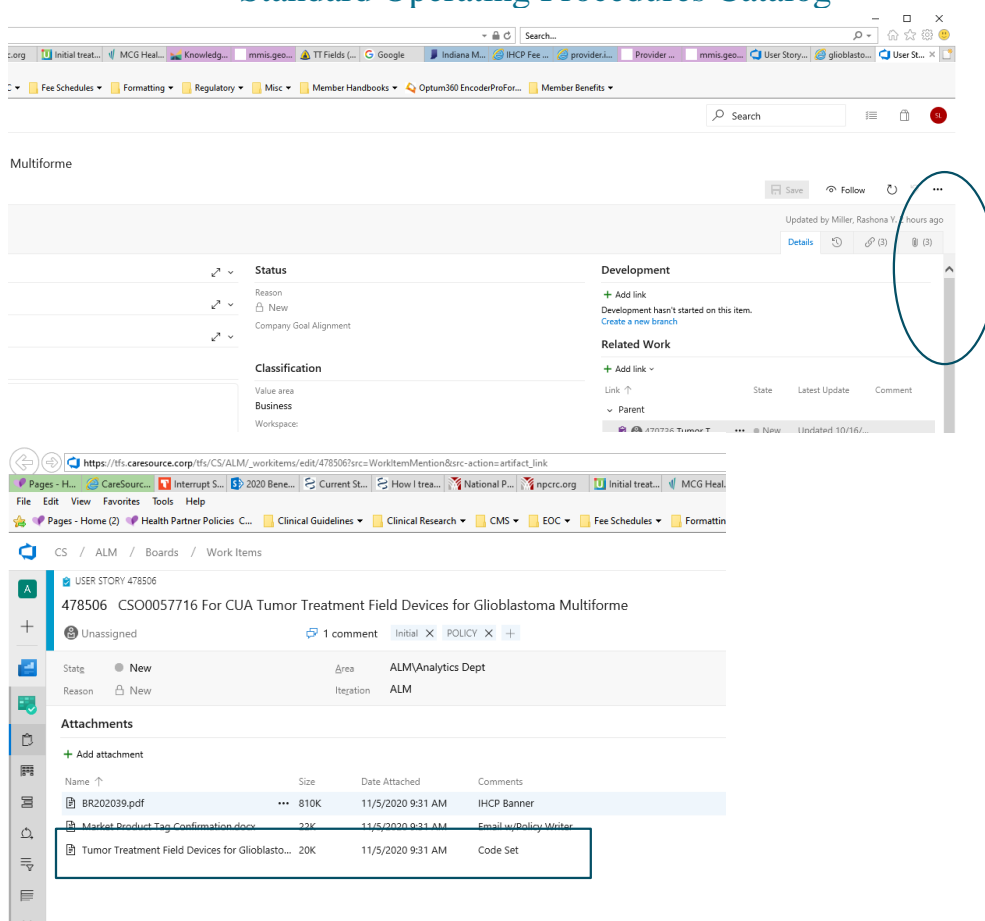


- After code sets have been completed, Policy Writer will receive a notification/user story email from the assigned coder with a link to the TFS Board.



- Click on *View work item* in the email.
- Click on the **Attachments** (paper clip - don’t confuse this with the Links icon) in the top right corner where you will be directed to the attachments to the story. Store this email and/or the actual code list (see below) to OneNote.


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D. REVIEW / REVISION HISTORY

Tracking history commenced January 2011			
Review	Revision	Date	Description of Changes
<input type="checkbox"/>	<input type="checkbox"/>	12/27/2018	Separated step in policy process into its own policy
<input type="checkbox"/>	<input type="checkbox"/>	5/9/2019	Updated screenshots and verbiage.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	3/6/2020	Updated screenshots and verbiage
<input type="checkbox"/>	<input checked="" type="checkbox"/>	05/01/2020	Updated format and process
<input type="checkbox"/>	<input checked="" type="checkbox"/>	12/01/2020	Updated process and screenshots.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	07/12/2021	Updated to remove financial analytics information.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	11/29/2021	Updated to include Policy Tech
<input type="checkbox"/>	<input checked="" type="checkbox"/>	03/02/2023	Updated to reflect new Operations Intake format

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STANDARD OPERATING PROCEDURE (SOP)		
Attachments	Creation Date	
<input type="checkbox"/> Yes <input type="checkbox"/> No	12/27/2018	Step Four: Financial Analysis

A. DESCRIPTION / PURPOSE

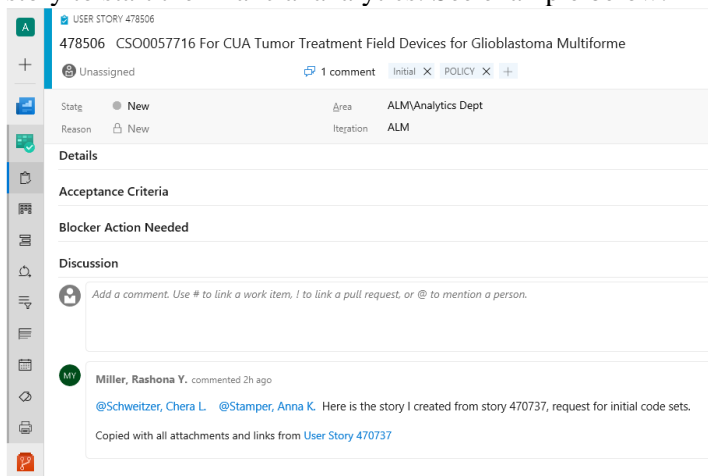
The purpose is to standardize the process in which the policy writer receives and reviews the financial analysis.

B. DEFINITIONS

Team Foundation Server (commonly abbreviated to **TFS board**) - is a Microsoft product that provides source code management, reporting, requirements management, project management (for both agile software development and waterfall teams), automated builds, lab management, testing and release management capabilities.

C. PROCEDURE

- I. Financial analytics are no longer a part of the standardized process when creating a new policy or during the annual update process of a policy. If you feel the policy warrants financial analytics please contact policy management to discuss. You must have management approval before submitting anything for financial analytics. Once initial code sets have been completed, the coding analyst will copy the coding story onto the Clinical Utilization Analytics board. The coding analyst will tag the Clinical Utilization Analytics Manager and the initial code set requestor in the TFS story to start the financial analytics. See example below:



- II. In the event financial analytics are requested with management's approval, an analyst will be assigned to the intake, the policy writer will be notified who is completing the analytics.
- III. Once financial analysis is complete, financial analyst will tag the policy writer in the TFS story and a link to TFS will be included in the notification email.
- IV. Save a copy of the analytics document to OneNote.
 - A. The financial analyst will set up a meeting with the policy writer, business owner, coder, Dr. Gregg, and Susan Dalton (optional) at this time to discuss the pending analytics and answer any questions about the policies, codes etc.


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- B. Policy writer will notify the Clinical Policy and Oversight Coordinator to add to Policy Governance Committee meeting agenda for **Financial Analytic Committee Update**.

D. REVIEW / REVISION HISTORY

<i>Tracking history commenced January 2011</i>			
Review	Revision	Date	Description of Changes
<input type="checkbox"/>	<input type="checkbox"/>	12/27/2018	Separated step in policy process into its own policy
<input type="checkbox"/>	<input type="checkbox"/>	5/9/2019	Updated screenshots.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	3/6/2020	Updated screenshots and verbiage
<input type="checkbox"/>	<input checked="" type="checkbox"/>	05/01/2020	Updated screenshots and verbiage
<input type="checkbox"/>	<input checked="" type="checkbox"/>	12/01/2020	Updated process and screenshots
<input type="checkbox"/>	<input checked="" type="checkbox"/>	07/12/2021	Updated to follow new financial analytics standards.

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STANDARD OPERATING PROCEDURE (SOP)		
Attachments	Creation Date	Step Five: Financial Analytic Committee Review
<input type="checkbox"/> Yes <input type="checkbox"/> No	12/27/2018	

A. DESCRIPTION / PURPOSE

- I. The purpose is to standardize the process in which the policy writer receives and reviews the financial analysis. This process only occurs when management has made the decision to move forward with a request for financial analytics on a policy. This step is no longer a standard in the policy process.

B. DEFINITIONS


C. PROCEDURE

- I. In the event financial analytics are completed and the Policy Writer has had the opportunity to meet with the Clinical Utilization Analyst, the Policy Writer will present to the Policy Governance Committee the executive summary that is provided to the Policy Writer from the Clinical Utilization Analyst.

D. REVIEW / REVISION HISTORY

<i>Tracking history commenced January 2011</i>			
Review	Revision	Date	Description of Changes
<input type="checkbox"/>	<input type="checkbox"/>	12/27/2018	Separated step in policy process into its own policy
<input type="checkbox"/>	<input checked="" type="checkbox"/>	03/06/2020	Updated screenshots and verbiage
<input type="checkbox"/>	<input checked="" type="checkbox"/>	07/12/2021	Updated to follow new financial analytics standards.

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STANDARD OPERATING PROCEDURE (SOP)		
Attachments <input type="checkbox"/> Yes <input type="checkbox"/> No	Creation Date 12/27/2018	
		Step Six: Research

A. DESCRIPTION / PURPOSE

The purpose is to standardize the process in which the policy writer researches administrative, medical, and reimbursement policies.

B. DEFINITIONS

1. **Business Owner:** The official owner of a policy.
2. **Cite Auto Auth:** An MCG product that allows payers and providers to automatically access evidence-based information in order to facilitate a prior authorization.
3. **HAYES:** Provides evidence-based assessments, evaluations and ratings of clinical programs and health technologies to determine health outcomes and patient safety.
4. **Intake form** - The initial policy development request that is submitted by the business owner. The Intake form is submitted electronically.
5. **MCG Health:** Provides evidence-based medical literature established through assessment of the latest research, scholarly articles and data analysis in order to develop clinical care guidelines used by payers, providers and patients.
6. **Policy Governance Committee (PGC):** This committee is comprised of clinical and non-clinical members of multiple CareSource departments. The goal of the committee is to review and approve/deny Medical, Reimbursement and Administrative policy requests, policy annual updates, policy revisions and new policies through Intake Request Forms
7. **Policy Governance Committee Intake Request Form:** A form submitted electronically by the policy Business Owner/Owners that documents a formal request for a policy.
8. **Policy Reporter:** Connects users to live medical, diagnostic and pharmaceutical policies across the marketplace to assess market trends and organize policy information.
9. **Revision:** Interim edits other than for purpose of an "Annual Update" due to criteria changes or other evidence-based, peer-reviewed information. A previous "Rejected" policy may be re-introduced as a revised policy for consideration and approval.
10. **Subject Matter Expert (SME):** A person who is an authority on a particular topic or subject matter.
11. **UpToDate:** A continuously updated evidence-based sourced for the latest medical care knowledge. Also includes point of care recommendations.

C. PROCEDURE

Note: Lines of Business and Markets -

Medicare markets follow state regulations (when available) found in LCDs and NCDs. If one exists, it may not be necessary to create a policy. A policy can be used to provide better clarification or extend coverage, but may not restrict coverage more than the LCD/NCD.

Medicaid markets follow state regulations, when available. Indiana and Georgia Medicaid both maintain provider manuals with detailed policies. When Georgia already has a policy for a specific service in their manual it may not be necessary to create a new CareSource policy. When Indiana has a policy, please refer to the Indiana manual for

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guidance. In some instances the Indiana Medicaid Manual may need to be followed “word for word” in the CareSource created policy.

Marketplace products maintain an Evidence of Coverage. It may not be necessary to create a new policy. The decision to create a policy is reviewed on a case by case basis.

MyCare utilizes the OH Medicaid and OH Medicare Advantage policies. It may not be necessary to create a separate policy for MyCare.

If MCG clinical guidelines are sufficient, it may not be necessary to create a policy.

I. Intake review

- A. Access the Policy Tech site and review the Policy Intake Form.
- B. Identify Business Owner/Owners as detailed in the request form.
- C. Determine Subject Matter Experts (SME) that may contribute to the policy. Collaborate with business owner/owners and SMEs (**access current [SME list](#)**) via email, WebEx, or in person meetings (depending on the complexity of the topic) to gain greater clarity on the policy topic or answer questions regarding the policy topic.

II. Create a research document

- A. Keep a detailed summary of your research findings, including:
 1. Summarized notes of key findings that will be incorporated into the drafted policy;
 2. Important hyperlinks in order to easily access articles, clinical studies, professional recommendations, federal or state regulations or any other critical information for later reference; and
 3. Key information provided by business owner/owners, SMEs or other partners in policy research and development.
- B. Maintain collaboration documentation, emails, and conversations in a folder or **OneNote** for future reference and audit purposes.
- C. When the research is complete and the policy has been written, attach the research document(s) to the policy in Policy Tech.

III. Policy research

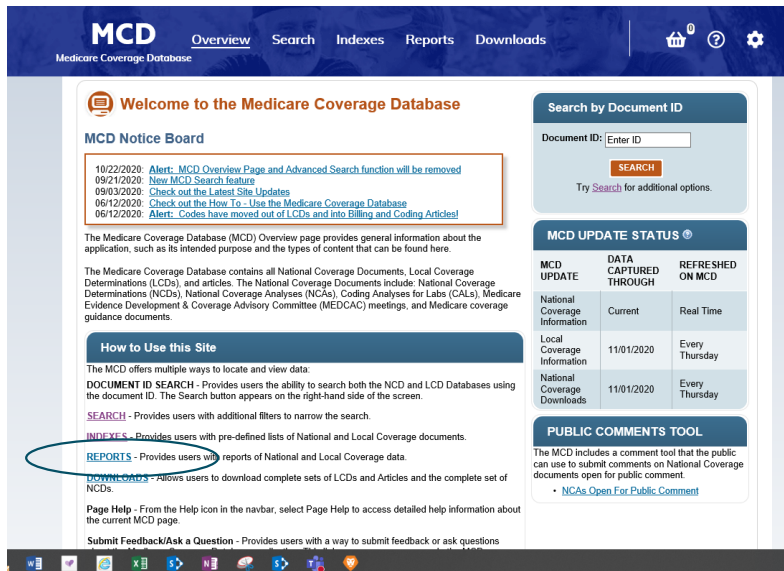
Note: When going through the below research process for a policy topic keep in mind if you are conducting research and not yielding any results, the information may not be available. Defer to Policy Management for further guidance. This may be the case in newer and less studied treatments and services etc.

Note: Only MCG Health, State/Federal Regulations (which includes an LCD/NCD), EOC, and Professional Society Guidelines or Recommendations may be copied word for word. All other sources should be used as only reference sources and not copied and pasted. When copied word for word, a footnote reference should be utilized.

- A. Determine current PA status. Reference the [2022 Prior Authorization List](#) and the Provider PA [LookUp Tool](#). Reference the [2022 Prior Authorization List](#) and the Provider PA [LookUp Tool](#).
- B. Benefit grid – is what you are researching a benefit in that LOB/state? Review Benefit Grid, if there is a discrepancy between the [present year] Prior Authorization List, Provider PA LookUp Tool and the Benefit Grid, contact policy management and reach out to member benefit analyst (Julia Oteroramos or Sheri Wagner) with questions.
- C. Consult with UM in Monday Collaborations.
 1. If Medical policy is being drafted, confirm with UM whether a PA is required for a product or service.
 2. Discuss PA look up tool discrepancies if applicable.
- D. Go to the Centers for Medicaid and Medicare website: [Medicare Coverage Database](#)

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Note: Keep in mind, you may use an NCD/LCD as a standard in place of a policy for Medicare Advantage, or in some instances you may be using the NCD/LCD guidelines and coverage description to assist in building clinical criteria and content within a policy.



MCD Medicare Coverage Database

Welcome to the Medicare Coverage Database

MCD Notice Board

- 10/22/2020: Alert: MCD Overview Page and Advanced Search function will be removed
- 09/21/2020: New MCD Search feature
- 09/03/2020: Check out the Latest Site Updates
- 06/12/2020: Check out the How To - Use the Medicare Coverage Database
- 06/12/2020: Alert: Codes have moved out of LCDs and into Billing and Coding Articles!

The Medicare Coverage Database (MCD) Overview page provides general information about the application, such as its intended purpose and the types of content that can be found here.

The Medicare Coverage Database contains all National Coverage Documents, Local Coverage Determinations (LCDs), and articles. The National Coverage Documents include National Coverage Determinations (NCDs), National Coverage Analyses (NCAs), Coding Analyses for Labs (CALs), Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) meetings, and Medicare coverage guidance documents.

How to Use this Site

The MCD offers multiple ways to locate and view data:

- DOCUMENT ID SEARCH** - Provides users the ability to search both the NCD and LCD Databases using the document ID. The Search button appears on the right-hand side of the screen.
- SEARCH** - Provides users with additional filters to narrow the search.
- INDEXES** - Provides users with pre-defined lists of National and Local Coverage documents.
- REPORTS** - Provides users with reports of National and Local Coverage data.
- DOWNLOADS** - Allows users to download complete sets of LCDs and Articles and the complete set of NCDs.

Page Help - From the Help icon in the navbar, select Page Help to access detailed help information about the current MCD page.

Submit Feedback/Ask a Question - Provides users with a way to submit feedback or ask questions

Search by Document ID

Document ID:

SEARCH

Try [Search](#) for additional options.

MCD UPDATE STATUS

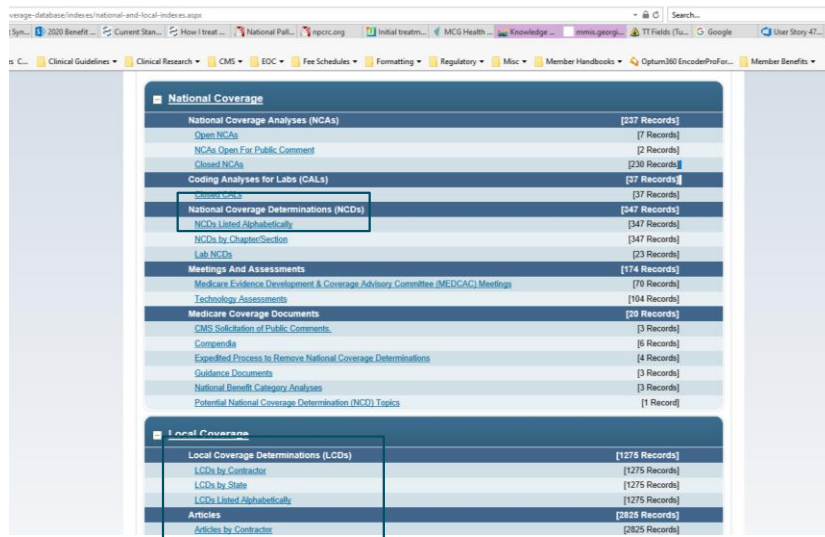
MCD UPDATE	DATA CAPTURED THROUGH	REFRESHED ON MCD
National Coverage Information	Current	Real Time
Local Coverage Information	11/01/2020	Every Thursday
National Coverage Downloads	11/01/2020	Every Thursday

PUBLIC COMMENTS TOOL

The MCD includes a comment tool that the public can use to submit comments on National Coverage documents open for public comment.

- [NCAs Open For Public Comment](#)

1. Scroll to *Indexes* to access the National Coverage Determinations (NCD) and Local Coverage Determinations (LCD).
2. For NCDs:
 - a. Select National Coverage Determinations – *NCDs Listed Alphabetically* under the National Coverage section.



National Coverage

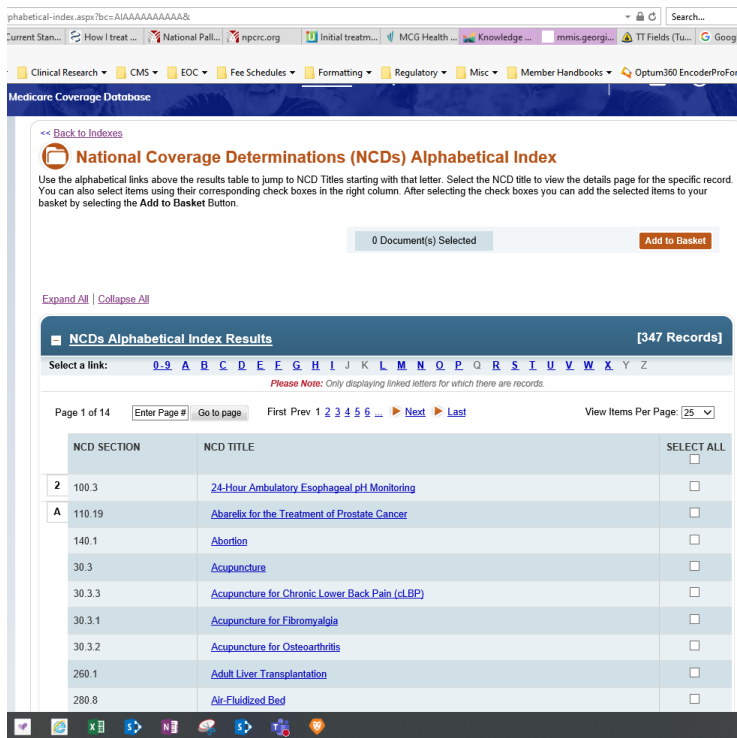
- National Coverage Analyses (NCAs) [237 Records]
 - Open NCAs [7 Records]
 - NCAs Open For Public Comment [2 Records]
 - Closed NCAs [230 Records]
- Coding Analyses for Labs (CALs) [37 Records]
- National Coverage Determinations (NCDs) [347 Records]
 - NCDs Listed Alphabetically [347 Records]
 - NCDs by Chapter/Section [347 Records]
 - Lab NCDs [23 Records]
- Meetings and Assessments [174 Records]
 - Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) Meetings [70 Records]
 - Technology Assessments [104 Records]
- Medicare Coverage Documents [20 Records]
 - CMS Solicitation of Public Comments [3 Records]
 - Compendia [5 Records]
 - Expedited Process to Remove National Coverage Determinations [4 Records]
 - Guidance Documents [3 Records]
 - National Benefit Category Analyses [3 Records]
 - Potential National Coverage Determination (NCD) Topics [1 Record]

Local Coverage

- Local Coverage Determinations (LCDs) [1275 Records]
 - LCDs by Contractor [1275 Records]
 - LCDs by State [1275 Records]
 - LCDs Listed Alphabetically [1275 Records]
- Articles [2855 Records]
 - Articles by Contractor [2825 Records]

- b. NCDs Alphabetical Index Results will come up by NCD Section and NCD Title.
- c. Search the index by Title.

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phibetical-index.aspx?bc=AIAAAAAAAAAA&

Current Status: How I treat... National Pall... npccr.org Initial treatm... MCG Health... Knowledge... mms.georgi... TT Fields (Tu... Google

Clinical Research CMS EOC Fee Schedules Formatting Regulatory Misc Member Handbooks Optum360 EncoderProFor...

Medicare Coverage Database

<< Back to Indexes

National Coverage Determinations (NCDs) Alphabetical Index

Use the alphabetical links above the results table to jump to NCD Titles starting with that letter. Select the NCD title to view the details page for the specific record. You can also select items using their corresponding check boxes in the right column. After selecting the check boxes you can add the selected items to your basket by selecting the Add to Basket Button.

0 Document(s) Selected Add to Basket

Expand All Collapse All

NCDs Alphabetical Index Results [347 Records]

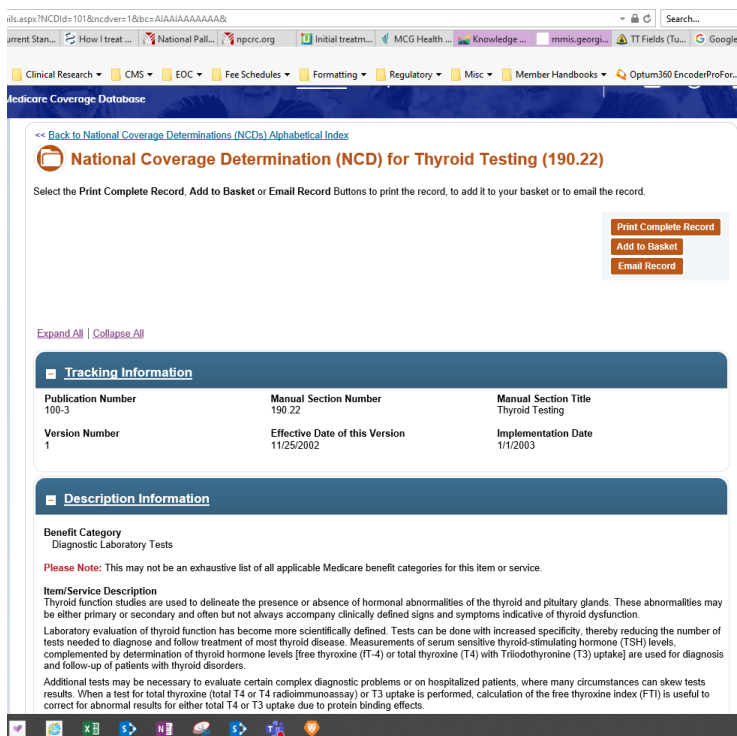
Select a link: 0 9 A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Please Note: Only displaying linked letters for which there are records.

Page 1 of 14 Enter Page # Go to page First Prev 1 2 3 4 5 6 ... Next Last View Items Per Page: 25

NCD SECTION	NCD TITLE	SELECT ALL
2 100.3	24-Hour Ambulatory Esophageal pH Monitoring	<input type="checkbox"/>
A 110.19	Abarelix for the Treatment of Prostate Cancer	<input type="checkbox"/>
140.1	Abortion	<input type="checkbox"/>
30.3	Acupuncture	<input type="checkbox"/>
30.3.3	Acupuncture for Chronic Lower Back Pain (CLBP)	<input type="checkbox"/>
30.3.1	Acupuncture for Fibromyalgia	<input type="checkbox"/>
30.3.2	Acupuncture for Osteoarthritis	<input type="checkbox"/>
260.1	Adult Liver Transplantation	<input type="checkbox"/>
280.8	Air-Fluidized Bed	<input type="checkbox"/>

- d. Select Title for *LCD Description Information* Select Local Coverage.



ils.aspx?NCDId=101&ncdver=1&bc=AIAAAAAAAAAA&

Current Status: How I treat... National Pall... npccr.org Initial treatm... MCG Health... Knowledge... mms.georgi... TT Fields (Tu... Google

Clinical Research CMS EOC Fee Schedules Formatting Regulatory Misc Member Handbooks Optum360 EncoderProFor...

Medicare Coverage Database

<< Back to National Coverage Determinations (NCDs) Alphabetical Index

National Coverage Determination (NCD) for Thyroid Testing (190.22)

Select the Print Complete Record, Add to Basket or Email Record Buttons to print the record, to add it to your basket or to email the record.

Print Complete Record Add to Basket Email Record

Expand All Collapse All

Tracking Information

Publication Number 100-3	Manual Section Number 190.22	Manual Section Title Thyroid Testing
Version Number 1	Effective Date of this Version 11/25/2002	Implementation Date 1/1/2003

Description Information

Benefit Category
Diagnostic Laboratory Tests

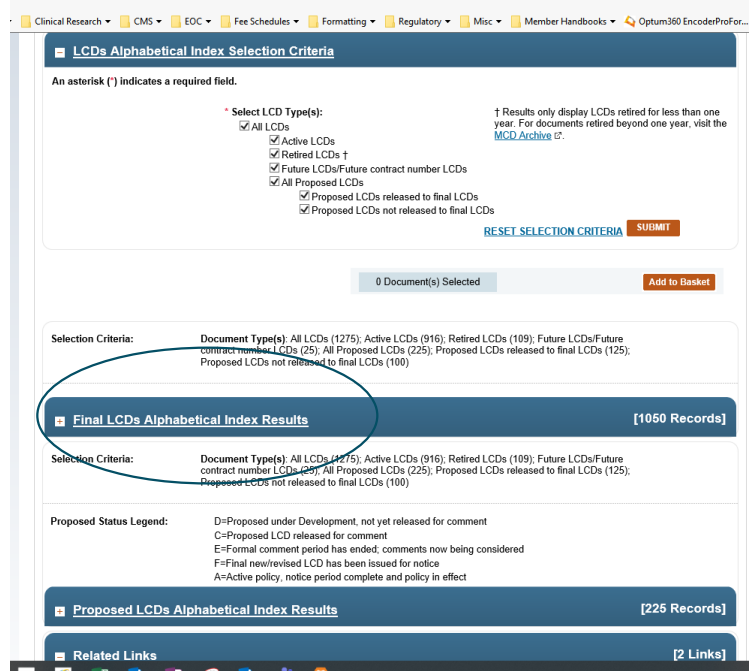
Please Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

Item/Service Description
Laboratory evaluation of thyroid function is used to delineate the presence or absence of hormonal abnormalities of the thyroid and pituitary glands. These abnormalities may be either primary or secondary and often but not always accompany clinically defined signs and symptoms indicative of thyroid dysfunction. Laboratory evaluation of thyroid function has become more scientifically defined. Tests can be done with increased specificity, thereby reducing the number of tests needed to diagnose and follow treatment of most thyroid disease. Measurements of serum sensitive thyroid-stimulating hormone (TSH) levels, complemented by determination of thyroid hormone levels [free thyroxine (T4) or total thyroxine (T4) with Triiodothyronine (T3) uptake] are used for diagnosis and follow-up of patients with thyroid disorders. Additional tests may be necessary to evaluate certain complex diagnostic problems or on hospitalized patients, where many circumstances can skew tests results. When a test for total thyroxine (total T4 or T4 radioimmunoassay) or T3 uptake is performed, calculation of the free thyroxine index (FTI) is useful to correct for abnormal results for either total T4 or T3 uptake due to protein binding effects.

- e. Save the NCD ID and hyperlink in your research summary.
3. For LCDs:
- Select Local Coverage Determinations (LCDs) –*LCDs Listed Alphabetically* –under the Local Coverage section

Medical and Clinical Policy Writer Standard Operating Procedures Catalog

b. Select: Final LCDs Alphabetical Index Results



LCDs Alphabetical Index Selection Criteria

An asterisk (*) indicates a required field.

Select LCD Type(s):

- ☒ All LCDs
- ☒ Active LCDs
- ☒ Retired LCDs †
- ☒ Future LCDs/Future contract number LCDs
- ☒ All Proposed LCDs
- ☒ Proposed LCDs released to final LCDs
- ☒ Proposed LCDs not released to final LCDs

† Results only display LCDs retired for less than one year. For documents retired beyond one year, visit the [LCD Archive](#).

[RESET SELECTION CRITERIA](#) [SUBMIT](#)

0 Document(s) Selected [Add to Basket](#)

Selection Criteria: Document Type(s): All LCDs (1275); Active LCDs (916); Retired LCDs (109); Future LCDs/Future contract number LCDs (25); All Proposed LCDs (225); Proposed LCDs released to final LCDs (125); Proposed LCDs not released to final LCDs (100)

Final LCDs Alphabetical Index Results [1050 Records]

Selection Criteria: Document Type(s): All LCDs (1275); Active LCDs (916); Retired LCDs (109); Future LCDs/Future contract number LCDs (25); All Proposed LCDs (225); Proposed LCDs released to final LCDs (125); Proposed LCDs not released to final LCDs (100)

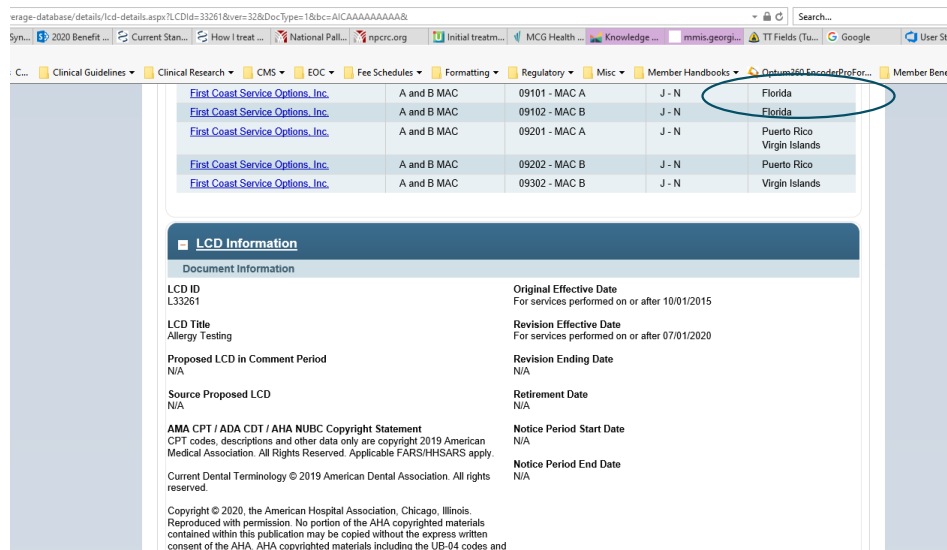
Proposed Status Legend:

- D=Proposed under Development, not yet released for comment
- C=Proposed LCD released for comment
- E=Formal comment period has ended, comments now being considered
- F=Final new/revised LCD has been issued for notice
- A=Active policy, notice period complete and policy in effect

Proposed LCDs Alphabetical Index Results [225 Records]

Related Links [2 Links]

- Search the index by Title.
- Review *Contractor Information* to determine if your market (i.e. Ohio, Kentucky etc.) has an LCD.
- When an LCD exists for your market proceed with review of the LCD Information and save the LCD ID and hyperlink in your research summary.



erage-database/details/lcd-details.aspx?LCDId=33261&ver=32&DocType=1&bcs=AICAAAAA...

Syn... 2020 Benefit... Current Stan... How I treat... National Pall... nprc.org... Initial treatm... MCG Health... Knowledge... mmis.georgi... TT Fields (Tu... Google... User Site

C... Clinical Guidelines... Clinical Research... CMS... EOC... Fee Schedules... Formatting... Regulatory... Misc... Member Handbooks... Optum360 EncoderProf... Member Benef

First Coast Service Options, Inc.	A and B MAC	09101 - MAC A	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09102 - MAC B	J - N	Florida
First Coast Service Options, Inc.	A and B MAC	09201 - MAC A	J - N	Puerto Rico
First Coast Service Options, Inc.	A and B MAC	09202 - MAC B	J - N	Virgin Islands
First Coast Service Options, Inc.	A and B MAC	09302 - MAC B	J - N	Virgin Islands

LCD Information

Document Information

LCD ID
L33261

LCD Title
Allergy Testing

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

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Original Effective Date
For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 07/01/2020

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
N/A

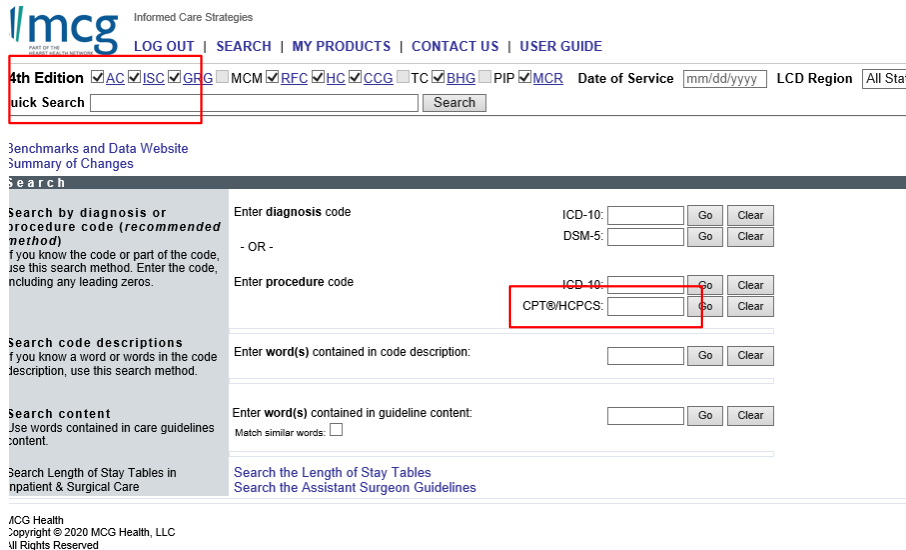
Notice Period End Date
N/A

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- Go to the [Medicare Learning Network \(MLN\)](#)
 - Review MLN Publications for pertinent information affecting your policy topic.
- Go to [CMS Manuals](#) [Got to CMS Manuals](#)
 - There are both paper-based manuals and internet-only manuals.
 - Review both for any pertinent information affecting your policy topic.
- Go to [MCG Health](#) for evidence-based care guidelines. Go to [MCG Health](#) for evidence-based care guidelines.
 - Use the Client Log In as follows:

Medical and Clinical Policy Writer Standard Operating Procedures Catalog

- b. User Name: **caresource**; Password: **mnr**



[LOG OUT](#) | [SEARCH](#) | [MY PRODUCTS](#) | [CONTACT US](#) | [USER GUIDE](#)
 4th Edition ☒ AC ☒ ISC ☒ GRG ☐ MCM ☒ RFC ☒ HC ☒ CCG ☐ TC ☒ BHG ☐ PIP ☒ MCR Date of Service LCD Region All States
 Quick Search
[Benchmarks and Data Website](#)
[Summary of Changes](#)
Search
 Search by diagnosis or procedure code (recommended method)
 If you know the code or part of the code, use this search method. Enter the code, including any leading zeros.
 Enter diagnosis code ICD-10: Go Clear
 - OR - DSM-5: Go Clear
 Enter procedure code ICD-10: Go Clear
 CPT®/HCPCS: Go Clear
 Search code descriptions
 If you know a word or words in the code description, use this search method.
 Enter word(s) contained in code description: Go Clear
 Search content
 Use words contained in care guidelines content.
 Enter word(s) contained in guideline content: Go Clear
 Match similar words: ☐
 Search Length of Stay Tables in inpatient & Surgical Care
[Search the Length of Stay Tables](#)
[Search the Assistant Surgeon Guidelines](#)
 MCG Health
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- c. Search policy topic as follows:
- Go to Quick Search (or you can look up the service by the CPT/HCPCS code if known).
Note: Clinical guidelines do not exist for every policy topic. MCG Health topic titles vary and may need to be slightly changed in order for the search engine to pull the information and in some cases only appear in search results through a CPT code search.
 - Click on appropriate hyperlink under *Guideline Code*.
 - Click and review *Clinical Indications* (This information may be expanded for full details)
 - Review *Evidence Summary* for Criteria, Inconclusive or Non-Supportive Evidence.
 - Review MCG Health's reference and bibliography section. This is very helpful in pointing to the latest and relevant clinical studies and standard of care guidelines
 - Save the associated Guideline Code and hyperlink and the information pertinent to the policy in the research summary document.
Note: MCG Health clinical indications and guidelines must be used "word for word". When using MCG Health clinical indications or guidelines in the policy, you must copy, paste and italicize all MCG verbiage exactly as it appears per MCG requirements. A footnote reference noted in the medical policy should be utilized.

10 results for mammography

Guideline Code	Product	Type	Title
N2204v1	MCR	NCD	NCD Mammograms (220.4) Version 1
L33950R017	MCR	LCD	LCD Breast Imaging Mammography/Breast Echography (Sonography)/Breast MRI/Ductograph
L34953R005	MCR	LCD	LCD Cardiac Event Detection Monitoring (L34953) Revision 5
L35007R012	MCR	LCD	LCD Vestibular and Audiologic Function Studies (L35007) Revision 12
L35434R005	MCR	LCD	LCD Oximetry Services (L35434) Revision 5
L35448R016	MCR	LCD	LCD Independent Diagnostic Testing Facility (IDTF) (L35448) Revision 16
L37371R004	MCR	LCD	LCD Electrorretinography (ERG) (L37371) Revision 4
A-0039	AC	ACG	Mammography
A-0048	AC	ACG	Breast MRI
A-MPC	GRG	ADV	Minor procedure; inpatient care need not clear

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24th Edition ☒ AC ☒ ISC ☒ GRG ☐ MCM ☒ RFC ☒ HC ☒ CCG ☐ TC ☒ BHG ☐ PIP ☒ MCR Date of
Quick Search

Ambulatory Care > Imaging > Miscellaneous Imaging Techniques > Mammography (A-0039)

Mammography

ACG: A-0039 (AC)
[Link to Codes](#)

- Clinical Indications for Procedure
- Evidence Summary
 - Background
 - Criteria
 - Inconclusive or Non-Supportive Evidence
- References
- Footnotes
- Codes

Clinical Indications for Procedure

[Return to top of Mammography - AC](#)

[Expand All / Collapse All]

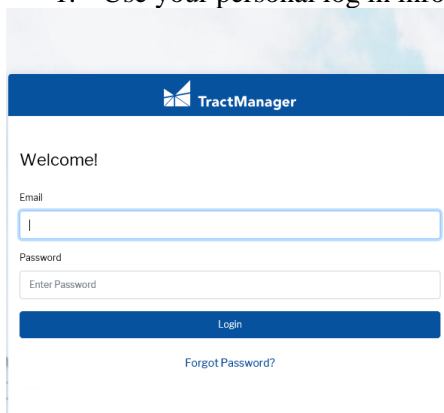
- Mammography may be indicated for 1 or more of the following (1)(2)(3)(4):
 - ☐ Breast abnormality, known or suspected, as indicated by
 - ☐ Breast cancer, known, and
 - ☐ Breast cancer screening (ie, no prior diagnosis of breast or ovarian cancer in patient), as indicated by
 - ☐ Gynecomastia, as indicated by
 - ☐ Occult breast cancer, suspected (eg, unknown primary), as indicated by
 - ☐ Repeat evaluation of specific area or structure with same imaging modality, as indicated by

Evidence Summary

[Return to top of Mammography - AC](#)

F. Go to [Hayes](#). Use the Hayes search engine to perform a search on the policy topic. The Hayes Medical Technology Directory will return search results when available.

1. Use your personal log in information (this is assigned by Policy Management).



TractManager

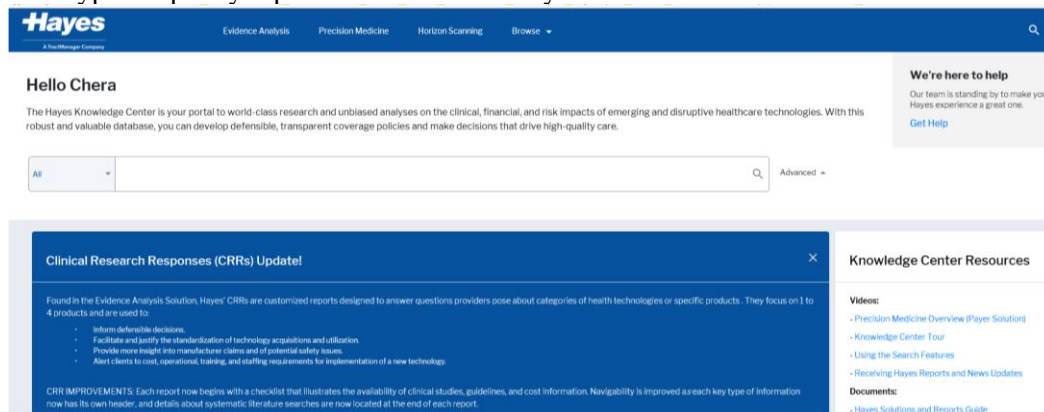
Welcome!

Email

Password

[Forgot Password?](#)

2. Type the policy topic/similar into “Enter your search here.”



Hayes
A TractManager Company

Evidence Analysis Precision Medicine Horizon Scanning Browse

Hello Chera

The Hayes Knowledge Center is your portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care.

We're here to help
Our team is standing by to make your Hayes experience a great one.
[Get Help](#)

All Advanced

Clinical Research Responses (CRRs) Update!

Found in the Evidence Analysis Solution, Hayes' CRRs are customized reports designed to answer questions providers pose about categories of health technologies or specific products. They focus on 1 to 4 products and are used for:

- Inform defensible decisions.
- Facilitate and justify the standardization of technology acquisitions and utilization.
- Provide more insight into manufacturer claims and of potential safety issues.
- Alert clients to cost, operational, training, and staffing requirements for implementation of a new technology.

CRR IMPROVEMENTS: Each report now begins with a checklist that illustrates the availability of clinical studies, guidelines, and cost information. Navigability is improved as each key type of information now has its own header, and details about systematic literature searches are now located at the end of each report.

Knowledge Center Resources

Videos:

- Precision Medicine Overview (Player Solution)
- Knowledge Center Tour
- Using the Search Features
- Recovering Hayes Reports and News Updates

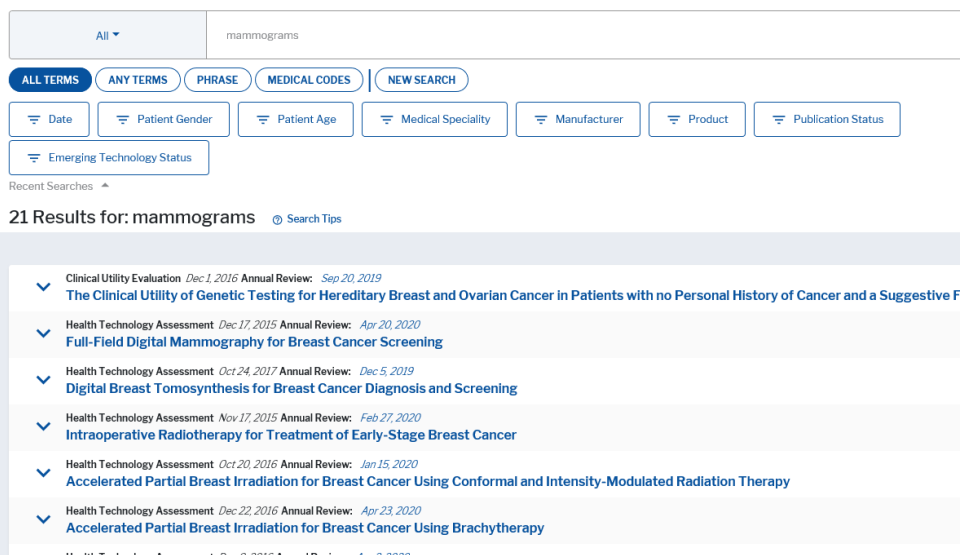
Documents:

- Hayes Solutions and Reports Guide

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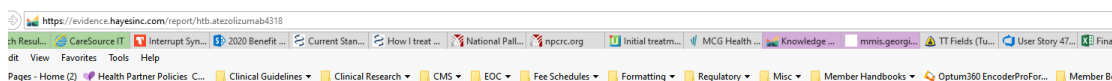
3. Review search results according to validity of the result and the publication date.
 - a. Standard guideline is to not use reports that are older than 5 years.

Search Results



The screenshot shows the CareSource search interface. At the top, there's a search bar with 'mammograms' entered. Below the search bar are filters for 'All', 'ANY TERMS', 'PHRASE', 'MEDICAL CODES', and 'NEW SEARCH'. There are also filters for 'Date', 'Patient Gender', 'Patient Age', 'Medical Specialty', 'Manufacturer', 'Product', and 'Publication Status'. A 'Recent Searches' section shows '21 Results for: mammograms'. The results list includes several clinical utility evaluations and health technology assessments, such as 'The Clinical Utility of Genetic Testing for Hereditary Breast and Ovarian Cancer in Patients with no Personal History of Cancer and a Suggestive F' and 'Full-Field Digital Mammography for Breast Cancer Screening'.

- b. Do not use reports that have been *Archived*.
4. Select valid reports reviewing the full report, including:
 - a. Executive summary.
 - b. Hayes Rating. CareSource generally only accepts reports with a rating of a “B” or above, but there may be exceptions.
 01. Any policy topic with a rating of a “C” or below should be brought to the appropriate medical director(s) or SME’s attention for further discussion re: quality of evidence around the policy topic.
 02. Continue preliminary topic research as instructed below to determine if other evidence-based results are found, but the policy topic may be considered “unproven and experimental” and require further discussion.
 03. Review elements in the report that may directly impact the policy.



The screenshot shows a web browser displaying the CareSource report for Atezolizumab. The browser address bar shows 'https://evidence.hayesinc.com/report/htb.atezolizumab4318'. The page header includes navigation links like 'Home', 'Health Partner Policies', 'Clinical Guidelines', 'Clinical Research', 'CMS', 'EOC', 'Fee Schedules', 'Formatting', 'Regulatory', 'Misc', 'Member Handbooks', 'Optum360 EncoderProFor...', and 'Member Bar'.

Precision Therapy Assessment Mar 5, 2018 | Annual Review: Jun 3, 2020

Atezolizumab (Tecentriq) for Non-Small Cell Lung Cancer



For atezolizumab for the treatment of advanced or metastatic non-small cell lung cancer (NSCLC).

At a Glance Health Technology Clinical Use Evidence Evaluation Technology Impact Regulation and Guidance Additional Information

At a Glance

Focus of the Report

This report focuses on atezolizumab (Tecentriq; Genentech Inc.) for the treatment of adults with advanced or metastatic non-small cell lung cancer (NSCLC).

Technology Description

Atezolizumab is an immune checkpoint inhibitor recently developed for the treatment of NSCLC and other tumors. It is a humanized monoclonal antibody that blocks the interaction between the programmed cell death-1 (PD-1) protein, which is expressed on T cells, binds with PD-L1. T-cell function is suppressed. Many tumor types, including NSCLC, also express PD-L1 either on the tumor cells (TC) themselves or on cells that infiltrate the tumor. Tumors can exploit the PD-1 pathway by upregulating their production of PD-L1, allowing them to evade natural immune surveillance. By blocking the PD-L1/PD-1 immune checkpoint, atezolizumab reduces the ability of tumor cells to evade the immune system and allows the T cells to function against the tumor.

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04. Save the hyperlink and the information pertinent to the policy in the research summary document.

G. Go to [UpToDate](#):

1. Use your personal log-in information (This is assigned by Policy Management).

Log In

UpToDate Username
"kara.nurrenbrock@caresource.com" x

UpToDate Password

☒ Remember me [Forgot Username or Password?](#)

[OpenAthens Log In](#) [Institutional Log In](#)

Log In

Subscribe

UpToDate offers a number of subscriptions and add-on products, allowing you to have the most up-to-date information and improve patient care.

2. Type the policy topic/similar into Search UpToDate.

3. Review search results according to topic and the publication date.

a. Standard guideline is not to use reports that are older than 5 years.

Contents Calculators Drug Interactions UpToDate Pathways

< Back

mammogram screenin Find Patient Print Share A Bookma

Topic Outline

SUMMARY AND RECOMMENDATIONS

INTRODUCTION

BREAST CANCER RISK DETERMINATION

Initial assessment of risk

Clinical use of risk prediction models

- Gail model
 - Limitations of the Gail model
- Models predicting pathogenic BRCA1/2 mutations

AVERAGE RISK: SCREENING

Age-related screening approach

- Age under 40
- Age 40 to 49
- Age 50 to 74
- Age 75 and older

Screening modalities

- Mammography as preferred screening modality
- Other imaging modalities
- Role of clinical breast examination
- Role of breast self-examination

Frequency of screening with mammography

Screening for breast cancer: Strategies and recommendations

Authors: Joann G Elmore, MD, MPH, Christoph I Lee, MD, MS
Section Editor: Mark D Aronson, MD
Deputy Editor: Lisa Kunins, MD
[Contributor Disclosures](#)

All topics are updated as new evidence becomes available and our [peer review process](#) is complete.
Literature review current through: Oct 2020. | This topic last updated: Oct 20, 2020.

INTRODUCTION

Breast cancer is the most frequent type of non-skin cancer and the most frequent cause of cancer death in women worldwide, and it is the second most frequent cause of cancer death in United States women. (See "Clinical features, diagnosis, and staging of newly diagnosed breast cancer", section on 'Introduction' and "Clinical features, diagnosis, and staging of newly diagnosed breast cancer", section on 'Epidemiology' and "Diagnostic evaluation of women with suspected breast cancer", section on 'Introduction'.)

The majority of breast cancers in the United States are diagnosed as a result of an abnormal screening study, although a significant number are first brought to attention by the patient. Findings suggest that screening mammography both reduces the odds of dying of breast cancer and facilitates the use of early treatment. Breast cancer mortality has dropped dramatically since the 1980s, and both earlier detection through screening and improvements in breast cancer treatment are responsible for this reduction in mortality [1-6].

Recommendations for breast cancer screening, taking into account the risk of developing breast cancer, other parameters that might affect screening decisions, and benefits and harms of screening, are discussed here.

Identification and management of women with a genetic predisposition to breast cancer, and surveillance in women with a personal history of breast cancer, are discussed in detail separately. (See "Genetic testing and management of individuals at risk of hereditary breast and ovarian cancer syndromes" and "Cancer risks and management of BRCA1/2 carriers without cancer" and "Approach to the patient following treatment for breast cancer".)

The evidence for the effectiveness and harms of screening for breast cancer in women, and performance characteristics of mammography, are discussed in detail separately. (See "Screening for breast cancer: Evidence for effectiveness and harms" and "Breast imaging for cancer screening: Mammography and ultrasonography".)

b. Save the hyperlink and the information pertinent to the policy in the research summary document.

H. Go to [Policy Reporter](#) - Policy Reporter provides a policy topic market comparison and should be used for research, review and market trending purposes only. **Do not copy and paste information from Policy Reporter into the policy draft. The information is considered proprietary and should only be used as a reference tool. (Please also see: [Navigating Policy Reporter](#) for more detailed information on Policy Reporter)**

1. Review a cross sampling of commercial plans and other Medicaid market Care Management Organization (CMO) plans for market trends.

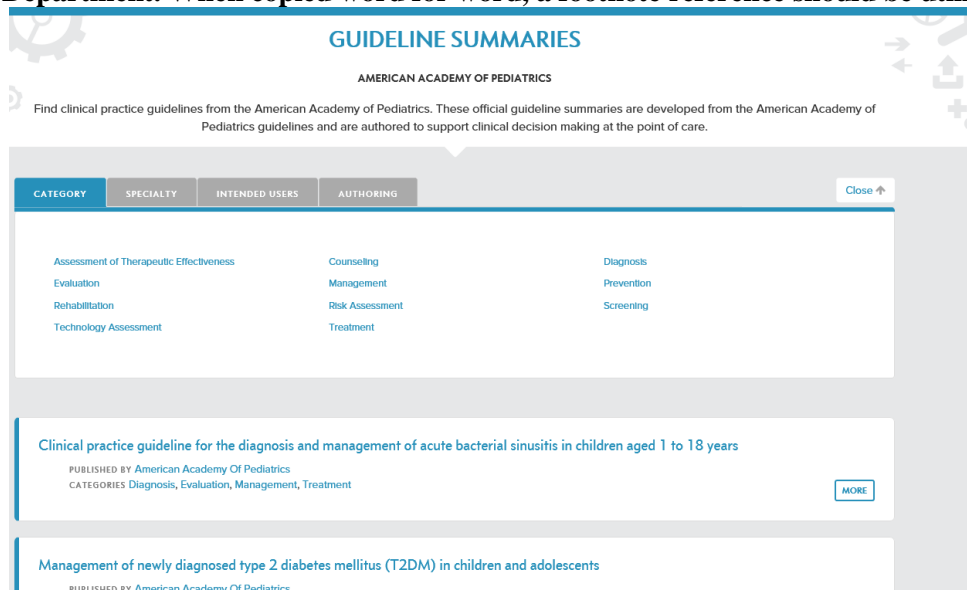
a. Ohio:

01. Buckeyehealth
02. UHCcommunity
03. Paramountadvantage
04. Molinahealthcare

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- b. Indiana:
 - 01. Anthem
 - 02. Mdwise
 - 03. Mhsindiana
- c. Georgia:
 - a. Pshpgeorgia
 - b. Wellcare
 - c. Amerigroup
- I. Research professional society recommendations and standards of care specific to the policy topic, including, but not limited to:
 - 1. American Diabetes Association
 - 2. American Academy of Pediatrics
 - 3. American Society for Metabolic and Bariatric Surgery
 - 4. American College of Obstetricians and Gynecologists
 - 5. Endocrine Society

Note: Professional society recommendations should be quoted verbatim within the policy per the Legal Department. When copied word for word, a footnote reference should be utilized.



- J. [General Benefit Guidance](#)
- K. MCD and MA guidance
 - 1. **Medicare Advantage:** Centers for Medicaid and Medicare Services (CMS) [CMS.gov](#)
 - 2. **Ohio Medicaid:** [Ohio Administrative Code OAC 5160 Medicaid](#); [Ohio Revised Code](#); [Covered Services](#); [ODM modifier](#); [ODM guidance](#)
 - 3. **Indiana Medicaid:** [IAC](#); [Medical Policy Manual](#); [Indiana Provider References](#)
 - 4. **Georgia Medicaid:** [GAMMIS Georgia Department of Community Health \(DCH\)](#) (go to Provider Information -> Provider Manuals), [Official Code of Georgia Annotated O.C.G.A](#)
 - 5. **Arkansas Passe:** [Forms and Docs](#), [Provider Manuals](#), [fee schedules](#), [code tables](#), [SharePoint](#)
 - 6. **Mississippi:** [Admin code](#), [fee schedule](#), [admin code](#), [Provider Handbook](#), [state plan](#)
- L. Marketplace guidance: Statutes have authority over regulations:
 - a. Government agencies are creatures of statute, so their rules and regulations may not exceed their statutory authority.

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- b. In matters of Federal requirements vs state requirement, the Federal government sets the minimum or “floor” for member protection.
 - c. A State legislature or DOI may require more protection, but not less:
 - a. For example, if the Federal law requires an insurer to respond within 30 days, a State may require a quicker response.
 - b. Conversely, if Federal law gives the member 180 days to appeal, the State may give the member a longer time frame.
- M. Other sources:
1. Code of Federal Regulations, Title 45 (Public Welfare), Subtitle A (Department of Health and Human Services), Subchapter B (Requirements Relating to Health Care Access) Primarily: 45 CFR 147 & 45 CFR 156 <https://www.cms.gov/ccio/resources/data-resources/ehb.html>, <https://www.federalregister.gov/>
 2. U.S. Code: Affordable Care Act in Title 42, Ch. 157 of USC, starting at Section 18001 (42 USC 18001, et al) [42 U.S. Code CHAPTER 157— QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS](#)
 3. Georgia:
 - a. Statutes: Official Code of Georgia (OCG) Title 33, Insurance
 - b. Regulations: Rules and Regulations of the State of Georgia (Ga. Comp. R. & Regs.) Title 120 Rules of the Comptroller General, Chapter 120-2 Rules of the Commissioner of Insurance
 - c. (For HMO): Title 290 Rules of the Department of Human Services, Chapter 2980-5 Public Health, Subject 37 Health Maintenance Organizations (290-5-37) <http://rules.sos.ga.gov/gac/>
 - d. Department of Insurance (DOI): <https://www.oci.ga.gov/>
 4. Indiana
 - a. Statutes: Indiana Code (IC), Title 27, Insurance
 - b. Regulations: Indiana Administrative Code (IAC),
 - c. Title 760 Department of Insurance (DOI), Article 1 <https://www.in.gov/doi/>
 5. Kentucky
 - a. Statutes: Kentucky Revised Statutes (KRS), Title XXV, Business and Financial Institutions, Chapter 304 Insurance Code
 - b. Dept. of Insurance (DOI): https://insurance.ky.gov/ppc/new_default.aspx
 - c. Regulations: Kentucky Administrative Regulations (KAR),
 6. North Carolina
 7. Ohio
 - a. Statutes: Ohio Revised Code (ORC) Title 39 Insurance; Title 17, Ch. 1751 Health Insuring Corp.
 - b. Regulations: Ohio Administrative Code (OAC) <http://codes.ohio.gov/oac/3901-8-16v1>
 - c. 3901 Department of Insurance (DOI) <https://insurance.ohio.gov/wps/portal/gov/odi>
 8. West Virginia
 - a. Statutes: West Virginia Code (W. Va. Code) Chapter 33 Insurance
 - b. Regulations: West Virginia Code of State Rules (W. Va. CSR), Insurance Commissioner (§ 114) <https://www.wvinsurance.gov/>
 - c. Department of Insurance (DOI) <https://www.wvinsurance.gov/HealthPolicy>
 9. Marketplace EOC links:
 - a. OH: [EOC](#)
 - b. IN : [EOC](#)
 - c. KY : [EOC](#)
 - d. WV: [EOC](#)
 - e. GA: [EOC](#)
 - f. NC: [EOC](#)
 10. Other marketplace resources:
 - a. [Preventive Health Services HealthCare.gov](#) Affordable Care Act (ACA) standards
 - b. [The Patient Protective and Affordable Care Act](#)
 - c. [Essential Health Benefits Benchmark Plans](#)


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- N. Research sources for standard of care guidelines, including but not limited to:
 1. [United States Preventive Services Task Force \(USPSTF\)](#)
 2. [National Institutes of Health \(NIH\)](#)
 3. [Centers for Disease Control and Prevention \(CDC\)](#) The CDC should be consulted for data and statistical information. This is also an excellent resource for Charts and Tables, including: Growth Charts etc.
 4. National Library of Medicine. [PubMed.gov](#)
 - O. Go to Google and Google Scholar Articles. Depending on the complexity of the policy and the medical literature it may be useful to google the policy topic.
 1. In general a quick google search is a good standard of practice during the research process in order to catch any new updates or information that may not have been encountered otherwise.
 2. [Google Scholar](#) is an excellent resource for more complex and in depth policy topics when the research sources above did not produce good results.
- IV. Review the CareSource provider manuals for accuracy to align manual and/or policy by clicking on the below links:
- A. Ohio
 1. Ohio Medicaid - <https://www.caresource.com/providers/ohio/ohio-providers/plan-resources/provider-manual/>
 2. Ohio Marketplace - <https://www.caresource.com/documents/mp-health-partner-manual/>
 3. Ohio Medicare Advantage - <https://www.caresource.com/documents/ma-health-partner-manual/> Ohio Medicare Advantage DSNP - [Provider Manual | Ohio – Dual Special Needs | CareSource](#)<https://www.caresource.com/documents/ma-health-partner-manual/>
 4. Ohio MyCare - [Provider Manual | Ohio – MyCare | CareSource](#)
 - B. Kentucky Marketplace - <https://www.caresource.com/documents/mp-health-partner-manual/> Kentucky Marketplace - <https://www.caresource.com/documents/mp-health-partner-manual/>
 - C. Indiana
 1. Indiana Medicaid - <https://www.caresource.com/documents/in-hip-hhw-health-partner-manual/>
 2. Indiana Marketplace - <https://www.caresource.com/documents/mp-health-partner-manual/>
 3. Indiana DSNP - [Provider Manual | Indiana – Dual Special Needs | CareSource](#)
 - D. Georgia
 1. Georgia Medicaid - <https://www.caresource.com/documents/ga-provider-manual/>
 2. Georgia Marketplace - <https://www.caresource.com/plans/marketplace/plan-documents/>
 3. Georgia DSNP - [Provider Manual | Georgia – Dual Special Needs | CareSource](#)
 - E. West Virginia Marketplace - <https://www.caresource.com/documents/mp-health-partner-manual/> West Virginia Marketplace - <https://www.caresource.com/documents/mp-health-partner-manual/>
 - F. Arkansas PASSE - [Provider Manual | Arkansas – CareSource PASSE | CareSource](#)
 - G. North Carolina Marketplace - [Provider Manual | North Carolina – Marketplace | CareSource](#)
 - H. Mississippi TrueCare -
- V. Collaborate with
- A. SME (see SME List)
 - B. Legal as needed
 - C. Finance as needed
 - D. Program Integrity (PY and AD)
 - E. Regulatory as needed
 - F. Configuration for all policies and addressed in the weekly Configuration Meeting.
 - G. Behavioral Health if applicable
 - H. Utilization Management for all policies and addressed in the weekly UM Meeting.
 - I. Medical Directors for all clinical policies
 - J. Other Writers.

Medical and Clinical Policy Writer
Standard Operating Procedures Catalog
D. REVIEW / REVISION HISTORY

<i>Tracking history commenced January 2011</i>			
Review	Revision	Date	Description of Changes
<input type="checkbox"/>	<input type="checkbox"/>	12/27/2018	Separated step in policy process into its own policy
<input type="checkbox"/>	<input type="checkbox"/>	5/9/2019	Updated links and verbiage.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	3/6/2020	Updated screenshots and verbiage
<input type="checkbox"/>	<input checked="" type="checkbox"/>	05/01/2020	Updated screenshots and process
<input type="checkbox"/>	<input checked="" type="checkbox"/>	12/01/2020	Updated process: PA List information (Accenture); hyperlinks; screenshots;
<input type="checkbox"/>	<input checked="" type="checkbox"/>	03/25/2021	Updated: PA List and EOC Links
<input type="checkbox"/>	<input checked="" type="checkbox"/>	07/12/2021	Updated to include PA LookUp Tool information.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	1/27/2022	Added Arkansas
<input type="checkbox"/>	<input checked="" type="checkbox"/>	03/02/2023	Added North Carolina, updated links, added Mississippi (no links yet)

Medical and Clinical Policy Writer
Standard Operating Procedures Catalog

STANDARD OPERATING PROCEDURE (SOP)		
Attachments	Creation Date	
<input type="checkbox"/> Yes <input type="checkbox"/> No	12/27/2018	Step Seven: Draft

A. DESCRIPTION / PURPOSE

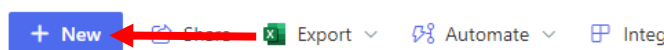
The purpose is to standardize the process in which the policy writer drafts administrative, medical, and reimbursement policies.

B. DEFINITIONS

- American Medical Association (AMA) Style:** A formatting style use to cite sources most commonly within the medical sciences.
- Annual Update:** A policy that is due for review every year on a specific date. These policies can be approved “Without Change”, “With Revisions”, or “Archived”.
- Business Owner:** The official owner of a policy.
- Effective Date:** The effective date is the date the policy goes into effect and is determined according to when the policy content and Network Notification is approved both internally and externally, depending on the state and market impacted.
- In-Text Citation:** a quick reference within the body of the written document that corresponds with the full document reference list
- Policy Governance Committee (PGC):** This committee is comprised of clinical and non-clinical members of multiple CareSource departments. The goal of the committee is to review and approve/deny Medical, Reimbursement and Administrative policy requests, policy annual updates, policy revisions and new policies.
- Policy Governance Committee Intake Request Form:** A form submitted electronically by the policy Business Owner/Owners that documents a formal request for a policy.
- Revision:** Interim edits other than for purpose of an “Annual Update” due to criteria changes or other evidence-based, peer-reviewed information. A previous “Rejected” policy may be re-introduced as a revised policy for consideration and approval.
- Subject Matter Expert (SME):** A person who is an authority on a particular topic or subject matter.

C. PROCEDURE

- Drafting policy:** Select A or B based on the appropriate scenario.
 - Creating a New Policy (new market, or new topic following intent meeting and research):**
 - In the Clinical Policy SharePoint Site, select the appropriate policy type (Administrative, Medical, or Reimbursement) under [Policy Number Generator](#). Select +New.



Policy Number Generator □ ⊙ > Administrative

- A New item window will open:

Medical and Clinical Policy Writer Standard Operating Procedures Catalog

Save Cancel Copy link

New item

Title *

Enter value here

You can't leave this blank.

Policy # *

Enter value here

Category *

—

LOB *

—

State(s) *

—

Comments

Enter value here

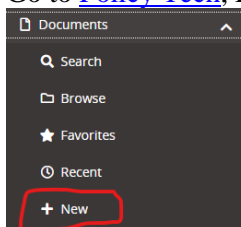
Attachments

Add attachments

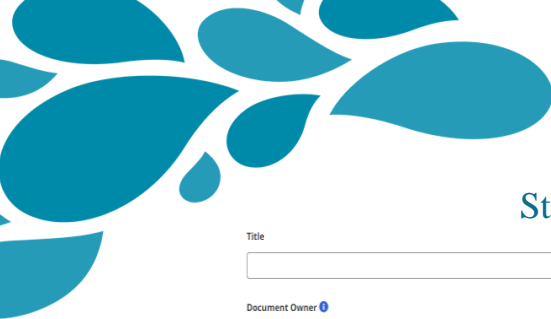
Save

Cancel

3. Required fields are marked by a red asterisk * on the intake form.
 - a. Enter **Title**. Policy title is subjective to research and clarity of titling.
 - b. Enter the next sequential ID number for **Policy #** based on the AD- MM- or PY- table.
 - c. Select policy **Category** from dropdown.
 - d. Select **Line of Business** from dropdown.
 - e. Select **State(s)** from dropdown.
 - f. Click **Save**.
4. When the policy number has been generated, the number can be added to the draft policy in Policy Tech.
5. Go to [Policy Tech](#), Documents, and + NEW.



6. Select Word Document.
7. In the new window, type the policy title, including the market, category, and newly generated policy number (e.g., Modifiers-OH MCD-PY-1234) (see below).



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Title [Advanced Settings](#) →

Document Owner ⓘ [Owner Instructions](#)

Vitullo, Kathleen (Medical/Clinical Policy Writer)

Template ⓘ

Clinical Policy Template [Preview](#)

Version Number

1


Reference # To be generated on next step

Publication Date ⓘ ⓘ [End Date \(Optional\)](#) ⓘ

Publish on (Require completion before publication)

8. Select the policy writer as the “Document Owner”.
9. Select appropriate Clinical Policy Template under the Template drop down menu.
10. Set Publication date as “12.25.2030”. Click Next Step.

Sites

Department 

Categories

****Clinical Policies**

****Document Type**


****Line of Business**



****Policy Type**


****Product**


****State**


11. On the Visibility tab, starting at the top, select “Sites” and change checked box from Enterprise to Clinical Policy. Skip Departments. Go through all remaining Categories and select all relevant boxes for the policy.
12. Under Clinical Policies, do NOT select ABC section – expand relevant alphabetical region and check box the appropriate policy title. If you do not see the title of your policy, contact Policy Tech administrator (e.g., Jessica or Kathleen) for assistance.

☒  ☐ A-D

☒   ☐ E-K

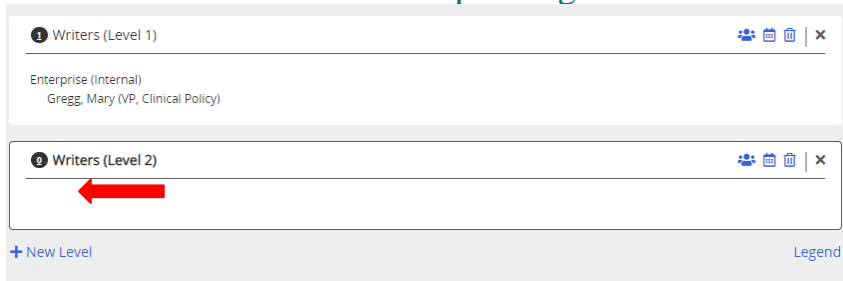
 ☐ Early Intervention Day Treatm

 ☐ Electrodiagnostic Testing

 ☐ Emergency Ambulatory Respi

13. Under Writers tab, make sure Dr. Gregg is listed as Level 1 Writer. Add any other appropriate SMEs to Level 1 (Intent meeting attendees?).
14. Remove any unnecessary writers from a level by clicking the name(s) (they’ll be located at the red arrow) and clicking the trash can icon (red circle). Add yourself as writer to Level 2.

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Writers (Level 1)

Enterprise (Internal)
Gregg, Mary (VP, Clinical Policy)

Writers (Level 2)

+ New Level

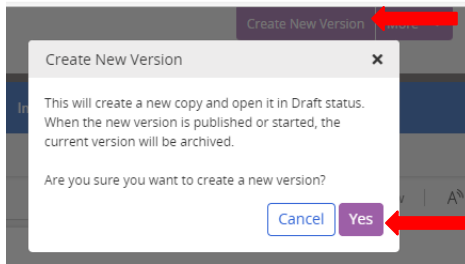
Legend

15. Add other writers to Level 3 (click +New Level).

16. Select Edit Document to begin working on the policy (see B.8 below) or Save if returning later.

B. Open a new web browser window, and navigate to [The Clinical Policy and Oversight](#) Sharepoint page. Open a new web browser window, and navigate to [The Clinical Policy and Oversight](#) Sharepoint page. **Revision or Annual Update of existing policy:**

1. Go to Policy Tech, My Tasks. Select a policy with a looming deadline to work on (Policy Tech adds tasks 6 months prior to a policy's deadline).
2. Select "Create New Version", and "Yes" when prompted if you want to create a new version.



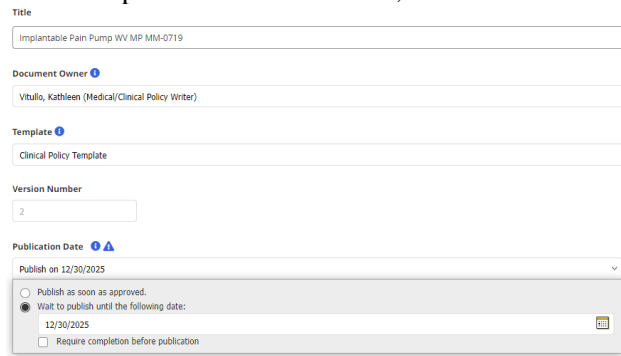
Create New Version

This will create a new copy and open it in Draft status.
When the new version is published or started, the current version will be archived.

Are you sure you want to create a new version?

Cancel Yes

3. In the Properties Wizard window, set the Publication Date to 12/25/2030. Click Next Step.



Title

Implantable Pain Pump WV MP MM-0719

Document Owner

Vitullo, Kathleen (Medical/Clinical Policy Writer)

Template

Clinical Policy Template

Version Number

2

Publication Date

Publish on 12/30/2025


☐ Publish as soon as approved.

☒ Wait to publish until the following date:

12/30/2025

☐ Require completion before publication

4. Verify the visibility is accurate for Site (Clinical Policy (External)) and all Category options. Click Next Step.



Choose where to make this content visible

Sites

Categories

**Clinical Policies

**Document Type

**Line of Business

**Policy Type

**Product

**State

Current Selections

Site: Clinical Policy (External)

Category: Clinical Policies

Implantable Pain Pump (E-K)

Category: Document Type

Policy

Category: Line of Business

WV - Marketplace

Category: Policy Type

MEDICAL

Category: Product

Marketplace

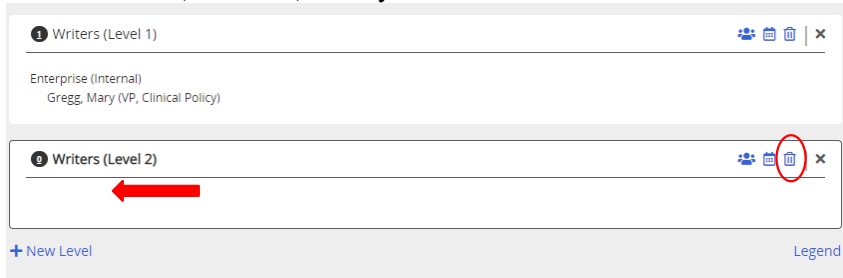
Category: State

West Virginia

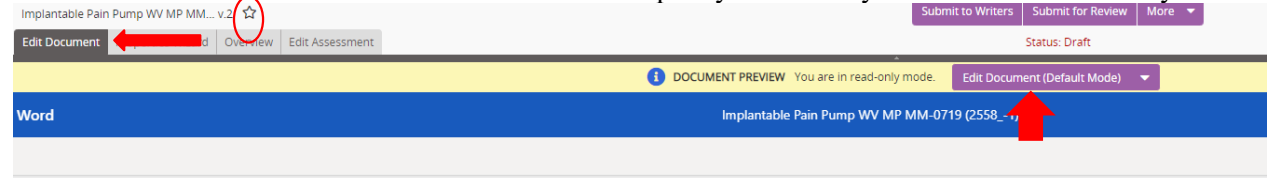
5. Under Writers, make sure Dr. Gregg is listed as Level 1 Writer. Add any other appropriate SMEs to Level 1.

Medical and Clinical Policy Writer Standard Operating Procedures Catalog

6. Remove any writers from a level by clicking the name(s) (they'll be located at the red arrow) and clicking the trash can icon (red circle). Add yourself as writer to Level 2.



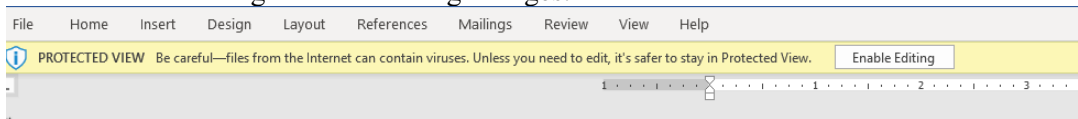
7. Add other policy writers to Level 3. Click Save.
8. Click "Edit Document". Click the star icon to save this policy version to your Favorites list for easy access.



9. Click the purple "Edit Document (Default Mode)" located in the top center of the page. Make changes to the policy in the desktop application of Word.

Note: do not close the webpage after the document opens in the desktop application. This will cause issues with saving the file when you've finished making edits.

10. Click "Enable Editing" to start making changes.



II. Section Specific Guidelines:

NOTE: For lists in any section of the policy, use number formatting tools in word (not key strokes) to make future edits easier.

A. **Subject**

1. The subject topic is the same as the policy name and should be in bold 11 font

B. **Background**

1. Background section should tell a story around the policy topic. The Hayes and UpToDate research databases used during the research step are good starting points for sourcing this information, but this section should be the summation of your research as a whole providing details such as:
 - a. Summary of the issue the policy is meant to address.
 - b. The latest medical evidence-based research and studies regarding the policy topic.
 - c. The latest statistics and data regarding the policy topic.
 - d. Policy's purpose/intent.

Example: Medical policy should address public health concern, how the policy topic addresses/treats concern, any known issues with the policy topic.

C. **Definitions**

1. Include any definitions that are pertinent to the understanding of the policy. The business owner may have also provided definitions in the Intake Request Form when they filled it out. This is a provider facing policy and should be written for the clinical reader, but should also be understandable to a non-clinical audience as the policy also serves non-clinical internal partners. Definitions for the policy should be obtained from the following sources:
 - a. Evidence-based medical literature sources encountered during the research portion of the process.

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- b. State or market definitions as found in the regulations The definitions designated by an individual state or federal resource for any term should be used for that particular state or market before using other sourced definitions. Other resources should be referenced only when these are not available.

NOTE: Wikipedia is not considered a credible medical policy source for definitions.

2. Definitions should be formatted as:
 - **Definitions** - normal font
 - **Secondary Definition Title** - normal font
 - **Third layer of definition Title** - normal font

D. **Policy**

1. This should be looked at in a holistic approach from the research previously gathered. Keeping in mind benefit determinations and best practices already discovered in the research phase of the process. Common set-up includes:
 - a. Medical Policy:
 1. Section I: CareSource considers (topic) medically necessary when ALL the following clinical criteria are met: (NOTE: only IN MCD allows use of “*Prior authorization is required for...*” language).
 2. Section II: Limitations/Exclusions
 3. Section III, IV, etc.: other pertinent situations.
 - b. Reimbursement Policy - should address:
 1. Appropriate scenarios for coverage
 2. Inappropriate scenarios/non-coverage information
 3. Any relevant coding information, if necessary (try to avoid using actual codes, to prevent excess re-writes)
 4. Limitations/exclusions
 5. Billing processes
 - c. Administrative Policy – should address:
 1. CareSource processes
 2. Regulatory details (e.g., rules and requirements)
 3. Limitations/Exclusions, if applicable.

E. **Conditions of Coverage**

This section is not currently being used except for occasional reimbursement policies.

F. **Related Policies/Rules**

1. This section should include a list of any CareSource provider accessible policies or rules that directly relate to the policy topic being drafted. This may include the following:
 - a. Corresponding policies with the same topic/benefit/service (only include the policy name, not the policy number to minimize risk. i.e. Itemized Billing, not Itemized Billing policy MM-0011).
 - b. An example of a rule, for example, the EOC.

G. **Review/Revision History**

1. This section is used to keep a record of policy activity, including:
 - a. Date Issued: This is the date the policy is first presented and approved at PGC but will be left as TBD during the drafting process of a new medical policy. For policy revisions, this date remains the same and does not change over the life of the policy.
 - b. Date Revised: This date documents any instances where the policy has been revised over the life of the document and should only be used when policy is revised. Use the PGC approval date here for any revisions to existing policies. This would not be utilized for a new policy. The *Date Revised* section should also include a brief description of the revisions made to the document (e.g., annual review:, out-of-cycle:).
 - c. Date Effective: This is the date the policy goes into effect. This should be left as TBD during the drafting process until this date is later determined by possible state approvals and regulatory requirements and added to the policy before being sent for Configuration and posting to the website. The Effective Date will change every time the policy is updated or revised.

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- d. Archive: This is the date the policy is no longer to be used to determine service/procedure eligibility. Depending on the market, policies may still be posted/visible on the CareSource website after archiving (IN and GA require policies be publically available for 3 years after archiving/retirement). **Leave blank**, as this will be filled out by the Clinical Policy Coordinator/Specialist.

H. References

1. The writer must ensure all information included in the policy is sourced properly and should include the following:
 - a. All references are in a Policy Department approved format that roughly follows the American Medical Association (AMA) format.
 - b. Hyperlinks should **NOT** be used within the references or anywhere within the document in order to source information. This is to minimize the risk of improper links being attached or links that become obsolete over the course of time between the policy effective date and the next policy review date. It is acceptable to place INACTIVE links in the document. Any web address should end in “.com”, “.gov”, etc., removing all but the base location of the reference.
 - c. Footnote format may be used.
 - d. Referenced information should not be more than five years old unless it is the only relevant evidence-based medical literature published on the subject. This is possible in instances when the policy topic is considered stable and the information does not necessarily undergo new studies or change. Any references considered obsolete should be removed, unless as stated above they are the only source of information on the topic.
 - e. Place references in alphabetical order.

III. Policy Review: The below steps are applicable to all policies (new and annual reviews). After policy draft is complete... Review the following:

- A. Arial script
- B. CareSource Logo: now grey (fix: reapply template in PT)
- C. State and line of business in all capitals bold font 18, Arial – E.g.: **OHIO MEDICAID**
- D. Policy name & number, date effective, policy type: font 11, Arial
- E. Effective Date – TBD, Not Set, or 12/25/2030.



MEDICAL POLICY STATEMENT West Virginia Marketplace	
Policy Name & Number	Date Effective
Implantable Pain Pump WV MP MM-0719	Not Set
Policy Type	
MEDICAL	

- F. Review the header information on all pages except for the first page.



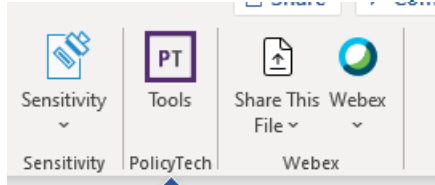
A. SUBJECT

Continuous Glucose Monitoring Systems (CGMS)

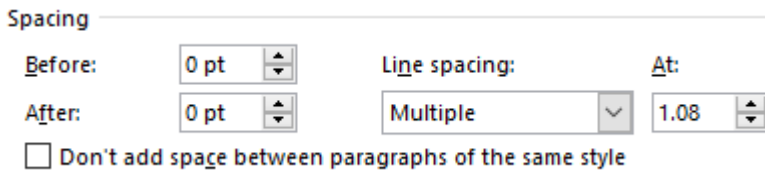
Continuous Glucose Monitoring
GEORGIA MEDICAID
MM-0223
Effective Date: TBD

1. Adjust title line, if too short or too long (hidden by logo).
2. If the information is not correct, use PT Tools, found under Insert > Add-Ins.

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G. Make sure paragraph settings are: Opt, Opt, multiple line spacing, at 1.08.



H. Hard enter between each section (A. B. C. D. (I. II. III. IV.) E. F. G. H) and each paragraph.

I. Section (A. B. C. D. E. F. G. H) font size 12.

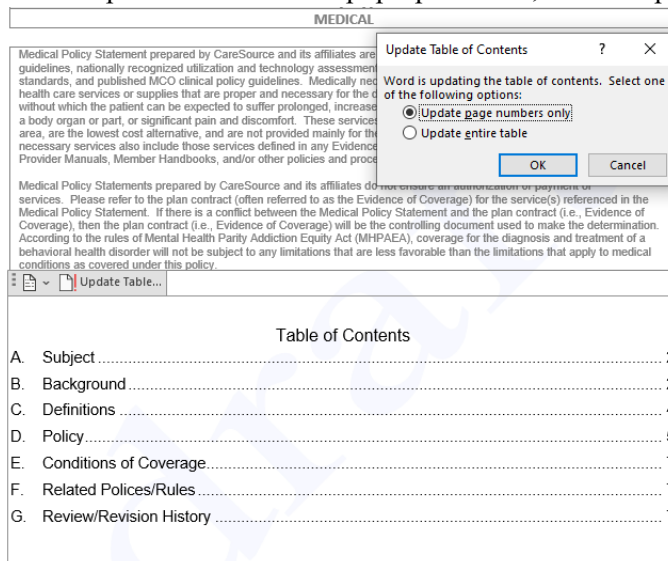
J. Fill in the policy table in Section G using the following information – font 10 or 11, based on what looks appropriate. Make sure data is relevant to policy and market.

K. Make sure the footer is not written twice (in actual footer and in body of document on last page) “[The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.](#)”

L. Remove Independent Medical Review if necessary (end of document).

M. Check for state approval (only applicable for IN MCD and GA MCD).

N. Ensure the page numbers correlate with the proper policy sections in the Table of Contents. Click in the table, then select “Update Table”. In the pop-up window, select “Update entire table” and OK.



IV. Policy Tech Feedback Loop

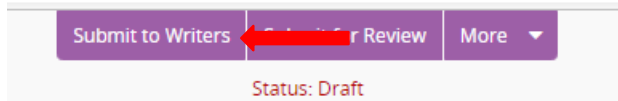
A. Once the policy review has been completed, the writer sends the policy to the Level 1 writers for their signoff.

B. Under Properties Wizard > Writers, set up writers as follows:

1. Level 1 = Dr. Gregg (required) plus any state/market-specific heads (see [SME list](#)) plus any business owner and other identified individuals from the Intent Meeting.
2. Level 2 = yourself.
3. Level 3 = all other policy writers.

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C. Click “Submit to Writers”.




- D. Send an email or message to Dr. Gregg and any relevant Level 1 policy writers to let them know if they need to review all of the policies, or just a few. Each policy must go through the collaboration step, but if the policies are identical, a note can be left in one document for the policy owner to apply the change to all documents.
NOTE: for a new policy topic, often one market is worked up with all the SMEs first (typically OH MCD). Once the language is agreed upon, the rest of the markets can be copied directly from that, and sent out to the market SMEs.
- E. If collaborating on a policy: when finished, hit the “finished writing” button, and leave any additional comments in the pop-up.
- F. If further discussion and review is required after receiving initial feedback from the SMEs during the collaboration step, add a new level and drag the name(s) down to the new level. This can be repeated as many times as necessary to reach agreement on the policy language.
- G. If further discussion and review is required after receiving initial feedback from the SMEs and the policy is back in draft step (e.g., all collaborators have hit “finished writing”), add/remove SMEs as needed, and resend to SMEs by hitting the “Submit to Writers” button again.

D. REVIEW / REVISION HISTORY

<i>Tracking history commenced January 2011</i>			
Review	Revision	Date	Description of Changes
<input type="checkbox"/>	<input type="checkbox"/>	12/27/2018	Separated step in policy process into its own policy
<input type="checkbox"/>	<input type="checkbox"/>	5/9/2019	Updated per new template
<input type="checkbox"/>	<input type="checkbox"/>	01/14/2020	Revised Policy Audit Criteria section and standardized reference format
<input type="checkbox"/>	<input type="checkbox"/>	05/01/2020	Updated screenshots and verbiage
<input type="checkbox"/>	<input checked="" type="checkbox"/>	11/30/2021	Revised criteria
<input type="checkbox"/>	<input checked="" type="checkbox"/>	05/05/2022	Updated process
<input type="checkbox"/>	<input checked="" type="checkbox"/>	04/13/2023	Changed APA to AMA style for references

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STANDARD OPERATING PROCEDURE (SOP)		
Attachments	Creation Date	Step Eight: Utilization Management Review
<input type="checkbox"/> Yes <input type="checkbox"/> No	12/27/2018	

A. DESCRIPTION / PURPOSE

The purpose is to standardize the process in which the policy writer collaborates with Utilization Management once a draft policy is ready for review.

B. DEFINITIONS

C. PROCEDURE


I. Utilization Management Review

- A. All medical policies must be brought for UM review.
 1. If new policy....Once a draft has been completed it must be reviewed by Utilization Management before it is added to the PGC Agenda for final approval. At this time, the policies are being reviewed by Deronda Honig. Present policy at UM fireside meeting.
 2. If existing policy....bring to UM fireside meeting during initial research phase, to identify any issues that need to be addressed during policy's review. The policy may need additional UM review, depending on results of discussion.

D. REVIEW / REVISION HISTORY

<i>Tracking history commenced January 2011</i>			
Review	Revision	Date	Description of Changes
<input type="checkbox"/>	<input type="checkbox"/>	12/27/2018	Separated step in policy process into its own policy
<input type="checkbox"/>	<input type="checkbox"/>	8/23/2019	Added Configuration SME Collaboration
<input type="checkbox"/>	<input checked="" type="checkbox"/>	3/6/2020	Updated screenshots and verbiage
<input type="checkbox"/>	<input checked="" type="checkbox"/>	12/01/20	Updated SME List
<input type="checkbox"/>	<input checked="" type="checkbox"/>	03/25/2021	Updated process from SME review in SharePoint to the current process of Utilization Management Review.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	11/30/2021	Updated contact persons
<input type="checkbox"/>	<input checked="" type="checkbox"/>	03/07/2023	Updated process to include both new policies and revisions

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STANDARD OPERATING PROCEDURE (SOP)		
Attachments <input type="checkbox"/> Yes <input type="checkbox"/> No	Creation Date 12/27/2018	
		Step Nine: Final Revision

A. DESCRIPTION / PURPOSE

The purpose is to standardize the process in which the policy writer prepares final revision of policy.

B. DEFINITIONS

C. PROCEDURE

I. Final Revision

- A. Once all SMEs are satisfied with the policy, create a clean version of the policy (if appropriate) for committee review.
 1. Leave track changes on IN MCD and GA MCD policies.
 2. OH MCD medical policies require specific marking for ODM review. Refer to the latest document from ODM for details.
- B. Check spacing between sentences (1 space).
- C. Check spacing between paragraphs and entire document (0 font before and after, multiple spacing, size 1.08).
- D. Check spelling.
- E. Update references. Verify websites are appropriately truncated.

II. Policy Writer Review

- A. Once you have completed the final version of your policy, add your peers in Properties Wizard as Writers to perform an audit to ensure the policy is ready for final approval. The peer audit should include the following:
 1. Omissions: missing effective and/or revision dates, missing header information (policy title, policy number), AllMed review date if applicable (medical policies – remove date from policy if review is more than 3 years out of date), review/revision summary, related policy title and number are accurate and updated if applicable.
 2. Formatting: use of horizontal and vertical rulers, approved alpha-numeric sequencing, font (Arial,11)
 - D. Policy
 - I. Testing
 - A. Testing
 - 1. Testing
 - a. Testing
 - 01. Testing
 - (1). Testing
 - i. Testing
 - a. Testing
 - A. Testing
 3. Spacing between letters, lines, paragraphs and pages.
 4. Hyperlinks: **NONE PERMITTED.**
 - a. www.cms.gov – ACCEPTABLE (ensure hyperlink is not active).
 - b. www.cms.gov/Medicare_Inpatient - NOT ACCEPTABLE
 5. References in alphabetical order with the appropriate format, detailed below. Please reference AMA formatting for any technical writing or bibliography issues/questions outside of the below standard developed by the policy department. No hyperlinks permitted.


Medical and Clinical Policy Writer Standard Operating Procedures Catalog

- a. Author's Last Name First initial Middle Initial. (Date Published). Title of Article. Source of Article. Date retrieved from URL OR doi.
 01. Example: Howard JA. (2013, December 21). How to Lower Blood Pressure. Retrieved December 21, 2014 from www.webmd.com
 - (1). If the author is unknown, the first few words of the reference should be used. This is usually the title of the source.
 - (2). If date is unknown, 'n.d.' should be used
 - (3). If more than 4 authors, list first 3, then et al.
 - b. Name of Regulation, Abbreviated name of source and regulation number, Section Number (if applicable), effective date of regulation. Date retrieved and URL
 01. Example: Ohio Administrative Code. OAC 5160-2-52. (12/1/2017). Physician Services. Retrieved January 14th, 2020 from www.oac.gov
 02. Example: Centers for Medicare and Medicaid Services. (last updated). Local Coverage Determination (LCD) - L##### - Title (Version#). Retrieved [date] from www.cms.gov.
 - c. Health Technology Assessment. (date). Title. Hayes. Retrieved [date] from www.evidence.hayesinc.com.
6. Grammar/spelling –use of appropriate standardized English language.
 7. Punctuation – correct usage of punctuation. Check consistency of punctuation in all lists.
 8. Consistency – state and line of business reference throughout the policy is consistent for each market and line of business.
 9. Duplication – ensure there are no redundancies in the information provided.

D. REVIEW / REVISION HISTORY

| <i>Tracking history commenced January 2011</i> | | | |
|--|-------------------------------------|------------|---|
| Review | Revision | Date | Description of Changes |
| <input type="checkbox"/> | <input type="checkbox"/> | 12/27/2018 | Separated step in policy process into its own policy |
| <input type="checkbox"/> | <input type="checkbox"/> | 5/9/2019 | Updated process |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3/6/2020 | Updated screenshots and verbiage |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 11/30/2021 | Added Policy Tech process |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 05/05/2022 | Added examples |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 06/08/2023 | Added AllMed detail: remove review information if date is older than 3 years (e.g., 2023 will delete 2019 review information) |

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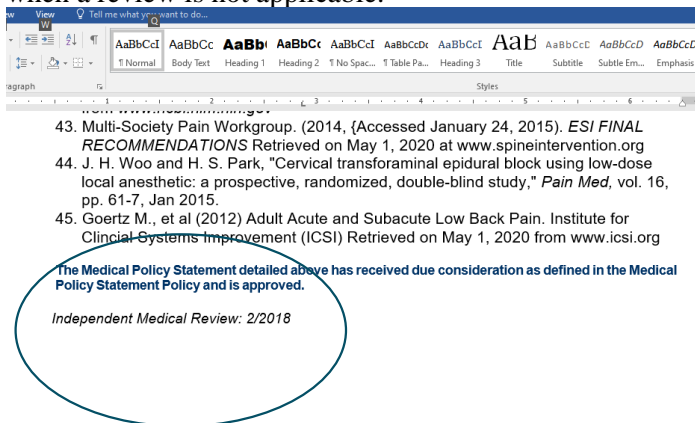
| STANDARD OPERATING PROCEDURE (SOP) | |  |
|--|---------------|---|
| Attachments | Creation Date | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 12/28/2018 | Step Ten: Vendor Medical Review |

A. DESCRIPTION / PURPOSE

This purpose is to address how we use external independent review specialists from a vendor, AllMed, in obtaining impartial medical reviews for policies.

B. DEFINITIONS

C. PROCEDURE

- I. Criteria for AllMed submission for external medical review:
 - A. All NEW medical policies
 - B. Medical policies that during revision have had clinically significant criteria changes
 - C. When recommended by Executive leadership or Director of Clinical Policy & Oversight
- II. When it is determined based on the above criteria that a policy needs to be sent to AllMed:
 - A. Follow steps in AllMed SOP (see Step Nineteen).
- III. After AllMed review:
 - A. Add the statement “Independent Review [AllMed review date]” at the bottom of the document. Delete this line when a review is not applicable.
 
 - B. Load AllMed review to OneNote (and/or attach in Policy Tech).
 - C. Forward AllMed review to leadership (Dr. Gregg).


D. REVIEW / REVISION HISTORY



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| Tracking history commenced July 2018 | | | |
|--------------------------------------|-------------------------------------|------------|--|
| Review | Revision | Date | Description of Changes |
| <input type="checkbox"/> | <input type="checkbox"/> | 12/28/2018 | Separated step in policy process into its own policy |
| <input type="checkbox"/> | <input type="checkbox"/> | 5/9/2019 | Updated process |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3/6/2020 | Updated screenshots and verbiage |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 05/01/2020 | Updated process |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 12/01/2020 | Updated screenshot |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 12/01/2021 | Updated Policy Tech |

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|--|----------------------|---|
| STANDARD OPERATING PROCEDURE
(SOP) | |  |
| Attachments | Creation Date | Step Twelve: Committee Final Review |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 12/27/2018 | |

A. DESCRIPTION / PURPOSE

This purpose is to standardize a process for policy writer to take a final policy draft to the policy governance committee for final review.

B. DEFINITIONS

Approved: The committee is in agreement to approve the policy and post on the caresource.com for provider and in-house use.

Rejected: The committee rejects the policy.

Tabled: The committee decides more information is needed before determining if the policy is to be approved or rejected.

Archived: The committee decides to remove the policy from caresource.com and place in an archive folder.

C. PROCEDURE

I. **E-Vote** (PGC email approvals) - typically this is only for archival or minor revisions of existing policies

A. Email the Clinical Policy Coordinator (Karen) and Clinical Policy Specialist (Jessica) with the following information:

1. State this is for archival and reason for archival;
2. Include the policy (policy title and market(s) and the Policy Tech link);
3. Link to any policy to be removed from cs.com
4. Note changes made; and
5. Any special concerns.

II. **For PGC approval:**

A. Email the Clinical Policy Coordinator and Clinical Policy Specialist, indicating that the policy is ready for PGC approval and request that the policy be added to the next PGC agenda for final approval. The email notification must include:

1. Policy Title and all market IDs;
2. Links to all policies from Policy Tech; and
3. Link to any policy being removed from cs.com (this includes all existing versions of the policy topic).

B. Perform mock presentation of policy at PGC prep meeting (Monday and Tuesday mornings the week of PGC). Make any necessary last-minute corrections to the policy.

C. Ensure policy is in final format (all notes/comments removed, clean version when appropriate, red-line when appropriate).


D. REVIEW / REVISION HISTORY

Tracking history commenced July 2018

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| Review | Revision | Date | Description of Changes |
|--------------------------|-------------------------------------|------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 12/28/2018 | Separated step in policy process into its own policy |
| <input type="checkbox"/> | <input type="checkbox"/> | 5/9/2019 | Updated verbiage and process |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3/6/2020 | Updated screenshots and verbiage |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 05/01/2020 | Updated process |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 12/01/2020 | Updated process: screenshots, hyperlinks and more detailed instruction. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 11/30/2021 | Updated process with Policy Tech |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 03/17/2023 | Updated process |

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| STANDARD OPERATING PROCEDURE
(SOP) | |  |
| Attachments | Creation Date | Step Thirteen: Policy Approved |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 12/28/2018 | |

A. DESCRIPTION / PURPOSE

This purpose is to standardize the process once a policy has been approved by the Policy Governance Committee.

B. DEFINITIONS

CRF – Communications Request Form, a project request form completed and submitted by business owners to request new or revised communications projects.

C. PROCEDURE

- I. E-Votes (PGC email approvals - typically this is only for archival and minor revisions on existing policies)
 - A. The senior administrative assistant will notify the policy writer, Clinical Policy Coordinator, and Clinical Policy Specialist when approved,
 1. The policy writer will make final policy edits and prepare for posting or state approval as described above.
 2. The Clinical Policy Coordinator will add to the next PGC agenda as an E-Vote approval.
- II. Once the policy has been presented to the Policy Governance Committee and has been approved, the policy writer will:
 - A. Make final policy edits and prepare for posting:
 1. Remove watermark;
 2. Add effective date (use [effective date calculator](#)):
 01. For Ohio MCD Medical policies: require state approval before 60 day notification Do NOT assign date.
 02. For IN MCD and GA MCD: require state approval before 60 day notification. Do NOT assign date.
 03. For all other markets/states: 60 day notification is required.
 3. Ensure all final formatting and editing is complete;
 4. Ensure hyperlinks working within document in table of contents;
 5. Convert to PDF and upload to the Q drive (Q:\Medical Directors\Private\Clinical Policy and Oversight Team\CRF Submissions\CRF Submissions\2021 - Current\Nov 2021\Final Files from Writers for Marketing) for the following markets and lines of business:
 - Ohio Medicaid (MCD)
 - Marketplace (MP)
 - North Carolina Marketplace (MP)
 - Arkansas in PASSE
 - Mississippi TrueCare (TrueCare)
 6. For GA and IN Medicaid markets:
 - a. Remove the watermark;
 - b. Do not add an effective date, but keep TBD or 12/25/2030 (this will be added once the state has approved the document).
 - c. Ensure all final formatting and editing is complete.


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- d. Ensure hyperlinks are working within the document table of contents.
- e. Do not convert to a PDF version of the policy. Attach the approved (redline version) policy Word version to the Q drive folder listed above.
 01. The state must approve the document before it can be converted to a PDF and posted to the website.
 02. This will be done at a later time once the policy has been approve.
 03. You will be notified of this approval by the Clinical Policy Coordinator.
 04. Instructions on Responding to a State Approval are included below in this SOP Catalogue.
- f. When the policy returns successfully from the state, add the effective date to Policy Tech.
- g. Add the approval language provided by the Clinical Policy Coordinator and Clinical Policy Specialist from the state to the bottom of the policy. Remove the watermark. Update section G of the policy. Save the policy.
- h. Convert to PDF and attach to approval email.
- i. Repeat step II.A.6 as applicable.

D. REVIEW / REVISION HISTORY

| <i>Tracking history commenced July 2018</i> | | | |
|---|-------------------------------------|------------|--|
| Review | Revision | Date | Description of Changes |
| <input type="checkbox"/> | <input type="checkbox"/> | 12/28/2018 | Separated step in policy process into its own policy |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3/6/2020 | Updated screenshots and verbiage |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 05/01/2020 | Updated process |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 12/01/2020 | Updated process: addition of GA and IN MCD process |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 12/01/2021 | Updated process |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 03/17/2023 | Updated process |
| | | 06/21/2023 | Updated OH marketing TAT from 90d to 60d |

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| STANDARD OPERATING PROCEDURE
(SOP) | |  |
|--|---------------|---|
| Attachments | Creation Date | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 05/13/2020 | Step Fourteen: Responding to a State Denial |

A. DESCRIPTION / PURPOSE

The purpose of this policy is to standardize the process where a state denies a policy submitted for their approval.

B. DEFINITIONS

C. PROCEDURE

1. Upon receipt, Clinical Policy Coordinator will submit the state denial of a policy to the affected policy writer(s).
2. The Clinical Policy Coordinator will track what was submitted to the policy writer(s).
The items to track include:
 - a. Policy writer(s);
 - b. Date sent to policy writer(s);
 - c. Policy name and number;
 - d. LOB/state; and
 - e. CRF number if applicable.

NOTE: If Clinical Policy Coordinator does not get a response from the policy writer(s) within one week, the Clinical Policy Coordinator is to follow up with the policy writer(s).

3. The policy writer(s) resolves the concern within one week.
 - a. If extenuating circumstances, the policy writer will give an estimated timeframe to the Clinical Policy Coordinator.
4. The Policy writer(s) submits the policy resolution back to the Clinical Policy Coordinator. The items to include are:
 - a. CRF number if applicable;
 - b. Updated policy if applicable (Word version with Watermark intact);
 - c. Response of what was changed or challenged; and
 - d. Any supporting documents.
5. The Clinical Policy Coordinator will send all items in 4. to marketing via Workfront by updating the CRF within 3 days of receipt.
6. The Clinical Policy Coordinator will track the following:
 - a. The date the response is received from policy writer(s); and
 - b. The date the response is sent back to marketing.




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D. REVIEW / REVISION HISTORY

| <i>Tracking history commenced January 2011</i> | | | |
|--|--------------------------|-----------|------------------------|
| Review | Revision | Date | Description of Changes |
| <input type="checkbox"/> | <input type="checkbox"/> | 5/13/2020 | New SOP |
| <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | |

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|--|------------------------------------|---|
| STANDARD OPERATING PROCEDURE
(SOP) | |  |
| Attachments
<input type="checkbox"/> Yes <input type="checkbox"/> No | Creation Date
12/28/2018 | Step Sixteen: Final Code Set /
Configuration |

A. DESCRIPTION / PURPOSE

This purpose is to standardize the process for submitting a request to Member Benefits for policy configuration.

B. DEFINITIONS

N/A

C. PROCEDURE

- I. Once the policy has been approved by PGC and ready for final code set/configuration, the Policy Writer will:
Note: Georgia and Indiana Medicaid both require state approval. Do not submit GA or IN MCD for final code sets or configuration until you have received notification from the Clinical Policy Coordinator that the policies have been state approved.

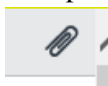
Note: Some policies, including: Medical, Reimbursement, and Administrative may not need to have any action taken for final code sets. If a new policy or an annual update policy does not have any information or changes that will affect configuration this will need to be notated within the Final Code Set ticket. Please see below for further instruction.

- A. Place a Service Now ticket for those policies ready for final code set
3. Go to MyServices - <https://caresource.service-now.com/myservices>
 4. Select Request Something
 5. Select Operations Intake
 6. Select *Benefit Coding and Support*
 7. Requested For
 - a. Your name will auto populate
 8. The cost center and cost center manager will also auto populate
 9. Select *Clinical Policy Code Sets* under options that best fits your issue or request.
 10. Select *Final Code Set/Configuration* under secondary option that best fits your request.
 11. Type in Policy title
 12. Type in policy number
 13. Type N/A in the link to the policy sharepoint intake request for this policy.
 14. List out each market and line of business and define what needs to be done for each (Ex. OH MCD – we follow OAC, GA MCD – see attached policy, etc.)
 15. When a policy does not have information or a revision (annual update or revised policy) that will affect a configuration change, this should be added to the instructions in this ticket. I.E. *Request: Final Code Sets and Configuration. Annual Update. No changes were made to this policy that will affect configuration. No changes to configuration.* Questions: please defer to management. Some policies will not require changes to configuration, but the ticket still needs to be submitted for tracking. This is a hard step to standardize and

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sometimes has to be decided on a case by case (policy by policy) basis. Reach out with questions as this part of the process is under review and still continues to evolve.

16. Attach the approved policy in pdf form with an effective date. Attach using paper clip icon that is in the right



upper corner

17. Select *All applicable Products/Markets*
18. Select *Corporate* for submitting Market
19. Type N/A in the requested date for claims analysis



20. Type N/A for the desired complete date through the icon



21. Select the icon to type in the business owner's name – This is the policy writer

22. Select: *Submit*

- B. Once ServiceNow ticket has been created, you will get an email with the CSO# attached.

1. Go to SharePoint, open the intake and in the coding notes you will type in the CSO#.

- II. Once the policy has been approved by PGC and ready for state approval (GA and IN MCD), the Policy Writer will:

- A. Send the link to the WORD documents in the document library to the Clinical Policy Coordinator
- B. Clinical Policy Coordinator will place workfront ticket to go for state approval.


- III. Once the policy has been approved by PGC and ready to be archived, the Clinical Policy Coordinator will complete the archival process per the PGC agenda. The Policy Writer does not need to notify the Clinical Policy Coordinator.

D. REVIEW / REVISION HISTORY

Created: October 8, 2018

| <i>Tracking history commenced July 2018</i> | | | |
|---|-------------------------------------|------------|--|
| Review | Revision | Date | Description of Changes |
| <input type="checkbox"/> | <input type="checkbox"/> | 12/28/2018 | Separated step in policy process into its own policy |
| <input type="checkbox"/> | <input type="checkbox"/> | 5/9/2019 | Updated process |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 3/6/2020 | Updated screenshots and verbiage |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 05/01/2020 | Updated process |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 12/01/2020 | Updated process: |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 07/12/2021 | Updated to include information regarding directions for policies that do not need configuration changes. |

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| | | |
|--|----------------------|---|
| STANDARD OPERATING PROCEDURE
(SOP) | |  |
| Attachments | Creation Date | Step Seventeen: Archiving a Policy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 09/01/2020 | |

A. DESCRIPTION / PURPOSE

The purpose is to ensure that the Clinical Policy & Oversight team have a good understanding of all of the processes of the departments that we support.

B. DEFINITIONS

C. PROCEDURE

I. Archiving a Policy

- A. Policies that are no longer in use, needed or considered active should be officially archived from the provider policy website and documented for future reference. The following steps should be followed in order to confirm the archival decision, allow proper communication among corresponding departments and determine the impact archiving the policy will have on current and future operations.
 1. Identify business owner.
 - a. This may be the Medical Director for the policy market, UM manager, other identified SME or a combination of owners.
 - b. Discuss reasons to request archiving the policy and how this will impact current operations.
 - c. If determined the policy needs to be archived add to the weekly Configuration Meeting Agenda.
 2. Add to Configuration Meeting Agenda.
 - a. Contact the current facilitator of the weekly Configuration Policy meeting Clinical Policy Coordinator and request the policy be added to the agenda for discussion with Member Benefits and Configuration representatives in attendance.
 - b. This discussion should include any steps that need to be taken by Member Benefits and Configuration and how this should be reflected in the SNOW ticket that must be submitted (including if archiving the policy will affect CES or FACETS).
 - c. Once Member Benefits and Configuration have determined operations moving forward the request to archive the policy will need to be approved via E-Vote.
 3. Send request for E-Vote approval.
 - a. Send E-Vote request to Jessica Scheidweiler or current administrator in charge of E-Vote requests.
 - b. Include the following information:
 - i. Policy name, number and market
 - ii. Reason for archiving.
 - c. Once you receive an E-Vote approval confirmation from Jessica S. or the current administrator, a SNOW ticket will need to be submitted to either Member Benefits or Configuration. This will be based on the Configuration meeting discussion and outcome.

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- i. If determined Member Benefits needs to take action to archive the policy, enter a SNOW ticket to Member Benefits according to the steps below.
 - ii. If determined Member Benefits does not need to take any action in order to archive the policy, **do not enter a SNOW ticket to Member Benefits**. Only a ticket for Configuration benefits will need to be submitted according to the steps below.
4. Submit a SNOW ticket to Member Benefits by following the steps below:
 - a. *Request Something*
 - b. Member Benefits & Clinical Utilization Analytics
 - c. *Requested For*: Use auto-populate option and select name
 - d. *Benefit Inquiry/Update*
 - e. *What Market and Product does this request impact or benefit*: Select markets that apply
 - f. *Please indicate the market you represent*: Corporate
 - g. *Please indicate the problem and the purpose of your request*: Provide very clear instructions in the detailed request. Ie: Is the policy being replaced by the OAC, GAMMIS, LCD etc. New code requests. Remember if there is nothing for member benefits to change/add/remove—this ticket is not needed.
 - h. *Impacted Codes*: Include any applicable codes that impact this request.
 - i. *Who is the Business Owner?* Auto-populate your (ticket requestor) name.
 - j. *Please provide any relevant claims examples*: N/A unless your request has relevant examples.
 - k. *Attachments*: Attach the policy to be archived
5. Archiving a policy in Policy Tech:
 - a. If the policy is in Published status:
 01. Open Properties Wizard and select Advanced Settings toward the upper right hand corner.
 02. Enter the date policy will be archived in the Archive Date field.
 03. SAVE your changes. ***DO NOT select Archive under the purple More drop down at the top of the page. Selecting Archive will automatically archive at current time rather than the future archive date.***
 04. Add necessary archive and CPGC documentation in the Discussion Board.
 - b. If the policy is in any other status:
 01. Navigate to the Discussion Board for the policy to be archived.
 02. Add a new discussion, including the following, “Approved to archive at PGC [date]” (or e-vote). If necessary, provide reason for archival (e.g., individual state policies being replaced by all-state policy, converting from AD to MM).
 05. Open Properties Wizard and select Advanced Settings toward the upper right hand corner.
 06. Enter the date policy will be archived in the Archive Date field.
 07. SAVE your changes. ***DO NOT select Archive under the purple More drop down at the top of the page. Selecting Archive will automatically archive at current time rather than the future archive date.***
 - c. If there is a need to access an archived document:
 01. go to Settings & Tools -> Tools -> Archive.
 02. Select the type of document you want to locate (e.g., Documents – Published, Documents – Unpublished).
 03. Use the search tool bar to find policy by title.
 04. If you want to restore a policy (bring out of archive), you must find the document on the Published page.
6. Submit a SNOW ticket to Configuration by following the steps below:
 - a. *Request Something*
 - b. Claims and Configuration Operations Intake
 - c. New Configuration
 - d. XXX

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- II. Archiving a Policy and Converting to a different policy type (MED, ADMIN, REIMB)
- A. The below steps are to be followed when a policy is being replaced with a different type (e.g., PY to AD).
1. Follow all standard policy steps to write the new policy.
 2. Present both the old (to-be-archived) policy and the new policy at PGC.
 3. Once approved, fill out the Review/Revision History section of the policy as follows:

Archived Policy:

| | DATE | ACTION |
|-----------------------|------------|------------------------------|
| Date Issued | XX/xx/xxxx | |
| Date Revised | | |
| Date Effective | Xx/xx/xxxx | |
| Date Archived | Xx/xx/xxxx | PY-#### converted to AD-#### |

New Policy:


| | DATE | ACTION |
|-----------------------|------------|------------------------------|
| Date Issued | Xx/xx/xxxx | PY-#### converted to AD-#### |
| Date Revised | | |
| Date Effective | Xx/xx/xxxx | |
| Date Archived | | |

4. Ensure that the archive date of the old policy and effective date of the new policy match up to allow continuity of criteria.
5. Refer to part I above for details to archive the policy in Policy Tech.

D. REVIEW / REVISION HISTORY

| <i>Tracking history commenced January 2011</i> | | | |
|--|-------------------------------------|------------|--|
| Review | Revision | Date | Description of Changes |
| <input type="checkbox"/> | <input type="checkbox"/> | 09/01/2020 | New SOP |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 04/01/2022 | Added Policy Tech steps, removed SharePoint step |
| <input type="checkbox"/> | <input type="checkbox"/> | | |

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|--|----------------------|---|
| STANDARD OPERATING PROCEDURE
(SOP) | |  |
| Attachments | Creation Date | Step Eighteen: Completing
Redbox Policy Requests |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 09/01/2020 | |

A. DESCRIPTION / PURPOSE

For policies related to COVID 19 and needing a “redbox” alert to address a temporary change to the policy due to the COVID 19 health crisis.

B. DEFINITIONS

Redbox – A box in red inside the policy to let providers know about an urgent temporary change to policy

C. PROCEDURE

- I. For temporary changes related to COVID-19 a Redbox is added to policies:
 - A. You will be alerted that a Redbox is needed by the Director or Manager of Clinical Policy
 - B. The change is made via word document of policy and converted to PDF when the verbiage has approval of the director or manager of policy.
- II. The policy writer will:
 - A. Make the Redbox in word
 - B. Verbiage is dependent on policy (see example below)
 - C. Get approval of director or manager of placement and verbiage of Redbox statement
 - D. Once approved change, to PDF and send to Director or Manager and Policy Coordinator for escalation
 - E. Upload new Redbox policy to appropriate document library folder

Example:

NOTICE: Due to the COVID-19 pandemic, the requirement for “evidence of face to face assessments by the SLP for speech therapy” will be waived, until such time when the pandemic is declared over. Telehealth may be utilized in place of the face to face assessments.


Example: SLP documentation of the screening or evaluation, including **evidence of a face to face assessment (see alert)** supporting medical necessity for speech therapy



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D. REVIEW / REVISION HISTORY

| <i>Tracking history commenced January 2011</i> | | | |
|--|--------------------------|------------|------------------------|
| Review | Revision | Date | Description of Changes |
| <input type="checkbox"/> | <input type="checkbox"/> | 09/01/2020 | New SOP |
| <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | |

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|--|----------------------|---|
| STANDARD OPERATING PROCEDURE
(SOP) | |  |
| Attachments | Creation Date | Step Nineteen: Additional
Standard Operating Procedures for
Department Specific Use |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 03/06/2020 | |

A. DESCRIPTION / PURPOSE

The purpose is to ensure that the Clinical Policy & Oversight team have a good understanding of all of the processes of the departments that we support.

B. DEFINITIONS

C. PROCEDURE

I. Navigating Policy Reporter



Policy Reporter
Guide.pdf

[file:///C:/Users/rlbraul/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/XVU39VEV/Policy Reporter Guide.pdf](file:///C:/Users/rlbraul/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/XVU39VEV/Policy%20Reporter%20Guide.pdf)
[file:///C:/Users/rlbraul/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/XVU39VEV/Policy Reporter Guide.pdf](file:///C:/Users/rlbraul/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/XVU39VEV/Policy%20Reporter%20Guide.pdf)

II. AllMed Submission


Located [Here](#)

D. REVIEW / REVISION HISTORY

| Tracking history commenced January 2011 | | | |
|---|-------------------------------------|------------|--|
| Review | Revision | Date | Description of Changes |
| <input type="checkbox"/> | <input type="checkbox"/> | 03/06/2020 | Updated screenshots and verbiage |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 05/01/2020 | Added hyperlinks. |
| <input type="checkbox"/> | <input checked="" type="checkbox"/> | 03/17/2023 | Removed Navigating Member Benefits and Predictive Health Analytic Findings. Updated remaining links. |



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| | | |
|---|-----------------------------|---|
| STANDARD OPERATING PROCEDURE
(SOP) | |  |
| Attachments | | Creation Date |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Step Twenty: Behavioral Health
Parity Attestation |

A. DESCRIPTION / PURPOSE

B. DEFINITIONS

C. PROCEDURE

D. REVIEW / REVISION HISTORY

| Tracking history commenced January 2011 | | | |
|---|--------------------------|------|------------------------|
| Review | Revision | Date | Description of Changes |
| <input type="checkbox"/> | <input type="checkbox"/> | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | |



Medical and Clinical Policy Writer
Standard Operating Procedures Catalog



| POLICY | | | |
|---------------------------------|--|----------------|--------------|
| 1707 - HPLC – QHP ECP/NA Policy | | | |
| Effective Date: 11/03/2023 | | | |
| Business Owner: | Pace, Bobby | Approver: | Patel, Sunit |
| Line of Business: | GA - Marketplace, IN - Marketplace, KY - Marketplace, NC - Marketplace, OH - Marketplace, WV - Marketplace | | |
| Department: | Health Partner Life Cycle | Policy Number: | 1707 |

Purpose:

Provide a framework to assure compliance with Network Adequacy (NA) and Essential Community Provider (ECP) standards. These procedures includes how CareSource Health Partner Life Cycle (HPLC) will complete the current ECP/NA template, complete write-ins, provide network gaps identified via network adequacy reporting, provide ECP gaps to CareSource Contracting teams and other CareSource Market owners (Markets), provide leads for addressing gaps, and serve as the subject matter expert for network provider data as required for Qualified Health Plan certification and maintaining compliance throughout the plan year.

Policy Statement:

It is the policy of CareSource to meet the Network Adequacy (NA) and Essential Community Providers (ECP) standards as required by law and minimum certification standards. Since CareSource uses a provider network consisting of in-network providers who are available to all enrollees, Health Partner Life Cycle (HPLC) assists in assuring we meet the standards by using a variety of methods:

1. Produce monthly NA reports for the Markets which identify and monitor gaps where CareSource's provider network is not meeting time and distance requirements in each of the five (5) county types (large metro, metro, micro, rural and extreme access) for at least 90% of our enrollees,

AND;

2. Provide ECP reports to the Markets, which identify where the contracted network is not meeting ECP standards,
 - a. ECP standards, are:
 - i. Access to 35% of available ECPs within each service area

- ii. Access to at least 35% of Federally Qualified Health Centers (FQHCs) in a service area
- iii. Access to at least 35% of Family Planning Providers in each service area
- iv. Contract with at least one ECP in each of the eight ECP categories in each county of the service area where an ECP is available
- v. Make “good faith” efforts to contract a sufficient number and types of providers for enrollee access
- vi. Contract with all available Indian Health Providers in each service area

AND;

- 3. Complete and perform validation of the ECP/NA Templates for filing, including write-ins, as needed,

AND;

- 4. Assist the Markets by providing additional ad-hoc data to address ECP/NA gaps,

AND;

- 5. Assist, act upon, and/or provide responses related to any formal provider network regulatory requests, such as formal Post Certification Monitoring (PCM) plans as required by CMS.

Related Citation(s):

45 CFR § 156.230 Network Adequacy Standards

45 CFR § 156.235 Essential Community Providers

Related Document(s):

Provider Network Adequacy and Access to Essential Community Providers (ECPs) Procedure.

| REVIEW/REVISION HISTORY | |
|--------------------------------|-------------------------------|
| Date | Description of changes |
| 11/2023 | Initial release |
| | |



| POLICY | | | |
|--|--|----------------|----------------|
| 0558- Pharmacy - Formulary Drug List and Clinical UM Evaluation Policy | | | |
| Effective Date: 10/13/2023 | | | |
| Business Owner: | Condon, Kelani | Approver: | Steadman, Ryan |
| Line of Business: | GA – Marketplace; IN – Marketplace; KY – Marketplace; NC – Marketplace; OH – Marketplace; WV – Marketplace | | |
| Department: | Pharmacy | Policy Number: | 0558 |

Purpose:

To outline the process by which products (including drugs) that have been approved or cleared by the U.S. Food and Drug Administration (FDA) are evaluated for inclusion on or exclusion from the CareSource pharmacy Formulary Drug List and are or are not subject to Clinical Utilization Management (UM) edits.

Background

CareSource works closely with a Pharmacy Benefit Manager (PBM) to administer pharmacy benefits. CareSource's PBM provides claims processing services, implements clinical protocols at point of sale, and offers convenience in working with healthcare providers and other third parties.

The CareSource Pharmacy & Therapeutics (P&T) Committee evaluates FDA-approved products based on the product's clinical safety and efficacy. The CareSource Value Assessment Committee (VAC) evaluates decisions made by the P&T Committee with focus on business considerations related to the products. Decisions regarding inclusion on the Formulary Drug List and application of Clinical UM edits are made by the P&T Committee and VAC within the restrictions of any regulatory and/or contractual requirements.

Policy Statement:

It is the policy of CareSource to maintain a Formulary and Clinical Utilization Management Edits and to ensure Essential Health Benefit (EHB) benchmarks and other Qualified Health Plan (QHP) requirements are met for Marketplace plans. Furthermore, it is the policy of CareSource to make decisions related to the Formulary and UM Edits without regard for a medication's use for medical/surgical versus behavioral health/substance use disorder indications.

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Related Procedure(s):

0558.01 – Pharmacy - Preferred Drug List and Clinical UM Evaluation Procedure

| REVIEW/REVISION HISTORY | |
|--------------------------------|---|
| Date | Description of changes |
| 04/2012 | Initial Release to P&P Committee |
| 08/2012 | 2012 Annual Review - Revisions to include more specific information in Procedure 1,2, and 6. Revisions made as a result of annual review. Detailed information removed from Policy Section and added as Background information under Description / Purpose Section. Reference to PT&T changed to P&T. |
| 10/2012 | Added KY for KY line of business |
| 08/2013 | 2013 Annual Review – Mention of availability of online formulary tool |
| 05/2014 | 2014 Annual Review -- Added information about formulary change notifications |
| 03/2015 | Removed information duplicated in another policy. Clarified section E3b, presentation to P&T Committee. |
| 05/2015 | No change |
| 08/2015 | 2015 Annual Review-Process Owner Change |
| 10/2015 | Added item 4 under section B, communication. |
| 08/2016 | 2016 Annual Review with No Changes |
| 08/2017 | 2017 Annual Review |
| 11/2017 | Change to BO. |
| 07/2018 | Change of BO and addition of MP information |
| 03/2019 | 2019 Annual Review |
| 12/2019 | Added Georgia Marketplace LOB |
| 12/2020 | 2020 Annual Review. Updated business owner and updated per delegation of formulary to PBM for Marketplace and not custom formulary management as in Medicaid. |
| 08/2021 | 2021 Annual Review |
| 08/2022 | 2022 Annual Review – typo correction, removed QIC, removed KY Medicaid (archived in 2020), removed specific criteria and procedure steps that are documented in corresponding procedure 0558.01. |
| 10/2022 | Reviewed |
| 02/2023 | 2023 Annual Review |
| 10/2023 | Minor updates to align with associated procedure update |



PROCEDURE

0558.01 - Pharmacy - Formulary Drug List and Clinical UM Evaluation Procedure

Effective Date: 10/26/2023

| | | | |
|--------------------------|--|--------------------------|----------------|
| Business Owner: | Condon, Kelani | Approver: | Steadman, Ryan |
| Line of Business: | GA – Marketplace; IN – Marketplace; KY – Marketplace; NC – Marketplace; OH – Marketplace; WV – Marketplace | | |
| Department: | Pharmacy | Procedure Number: | 0558.01 |

Purpose:

To outline the process by which products (including drugs) that have been approved or cleared by the U.S. Food and Drug Administration (FDA) are evaluated for inclusion on or exclusion from the CareSource pharmacy Formulary Drug List and are or are not subject to Clinical Utilization Management (UM) edits.

Background:

CareSource works closely with a Pharmacy Benefit Manager (PBM) to administer pharmacy benefits. CareSource's PBM provides claims processing services, implements clinical protocols at point of sale, and offers convenience in working with healthcare providers and other third parties.

The CareSource Pharmacy & Therapeutics (P&T) Committee evaluates FDA-approved products based on the product's clinical safety and efficacy. The CareSource Value Assessment Committee (VAC) evaluates decisions made by the P&T Committee with focus on business considerations related to the products. Decisions regarding inclusion on the Formulary Drug List and application of Clinical UM edits are made by the P&T Committee and VAC within the restrictions of any regulatory and/or contractual requirements.

Definitions:

- 1. Clinical Utilization Management (UM) Edits** – Includes all types of pharmacy programs used to direct members and/or providers toward preferred products and/or Formulary products and toward appropriate use of any product regardless of preferred or Formulary status. Clinical UM Edits can include, but are not limited to, prior authorization and step therapy. Clinical UM Edits also include drug-specific clinical appropriateness review criteria for drugs that are not included on the Formulary Drug List when applicable.

2. **Formulary Drug List** – A list of brand name and generic drugs, as well as other pharmaceutical products, that are available to CareSource members when prescribed by a physician or other duly licensed healthcare provider. The Formulary includes drugs that are eligible to be covered provided they are clinically appropriate; these drugs may be subject to Utilization Management strategies such as step therapy and quantity limits.
3. **Non-Formulary Drug or Product** – A drug or pharmaceutical product that is not included on the formulary but is eligible for coverage by CareSource when a request by a member or provider is received, undergoes review for clinical appropriateness, and is approved.
4. **Medical Necessity Review** - A review performed by CareSource to determine products which are reasonably necessary for the diagnosis or treatment of disease, illness, and injury, and meet accepted guidelines of medical practice. A medically necessary product or service must be reasonably related to the illness or injury for which it is performed regarding type, intensity, and duration of service and setting of treatment. Medical necessity determinations are made based on scientific evidence published in peer reviewed medical literature generally recognized by the medical community, physician specialty society recommendations, and the opinions of physicians practicing in clinical areas relevant to the member's clinical circumstances.
5. **Pharmacy Benefit Manager (PBM)** – An entity responsible for the provision and administration of pharmacy benefit management services including, but not limited to, claims processing and maintenance of associated systems and related processes.
6. **Pharmacy & Therapeutics (P&T) Committee** – One of two committees that serve as the decision-making bodies for the CareSource Pharmacy Formulary and Utilization Management strategies. The P&T Committee evaluates the clinical efficacy and safety of products and approves decisions made by the Value Assessment Committee.
7. **Value Assessment Committee (VAC)** – One of two committees that serve as the decision-making bodies for the CareSource Pharmacy Formulary and Clinical UM Edits. VAC evaluates P&T Committee decisions and with focus on business considerations related to products. The decisions made by VAC are subject to review and approval by the P&T Committee.

Process Steps:

Identification of Products for Review – Products are presented to the P&T Committee and VAC for review based on one or more of the following:

1. The FDA approves a new molecular entity or approves an update to the label for an existing molecular entity (including new indications, new indicated ages, etc.),
2. The CareSource Pharmacy Operations team receives requests for a product from CareSource providers,
3. The CareSource Pharmacy Clinical Strategy team identifies products for review during an annual evaluation based on new clinical evidence, new guidelines, updates to existing guidelines, etc.,
4. The CareSource Pharmacy Clinical Strategy team receives a request to review a product from a CareSource market, internal team, or external party (such as a regulator, provider group, or other party).

Product Review Process – The CareSource Pharmacy Clinical Strategy team follows the process outlined below when reviewing products to be presented to the P&T Committee and VAC.

1. The team evaluates all applicable product information and presents a recommendation to the P&T Committee based on clinical safety and efficacy. The information reviewed may include, but is not limited to:
 - a. Published clinical literature including clinical trials,
 - b. Current, accepted clinical guidelines,
 - c. Authoritative compendia such as:
 - i. Drug Facts and Comparisons
 - ii. Clinical Pharmacology
 - iii. Pharmacist's Letter and/or Physician's Letter,
(Note: Either/both Drug Facts and Comparisons or Clinical Pharmacology must be used during the review.)
 - d. Information provided to CareSource by the pharmaceutical manufacturer,
 - e. The product label as approved by the FDA including any treatment criteria found therein,
 - f. The therapeutic category in which the product is found, including:
 - i. Products within the class which are included on the formulary at any tier, if applicable,
 - ii. Previously approved prior authorization criteria for any products within the class, if applicable,
 - iii. Brand and generic availability within the class and any substitutions that can be made automatically or with physician permission, if applicable,
 - iv. Evidence that any product in the class may produce similar or better health outcomes for a majority of the population compared to other products in the same class, and
 - g. The expected clinical impact of limiting access to products in the therapeutic class.
2. The team solicits input regarding the content of drug-specific clinical policies from an independent external review service with specialization in the applicable disease state for review and recommendations prior to final presentation to the P&T Committee.
3. The team evaluates all applicable product information and presents a recommendation to the VAC based on cost, utilization, and market share. The information reviewed may include, but is not limited to:
 - a. Published pricing for a product which may include average wholesale price (AWP), wholesale acquisition cost (WAC), or other published pricing,
 - b. Information provided to CareSource by the pharmaceutical manufacturer,
 - c. Volume of claims and/or total spend for the product within a given timeframe,
 - d. Contractual discounts made available by either CareSource's PBM or the drug manufacturer,
 - e. Volume of approved and denied requests for the product by CareSource members and/or providers within a given timeframe, and
 - f. Total anticipated financial impact to CareSource and/or CareSource members based on the proposed or existing Formulary or UM status of the product.

4. Finally, the team considers relevant findings of government agencies, medical associations, and national commissions and accounts for regulatory and/or contractual requirements when making recommendations to the P&T Committee and VAC.

Pharmacy and Therapeutics Committee Review and Decision Process – The CareSource P&T Committee follows the standards set forth in 45 CFR 156.122(a)(3). The P&T Committee is composed of practicing physicians and pharmacist across multiple specialties including adult and pediatric behavioral health, obstetrics and gynecology, surgery, and primary care. The P&T Committee meets quarterly and is responsible for the clinical evaluation of the Formulary Drug List. The P&T Committee is a subcommittee of the Quality Enterprise Committee (QEC) and is subject to QEC oversight.

Following recommendations from the Pharmacy Clinical Strategy team, the P&T Committee will assign one of the following designations to each of the products being reviewed:

1. **Include:** Product must be included on all formularies. The product has a unique indication addressing a clinically significant unmet treatment need and/or has superior efficacy or safety to alternatives. Excluding the product from the formulary will result in unacceptable adverse impact to members.
2. **Optional:** Product may be included on or excluded from one or more formularies. The product is safe and effective for its intended use. Products denoted as optional may be clinically similar to alternatives and/or may be only marginally better than alternatives. Products designated as “Optional” are referred to the VAC to be reviewed for inclusion on the formulary based on non-clinical business considerations including cost, utilization, and market share.
3. **Exclude:** Products may not be added to any formulary. The product has inferior efficacy or higher safety risks compared to alternatives, insufficient evidence is available for evaluation, or the clinical effectiveness of the product has not been demonstrated. Products may also be designated as “Exclude” from the formulary if coverage of the product is prohibited by Federal or State regulation or requirement.

The P&T Committee also reviews and approves all coverage criteria related to Utilization Management strategies (e.g. prior authorization, step therapy, clinical appropriateness review for Non-Formulary products, etc.) The designations described above and the approved coverage criteria proceed to the VAC for business review.

All drugs and pharmaceutical products reviewed by the P&T Committee are managed without regard to use for medical/surgical indications or behavioral health/substance use disorders and in accordance with Mental Health Parity and Addiction Equity requirements at both the state and federal level.

Value Assessment Committee Review and Decision Process – The VAC is composed of CareSource plan executives including, for example, Market Presidents and Market Finance Directors. The VAC meets quarterly and is responsible for the financial evaluation of products/drugs and drug classes reviewed through the P&T Committee and of any additional formulary strategy opportunities. All decisions made by the VAC are subject to the review and approval of the P&T Committee to ensure that clinical appropriateness is maintained.

Following recommendations from the Pharmacy Clinical Strategy team, the VAC will select a final Formulary placement for products reviewed by the P&T Committee. Additionally, the VAC may propose adjustments to coverage criteria based on business review. All adjustments made by the VAC proceed back to the P&T Committee for final clinical review and approval.

The Pharmacy Clinical Strategy team may also present additional market information to the VAC including drug shortages, recalls, and safety-related market withdrawals, new drug pipelines, generic drug pipelines, and other notable market events (such as significant price increases, impactful legislative action, etc.).

The decisions made by the VAC return to the P&T Committee for final clinical review and approval. All final decisions as approved by both the VAC and the P&T Committee proceed to the Quality Enterprise Committee (QEC) for oversight.

All drugs and pharmaceutical products reviewed by the VAC are managed without regard to use for medical/surgical indications or behavioral health/substance use disorders and in compliance with Mental Health Parity and Addiction Equity requirements at both the state and federal level.

Member and Provider Notification Process – CareSource sends notifications to members who are directly impacted by negative changes to the formulary following the final decisions of the P&T Committee and VAC in compliance with both state and federal regulation, including timelines. CareSource communicates additional information to members and providers regarding the Formulary Drug List, how to use pharmaceutical management procedures, an explanation of limits or quotas, how to make an exception request for a Non-Formulary product including what information a provider must provide, and CareSource's process for generic substitution, therapeutic interchange, and step-therapy protocols.

New Drug Review Process Prior to Committee Review – Except as required by state regulation or other CareSource policy, new brand name products will be considered Non-Formulary prior to proceeding through the P&T Committee and VAC review and decision process described above. This includes, but is not limited to, new molecular entities, new formulations of existing molecular entities, and new brand names of existing molecular entity dosage forms.

Obtaining Non-Formulary Products – Non-Formulary products will be available to members through Formulary exception requests. These requests will be reviewed for clinical appropriateness as described in 0596 – Pharmacy Exception Process Policy and in the related procedure and as governed by CareSource administrative policy(ies).

Related Citation(s):

45 CFR § 156.122(a), (b), and (c)

Related Document(s):

1. 0558 – Formulary Drug List and Clinical UM Evaluation Policy

2. 0596 – Pharmacy Exception Process Policy
3. 0596.01 – Pharmacy Exception Process Procedure

| REVIEW/REVISION HISTORY | |
|-------------------------|---|
| Date | Description of Changes |
| 04/2012 | Initial release to P&P committee |
| 08/2012 | 2012 Annual Review - Revisions to include more specific information in Procedure 1,2, and 6.
Revisions made as a result of annual review.
Detailed information removed from Policy Section and added as Background information under Description / Purpose Section. Reference to PT&T changed to P&T. |
| 10/2012 | Added KY for KY line of business |
| 08/2013 | 2013 Annual Review – Mention of availability of online formulary tool |
| 05/2014 | 2014 Annual Review -- Added information about formulary change notifications |
| 03/2015 | Removed information duplicated in another policy. Clarified section E3b, presentation to P&T Committee. |
| 05/2015 | No change |
| 08/2015 | 2015 Annual Review-Process Owner Change |
| 10/2015 | Added item 4 under section B, communication. |
| 08/2016 | 2016 Annual Review with No Changes |
| 08/2017 | 2017 Annual Review |
| 11/2017 | Change to BO. |
| 07/2018 | Added MP information |
| 03/2019 | Changed business owner and process owner. Added step for external specialist review for specialty drug utilization management policies prior to the presentation to P&T. |
| 12/2019 | Miscellaneous Changes |
| 08/2020 | 2020 Annual Review. Updated business owner and per P&T and VAC updated processes. |
| 05/2021 | 2021 Annual Review; Updated to include addition of Ohio Department of Medicaid and their P&T process regarding the Unified PDL. |
| 08/2021 | Miscellaneous Changes |
| 09/2022 | 2022 Annual Review – adjusted language about communicating to members and providers about changes annually and as changes occur and methods |
| 10/2022 | Reviewed |
| 02/2023 | 2023 Annual Review |
| 10/2023 | Comprehensive revision to clarify language and align terms and processes to updated committee charters; updated language around medical necessity for Non-Formulary drugs |



| POLICY | | | |
|--|--|----------------|----------------|
| 0596 - Pharmacy -Pharmacy Exception Process Policy | | | |
| Effective Date: 12/15/2023 | | | |
| Business Owner: | Rattan, Sangeet | Approver: | Steadman, Ryan |
| Line of Business: | GA – Marketplace, IN – Marketplace, NC – Marketplace, OH – Marketplace, WV – Marketplace | | |
| Department: | Pharmacy | Policy Number: | 0596 |

Purpose:

CareSource is responsible for administering an exception process that allows our member, their representative, or prescriber to request an exception to the drug formulary.

Policy Statement:

1. It is the policy of CareSource to have a process for reviewing exception requests for pharmaceuticals. As this process usually occurs before the organization denies a pharmaceutical, an issue can be resolved before it reaches the formal review level.
2. CareSource allows the member, their authorized representative, or prescriber to initiate the exception process. CareSource members may initiate the exception process on their own behalf.
3. The Plan has an exception process in place that allows the member to request benefits for prescription drugs. The exception process is described in the procedure document and applies to outpatient prescription drugs.

Related Citation(s):

1. 29 CFR § 2560.503-1 (g)(i)(ii)(iii)
2. 45 CFR § 156.122
3. Mental Health Parity and Addiction Equity Act (MHPAEA)
4. O.C.G.A. § 33-20A-9(2)
5. ORC 1753.21(A)(2)
6. IC 27-13-38-1(b)

Related Procedure(s):

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0596.01 – Pharmacy - Exception Process Procedure

| REVIEW/REVISION HISTORY | |
|--------------------------------|---|
| Date | Description of changes |
| 02/2015 | Initial Release to P&P Committee |
| 04/2015 | Removed reference to exception resulting from a denial. |
| 08/2015 | 2015 Annual Review |
| 08/2016 | 2016 Annual Review with No Changes |
| 08/2017 | 2017 Annual Review |
| 11/2017 | Miscellaneous changes. Updated BO. |
| 11/2018 | 2018 Annual Review |
| 12/2019 | 2019 Annual review; added Marketplace (retiring 0590 & 0590.01, |
| 05/2020 | Review. Miscellaneous changes. |
| 06/2020 | Added TAT grid to Procedure (0596.01) |
| 02/2021 | 2021 Annual Review; minor formatting and grammatical updates |
| 03/2022 | 2022 Annual Review. BO updated and minor grammatical updates. |
| 05/2022 | Miscellaneous Changes |
| 10/2022 | Added Related Citations. Minor formatting changes. |
| 01/2023 | 1/1/2023 NC Marketplace update. |
| 02/2023 | Cited 29 CFR § 2560.503-1 (g)(i)(ii)(iii) and the Mental Health Parity and Addiction Equity Act (MHPAEA). |
| 12/2023 | Reviewed |



PROCEDURE

0596.01 - Pharmacy -Pharmacy Exception Process Procedure

Effective Date: 12/15/2023

| | | | |
|--------------------------|--|--------------------------|-----------------|
| Business Owner: | Brock, Jessica | Approver: | Rattan, Sangeet |
| Line of Business: | GA – Marketplace, IN – Marketplace, NC – Marketplace, OH – Marketplace, WV – Marketplace | | |
| Department: | Pharmacy | Procedure Number: | 0596.01 |

Purpose:

CareSource is responsible for administering a process that allows a member, their representative, or prescriber to request an exception to the drug formulary. CareSource will accept verbal, written, or electronic exception requests.

Definitions:

1. **Clinical Pharmacy Staff:** Includes licensed pharmacists, medical directors, licensed physicians (MD or DO), and nurse practitioners (when allowed by state law)
2. **Covered Prescription Drug:** Medications prescribed by a licensed health care provider for purposes which are Medically Necessary, are covered by CareSource for a member, and not excluded by the Plan.
3. **Drug Formulary:** The formulary is a list of prescription drugs (which includes covered outpatient prescription drugs), both generic and brand name, that CareSource covers.
4. **NCQA:** The National Committee for Quality Assurance is an independent 501 nonprofit organization that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.
5. **Non-Formulary Prescription Drug:** A drug which requires a prescription to be dispensed and is not covered per the CareSource Drug Formulary.
6. **P&T (Pharmacy and Therapeutics committee):** A committee made up of medical staff who evaluate the clinical use of medications, determine formulary placement, and develop policies for managing access to medications, ensuring effective drug use and administration.

Process Steps:

1. A member, their authorized representative, or provider may contact CareSource via telephone, in writing, or electronically to request CareSource make an exception for coverage of an outpatient drug.
2. Electronic, written, and verbal exception requests will be communicated to the pharmacy department via the CareSource “Formulary Exception” shared mailbox.
3. Pharmacy technicians monitor the “Formulary Exception” mailbox to ensure all requests are reviewed and addressed promptly according to state, federal, and NCQA requirements.
4. The technician will evaluate the request per P&T approved criteria/policy, if available, and/or seek clinical pharmacy staff guidance for the appropriateness of the exception request.
5. All exception requests will be reviewed and resolved per the grid below unless a more stringent process is required by state, federal, or NCQA requirements. Federal law prohibits any less stringent process.

| LOB | Urgent | Standard |
|----------------------------|----------|----------|
| Ohio Marketplace | 24 Hours | 72 Hours |
| Indiana Marketplace | 24 Hours | 72 Hours |
| Georgia Marketplace | 24 Hours | 48 Hours |
| North Carolina Marketplace | 24 Hours | 72 Hours |
| West Virginia Marketplace | 24 Hours | 72 Hours |

6. Decisions to approve may be made by non-clinical pharmacy staff (i.e., pharmacy technicians) as permitted per P&T approved criteria/policy.
7. Decisions to deny must be made by clinical pharmacy staff.
 - a. Clinical pharmacy staff will evaluate the request based on:
 1. Clinical policy as determined by the state or CareSource P&T committee, OR
 2. Generally accepted standards of medical practice,
 3. Appropriateness to the illness or injury for which it is prescribed,
 4. Status as the lowest cost alternative that effectively addresses and treats the medical problem, and

5. General principles regarding reimbursement for covered services.
 - a. If the request meets criteria, then the exception will be granted without provider outreach.
 - b. If additional information is needed, the pharmacy department will reach out to the provider to obtain the required information within the 24-hour time frame.
7. If the exception is granted, pharmacy staff will place the authorization in the pharmacy claim adjudication system that allows for point of sale processing.
 - a. The pharmacy staff representative will note in the pharmacy prior authorization processing system that the approval was due to an exception request.
 - b. The pharmacy staff representative will notify both the member (via mail) and prescriber (via fax) of the approved exception request.
 - i. The notification will outline the details of the authorization, including the approval duration.
 - c. The pharmacy staff representative will contact the servicing pharmacy to request claim reprocessing and to notify the member when the prescription is ready for pick up.
 - d. Unless otherwise required by state or federal regulations, exception requests may be approved for the lesser of:
 - i. One (1) year from the date CareSource receives the request*; or
 - ii. Until the last day of coverage under the member's health benefit

***NOTE** – The provisions of approval shall not apply to:

- a. Medications prescribed for non-maintenance conditions;
 - b. Medications that have a typical treatment period of less than twelve (12) months; or
 - c. Medications where the medical or scientific evidence does not support a twelve (12) month approval.
8. If the exception request is denied by clinical pharmacy staff, written notification of the denial will be sent to both the prescriber (via fax) and member (via mail).
 - a. Written notification will include the following:
 - i. Member Notice:
 1. The reason for the action;
 2. The reference to the benefit provision, guideline, protocol or criteria used to make the determination
 3. The member's right to file an external review for the non-formulary exception;
 4. If applicable, the member's or authorized representative's right to request a state hearing;
 5. Procedures for grieving the action;
 6. How and when an expedited resolution can be requested;
 7. If applicable, the member's right to have benefits continue pending the resolution of the external review, how to request that benefits be continued, and the circumstances under which the member may be required to pay for the cost of these services;
 8. The date the notice is being issued; and

9. How members and providers can obtain the clinical criteria utilized to make the determination:
 - a. Information about the member and provider rights to initiate a secondary review.
 - b. The State Hearing rights are included in the member's letter, as appropriate.
 - c. A copy of the letter is mailed to the member while a copy of the provider letter is faxed to the denied prescriber.
 - d. A copy of each letter is maintained in the pharmacy authorization processing system.
- ii. Provider Notice:
 1. The reason for the action;
 2. The reference to the benefit provision, guideline, protocol or criteria used to make the determination;
 3. The provider's right to have a peer-to-peer consultation with the pharmacist;
 4. The provider's right to file a secondary review;
 5. How and when an expedited resolution can be requested;
 6. The date the notice is being issued.
 7. How the provider can obtain the criteria utilized to make the determination

NOTE:

The term "covered outpatient drug" does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this subchapter as part of payment for the following and not as direct reimbursement for the drug):

- A. Inpatient hospital services
- B. Hospice services.
- C. Dental services, except drugs for which the State plan authorizes direct reimbursement to the dispensing dentist
- D. Physicians' services.
- E. Outpatient hospital services.
- F. Nursing facility services and services provided by an intermediate care facility for the mentally retarded.
- G. Other laboratory and x-ray services.
- H. Renal dialysis.

The term "covered outpatient drug" also does not include any drug or product for which a National Drug Code number has not been issued by the Food and Drug Administration or a drug or biologic [8] used for a medical indication which is not a medically accepted indication. Any drug, biological product, or insulin excluded from the definition of such term(s) as a result of this paragraph shall be treated as a covered outpatient drug for purposes of determining the best price (as defined in subsection (c)(1)(C)) for such drug, biological product, or insulin.

If a State plan for medical assistance includes coverage of prescribed drugs which may be sold without a prescription (commonly referred to as "over-the-counter" drugs), if prescribed

by a physician (or other person authorized to prescribe under State law), such a drug shall be regarded as a covered outpatient drug.

Related Citation(s):

1. 29 CFR § 2560.503-1 (g)(i)(ii)(iii)
2. 45 CFR § 156.122
3. IC 27-13-38-1(b)
4. Mental Health Parity and Addiction Equity Act (MHPAEA)
5. O.C.G.A. § 33-20A-9(2)
6. ORC 1753.21(A)(2)

Related Document(s):

1. NCQA Utilization Management Elements
2. U.S. Code § 1396r–8 Payment for covered outpatient drugs
3. CareSource Pharmacy Policy
4. 0596: Pharmacy- Exception Process Policy
5. 0592: Pharmacy Utilization Review Request Handling

| REVIEW/REVISION HISTORY | |
|-------------------------|--|
| Date | Description of changes |
| 2/2015 | Initial Release to P&P Committee |
| 04/2015 | Removed reference to exception resulting from a denial. |
| 08/2015 | 2015 Annual Review |
| 08/2016 | 2016 Annual Review with No Changes |
| 08/2017 | 2017 Annual Review |
| 11/2017 | Miscellaneous changes. Updated BO. |
| 11/2018 | 2018 Annual Review |
| 10/2019 | 2019 Annual Review, added Marketplace (retiring 0590 & 0590.01, |
| 12/2019 | Updates made based on regulation changes |
| 04/2020 | Updates made based on regulations and business practice |
| 06/2020 | Added TAT grid to Procedure (0596.01) |
| 02/2021 | 2021 Annual Review; minor grammatical updates |
| 03/2022 | 2022 Annual Review. BO updated and minor grammatical edits. |
| 05/2022 | Miscellaneous Changes |
| 10/2022 | Added Federal Citations. TAT Updates. Workflow clarifications. Grammatical and formatting updates, and updated member rights |
| 01/2023 | 2023 Updates to include NC product |
| 02/2023 | Cited 29 CFR § 2560.503-1 (g)(i)(ii)(iii) and the Mental Health Parity and Addiction Equity Act (MHPAEA). |
| 12/2023 | Reviewed |

New Medical Technology Subcommittee Charter

1. PROCESS INFORMATION

1.1. SUBCOMMITTEE NAME: NEW MEDICAL TECHNOLOGY SUBCOMMITTEE

1.2. REPORTS TO: CLINICAL POLICY GOVERNANCE COMMITTEE

1.3. CHAIRPERSON(S): VP, CLINICAL POLICY

1.4. DOCUMENT AUTHOR: MANAGER, ENTERPRISE QUALITY IMPROVEMENT

1.5. DOCUMENT REVISION HISTORY

| DATE | REV # | DESCRIPTION OF CHANGE | AUTHOR |
|-----------|-------|-----------------------|--|
| 7/9/2020 | 1 | INITIAL CHARTER | LAUREN KNICKLE, DR. MARY GREGG |
| 1/13/2021 | 2 | 2021 ANNUAL REVIEW | LAUREN KNICKLE, DR. MARY GREGG, CLINICAL POLICY TEAM |
| 5/3/2021 | 3 | UPDATED MEMBER TITLES | LAUREN KNICKLE |
| 1/1/2022 | 4 | 2022 ANNUAL REVIEW | LAUREN KNICKLE, DR. MARY GREGG, CLINICAL POLICY TEAM |
| 12/6/2022 | 5 | 2023 ANNUAL REVIEW | LAUREN KNICKLE, DR. MARY GREGG, CLINICAL POLICY TEAM |

1.6. PURPOSE DESCRIPTION

The Utilization Management National Committee for Quality Assurance module requires that CareSource has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its benefits plan to keep pace with changes and to ensure that members have equitable access to safe and effective care. In addition, CareSource quality best practices dictate a need for a fair and consistent process.

The New Medical Technology Subcommittee is a component of CareSource's formal process for the evaluation of new or emerging technologies. The Subcommittee conducts a quality & safety assessment of the proposed technology. The Subcommittee is comprised of medical and quality expertise which include in their review the science behind the technology or equipment, comparisons with existing technology and U.S. Food and Drug Administration (FDA) approval details.

New or emerging technologies are those product or equipment innovations which represent progressive developments for advancements within the medical field. These innovations are currently in a state of evolution and will substantially alter the business or medical outcome.

This Subcommittee reviews technology for all lines of business except where states mandate the benefits and new technology determinations.

1.7. BUSINESS OBJECTIVES

The following are business objectives of the New Medical Technology Subcommittee:

New Medical Technology Subcommittee Charter

The New Medical Technology Subcommittee will review the proposed technology's strengths, limitations, and comparison to existing technology. The Subcommittee will decide whether a financial analysis of the opportunity should be performed.

The evaluation process includes the following:

1. Input from relevant specialists and professionals who have expertise in the technology.
2. A review of information from appropriate government regulatory bodies.
3. A review of information from published scientific evidence.
 - Articles in peer-reviewed literature.
 - Recommendations from professional societies.

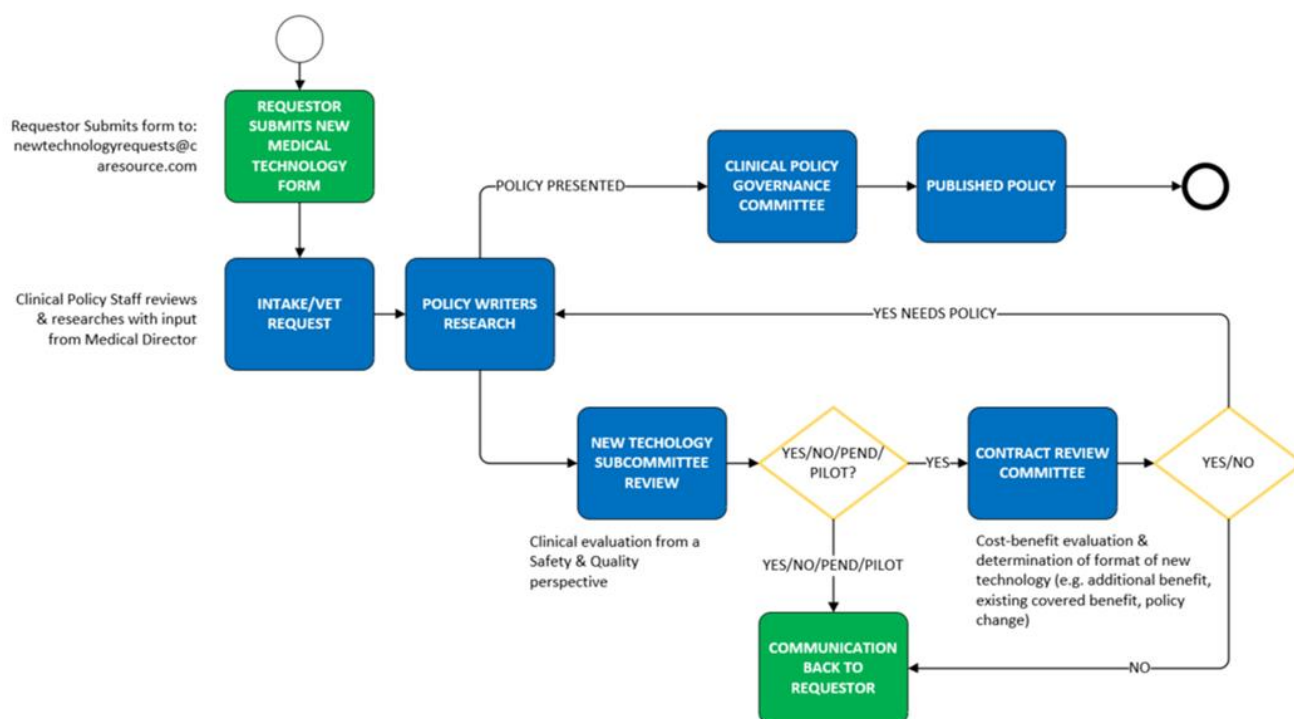
1.8. PROCESS APPROACH:

- The Subcommittee will convene quarterly basis.
- Additional Subcommittee members will attend when needed. These will be non-voting subject matter experts from within CareSource representing various departments and functions including Utilization Management, Clinical Operations, Medical Policy, Member Benefits & Predictive Health, Quality Improvement, Health Partners, Legal, etc. will be participating on an as needed basis.
- Subcommittee members will be granted voting rights for all decisions presented to the Subcommittee
- Decisions and recommendations will be communicated to the Contract Review Committee.
- If a decision is to deny the request for the technology is made by the committee, the Committee will email the requestor.
- Participants are approved by the EVP & Chief Medical Officer (EVP & CMO).
- Voting

Voting members:

- Assigned and Appointed Medical Directors by the EVP & CMO, including Behavioral Health, Medical and Dental Directors
- Each market should be represented by the Chief Market Medical Officer for a market vote. If the Chief Market Medical Officer is not able to attend, then they must send a proxy. That proxy is expected to attend and will execute the voting privilege for the Markets. Each member has equal voting rights.
- Quorum definition – 50% plus one of voting members required
- Passage rules – simple majority of voting members present for passage

New Medical Technology Subcommittee Charter



2. SCOPE

2.1. DELIVERABLES

- A decision to go forward or not go forward with a detailed financial analysis of the technology. This decision will focus on the technologies ability to offer an alternative that is shown to offer increased quality and safety to CareSource's members.
- A decision whether a demonstration from the technology vendor should be initiated to further assess the technology.
- The Subcommittee will identify opportunities for proof of concepts and use the Institute of Healthcare Improvement (IHI) methodology if further study is necessary to move forward with the concept.

2.2. OUT OF SCOPE:

- Pharmaceutical Requests
- Request to become a CareSource Vendor
- IT Technology Requests

New Medical Technology Subcommittee Charter

3. NEW MEDICAL TECHNOLOGY SUBCOMMITTEE STAKEHOLDERS

| Role | Responsibilities | Representing | ROLE |
|------------------------------|--|---|---|
| EXECUTIVE SPONSORS | <ul style="list-style-type: none"> ASSIGN SUBCOMMITTEE RESOURCES FINAL ESCALATION/DECISION MAKERS | ENTERPRISE & INDIVIDUAL MARKETS | EVP & CHIEF MEDICAL OFFICER |
| SUBCOMMITTEE CHAIR | <ul style="list-style-type: none"> APPROVE SCOPE CHANGES FACILITATION OF SUBCOMMITTEE MEETINGS REVIEW INTERNAL SUBCOMMITTEE PROCEDURES | ENTERPRISE & INDIVIDUAL MARKETS | VP, CLINICAL POLICY |
| STAKEHOLDERS/ VOTING MEMBERS | <ul style="list-style-type: none"> EXECUTE BUSINESS DECISIONS MANAGE ISSUE ESCALATIONS COMMUNICATE PRIORITIES AND ACCOUNTABILITY | ENTERPRISE & INDIVIDUAL MARKETS
CHIEF MEDICAL OFFICERS, DENTAL & BEHAVIOR HEALTH DIRECTORS, CLINICAL OPERATIONS, UTILIZATION MANAGEMENT, NATIONAL PROVIDER NETWORK & CLINICAL STRATEGY | CHIEF MEDICAL OFFICERS
MEDICAL DIRECTORS AS DESIGNATED BY EVP CMO INCLUDING
BEHAVIORAL HEALTH, MEDICAL, AND DENTAL DIRECTORS
SVP, CLINICAL OPERATIONS
VP, UTILIZATION MANAGEMENT
SVP, NATIONAL PROVIDER NETWORKS
SENIOR DIRECTOR, CLINICAL OPERATIONS STRATEGY AND IMPLEMENTATION |
| NONVOTING MEMBERS | <ul style="list-style-type: none"> PREPARATION AND FACILITATION OF TECHNOLOGY INFORMATION MAINTAIN AGENDA, MINUTES, FOLLOW UP PROCESS FOR SUBCOMMITTEE DECISIONS PROVIDE ADDITIONAL PERTINENT INFORMATION TO AID IN DECISION MAKING | ENTERPRISE QUALITY IMPROVEMENT
PERSONNEL
MEDICAL POLICY PERSONNEL
CLINICAL OPERATIONS PERSONNEL
UTILIZATION MANAGEMENT PERSONNEL
MEMBER BENEFITS | ENTERPRISE QUALITY IMPROVEMENT
MEDICAL POLICY PERSONNEL
CLINICAL OPERATIONS PERSONNEL
UTILIZATION MANAGEMENT PERSONNEL |



POLICY - PROCEDURE

1410 - Administrative Denials Policy-Procedure - GA Marketplace

Effective Date: 04/11/2023

| | | | |
|--------------------------|------------------------|-----------------------|------------|
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | GA - Marketplace | | |
| Department: | Utilization Management | Policy Number: | 1410 |

Scope:

This Policy and Procedure document applies to all CareSource Utilization Management business operations as necessary to comply with all local, state and federal regulations, as well as all contractual and accreditation standards.

Purpose:

The purpose of this policy is to outline the process used for an administrative denial. **An administrative denial is a decision not to approve coverage for a requested service where the decision is not based on medical necessity.**

Policy Statement:

CareSource authorization/notification requirements are outlined in the Provider Handbook found on the CareSource website. Failure to adhere to CareSource policies and procedures may result in an administrative denial or delay of reimbursement.

Provider Services and Utilization Management (UM) staff are available to help providers understand and navigate the UM Process.

Members are not financially responsible for covered services received when providers do not adhere to CareSource's authorization or notification policies and procedures.

Administrative denials are made when a provider does not adhere to CareSource policies or processes pertaining to obtaining an authorization and/or providing notification in a timely manner. Examples of these rules may include, but are not limited to:

- Late notification of an inpatient admission.
- Failure to obtain prior authorization.
- Lack of clinical information to support a prior authorization request.
- Failure of the provider to submit required clinical information when requested.
- Non-covered benefit or service.
- Services rendered by an out of network provider without prior authorization in non-emergent situations.
- Duplicative services without prior authorization.
- Lack of/Loss of Member eligibility.
- Exhaustion of benefits

CareSource authorizes services consistent with Policy #1412, *Initial and Concurrent Review*, Policy #1417, *Standard and Urgent Prior Authorization* and Policy #1416, *Post- Service Review* in addition to contract requirements.

Requests for services that are not covered benefits under the Plan benefit as outlined in the applicable State contract, member and provider handbooks and/or Evidence of Coverage may be administratively denied.

Process Steps:

- i. CareSource staff receive requests for services via telephone, fax, in writing or electronically through the provider portal.
- ii. When clinical information is not submitted at the time of notification or submission of a prior authorization request, CareSource UM staff make at least one attempt to obtain any needed clinical information.
 - a. Acute Care Hospitals, Skilled Nursing Facilities and Acute Rehabilitation Facilities are responsible to notify CareSource of admission for inpatient services within 1 business day of the admission.
 - b. Initial requests for authorization of an inpatient admission must include supporting clinical documentation for review.
 - c. All attempts to collect clinical information are documented in the Medical Management Information System (MMIS)
- iii. When clinical information necessary to support the request is not received, CareSource staff make at least one attempt to obtain clinical information. When clinical information is not received the request may be administratively denied.

- iv. When the request for prior authorization of a service is administratively denied, the reviewer documents the decision including the date and time of the determination, name/title of the individual the determination was given to, method of notification, and provider contact information in the medical management information system (MMIS).
- v. Written notification to the Provider and Member includes:
 - a. Service Requested
 - b. Reason for the administrative denial.
 - c. An explanation of the Provider Complaint rights, including the right to submit written comments, documents or other information relevant to the Complaint
 - d. An explanation of the process for initiating a Provider Complaint, including the time frame to initiate and respond to a Provider Complaint.
 - e. Members are notified of their right to appeal and provided with information on how to submit an appeal in the written notification as indicated by market specific regulatory requirements.

Definitions:

Medical Management Information System (MMIS): an electronic data system used by CareSource to document the utilization review authorization and determination process from intake through notification. Access is limited to users with approved log-in (username and password protected). Information entered into the system is automatically stamped with date, time and user identification.

Medical Necessity (includes concepts of Medically Necessary and Medically Necessary Services):

- i. For individuals covered by early and periodic screening, diagnosis and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
- ii. For individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

Prior Authorization: Utilization review conducted prior to an admission or the provision of a Health Care Service or a course of treatment in accordance with CareSource's requirement that the Health Care Service or course of treatment, in whole or in part, be approved prior to its provision. Also known as Pre-Authorization or Prior Approval.

Utilization Management ("UM"): The evaluation of the medical necessity, appropriateness,

and efficiency of the use of health care services, medication, procedures, and facilities under the provisions of the applicable health benefits plan. It aids clinicians or members, in cooperation with other parties, to ensure appropriate use of resources. Utilization management is sometimes called “utilization review” or “medical management”.

Utilization Management Staff (UM Staff): Administrative and Professional Staff members with titles such as Associate Prior Authorization Specialist (APAS), Prior Authorization Specialist (PAS), or Patient Care Coordinator (PCC), Autism UM Specialist, Behavioral Health UM Specialist.

Related Citation(s):

- i. 42 CFR 438.210

Related Document(s):

- i. CareSource Provider Handbook
- ii. Evidence of Coverage and Health Insurance Contract- Georgia
- iii. Health Plan Standards for Accreditation- National Committee for Quality Assurance (NCQA) Standards and Guidelines for Health Plans, Utilization Management Standards
- iv. Policy 1412, *Inpatient Initial and Concurrent Review*
- v. Policy 1417, *Standard and Urgent Prior Authorization*
- vi. Policy 1416, *Post-Service Review*

| REVIEW/REVISION HISTORY | |
|-------------------------|---|
| Date | Description of changes |
| 04/2023 | Initial Release; GA Marketplace split from 0803 |



POLICY - PROCEDURE

1412 - Inpatient Initial and Concurrent Review Policy-Procedure - GA Marketplace

Effective Date: 04/11/2023

| | | | |
|--------------------------|------------------------|-----------------------|------------|
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | GA - Marketplace | | |
| Department: | Utilization Management | Policy Number: | 1412 |

Scope:

This Policy and Procedure document applies to all CareSource Utilization Management business operations as necessary to comply with all local, state and federal regulations, as well as all contractual and accreditation standards. The contents of this policy may be copied into a stand-alone document for a specific business operation.

Purpose:

To define a consistent process which ensures CareSource members receive the care that best meets their individual medical and behavioral health needs in a safe, appropriate, and cost-effective treatment setting given the nature of the diagnosis and the severity of the symptoms.

CareSource conducts initial and continued stay reviews of inpatient hospital admissions and continued stays at the following facility types:

- Acute inpatient hospitals
- Skilled Nursing facilities (SNF)
- Long Term Acute Care facilities (LTAC)
- Inpatient Rehabilitation facilities (IP Rehab)
- Institute for Mental Disease (IMD)

Policy Statement:

Healthcare coverage is limited to items and services that are included in a defined benefit package and that are medically necessary. A determination of whether a covered benefit or service is medically necessary is based on an individualized assessment of the patient's medical needs and may be expedited if the member's healthcare needs warrant it. CareSource follows federal, state and National Committee for Quality Assurance (NCQA) decision and notification timeframes for all utilization review determinations. Where regulatory and

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accreditation bodies differ, the strictest/shortest timeframe is used to assure compliance with all requirements.

CareSource does not require Prior Authorization and/or Pre-Certification for Emergency Services, including crisis Stabilization services, Post- Stabilization Services, or Urgent Care services. Emergency services or emergency care includes health care services that are provided for a mental health condition or substance use disorder and include post-stabilization health care services

CareSource performs initial admission and concurrent review of inpatient hospitalizations to:

- Assess the medical necessity of inpatient confinement based on documentation of the Member's care.
- Evaluate appropriate utilization of inpatient services, and
- Promote the delivery of quality care on a timely basis.

In addition, Concurrent Review provides information to facilitate discharge planning and allows for peer consultation between the attending facility physician and the CareSource medical director, Behavioral Health Medical Director or physician designee, as needed (See also Policy #1415, *Peer-to-Peer Discussion*). Concurrent Review also identifies and facilitates transition to alternate levels of care when appropriate.

CareSource requires notification of an emergent admission within one (1) business day of the admission. Admissions to SNF, LTAC, IP Rehab, IMDs and Behavioral Health residential facilities require prior authorization. Initial and Concurrent Review are performed by licensed qualified clinicians including nurses and licensed behavioral health (BH) and substance use disorder (SUD) clinicians who are supported by licensed physicians.

Initial and Concurrent Review decisions are based on nationally accepted, evidence-based guidelines, developed by specialty organizations, national policy committees (clinical practice guidelines) and industry recognized review organizations, as outlined in Policy #1411, *Clinical Criteria*. The Clinical Care Reviewer (CCR) staff approve inpatient lengths of stay when UM criteria are met. For initial admission reviews, when UM criteria are met, the CCR approves up to maximum MCG length of stay. Once maximum MCG LOS is exhausted, the facility/provider is required to submit up-to-date clinical documentation to substantiate the need for additional inpatient days. The number of days given upon continued stay review is determined by the member's clinical status and MCG guidelines.

Any decision to deny, alter, or approve coverage for an admission, service, procedure or extension of stay in an amount, duration or scope that is less than requested is made by the CareSource medical director, BH medical director or physician designee after evaluating the individual health needs of the Member, characteristics of the local delivery system and, as needed, consultation with the treating physician.

Assessment of the local delivery system and their ability to meet a member's health care needs include:

- Availability of inpatient, outpatient and transitional facilities;

- Availability of outpatient services in lieu of inpatient services;
- Availability of highly specialized services;
- Availability of skilled nursing facilities, subacute care facilities or home care in the Plan's service area to support the member post discharge; and
- The local hospital's ability to provide all recommended services within the estimated length of stay.

Concurrent review determinations are documented in the appropriate medical management information system (MMIS) to facilitate claim payment, and are communicated to the facility, attending physician and Member in accordance with Policy #0806, *Timeliness of Decision and Notification*. The CareSource MMIS generates and stores an authorization number and the effective dates of the authorization to servicing and requesting Practitioners/Providers, regardless of contracted status. Once a decision to approve a Health Care service is made the determination is not reversed unless new information is received that is relevant to the approval, and that was not available at the time of the original approval

Any decision to deny coverage is communicated in writing to the facility, attending physician, and to the Member in accordance with Policy #1413, *Notification of Adverse Benefit Determination*. A provider's failure to adhere to CareSource contractual requirements may result in an administrative denial in accordance with Policy #1410, *Administrative Denial*. Administrative denials do not require a review by a CareSource medical director.

Utilization Management (UM) CCR staff review clinical information for initial/continued stays received via telephone, fax, in writing or through the provider portal, per the provider's preference. CareSource Providers are able, in most instances, to receive a real time determination when they enter their notification/continued stay request through Cite Auto Auth. All determinations are made in accordance with the applicable timeliness standards by line of business.

Process Steps:

- i. Initial/Concurrent Review is initiated
 - a. When a facility notifies the CareSource UM Department of an inpatient admission;
 - i. Notification is required within 1 business day of admission
 - b. When an inpatient stay extends beyond the last approved or last reviewed day.
- ii. CareSource UM staff verify the following:
 - a. Member eligibility
 - b. Benefit availability
 - c. Provider/Facility network status
 - i. When the Utilization Review request is to be provided by a non -

Participating Provider, UM staff redirect to a participating provider when it is confirmed an in- network provider can deliver the treatment needed.

- d. Date of admission
 - e. Criteria for Continuity of Care
 - f. Once member eligibility and benefit coverage are confirmed, clinical information to facilitate the initial or concurrent review is requested from the facility when needed. Clinical information should include, but is not limited to, the following:
 - Medical history
 - History of present illness
 - Mental Health and Substance Abuse History
 - Presenting symptoms
 - ER treatment
 - Current clinical status
 - Plan of care
 - Current treatment
 - Disposition
 - Discharge Plan
 - Information regarding condition and Instructions at prior discharge if readmission
 - Psychosocial situation including home environment
 - g. Special communication needs
 - i. When special communication needs are identified during the determination process, UM staff communicate the identified needs through the Streamline Customer Service Application to all CareSource staff. All special communications needs are considered during the determination process.
- iii. For the scope of review information, staff:
- a. Accept information for continued stay reviews from any reasonably reliable source at the facility/practitioner.
 - b. Collect only the information necessary to certify the requested treatment stay and assist in treatment planning.
 - c. Do not routinely request copies of all medical records on all members reviewed.
 - d. When medical records are requested, only request that section(s) of the record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of treatment
 - i. All attempts to collect clinical information are documented in the MMIS
 - e. Administer a process to share all clinical and demographic information on individual members among its various clinical and administrative departments

that have a need to know, to avoid duplicate requests for information from members or providers.

- iv. The CCR staff may make a determination that coverage for the admission or continued stay is Medically Necessary based on the CareSource's accepted utilization management criteria (See Policy #1411, *Clinical Criteria*). The facility, attending physician and/or Member are notified of this determination as outlined in Policy #0806, *Timeliness of Decision and Notification*.
- v. Authorization of coverage for inpatient services is based on the information available at the time it is issued (including information regarding the member's eligibility for coverage). Staff performing initial/concurrent review base determinations solely on the medical information obtained at the time of the review determination.
- vi. In the instance where the medical director or BH medical director gives verbal approval after discussion with the review clinician, the review clinician documents the approval, along with the reason for approval, within the specific case notes in the MMIS.
 - a. The medical director documents the decision rationale within 1 business day.
- vii. When the review clinician is not able to approve the admission or additional day(s), he/she refers the case to the CareSource medical director, Behavioral Health medical director or physician designee for review. Cases referred to the CareSource medical director or physician designee include, but are not limited to, the following:
 - a. Cases that do not meet currently accepted utilization management criteria for appropriateness of service or setting.
 - b. Cases where the number of approved days has been reached.
 - c. Cases where member's care is not progressing or progressing slowly leading to potential delays in treatment and/or discharge.
 - d. Cases that require secondary review by a medical director.
- viii. Under no circumstances may the CCR deny or downgrade coverage for services or downgrade the covered level of care based on medical necessity; any such denial or downgrade must be made by the CareSource medical director, BH medical director or physician designee.
 - a. The CCR can process an administrative denial which *is not* based on medical necessity or medical review.
- ix. The medical director/BH medical director or physician designee reviews the clinical information submitted in support of the request. He/She may also consult a specialty Practitioner/Provider for input into the determination.

- x. The CCR is responsible for communicating the medical director or physician designee's determination to the facility, treating physician and/or Member as outlined in Policy #0806, *Timeliness of Decision and Notification* and, as applicable, Policy #1413, *Notification of Adverse Benefit Determination*.
 - a. When, after medical director review, an adverse determination is delivered, the CCR communicates the opportunity to discuss the determination with the CareSource medical director, BH medical director or physician designee within five (5) business days of the notification to the facility and the attending practitioner as outlined in Policy #1415, *Peer-to- Peer Discussion*.
 - b. A reconsideration of the adverse decision is performed if additional clinical information is received in the UM department within 1 business day of the denial notification.
- xi. Upon admission and with each new review, CareSource requests discharge assessment and planning information. When the Member is nearing discharge level of care, CareSource communicates with the facility discharge planner to facilitate the discharge plan, finalize the discharge disposition, and arrange appropriate follow-up care.
 - a. The frequency of reviews performed is determined by the acuity of the Member's illness and the contract with the facility.
 - b. For Inpatient continued stay reviews, if clinical information is not received after two (2) requests, discharge of member will be assumed and documented as last approved day.
- xii. When a member's enrollment status changes during an inpatient stay, the following applies:
 - a. CareSource is not responsible for payment of inpatient facility claims provided during a hospital stay when the Enrollee is not eligible with CareSource

Definitions:

Adverse Action/ Non-Certification/Denial: A determination that an admission, extension of stay, or other health care service has been reviewed and based on the information provided, does not meet the clinical requirements for medical necessity, (as defined in State/Commonwealth Administrative Regulation or Code) appropriateness, level of care, or effectiveness; or the requested service is an exclusion as determined by state regulations.

Approval/Authorization/Fully Favorable: A determination that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness.

Behavioral Health: The discipline or treatment focused on the care and oversight of individuals with mental disorders and/or substance abuse disorders as classified in the Diagnostic and Statistical Manual of Mental Disorders-Five [DSM 5] published by the American Psychiatric Association. Those meeting the medical necessity requirements for services in Behavioral Health usually have symptoms, behaviors and/or skill deficits which impede their functional abilities and affect their quality of life.

Clinical Care Review (CCR) – Registered Nurses (RN), Licensed Practical Nurses (LPN), or Licensed Social Workers (LSW) with active unrestricted and current licenses in a state of the United States in which CareSource operates. CCR's conduct initial clinical reviews and may approve services using established criteria. They do not make adverse determinations. They have access to consultation with a licensed Doctor of Medicine or Doctor of Osteopathic Medicine; a licensed Psychiatrist or licensed health professional in the same licensure category as an ordering provider, or health professional with the same clinical education as an ordering provider in clinical specialties where licensure is not issued.

Clinical Review Criteria: The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by CareSource to determine the Medical Necessity and appropriateness of Health Care Services

Concurrent Review: Utilization management reviews conducted during a member's continued hospital stay for DRG outlier payment or review for ongoing per diem payment. Concurrent review determines medical necessity for treatment at the appropriate level of care. Concurrent reviews are also conducted for outpatient procedures and services to extend a current course of treatment.

Inpatient Review: Utilization management review conducted upon notification of a member's urgent hospital admission to determine the appropriate payment methodology (Per Diem or DRG vs. Observation payment).

Inpatient Services: Health Care Services relating to a Covered Person admitted to a Hospital, Skilled Nursing Facility, or Inpatient Rehabilitation Facility.

Medical Necessity (includes concepts of Medically Necessary and Medically Necessary Services):

- i. For individuals covered by early and periodic screening, diagnosis and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.

- ii. For individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

Non-clinical staff: non-clinical staff responsible for the pre-review screening of authorization requests. The APAS, PAS, and PAC's review requests for completeness of information. They collect and transfer non-clinical data and structured clinical data and perform activities that do not require evaluation or interpretation of clinical information. They assist or refer members and/or providers with questions regarding authorizations, authorization process and/or benefit information.

Utilization Management ("UM"): The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, medication, procedures, and facilities under the provisions of the applicable health benefits plan. It aids clinicians or members, in cooperation with other parties, to ensure appropriate use of resources. Utilization management is sometimes called "utilization review" or "medical management".

Utilization Management Staff (UM Staff): Administrative and Professional Staff members with titles such as Associate Prior Authorization Specialist (APAS), Prior Authorization Specialist (PAS), or Patient Care Coordinator (PCC), Autism UM Specialist, Behavioral Health UM Specialist.

Utilization Review: A formal evaluation (pre-service, concurrent or post service) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment.

Related Citation(s):

- i. 42 CFR 422.113
- ii. 42 CFR 422.568
- iii. 42 CFR 422.570
- iv. 42 CFR 422.572
- v. 42 CFR 422.620 How enrollees must be notified of non-covered inpatient hospital care
- vi. 42 CFR 438.210 Coverage and authorization of services

Related Document(s):

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- i. CareSource Provider Handbook
- ii. Evidence of Coverage and Health Insurance Contract – Georgia
- iii. Health Plan Standards for Accreditation – National Committee for Quality Assurance (NCQA) Standards and Guidelines for Health Plans, Utilization Management Standards
- iv. GA Senate Bill 566
- v. CareSource Provider Handbook
- vi. Policy 1411, Utilization Management Clinical Criteria
- vii. Policy 0806, Timeliness of Decision and Notification
- viii. Policy 1413, Notification of Adverse Benefit Determination
- ix. Policy 1415, Peer-to-Peer Discussion
- x. Policy 1410, Administrative Denial

| REVIEW/REVISION HISTORY | |
|-------------------------|--|
| Date | Description of changes |
| 04/2023 | Initial Release; Update to template, update for current processes, move to Georgia Marketplace specific document split from 0814 |



MARKETPLACE PLAN |

Georgia
Drug Formulary
2023

INTRODUCTION

We are pleased to provide the 2023 CareSource Drug Formulary. The Drug Formulary is a list of the drugs covered by CareSource.

This document is divided into three parts:

1. The [Introduction](#) – Provides important facts about the CareSource prescription drug benefit. This section explains terms, such as network pharmacy, prior authorizations, quantity limits, step therapy, therapeutic interchange and exceptions.
2. The [Drug Formulary](#) – Lists the drugs we cover.
3. The [Index](#) – Lists all of the covered drugs in alphabetical order. You can find the Index in the back of this document.

PRESCRIPTION DRUG COVERAGE DETAILS

Best Medical Practices

We want to make sure our members get the safest, most cost-effective drugs for their needs. We use evidence-based guidelines to make sure our Formulary meets best medical practices.

Network Pharmacies

CareSource provides coverage for prescription drugs and some prescription medical supplies. CareSource contracts with pharmacies in order to provide members with a full range of prescription benefits. Members may choose and receive prescriptions from any pharmacy that is contracted with CareSource. These are often referred to as network pharmacies. It is important that members receive prescriptions from network pharmacies because prescriptions received from non-network pharmacies are generally not reimbursable or covered by CareSource, except as otherwise required by applicable federal and state law and your Evidence of Coverage. Accordingly, members may be responsible for the entire amount charged by a non-network pharmacy.

Network pharmacies can include local pharmacies, mail-order pharmacies or specialty pharmacies. To find a network pharmacy, use our online Find a Pharmacy tool under “Quick Links” at [CareSource.com/marketplace](https://www.caresource.com/marketplace).

CareSource may also cover drugs administered in the member’s home, such as medicines given through a home health agency.

Cost Sharing

Members may pay part of the costs of some drugs and supplies. These cost-sharing amounts are called deductibles, copays and/or coinsurance. For some drugs, members may pay coinsurance. Coinsurance is a percent of a drug's cost.

The Drug Formulary shows drugs in different levels or tiers. Drugs are grouped into tiers based on the amounts that members pay.

Tiered Medications

The CareSource Formulary has up to five levels or tiers, including tiers 0, 1, 2, 3, and 4. In general, the higher the cost-sharing tier number, the higher the cost for the drug. In general, the copay amount increases as the tier number increases. All deductibles, coinsurance and copay amounts paid count toward members' maximum out-of-pocket amount.

To find tier levels for drugs, go to the [drug list](#) section of this document.

Prior Authorizations

CareSource may require health partners (doctors or other providers) to send us information about why a drug or a certain amount is needed. This is called a prior authorization request. CareSource must approve the request before a member can get the drug. The abbreviation "PA" is used in the Drug Formulary to show that a prior authorization is needed.

Here are some reasons for a prior authorization:

- A generic or alternative drug is available.
- The drug can be misused or abused.
- The drug requires special handling, monitoring or is available from limited shipping locations.
- There are other drugs that must be tried first.

Prior Authorization Requests

Health partners may make prior authorization requests electronically or by phone or fax. Please call the Provider Services telephone number for your state and follow the prompts, or fax to the Medical Management provider fax number for your state.

We may not approve a prior authorization request for a drug. If we don't, we will send the member information about how to appeal our decision.

Quantity Limits

Some drugs have limits on how much can be given to a member at one time. The abbreviation "QL" is used in the Drug Formulary to show there is a quantity limit. Quantity limits are based on the drug makers' recommended dosing frequencies. Patient safety is also considered.

Therapy with opioid analgesics may have quantity limits based on drug makers' recommended dosing frequencies and/or state regulations.

Step Therapy

Members may need to try one drug before taking another. This is called Step Therapy. A member must first try one medicine on the Formulary before another Formulary drug would be approved for use.

CareSource will cover certain drugs only if Step Therapy is used. The abbreviation “ST” is used in the Drug Formulary to show when Step Therapy is required.

Generic Substitution and Therapeutic Interchange

A pharmacy may provide a generic drug in place of a brand-name drug. This is called generic substitution. Members and health partners can expect the generic to produce the same effect and have the same safety profile as the brand-name drug. This is known as therapeutic interchange.

Generic drugs usually cost less than their brand-name equivalents.

Note to Health Partners: Generic drugs should be considered the first line of prescribing, subject to applicable rules.

Prescription generic drugs are:

- Approved by the U.S. Food and Drug Administration for safety and effectiveness, and are manufactured under the same strict standards that apply to brand-name drugs.
- Tested in humans to assure the generic is absorbed into the bloodstream in a similar rate and extent compared to the brand-name drug (bioequivalence). Generics may be different from the brand in size, color and inactive ingredients, but this does not alter their effectiveness or ability to be absorbed just like the brand-name drugs.
- Manufactured in the same strength and dosage form as the brand-name drugs.
- In most instances, a brand-name drug for which a generic product becomes available will become non-Formulary, with the generic product covered in its place, upon release of the generic product onto the market. However, the Formulary document is subject to state- specific regulations and rules regarding generic substitution and mandatory generic rules apply where appropriate.

Choosing a brand name drug when there is a generic available may cost you more. When a generic is available and you choose the brand name drug, you may be responsible to pay the cost difference between the two in addition to your copay or coinsurance. Or you could be responsible for the entire cost of the brand.

Tell Us the Medical Reasons for Exceptions

Sometimes a member may have a drug allergy or intolerance or, a certain drug may not be effective for a member. In these cases, the member or the member's representative may ask for an exception to a drug listed on the Drug Formulary. The member or member's representative may make the request online or by calling Member Services. The member services telephone number for your state is listed on the back of the member ID card.

CareSource then contacts the appropriate health partner. CareSource may ask the health partner to provide written clinical documentation about why the member needs an exception. Health partners must provide this information.

Typically, our Drug Formulary includes more than one drug for treating a condition. These medicines are called “alternative” drugs. CareSource will generally not approve the request for an exception if an alternative drug would be just as effective as the drug requested and would not cause other health problems.

Specialty Pharmacy

One specialty pharmacy that CareSource works with to supply specialty medications that health partners may prescribe is Accredo Pharmacy. Accredo Pharmacy can:

- Accept new prescriptions from your provider or transfers from your current pharmacy
- Deliver members’ specialty medicines to their homes, workplaces or their doctors’ offices
- Help members learn about their specialty medications and give them support from specially-trained health care professionals

For more information, call Accredo Pharmacy at 1-866-231-3520. Hours are Monday through Friday from 8 a.m. to 11 p.m. Eastern Time (ET). If Accredo Pharmacy is not the right choice for you, use the Find A Pharmacy tool on CareSource.com to see what other specialty pharmacies are available.

Mail Order Medications

CareSource works with Express Scripts Pharmacy to supply prescription medicines to members’ homes. This could change a member’s copay amount. Express Scripts Pharmacy can:

- Accept prescriptions from your provider or transfers from your current pharmacy.
- Deliver prescriptions to members’ homes, workplaces or doctors’ offices.

For more information, call CareSource Member Services at **1-833-230-2099 (TTY: 711)**. Hours are Monday through Friday from 7 a.m. to 7 p.m. Eastern Time.

Members may also access the [express-scripts.com](https://www.express-scripts.com) website through the CareSource member portal to manage prescription refills for their specialty and mail order medications and to check coverage. To create an account on the CareSource member portal, go to mycaresource.com.

Medications Administered in the Health Partner Setting

Medications that are administered in a health partner setting will be billed to the health plan under your medical benefit. Such settings include a physician office, hospital outpatient department, clinic, dialysis center, or infusion center. Prior authorization requirements exist for many injectable medicines.

Medication Therapy Management Program

CareSource offers a Medication Therapy Management (MTM) program for all members. MTM services allow local pharmacists to work with doctors and other prescribers to enhance quality of care, improve medication compliance, address medication needs, and provide health care to patients in a cost-effective manner. Members and health partners may be contacted by a pharmacist to discuss medications. We encourage members to talk with their pharmacists about their medications. This can help members to get the best results from the medications they are taking.

HOW TO USE THIS DOCUMENT

Go to the [Index](#) to look up a drug by name. Drugs are listed in alphabetical order. The Index will show the page number on which the drug is found in the Drug Formulary. Turn to that page number to get details about the drug.

Note to Health Partners: The CareSource Drug Formulary is organized by sections. Each section is divided by therapeutic drug class, primarily defined by mechanism of action. Products are listed by generic name with brand name for reference only. Unless the cited drug is available as an injectable or an exception is specifically noted, generally, all applicable dosage forms and strengths of the drug cited are included in the document.

ADDITIONAL INFORMATION FOR HEALTH PARTNERS

The drugs represented have been reviewed and approved by a Pharmacy, Therapeutics and Technology (PT&T) Committee for inclusion. The document is reflective of current medical practice as of the date of review.

The information contained in this document and its appendices is provided solely for the convenience of medical providers. We do not warrant or assure accuracy of such information nor is it intended to be comprehensive in nature. This document is not intended to be a substitute for the knowledge, expertise, skill and judgment of the medical provider in his or her choice of prescription drugs. All the information in the document is provided as a reference for drug therapy selection. Specific drug selection for an individual patient rests solely with the prescriber.

The document is subject to state-specific regulations and rules, including, but not limited to, those regarding generic substitution, controlled substance schedules, preference for brands and mandatory generics whenever applicable.

We assume no responsibility for the actions or omissions of any medical provider based upon reliance, in whole or in part, on the information contained herein. The medical provider should consult the drug manufacturer's product literature or standard references for more detailed information.

National guidelines can be found on the National Guideline Clearinghouse site at www.guideline.gov.

CARESOURCE ONLINE FORMULARY SEARCH TOOLS AVAILABLE

CareSource has easy-to-use online drug formulary tools that can help you save time by quickly looking up medications to make sure they are covered by CareSource. Also, you can check for generic alternatives, prior authorization requirements, and any restrictions or limits that may apply. To start using the tool, visit [CareSource.com](https://www.caresource.com), and visit the Pharmacy page of the appropriate line of business, and select Formulary Search Tool. You can also find CareSource policies on the [CareSource.com](https://www.caresource.com) Health Partner Policies page.

PHARMACY AND THERAPEUTICS (P&T) COMMITTEE

The services of a Pharmacy and Therapeutics (P&T) Committee are utilized to approve safe and clinically effective drug therapies. The P&T Committee is a multi-disciplinary committee whose voting members include physicians and pharmacists with many different specialties. Voting members of the P&T Committee must disclose any financial relationship or conflicts of interest with any pharmaceutical manufacturers. The CareSource Pharmacy & Therapeutics (P&T) Committee also includes regional member demographics in its formulary recommendations.

DRUG LIST PRODUCT DESCRIPTIONS

To assist in understanding which specific strengths and dosage forms on the document are covered, we have provided examples below. The general principles shown in the examples can usually be extended to other entries in the document.

When a strength, dosage or different formulation is specified, only that specific strength, dosage or formulation may be covered. Other strengths/dosages/formulations, including injectable dosage forms of the reference product, are not covered. Extended-release and delayed-release products require their own entry.

metformin Glucophage

The immediate-release product listing of Glucophage alone would not include the extended-release product Glucophage XR.

metformin ext-rel Glucophage XR

A separate entry for Glucophage XR confirms that the extended-release product is on the document.

Dosage forms on the document will be consistent with the category and use where listed.

neomycin/polymyxin B/hydrocortisone Cortisporin

Since Cortisporin is listed only in the OTIC section, it is limited to the OTIC solution and suspension. From this entry the topical cream cannot be assumed to be on the list unless there is an entry for this product in the DERMATOLOGY section of the document.

PLAN DESIGN

The document represents a closed formulary plan design. The medications listed on the document are covered by the plan as represented. Certain medications on the list are covered if utilization management criteria are met (i.e., Step Therapy, Prior Authorization, Quantity Limits, etc.); requests for use of such medications outside of their listed criteria will be reviewed for medical necessity. If a medication is not listed on the document, a Formulary exception may be requested for coverage. Medical necessity or Formulary exception requests will be reviewed based on drug-specific prior authorization criteria or standard non-formulary prescription request criteria.

NOTICE

This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers.

Please be advised that this document is updated periodically and changes may appear prior to their effective date to allow for member notification.

While we make every effort to ensure that our Drug Formulary is up-to-date, this list may have changed since printing. For the most up-to-date information, you must use the 'Find My Prescription' tool on [CareSource.com/Marketplace](https://www.caresource.com/marketplace), or contact Member Services at the toll-free telephone number on your ID card to confirm the accuracy of the information in this copy of the Drug Formulary.

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List of Abbreviations

ACA: Affordable Care Act

AR: Age Restriction. For certain drugs, the drug may be covered for members in a certain age range without a prior authorization.

OTC: Over-the-Counter. An OTC drug is a non-prescription drug.

PA: Prior Authorization. The Plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the drug.

QL: Quantity Limit. For certain drugs, the Plan limits the amount of the drug that we will cover.

ST: Step Therapy. In some cases, the Plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

CURRENT AS OF 10/1/2023

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------|
| ANALGESIC, ANTI-INFLAMMATORY OR ANTIPYRETIC | | |
| ANALGESIC OPIOID AGONISTS | | |
| <i>codeine sulfate</i> | Tier 1 | PA |
| <i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i> | Tier 1 | PA; QL (15 EA per 30 days) |
| <i>hydrocodone bitartrate oral capsule, oral only, er 12hr</i> | Tier 1 | PA; QL (90 EA per 30 days) |
| <i>hydromorphone oral liquid</i> | Tier 1 | PA; QL (6 ML per 1 day) |
| <i>hydromorphone oral tablet</i> | Tier 1 | PA; QL (6 EA per 1 day) |
| <i>hydromorphone oral tablet extended release 24 hr</i> | Tier 1 | QL (60 EA per 30 days) |
| <i>levorphanol tartrate</i> | Tier 1 | |
| METHADONE INTENSOL | Tier 1 | PA |
| <i>methadone oral concentrate</i> | Tier 1 | PA |
| <i>methadone oral solution 10 mg/5 ml</i> | Tier 1 | PA; QL (8.67 ML per 1 day) |
| <i>methadone oral solution 5 mg/5 ml</i> | Tier 1 | PA; QL (20 ML per 1 day) |
| <i>methadone oral tablet 10 mg</i> | Tier 1 | PA; QL (2 EA per 1 day) |
| <i>methadone oral tablet 5 mg</i> | Tier 1 | PA; QL (4 EA per 1 day) |
| <i>morphine concentrate oral solution</i> | Tier 1 | PA; QL (6 ML per 1 day) |
| <i>morphine oral capsule, extend.release pellets 10 mg, 100 mg, 20 mg, 50 mg, 80 mg</i> | Tier 1 | PA; QL (90 EA per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-----------------------------|
| <i>morphine oral solution</i> | Tier 1 | PA; QL (30 ML per 1 day) |
| <i>morphine oral tablet</i> | Tier 1 | PA; QL (6 EA per 1 day) |
| <i>morphine oral tablet extended release</i> | Tier 1 | PA; QL (120 EA per 30 days) |
| <i>morphine rectal</i> | Tier 1 | PA; QL (6 EA per 1 day) |
| <i>oxycodone oral capsule</i> | Tier 1 | PA; QL (6 EA per 1 day) |
| <i>oxycodone oral concentrate</i> | Tier 1 | PA; QL (6 ML per 1 day) |
| <i>oxycodone oral solution</i> | Tier 1 | PA; QL (30 ML per 1 day) |
| <i>oxycodone oral tablet</i> | Tier 1 | PA; QL (6 EA per 1 day) |
| <i>oxycodone oral tablet, oral only, ext.rel. 12 hr</i> | Tier 2 | PA; QL (90 EA per 30 days) |
| <i>oxymorphone oral tablet</i> | Tier 1 | PA |
| <i>oxymorphone oral tablet extended release 12 hr</i> | Tier 1 | PA; QL (90 EA per 30 days) |
| <i>tramadol oral tablet 50 mg</i> | Tier 1 | PA; QL (240 EA per 30 days) |
| <i>tramadol oral tablet extended release 24 hr</i> | Tier 1 | PA; QL (30 EA per 30 days) |
| <i>tramadol oral tablet, er multiphase 24 hr</i> | Tier 1 | PA; QL (30 EA per 30 days) |
| ANALGESIC OPIOID CODEINE COMBINATIONS | | |
| <i>acetaminophen-codeine oral solution</i> | Tier 1 | PA; QL (125 ML per 1 day) |
| <i>acetaminophen-codeine oral tablet</i> | Tier 1 | PA; QL (10 EA per 1 day) |
| <i>butalbital-acetaminophen-cod oral capsule 50-325-40-30 mg</i> | Tier 1 | PA |
| ANALGESIC OPIOID HYDROCODONE AND NON-SALICYLATE COMBINATIONS | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|--------------------------|
| <i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i> | Tier 1 | PA; QL (10 EA per 1 day) |
| <i>hydrocodone-acetaminophen oral tablet 2.5-325 mg</i> | Tier 1 | |
| ANALGESIC OPIOID HYDROCODONE AND NSAID COMBINATIONS | | |
| <i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg</i> | Tier 1 | PA |
| <i>hydrocodone-ibuprofen oral tablet 7.5-200 mg</i> | Tier 1 | PA; QL (5 EA per 1 day) |
| ANALGESIC OPIOID HYDROCODONE COMBINATIONS | | |
| <i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i> | Tier 1 | PA; QL (10 EA per 1 day) |
| <i>hydrocodone-acetaminophen oral tablet 2.5-325 mg</i> | Tier 1 | |
| <i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg</i> | Tier 1 | PA |
| <i>hydrocodone-ibuprofen oral tablet 7.5-200 mg</i> | Tier 1 | PA; QL (5 EA per 1 day) |
| ANALGESIC OPIOID OXYCODONE AND NON-SALICYLATE COMBINATIONS | | |
| ENDOCET | Tier 1 | PA; QL (10 EA per 1 day) |
| <i>oxycodone-acetaminophen oral solution</i> | Tier 1 | PA |
| <i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i> | Tier 1 | PA; QL (10 EA per 1 day) |
| <i>oxycodone-acetaminophen oral tablet 2.5-300 mg</i> | Tier 1 | |
| <i>oxycodone-acetaminophen oral tablet 7.5-300 mg</i> | Tier 1 | PA |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------|
| <i>oxycodone-acetaminophen oral tablet 2.5-300 mg</i> | Tier 1 | |
| <i>oxycodone-acetaminophen oral tablet 7.5-300 mg</i> | Tier 1 | PA |
| ANALGESIC OPIOID OXYCODONE COMBINATIONS | | |
| ENDOCET | Tier 1 | PA; QL (10 EA per 1 day) |
| <i>oxycodone-acetaminophen oral solution</i> | Tier 1 | PA |
| <i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i> | Tier 1 | PA; QL (10 EA per 1 day) |
| <i>oxycodone-acetaminophen oral tablet 2.5-300 mg</i> | Tier 1 | |
| <i>oxycodone-acetaminophen oral tablet 7.5-300 mg</i> | Tier 1 | PA |
| ANALGESIC OPIOID PARTIAL-MIXED AGONISTS | | |
| <i>buprenorphine</i> | Tier 1 | PA |
| <i>buprenorphine hcl injection solution</i> | Tier 1 | |
| ANALGESIC OPIOID TRAMADOL AND NON-SALICYLATE COMBINATIONS | | |
| <i>tramadol-acetaminophen</i> | Tier 1 | PA; QL (240 EA per 30 days) |
| ANALGESIC OPIOID TRAMADOL COMBINATIONS | | |
| <i>tramadol-acetaminophen</i> | Tier 1 | PA; QL (240 EA per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| ANALGESIC OR ANTIPYRETIC NON-OPIOID/SEDATIVE COMBINATIONS | | |
| <i>butalbital-acetaminophen-caff oral capsule 50-325-40 mg</i> | Tier 1 | QL (48 EA per 30 days) |
| <i>butalbital-acetaminophen-caff oral tablet</i> | Tier 1 | QL (48 EA per 30 days) |
| ZEBUTAL | Tier 1 | QL (48 EA per 30 days) |
| ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITING AGENTS, NON-SELECTIVE | | |
| ENBREL MINI | Tier 4 | PA; QL (4 ML per 28 days) |
| ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5) | Tier 4 | PA; QL (8 ML per 30 days) |
| ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML) | Tier 4 | PA; QL (4 ML per 28 days) |
| ENBREL SURECLICK | Tier 4 | PA; QL (4 ML per 28 days) |
| ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITING AGENTS, TNF-ALPHA SEL | | |
| <i>adalimumab-adaz</i> | Tier 4 | PA |
| <i>adalimumab-fkjp</i> | Tier 4 | PA |
| CIMZIA | Tier 4 | PA; QL (2 EA per 28 days) |
| CIMZIA POWDER FOR RECONST | Tier 4 | PA; QL (1 EA per 28 days) |
| CIMZIA STARTER KIT | Tier 4 | PA; QL (6 EA per 365 days) |
| HADLIMA | Tier 4 | PA |
| HADLIMA PUSHTOUCH | Tier 4 | PA |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| HADLIMA(CF) | Tier 4 | PA |
| HADLIMA(CF) PUSHTOUCH | Tier 4 | PA |
| HUMIRA | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA PEN | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA PEN CROHNS-UC-HS START | Tier 4 | PA; QL (6 EA per 365 days) |
| HUMIRA PEN PSOR-UVEITS-ADOL HS | Tier 4 | PA; QL (4 EA per 365 days) |
| HUMIRA(CF) | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML | Tier 4 | PA; QL (3 EA per 365 days) |
| HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML | Tier 4 | PA; QL (2 EA per 365 days) |
| HUMIRA(CF) PEN | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA(CF) PEN CROHNS-UC-HS | Tier 4 | PA; QL (3 EA per 365 days) |
| HUMIRA(CF) PEN PEDIATRIC UC | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA(CF) PEN PSOR-UV-ADOL HS | Tier 4 | PA; QL (3 EA per 365 days) |
| DMARD - ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITING AGENTS | | |
| <i>adalimumab-adaz</i> | Tier 4 | PA |
| <i>adalimumab-fkjp</i> | Tier 4 | PA |
| CIMZIA | Tier 4 | PA; QL (2 EA per 28 days) |
| CIMZIA POWDER FOR RECONST | Tier 4 | PA; QL (1 EA per 28 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------|
| CIMZIA STARTER KIT | Tier 4 | PA; QL (6 EA per 365 days) |
| ENBREL MINI | Tier 4 | PA; QL (4 ML per 28 days) |
| ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5) | Tier 4 | PA; QL (8 ML per 30 days) |
| ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML) | Tier 4 | PA; QL (4 ML per 28 days) |
| ENBREL SURECLICK | Tier 4 | PA; QL (4 ML per 28 days) |
| HADLIMA | Tier 4 | PA |
| HADLIMA PUSHTOUCH | Tier 4 | PA |
| HADLIMA(CF) | Tier 4 | PA |
| HADLIMA(CF) PUSHTOUCH | Tier 4 | PA |
| HUMIRA | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA PEN | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA PEN CROHNS-UC-HS START | Tier 4 | PA; QL (6 EA per 365 days) |
| HUMIRA PEN PSOR- UVEITS-ADOL HS | Tier 4 | PA; QL (4 EA per 365 days) |
| HUMIRA(CF) | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML | Tier 4 | PA; QL (3 EA per 365 days) |
| HUMIRA(CF) PEN | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA(CF) PEN CROHNS-UC-HS | Tier 4 | PA; QL (3 EA per 365 days) |
| HUMIRA(CF) PEN PEDIATRIC UC | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA(CF) PEN PSOR-UV-ADOL HS | Tier 4 | PA; QL (3 EA per 365 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|---------------------------|
| DMARD - ANTIMALARIALS | | |
| <i>hydroxychloroquine</i> | Tier 1 | |
| DMARD - ANTIMETABOLITES | | |
| <i>methotrexate sodium oral</i> | Tier 1 | |
| TREXALL | Tier 2 | |
| DMARD - IMMUNOSUPPRESSIVES | | |
| <i>azathioprine</i> | Tier 1 | |
| <i>cyclophosphamide oral capsule</i> | Tier 1 | |
| <i>cyclosporine modified</i> | Tier 1 | |
| <i>cyclosporine oral</i> | Tier 1 | |
| GENGRAF | Tier 1 | |
| <i>mycophenolate mofetil</i> | Tier 1 | |
| DMARD - INTERLEUKIN-6 (IL-6) RECEPTOR INHIBITORS, MONOCLONAL ANTIBODY | | |
| ACTEMRA ACTPEN | Tier 4 | PA; QL (2 ML per 28 days) |
| ACTEMRA SUBCUTANEOUS | Tier 4 | PA; QL (2 ML per 28 days) |
| DMARD - JANUS KINASE (JAK) INHIBITORS | | |
| RINVOQ | Tier 4 | PA; QL (1 EA per 1 day) |
| DMARD - OTHER | | |
| D-PENAMINE | Tier 2 | PA |
| <i>minocycline oral capsule</i> | Tier 1 | |
| <i>minocycline oral tablet</i> | Tier 1 | |
| <i>penicillamine</i> | Tier 1 | PA |
| <i>sulfasalazine</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| DMARD - PHOSPHODIESTERASE-4 (PDE4) INHIBITORS | | |
| OTEZLA | Tier 4 | PA; QL (60 EA per 30 days) |
| DMARD - PYRIMIDINE SYNTHESIS INHIBITORS | | |
| <i>leflunomide</i> | Tier 1 | QL (30 EA per 30 days) |
| NSAID ANALGESIC AND HISTAMINE H2 RECEPTOR ANTAGONIST COMBINATIONS | | |
| <i>ibuprofen-famotidine</i> | Tier 1 | |
| NSAID ANALGESIC AND PROSTAGLANDIN ANALOG COMBINATIONS | | |
| <i>diclofenac-misoprostol</i> | Tier 1 | |
| NSAID ANALGESIC AND PROTON PUMP INHIBITOR COMBINATIONS | | |
| <i>naproxen-esomeprazole</i> | Tier 1 | ST |
| NSAID ANALGESIC, CYCLOOXYGENASE-2 (COX-2) SELECTIVE INHIBITORS | | |
| <i>celecoxib</i> | Tier 1 | ST |
| NSAID ANALGESICS (COX NON-SPECIFIC) - ANTHRANILIC ACID DERIVATIVES | | |
| <i>mefenamic acid</i> | Tier 1 | |
| NSAID ANALGESICS (COX NON-SPECIFIC) - OTHER | | |
| <i>ketorolac oral</i> | Tier 1 | QL (20 EA per 30 days) |
| <i>nabumetone</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>sulindac</i> | Tier 1 | |
| NSAID ANALGESICS (COX NON-SPECIFIC) - OXICAM DERIVATIVES | | |
| <i>meloxicam oral tablet 15 mg</i> | Tier 1 | |
| <i>meloxicam oral tablet 7.5 mg</i> | Tier 1 | QL (30 EA per 30 days) |
| <i>piroxicam</i> | Tier 1 | |
| NSAID ANALGESICS (COX NON-SPECIFIC) - PHENYLACETIC ACID DERIVATIVES | | |
| <i>diclofenac potassium oral tablet 25 mg</i> | Tier 2 | |
| <i>diclofenac potassium oral tablet 50 mg</i> | Tier 1 | |
| <i>diclofenac sodium oral</i> | Tier 1 | |
| NSAID ANALGESICS (COX NON-SPECIFIC) - PROPIONIC ACID DERIVATIVES | | |
| EC-NAPROXEN | Tier 1 | |
| <i>fenoprofen oral tablet</i> | Tier 1 | ST |
| <i>flurbiprofen</i> | Tier 1 | |
| IBU | Tier 1 | |
| <i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i> | Tier 1 | |
| <i>ketoprofen oral capsule 25 mg</i> | Tier 1 | ST |
| <i>ketoprofen oral capsule 50 mg, 75 mg</i> | Tier 1 | |
| <i>naproxen oral tablet</i> | Tier 1 | |
| <i>naproxen oral tablet, delayed release (dr/ec)</i> | Tier 1 | |
| <i>naproxen sodium oral tablet 275 mg, 550 mg</i> | Tier 1 | |
| <i>oxaprozin</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|---------------------------|
| NSAID ANALGESICS,
(COX NON-SPECIFIC)
- INDOLE ACETIC
ACID DERIVATIVES | | |
| <i>etodolac</i> | Tier 1 | |
| <i>indomethacin oral capsule</i> | Tier 1 | |
| SALICYLATE
ANALGESIC AND
SEDATIVE
COMBINATIONS | | |
| <i>butalbital-aspirin-
caffeine oral capsule</i> | Tier 1 | QL (48 EA per
30 days) |
| SALICYLATE
ANALGESICS | | |
| <i>diflunisal</i> | Tier 1 | |
| ANESTHETICS | | |
| GENERAL
ANESTHETIC -
INHALANT VOLATILE | | |
| <i>desflurane</i> | Tier 1 | |
| FORANE | Tier 1 | |
| <i>isoflurane</i> | Tier 1 | |
| <i>sevoflurane</i> | Tier 1 | |
| TERRELL | Tier 1 | |
| GENERAL
ANESTHETIC -
PARENTERAL,
BENZODIAZEPINES | | |
| <i>midazolam (pf) injection
solution</i> | Tier 1 | |
| <i>midazolam (pf) injection
syringe 2 mg/2 ml (1
mg/ml)</i> | Tier 1 | |
| <i>midazolam injection</i> | Tier 1 | |
| <i>midazolam intravenous
syringe 150 mg/30 ml (5
mg/ml)</i> | Tier 2 | |
| LOCAL ANESTHETIC -
AMIDES | | |
| <i>lidocaine hcl
laryngotracheal</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| ANORECTAL
PREPARATIONS | | |
| ANAL FISSURE
PAIN/TREATMENT
AGENTS - NITRATES | | |
| RECTIV | Tier 2 | PA |
| ANORECTAL -
GLUCOCORTICOIDS | | |
| <i>hydrocortisone acetate
rectal suppository 25
mg</i> | Tier 1 | |
| <i>hydrocortisone topical
cream with perineal
applicator</i> | Tier 1 | |
| PROCTO-MED HC | Tier 1 | |
| PROCTOSOL HC | Tier 1 | |
| PROCTOZONE-HC | Tier 1 | |
| ANTIDOTES AND
OTHER REVERSAL
AGENTS | | |
| ANTIDOTE -
ACETAMINOPHEN
POISONING | | |
| <i>acetylcysteine</i> | Tier 1 | |
| CHELATING AGENTS
- COPPER | | |
| D-PENAMINE | Tier 2 | PA |
| <i>penicillamine</i> | Tier 1 | PA |
| CHELATING AGENTS
- IRON | | |
| <i>deferasirox oral tablet</i> | Tier 4 | |
| <i>deferasirox oral tablet,
dispersible</i> | Tier 4 | |
| MU-OPIOID
RECEPTOR
ANTAGONISTS,
PERIPHERALLY-
ACTING | | |
| MOVANTI-K | Tier 2 | PA; QL (30 EA
per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-----------------------------|
| OPIOID REVERSAL AGENTS - OPIOID ANTAGONISTS | | |
| <i>nalmefene</i> | Tier 2 | QL (2 Units per 1 Month) |
| <i>naloxone injection solution</i> | Tier 1 | QL (2 ML per 30 days) |
| <i>naloxone injection syringe 1 mg/ml</i> | Tier 1 | |
| ANTI-INFECTIVE AGENTS | | |
| AMINOGLYCOSIDE ANTIBIOTIC | | |
| <i>neomycin</i> | Tier 1 | |
| <i>tobramycin sulfate injection recon soln</i> | Tier 1 | PA |
| <i>tobramycin sulfate injection solution 40 mg/ml</i> | Tier 1 | PA |
| AMINOPENICILLIN ANTIBIOTIC | | |
| <i>amoxicillin</i> | Tier 1 | |
| <i>ampicillin</i> | Tier 1 | |
| AMINOPENICILLIN ANTIBIOTIC - BETA-LACTAMASE INHIBITOR COMBINATIONS | | |
| <i>amoxicillin-pot clavulanate</i> | Tier 1 | |
| ANTHELMINTIC AGENTS - BENZIMIDAZOLE DERIVATIVES | | |
| <i>albendazole</i> | Tier 1 | PA; QL (120 EA per 30 days) |
| EMVERM | Tier 2 | QL (6 EA per 30 days) |
| ANTHELMINTIC AGENTS - MACROCYCLIC LACTONES | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| <i>ivermectin oral</i> | Tier 1 | QL (20 EA per 30 days) |
| ANTHELMINTIC AGENTS OTHER | | |
| <i>praziquantel</i> | Tier 1 | |
| ANTIBACTERIAL FOLATE ANTAGONIST - OTHER COMBINATIONS | | |
| <i>sulfamethoxazole-trimethoprim oral</i> | Tier 1 | |
| SULFATRIM | Tier 1 | |
| ANTIBACTERIAL FOLATE ANTAGONIST OTHERS | | |
| <i>trimethoprim</i> | Tier 1 | |
| ANTIBACTERIAL NITROFURAN DERIVATIVES | | |
| <i>nitrofurantoin macrocrystal</i> | Tier 1 | |
| <i>nitrofurantoin monohyd/m-cryst</i> | Tier 1 | |
| <i>nitrofurantoin oral suspension 25 mg/5 ml</i> | Tier 1 | |
| ANTIFUNGAL - ALLYLAMINES | | |
| <i>terbinafine hcl oral</i> | Tier 1 | QL (1 EA per 1 day) |
| ANTIFUNGAL - AMPHOTERIC POLYENE MACROLIDES | | |
| <i>nystatin oral tablet</i> | Tier 1 | |
| ANTIFUNGAL - FLUORINATED PYRIMIDINE-TYPE AGENTS | | |
| <i>flucytosine</i> | Tier 1 | |
| ANTIFUNGAL - IMIDAZOLES | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| <i>ketoconazole oral</i> | Tier 1 | |
| ANTIFUNGAL -
TRIAZOLES | | |
| CRESEMBA ORAL
CAPSULE 186 MG | Tier 3 | PA |
| <i>fluconazole oral
suspension for
reconstitution</i> | Tier 1 | |
| <i>fluconazole oral tablet
100 mg, 200 mg, 50 mg</i> | Tier 1 | |
| <i>fluconazole oral tablet
150 mg</i> | Tier 1 | QL (2 EA per
30 days) |
| <i>voriconazole oral</i> | Tier 1 | PA |
| ANTIFUNGAL OTHER | | |
| <i>griseofulvin microsize</i> | Tier 1 | |
| <i>griseofulvin
ultramicrosize</i> | Tier 1 | |
| ANTILEPTIC -
IMMUNOMODULATOR
S | | |
| THALOMID ORAL
CAPSULE 100 MG, 50
MG | Tier 4 | PA; QL (30 EA
per 30 days) |
| THALOMID ORAL
CAPSULE 150 MG, 200
MG | Tier 4 | PA; QL (60 EA
per 30 days) |
| ANTILEPTIC -
SULFONE AGENTS | | |
| <i>dapsone oral</i> | Tier 1 | |
| ANTIMALARIAL
COMBINATIONS | | |
| <i>atovaquone-proguanil
oral tablet 250-100 mg</i> | Tier 1 | QL (60 EA per
180 days) |
| <i>atovaquone-proguanil
oral tablet 62.5-25 mg</i> | Tier 1 | QL (180 EA per
180 days) |
| COARTEM | Tier 2 | QL (24 EA per
30 days) |
| ANTIMALARIALS | | |
| <i>chloroquine phosphate</i> | Tier 1 | QL (1000 EA
per 1 day) |
| <i>hydroxychloroquine</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------|
| <i>mefloquine</i> | Tier 1 | QL (13 EA per
180 days) |
| <i>pyrimethamine</i> | Tier 4 | PA |
| <i>quinine sulfate</i> | Tier 1 | QL (42 EA per
30 days) |
| ANTIPROTOZOAL
AGENTS -
NITROIMIDAZOLE
DERIVATIVES | | |
| <i>benznidazole oral tablet
100 mg</i> | Tier 2 | QL (120 EA per
30 days) |
| <i>benznidazole oral tablet
12.5 mg</i> | Tier 2 | QL (720 EA per
365 days) |
| ANTIPROTOZOAL
AGENTS - OTHER | | |
| <i>atovaquone</i> | Tier 1 | |
| ANTIPROTOZOAL
AGENTS
(ANTIPARASITIC) - 5-
NITROTHIAZOLYL
DERIVATIVES | | |
| <i>nitazoxanide</i> | Tier 1 | QL (14 EA per
30 days) |
| ANTIPROTOZOAL-
ANTIBACTERIAL 1ST
GENERATION 2-
METHYL-5-
NITROIMIDAZOLE | | |
| <i>metronidazole oral</i> | Tier 1 | |
| ANTIPROTOZOAL-
ANTIBACTERIAL 2ND
GENERATION 2-
METHYL-5-
NITROIMIDAZOLE | | |
| <i>tinidazole oral tablet
250 mg</i> | Tier 1 | QL (40 EA per
30 days) |
| <i>tinidazole oral tablet
500 mg</i> | Tier 1 | QL (20 EA per
30 days) |
| ANTIRETROVIRAL -
CCR5 CO-RECEPTOR
ANTAGONIST | | |
| <i>maraviroc oral tablet
150 mg</i> | Tier 1 | QL (2 EA per 1
day) |

| Drug Name | Tier | Restrictions/
Limits |
|---|---------|--------------------------|
| <i>maraviroc oral tablet 300 mg</i> | Tier 1 | QL (4 EA per 1 day) |
| SELZENTRY ORAL SOLUTION | Tier 2 | QL (1840 ML per 30 days) |
| ANTIRETROVIRAL - HIV-1 INTEGRASE STRAND TRANSFER INHIBITORS | | |
| APRETUDE | Tier 10 | |
| ISENTRESS ORAL POWDER IN PACKET | Tier 2 | QL (2 EA per 1 day) |
| ISENTRESS ORAL TABLET | Tier 2 | QL (4 EA per 1 day) |
| ISENTRESS ORAL TABLET,CHEWABLE | Tier 2 | QL (6 EA per 1 day) |
| ANTIRETROVIRAL - INTEGRASE INHIBITOR AND NNRTI COMBINATIONS | | |
| CABENUVA INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE 400 MG/2 ML- 600 MG/2 ML | Tier 10 | QL (1 ML per 28 days) |
| CABENUVA INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE 600 MG/3 ML- 900 MG/3 ML | Tier 10 | QL (1 ML per 365 days) |
| JULUCA | Tier 2 | QL (1 EA per 1 day) |
| ANTIRETROVIRAL - INTEGRASE INHIBITOR AND NRTI COMBINATIONS | | |
| DOVATO | Tier 2 | QL (1 EA per 1 day) |
| ANTIRETROVIRAL - NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIB (NNRTI) | | |
| <i>efavirenz oral capsule</i> | Tier 1 | QL (3 EA per 1 day) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>efavirenz oral tablet</i> | Tier 1 | QL (1 EA per 1 day) |
| <i>nevirapine oral suspension</i> | Tier 1 | QL (40 ML per 1 day) |
| <i>nevirapine oral tablet</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>nevirapine oral tablet extended release 24 hr 100 mg</i> | Tier 1 | QL (3 EA per 1 day) |
| <i>nevirapine oral tablet extended release 24 hr 400 mg</i> | Tier 1 | QL (1 EA per 1 day) |
| PIFELTRO | Tier 2 | QL (1 EA per 1 day) |
| ANTIRETROVIRAL - NUCLEOSIDE AND NUCLEOTIDE ANALOG RTIS COMBINATIONS | | |
| DESCOVY ORAL TABLET 120-15 MG | Tier 2 | ST |
| DESCOVY ORAL TABLET 200-25 MG | Tier 2 | ST; QL (1 EA per 1 day) |
| <i>emtricitabine-tenofovir (tdf) oral tablet 200-300 mg</i> | Tier 0 | QL (1 EA per 1 day) |
| ANTIRETROVIRAL - NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI) | | |
| <i>abacavir oral solution</i> | Tier 1 | QL (30 ML per 1 day) |
| <i>abacavir oral tablet</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>emtricitabine</i> | Tier 1 | QL (1 EA per 1 day) |
| EMTRIVA ORAL SOLUTION | Tier 2 | QL (680 ML per 30 days) |
| <i>lamivudine oral solution</i> | Tier 1 | QL (30 ML per 1 day) |
| <i>lamivudine oral tablet 150 mg</i> | Tier 1 | QL (2 EA per 1 day) |

| Drug Name | | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>lamivudine oral tablet 300 mg</i> | Tier 1 | QL (1 EA per 1 day) |
| ANTIRETROVIRAL - NUCLEOTIDE ANALOG REVERSE TRANSCRIPTASE INHIBITORS | | |
| <i>tenofovir disoproxil fumarate</i> | Tier 1 | QL (1 EA per 1 day) |
| VIREAD ORAL POWDER | Tier 2 | QL (8 GM per 1 day) |
| VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG | Tier 2 | QL (1 EA per 1 day) |
| ANTIRETROVIRAL COMBINATIONS - PROTEASE INHIBITORS | | |
| EVOTAZ | Tier 2 | QL (1 EA per 1 day) |
| <i>lopinavir-ritonavir oral solution</i> | Tier 1 | QL (13 ML per 1 day) |
| PREZCOBIX | Tier 2 | QL (1 EA per 1 day) |
| ANTIRETROVIRAL-NUCLEOSIDE AND NUCLEOTIDE ANALOGS,PROTEASE INHIBITORS | | |
| SYMTUZA | Tier 2 | QL (1 EA per 1 day) |
| ANTIRETROVIRAL- INTEGRASE INHIBITOR,NUCLEOSIDE AND NUCLEOTIDE RTIS COMB | | |
| BIKTARVY ORAL TABLET 30-120-15 MG | Tier 2 | |
| BIKTARVY ORAL TABLET 50-200-25 MG | Tier 2 | QL (1 EA per 1 day) |
| GENVOYA | Tier 2 | QL (1 EA per 1 day) |
| STRIBILD | Tier 2 | QL (1 EA per 1 day) |

| Drug Name | | Restrictions/
Limits |
|---|--------|-------------------------|
| ANTIRETROVIRAL-NUCLEOSIDE ANALOGS AND INTEGRASE INHIBITOR COMBINATIONS | | |
| TRIUMEQ | Tier 2 | PA; QL (1 EA per 1 day) |
| ANTIRETROVIRAL-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI) COMB | | |
| <i>abacavir-lamivudine</i> | Tier 1 | QL (1 EA per 1 day) |
| <i>lamivudine-zidovudine</i> | Tier 1 | QL (2 EA per 1 day) |
| ANTIRETROVIRAL-NUCLEOSIDE, NUCLEOTIDE ANALOGS AND NON-NUCLEOSIDE RTI | | |
| COMPLERA | Tier 2 | QL (1 EA per 1 day) |
| DELSTRIGO | Tier 2 | QL (1 EA per 1 day) |
| <i>efavirenz-lamivudine-tenofovir disoproxil fumarate</i> | Tier 1 | |
| ODEFSEY | Tier 2 | QL (1 EA per 1 day) |
| ANTITUBERCULAR - AMINO BENZOIC ACID ANALOGS | | |
| PASER | Tier 2 | |
| ANTITUBERCULAR - D-ALANINE ANALOGS | | |
| <i>cycloserine</i> | Tier 2 | |
| ANTITUBERCULAR - ISONICOTINIC ACID DERIVATIVES | | |
| <i>isoniazid oral</i> | Tier 1 | |

| Drug Name | | Restrictions/
Limits |
|--|--------|----------------------------|
| ANTITUBERCULAR -
NIACINAMIDE
DERIVATIVES | | |
| <i>pyrazinamide</i> | Tier 1 | |
| ANTITUBERCULAR -
NITROIMIDAZOLE
DERIVATIVES | | |
| <i>pretomanid</i> | Tier 2 | PA; QL (1 EA
per 1 day) |
| ANTITUBERCULAR -
RIFAMYCIN AND
DERIVATIVES | | |
| <i>rifabutin</i> | Tier 1 | |
| <i>rifampin oral</i> | Tier 1 | |
| ANTITUBERCULAR
AGENTS OTHER | | |
| <i>ethambutol</i> | Tier 1 | |
| CEPHALOSPORIN
ANTIBIOTICS - 1ST
GENERATION | | |
| <i>cefadroxil</i> | Tier 1 | |
| <i>cephalexin oral capsule
250 mg, 500 mg</i> | Tier 1 | |
| <i>cephalexin oral
suspension for
reconstitution</i> | Tier 1 | |
| <i>cephalexin oral tablet
250 mg</i> | Tier 1 | |
| CEPHALOSPORIN
ANTIBIOTICS - 2ND
GENERATION | | |
| <i>cefprozil</i> | Tier 1 | |
| <i>cefuroxime axetil</i> | Tier 1 | |
| CEPHALOSPORIN
ANTIBIOTICS - 3RD
GENERATION | | |
| <i>cefdinir</i> | Tier 1 | |
| FLUOROQUINOLONE
ANTIBIOTICS | | |
| <i>ciprofloxacin</i> | Tier 1 | |
| <i>ciprofloxacin hcl oral</i> | Tier 1 | |
| <i>levofloxacin oral</i> | Tier 1 | |

| Drug Name | | Restrictions/
Limits |
|--|--------|-----------------------------------|
| <i>moxifloxacin oral</i> | Tier 1 | |
| <i>ofloxacin oral</i> | Tier 1 | QL (2 EA per 1
day) |
| GLYCOPEPTIDE
ANTIBIOTICS | | |
| FIRVANQ ORAL
RECON SOLN 25
MG/ML | Tier 2 | PA; QL (300
ML per 30
days) |
| FIRVANQ ORAL
RECON SOLN 50
MG/ML | Tier 2 | PA; QL (450
ML per 30
days) |
| <i>vancomycin oral
capsule 125 mg</i> | Tier 1 | PA; QL (40 EA
per 30 days) |
| <i>vancomycin oral
capsule 250 mg</i> | Tier 1 | PA; QL (80 EA
per 30 days) |
| <i>vancomycin oral recon
soln 50 mg/ml</i> | Tier 1 | PA; QL (450
ML per 30
days) |
| HEPATITIS B
TREATMENT-
NUCLEOSIDE
ANALOGS
(ANTIVIRAL) | | |
| BARACLUDE ORAL
SOLUTION | Tier 2 | |
| <i>entecavir</i> | Tier 1 | |
| <i>lamivudine oral tablet
100 mg</i> | Tier 1 | |
| HEPATITIS B
TREATMENT-
NUCLEOTIDE
ANALOGS
(ANTIVIRAL) | | |
| <i>adefovir</i> | Tier 1 | |
| <i>tenofovir disoproxil
fumarate</i> | Tier 1 | QL (1 EA per 1
day) |
| VIREAD ORAL
POWDER | Tier 2 | QL (8 GM per 1
day) |
| VIREAD ORAL TABLET
150 MG, 200 MG, 250
MG | Tier 2 | QL (1 EA per 1
day) |
| HEPATITIS C -
INTERFERONS | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|------------------------------|
| PEGASYS
SUBCUTANEOUS
SOLUTION | Tier 4 | PA; QL (4 ML
per 30 days) |
| PEGASYS
SUBCUTANEOUS
SYRINGE | Tier 4 | PA; QL (2 ML
per 28 days) |
| HEPATITIS C - NS5B
POLYMERASE AND
NS5A INHIBITOR
COMBINATIONS | | |
| <i>sofosbuvir-velpatasvir</i> | Tier 4 | PA; QL (1 EA
per 1 day) |
| HEPATITIS C -
NUCLEOSIDE
ANALOGS | | |
| <i>ribavirin oral</i> | Tier 4 | |
| HERPES ANTIVIRAL
AGENT - PURINE
ANALOGS | | |
| <i>acyclovir oral capsule</i> | Tier 1 | |
| <i>acyclovir oral
suspension 200 mg/5
ml</i> | Tier 1 | |
| <i>acyclovir oral tablet</i> | Tier 1 | |
| <i>valacyclovir</i> | Tier 1 | QL (30 EA per
30 days) |
| HERPES ANTIVIRAL
AGENT - THYMIDINE
ANALOGS | | |
| <i>famciclovir oral tablet
125 mg, 500 mg</i> | Tier 1 | QL (21 EA per
30 days) |
| <i>famciclovir oral tablet
250 mg</i> | Tier 1 | QL (60 EA per
30 days) |
| INFLUENZA
ANTIVIRAL AGENTS -
NEURAMINIDASE
INHIBITORS | | |
| <i>oseltamivir oral capsule
30 mg</i> | Tier 1 | QL (40 EA per
365 days) |
| <i>oseltamivir oral capsule
45 mg, 75 mg</i> | Tier 1 | QL (20 EA per
365 days) |
| <i>oseltamivir oral
suspension for
reconstitution</i> | Tier 1 | QL (360 ML
per 365 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| INFLUENZA
ANTIVIRAL AGENTS -
PA ENDONUCLEASE
INHIBITOR | | |
| XOFLUZA ORAL
TABLET 20 MG, 40 MG | Tier 2 | QL (4 EA per
365 days) |
| INFLUENZA-A
ANTIVIRAL AGENTS | | |
| <i>rimantadine</i> | Tier 1 | |
| LINCOSAMIDE
ANTIBIOTICS | | |
| <i>clindamycin hcl</i> | Tier 1 | |
| CLINDAMYCIN
PEDIATRIC | Tier 1 | |
| MACROLIDE
ANTIBIOTICS | | |
| <i>azithromycin oral</i> | Tier 1 | |
| <i>clarithromycin</i> | Tier 1 | |
| DIFICID ORAL
SUSPENSION FOR
RECONSTITUTION | Tier 2 | PA; QL (1 ML
per 30 days) |
| DIFICID ORAL TABLET | Tier 2 | PA; QL (20 EA
per 30 days) |
| ERYTHROCIN (AS
STEARATE) | Tier 1 | |
| <i>erythromycin
ethylsuccinate</i> | Tier 1 | |
| <i>erythromycin oral</i> | Tier 1 | |
| MISC ANTI-INFECTIVE | | |
| <i>pentamidine inhalation</i> | Tier 1 | PA; QL (1 EA
per 28 days) |
| MISC ANTI-INFECTIVE
COMBINATIONS | | |
| URETRON D-S | Tier 1 | |
| URO-SP | Tier 1 | |
| UTIRA-C | Tier 1 | |
| OXAZOLIDINONE
ANTIBIOTICS | | |
| <i>linezolid</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| PENICILLIN
ANTIBIOTIC -
NATURAL | | |
| <i>penicillin v potassium</i> | Tier 1 | |
| PENICILLIN
ANTIBIOTIC -
PENICILLINASE-
RESISTANT | | |
| <i>dicloxacillin</i> | Tier 1 | |
| PROTEASE
INHIBITORS (NON-
PEPTIDIC)
ANTIRETROVIRAL | | |
| APTIVUS | Tier 2 | QL (4 EA per 1 day) |
| PREZCOBIX | Tier 2 | QL (1 EA per 1 day) |
| PREZISTA ORAL
SUSPENSION | Tier 2 | QL (1 ML per 1 day) |
| PREZISTA ORAL
TABLET 150 MG | Tier 2 | QL (6 EA per 1 day) |
| PREZISTA ORAL
TABLET 600 MG | Tier 2 | QL (2 EA per 1 day) |
| PREZISTA ORAL
TABLET 75 MG | Tier 2 | QL (10 EA per 1 day) |
| PREZISTA ORAL
TABLET 800 MG | Tier 2 | QL (1 EA per 1 day) |
| PROTEASE
INHIBITORS
(PEPTIDIC)
ANTIRETROVIRAL | | |
| <i>atazanavir oral capsule 150 mg</i> | Tier 1 | QL (1 EA per 1 day) |
| <i>atazanavir oral capsule 200 mg</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>atazanavir oral capsule 300 mg</i> | Tier 1 | |
| EVOTAZ | Tier 2 | QL (1 EA per 1 day) |
| <i>fosamprenavir</i> | Tier 1 | QL (2 EA per 1 day) |
| LEXIVA ORAL
SUSPENSION | Tier 2 | QL (56 ML per 1 day) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| NORVIR ORAL
POWDER IN PACKET | Tier 2 | QL (6 EA per 180 days) |
| <i>ritonavir</i> | Tier 1 | |
| VIRACEPT ORAL
TABLET 250 MG | Tier 2 | QL (10 EA per 1 day) |
| VIRACEPT ORAL
TABLET 625 MG | Tier 2 | QL (4 EA per 1 day) |
| RIFAMYCINS AND
RELATED
DERIVATIVE
ANTIBIOTICS | | |
| <i>rifabutin</i> | Tier 1 | |
| <i>rifampin oral</i> | Tier 1 | |
| XIFAXAN ORAL
TABLET 200 MG | Tier 2 | PA; QL (9 EA per 30 days) |
| XIFAXAN ORAL
TABLET 550 MG | Tier 2 | PA; QL (60 EA per 30 days) |
| SARS-COV-2
ANTIVIRAL AGENT -
RNA POLYMERASE
INHIBITORS | | |
| LAGEVRIO (EUA) | Tier 2 | QL (40 EA per 180 days) |
| SULFONAMIDE
ANTIBIOTIC | | |
| <i>sulfadiazine</i> | Tier 1 | |
| TETRACYCLINE
ANTIBIOTICS | | |
| <i>demeclocycline</i> | Tier 1 | |
| <i>doxycycline hyclate oral capsule</i> | Tier 1 | |
| <i>doxycycline hyclate oral tablet 100 mg</i> | Tier 1 | |
| <i>doxycycline monohydrate oral capsule 100 mg, 50 mg, 75 mg</i> | Tier 1 | |
| <i>doxycycline monohydrate oral capsule 150 mg</i> | Tier 1 | ST |

| Drug Name | | Restrictions/
Limits |
|---|--------|-----------------------------|
| <i>doxycycline monohydrate oral suspension for reconstitution</i> | Tier 1 | |
| <i>doxycycline monohydrate oral tablet 100 mg, 50 mg</i> | Tier 1 | |
| <i>minocycline oral capsule</i> | Tier 1 | |
| <i>minocycline oral tablet</i> | Tier 1 | |
| <i>tetracycline</i> | Tier 1 | |
| ANTINEOPLASTICS | | |
| ANTINEOPLASTIC - CYP17 (17 ALPHA-HYDROXYLASE/C17,20-LYASE) INHIBITOR | | |
| <i>abiraterone oral tablet 250 mg</i> | Tier 4 | PA; QL (120 EA per 30 days) |
| ANTINEOPLASTIC - 1ST GENERATION EGFR TYROSINE KINASE INHIBITOR | | |
| <i>erlotinib oral tablet 100 mg, 150 mg</i> | Tier 4 | PA; QL (30 EA per 30 days) |
| <i>erlotinib oral tablet 25 mg</i> | Tier 4 | PA; QL (60 EA per 30 days) |
| ANTINEOPLASTIC - 2ND GENERATION EGFR TYROSINE KINASE INHIBITOR | | |
| GILOTRIF | Tier 4 | PA; QL (30 EA per 30 days) |
| ANTINEOPLASTIC - ALKYLATING AGENT - ALKYL SULFONATES | | |
| MYLERAN | Tier 2 | |
| ANTINEOPLASTIC - ALKYLATING AGENT - METHYLHYDRAZINES | | |
| MATULANE | Tier 4 | |

| Drug Name | | Restrictions/
Limits |
|--|--------|-----------------------------|
| ANTINEOPLASTIC - ALKYLATING AGENT - NITROGEN MUSTARDS | | |
| <i>cyclophosphamide oral capsule</i> | Tier 1 | |
| LEUKERAN | Tier 2 | |
| <i>melphalan</i> | Tier 1 | |
| ANTINEOPLASTIC - ALKYLATING AGENT - TRIAZENES | | |
| <i>temozolomide</i> | Tier 4 | |
| ANTINEOPLASTIC - ANTIADRENALS | | |
| LYSODREN | Tier 4 | |
| ANTINEOPLASTIC - ANTIANDROGENS | | |
| <i>abiraterone oral tablet 250 mg</i> | Tier 4 | PA; QL (120 EA per 30 days) |
| <i>bicalutamide</i> | Tier 1 | |
| <i>nilutamide</i> | Tier 1 | PA |
| ANTINEOPLASTIC - ANTIMETABOLITE - FOLIC ACID ANALOGS | | |
| <i>methotrexate sodium oral</i> | Tier 1 | |
| TREXALL | Tier 2 | |
| ANTINEOPLASTIC - ANTIMETABOLITE - PURINE ANALOGS | | |
| <i>mercaptopurine</i> | Tier 1 | |
| ANTINEOPLASTIC - ANTIMETABOLITE - PYRIMIDINE ANALOGS | | |
| <i>capecitabine</i> | Tier 4 | PA |
| ANTINEOPLASTIC - ANTIMETABOLITE - UREA DERIVATIVES | | |
| <i>hydroxyurea</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------------|
| ANTINEOPLASTIC -
AROMATASE
INHIBITORS | | |
| <i>anastrozole</i> | Tier 0 | |
| <i>exemestane</i> | Tier 0 | |
| <i>letrozole</i> | Tier 1 | |
| ANTINEOPLASTIC -
BRAF KINASE
INHIBITORS | | |
| TAFINLAR ORAL
CAPSULE | Tier 4 | PA; QL (120
EA per 30
days) |
| ZELBORAF | Tier 4 | PA; QL (240
EA per 30
days) |
| ANTINEOPLASTIC -
BRUTON'S TYROSINE
KINASE (BTK)
INHIBITOR | | |
| IMBRUVICA ORAL
CAPSULE 140 MG | Tier 4 | PA; QL (120
EA per 30
days) |
| IMBRUVICA ORAL
CAPSULE 70 MG | Tier 4 | PA; QL (30 EA
per 30 days) |
| IMBRUVICA ORAL
SUSPENSION | Tier 4 | |
| IMBRUVICA ORAL
TABLET | Tier 4 | PA; QL (30 EA
per 30 days) |
| ANTINEOPLASTIC -
CYCLIN-DEPENDENT
KINASE (CDK) 4/6
INHIBITORS | | |
| IBRANCE | Tier 4 | PA; QL (21 EA
per 30 days) |
| ANTINEOPLASTIC -
EPIPODOPHYLLOTOX
INS | | |
| <i>etoposide oral</i> | Tier 1 | |
| ANTINEOPLASTIC -
ESTROGENS | | |
| EMCYT | Tier 2 | |
| ANTINEOPLASTIC -
HEDGEHOG
PATHWAY INHIBITOR | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-----------------------------------|
| ERIVEDGE | Tier 4 | PA; QL (30 EA
per 30 days) |
| ANTINEOPLASTIC -
HISTONE
DEACETYLASE
(HDAC) INHIBITORS | | |
| ZOLINZA | Tier 4 | PA |
| ANTINEOPLASTIC -
JANUS KINASE (JAK)
INHIBITORS | | |
| JAKAFI | Tier 4 | PA; QL (60 EA
per 30 days) |
| ANTINEOPLASTIC -
LHRH (GNRH)
AGONIST ANALOG
PITUITARY
SUPPRESSANTS | | |
| ELIGARD | Tier 4 | |
| ELIGARD (3 MONTH) | Tier 4 | |
| ELIGARD (4 MONTH) | Tier 4 | |
| ELIGARD (6 MONTH) | Tier 4 | |
| ANTINEOPLASTIC -
MAST CELL
STABILIZERS | | |
| <i>cromolyn oral</i> | Tier 1 | |
| ANTINEOPLASTIC -
MEK1 AND MEK2
KINASE INHIBITORS | | |
| MEKINIST ORAL
TABLET 0.5 MG | Tier 4 | PA; QL (90 EA
per 30 days) |
| MEKINIST ORAL
TABLET 2 MG | Tier 4 | PA; QL (30 EA
per 30 days) |
| ANTINEOPLASTIC -
MULTIKINASE
INHIBITORS | | |
| COMETRIQ ORAL
CAPSULE 100
MG/DAY(80 MG X1-20
MG X1) | Tier 4 | PA |
| <i>sorafenib</i> | Tier 4 | PA; QL (120
EA per 30
days) |
| ANTINEOPLASTIC -
PROGESTINS | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------------|
| <i>megestrol oral tablet</i> | Tier 1 | |
| ANTINEOPLASTIC -
PROTEIN-TYROSINE
KINASE INHIBITORS | | |
| CAPRELSA ORAL
TABLET 100 MG | Tier 4 | PA; QL (60 EA
per 30 days) |
| CAPRELSA ORAL
TABLET 300 MG | Tier 4 | PA; QL (30 EA
per 30 days) |
| <i>imatinib oral tablet 100
mg</i> | Tier 4 | PA; QL (180
EA per 30
days) |
| <i>imatinib oral tablet 400
mg</i> | Tier 4 | PA; QL (60 EA
per 30 days) |
| IMBRUVICA ORAL
CAPSULE 140 MG | Tier 4 | PA; QL (120
EA per 30
days) |
| IMBRUVICA ORAL
CAPSULE 70 MG | Tier 4 | PA; QL (30 EA
per 30 days) |
| IMBRUVICA ORAL
SUSPENSION | Tier 4 | |
| IMBRUVICA ORAL
TABLET | Tier 4 | PA; QL (30 EA
per 30 days) |
| INLYTA ORAL TABLET
1 MG | Tier 4 | PA; QL (180
EA per 30
days) |
| INLYTA ORAL TABLET
5 MG | Tier 4 | PA; QL (120
EA per 30
days) |
| LENVIMA ORAL
CAPSULE 10 MG/DAY
(10 MG X 1), 14
MG/DAY(10 MG X 1-4
MG X 1), 18 MG/DAY
(10 MG X 1-4 MG X2),
20 MG/DAY (10 MG X
2), 24 MG/DAY(10 MG
X 2-4 MG X 1), 8
MG/DAY (4 MG X 2) | Tier 4 | PA |
| OFEV | Tier 4 | PA; QL (60 EA
per 30 days) |
| <i>sunitinib malate oral
capsule 12.5 mg</i> | Tier 4 | PA; QL (90 EA
per 30 days) |
| <i>sunitinib malate oral
capsule 25 mg, 37.5
mg, 50 mg</i> | Tier 4 | PA; QL (30 EA
per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------------|
| VOTRIENT | Tier 4 | PA; QL (120
EA per 30
days) |
| ANTINEOPLASTIC -
RETINOIDS | | |
| <i>tretinoin (antineoplastic)</i> | Tier 1 | |
| ANTINEOPLASTIC -
SELECTIVE
ESTROGEN
RECEPTOR
MODULATORS
(SERMS) | | |
| <i>tamoxifen</i> | Tier 0 | |
| <i>toremifene</i> | Tier 1 | |
| ANTINEOPLASTIC -
SELECTIVE RETINOID
X RECEPTOR
AGONISTS | | |
| <i>bexarotene oral</i> | Tier 4 | PA |
| ANTINEOPLASTIC -
THALIDOMIDE
ANALOGS | | |
| <i>lenalidomide</i> | Tier 4 | PA; QL (30 EA
per 30 days) |
| POMALYST | Tier 4 | PA |
| REVLIMID | Tier 4 | PA; QL (30 EA
per 30 days) |
| THALOMID ORAL
CAPSULE 100 MG, 50
MG | Tier 4 | PA; QL (30 EA
per 30 days) |
| THALOMID ORAL
CAPSULE 150 MG, 200
MG | Tier 4 | PA; QL (60 EA
per 30 days) |
| ANTINEOPLASTIC
ANTIBIOTIC -
ANTHRACYCLINES | | |
| <i>valrubicin</i> | Tier 4 | PA |
| METHOTREXATE
RESCUE AGENTS | | |
| <i>leucovorin calcium oral</i> | Tier 1 | |
| METHOTREXATE
RESCUE AGENTS -
FOLIC ACID
ANTAGONIST TYPE | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| <i>leucovorin calcium oral</i> | Tier 1 | |
| BIOLOGICALS | | |
| HEPATITIS A AND
HEPATITIS B
VACCINE
COMBINATIONS | | |
| TWINRIX (PF) | Tier 0 | |
| HEPATITIS A
VACCINE - SINGLE
AGENTS | | |
| HAVRIX (PF) | Tier 0 | |
| VAQTA (PF) | Tier 0 | |
| HEPATITIS B
VACCINE
COMBINATIONS | | |
| PEDIARIX (PF) | Tier 0 | |
| HEPATITIS B
VACCINES - SINGLE
AGENTS | | |
| ENGRIX-B (PF) | Tier 0 | |
| ENGRIX-B
PEDIATRIC (PF) | Tier 0 | |
| HEPLISAV-B (PF) | Tier 0 | |
| PREHEVBRIO (PF) | Tier 0 | |
| RECOMBIVAX HB (PF)
INTRAMUSCULAR
SUSPENSION 40
MCG/ML, 5 MCG/0.5
ML | Tier 0 | |
| RECOMBIVAX HB (PF)
INTRAMUSCULAR
SYRINGE | Tier 0 | |
| LIVE VACCINE AND
LIVE VIRUS
FORMULATIONS | | |
| <i>bcg vaccine, live (pf)</i> | Tier 0 | |
| M-M-R II (PF) | Tier 0 | |
| PRIORIX (PF) | Tier 0 | |
| PROQUAD (PF) | Tier 0 | |
| ROTATEQ VACCINE | Tier 0 | |
| STAMARIL (PF) | Tier 0 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| VARIVAX (PF) | Tier 0 | |
| VIVOTIF | Tier 0 | |
| YF-VAX (PF) | Tier 0 | |
| TOXOID VACCINE
COMBINATIONS | | |
| ADACEL(TDAP
ADOLESN/ADULT)(PF) | Tier 0 | |
| BOOSTRIX TDAP | Tier 0 | |
| DAPTACEL (DTAP
PEDIATRIC) (PF) | Tier 0 | |
| INFANRIX (DTAP) (PF) | Tier 0 | |
| KINRIX (PF) | Tier 0 | |
| PEDIARIX (PF) | Tier 0 | |
| PENTACEL (PF) | Tier 0 | |
| QUADRACEL (PF) | Tier 0 | |
| TDVAX | Tier 0 | |
| TENIVAC (PF) | Tier 0 | |
| VACCINE BACTERIAL
- GRAM NEGATIVE
BACILLI (NON-
ENTERIC) | | |
| ACTHIB (PF) | Tier 0 | |
| HIBERIX (PF) | Tier 0 | |
| PEDVAX HIB (PF) | Tier 0 | |
| PENTACEL ACTHIB
COMPONENT (PF) | Tier 0 | |
| TYPHIM VI | Tier 0 | |
| VIVOTIF | Tier 0 | |
| VACCINE BACTERIAL
- GRAM NEGATIVE
COCCI | | |
| MENACTRA (PF) | Tier 0 | |
| MENVEO A-C-Y-W-
135-DIP (PF)
INTRAMUSCULAR KIT | Tier 0 | |
| VACCINE BACTERIAL
- GRAM POSITIVE
COCCI | | |
| PNEUMOVAX-23 | Tier 0 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| PREVNAR 13 (PF) | Tier 0 | |
| PREVNAR 20 (PF) | Tier 0 | |
| VAXNEUVANCE (PF) | Tier 0 | |
| VACCINE BACTERIAL - MENINGOCOCCAL GROUP B VACCINES | | |
| BEXSERO | Tier 0 | |
| TRUMENBA | Tier 0 | |
| VACCINE BACTERIAL - OTHER | | |
| <i>bcg vaccine, live (pf)</i> | Tier 0 | |
| VACCINE BACTERIAL - TOXIN-PRODUCING BACILLI | | |
| BIOTHRAX | Tier 0 | |
| VACCINE VIRAL - COVID-19 (SARS-COV-2) | | |
| NOVAVAX COVID-19 VACC,ADJ(EUA) | Tier 0 | QL (3 ML per 365 days) |
| VACCINE VIRAL - HUMAN PAPILLOMAVIRUS (HPV) VACCINES | | |
| GARDASIL 9 (PF) | Tier 0 | |
| VACCINE VIRAL - JAPANESE ENCEPHALITIS | | |
| IXIARO (PF) | Tier 0 | |
| VACCINE VIRAL - MEASLES | | |
| M-M-R II (PF) | Tier 0 | |
| PRIORIX (PF) | Tier 0 | |
| PROQUAD (PF) | Tier 0 | |
| VACCINE VIRAL - MUMPS AND RELATED | | |
| M-M-R II (PF) | Tier 0 | |
| PRIORIX (PF) | Tier 0 | |
| PROQUAD (PF) | Tier 0 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| VACCINE VIRAL - POLIOMYELITIS | | |
| IPOLE | Tier 0 | |
| VACCINE VIRAL - RABIES | | |
| IMOVAX RABIES VACCINE (PF) | Tier 0 | |
| RABAVERT (PF) | Tier 0 | |
| VACCINE VIRAL - ROTAVIRUS | | |
| ROTATEQ VACCINE | Tier 0 | |
| VACCINE VIRAL - RUBELLA | | |
| M-M-R II (PF) | Tier 0 | |
| PRIORIX (PF) | Tier 0 | |
| PROQUAD (PF) | Tier 0 | |
| VACCINE VIRAL - VARICELLA | | |
| PROQUAD (PF) | Tier 0 | |
| SHINGRIX (PF) | Tier 0 | |
| VARIVAX (PF) | Tier 0 | |
| VACCINE VIRAL - YELLOW FEVER | | |
| STAMARIL (PF) | Tier 0 | |
| YF-VAX (PF) | Tier 0 | |
| VACCINE VIRAL COMBINATIONS | | |
| M-M-R II (PF) | Tier 0 | |
| PRIORIX (PF) | Tier 0 | |
| PROQUAD (PF) | Tier 0 | |
| CARDIOVASCULAR THERAPY AGENTS | | |
| ACE INHIBITOR AND CALCIUM CHANNEL BLOCKER COMBINATIONS | | |
| <i>amlodipine-benazepril</i> | Tier 1 | |
| ACE INHIBITOR AND DIURETIC COMBINATIONS | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>benazepril-hydrochlorothiazide</i> | Tier 1 | |
| <i>captopril-hydrochlorothiazide</i> | Tier 1 | |
| <i>enalapril-hydrochlorothiazide</i> | Tier 1 | |
| <i>fosinopril-hydrochlorothiazide</i> | Tier 1 | |
| <i>lisinopril-hydrochlorothiazide</i> | Tier 1 | |
| <i>quinapril-hydrochlorothiazide</i> | Tier 1 | |
| ACE INHIBITORS | | |
| <i>benazepril</i> | Tier 1 | |
| <i>captopril</i> | Tier 1 | |
| <i>enalapril maleate oral solution</i> | Tier 1 | ST |
| <i>enalapril maleate oral tablet</i> | Tier 1 | |
| <i>fosinopril</i> | Tier 1 | |
| <i>lisinopril</i> | Tier 1 | |
| <i>quinapril</i> | Tier 1 | |
| <i>ramipril</i> | Tier 1 | |
| <i>trandolapril</i> | Tier 1 | |
| ALDOSTERONE RECEPTOR ANTAGONISTS | | |
| <i>eplerenone</i> | Tier 1 | |
| <i>spironolactone</i> | Tier 1 | |
| ALPHA-BETA BLOCKERS | | |
| <i>carvedilol</i> | Tier 1 | |
| <i>labetalol oral</i> | Tier 1 | |
| ANGIOTENSIN II RECEPTOR BLOCKER (ARB)-CALCIUM CHANNEL BLOCKER COMB. | | |
| <i>amlodipine-olmesartan</i> | Tier 1 | |
| <i>amlodipine-valsartan</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| <i>telmisartan-amlodipine</i> | Tier 1 | |
| ANGIOTENSIN II RECEPTOR BLOCKER (ARB)-CALCIUM CHANNEL BLOCKER-DIURETIC | | |
| <i>olmesartan-amlodipin-hcthiiazid</i> | Tier 1 | |
| ANGIOTENSIN II RECEPTOR BLOCKER (ARB)-DIURETIC COMBINATIONS | | |
| <i>candesartan-hydrochlorothiazid</i> | Tier 1 | |
| <i>irbesartan-hydrochlorothiazide</i> | Tier 1 | |
| <i>losartan-hydrochlorothiazide</i> | Tier 1 | |
| <i>olmesartan-hydrochlorothiazide</i> | Tier 1 | |
| <i>telmisartan-hydrochlorothiazid</i> | Tier 1 | |
| <i>valsartan-hydrochlorothiazide</i> | Tier 1 | |
| ANGIOTENSIN II RECEPTOR BLOCKER-NEPRILYSIN INHIBITOR COMB. (ARNI) | | |
| ENTRESTO | Tier 2 | PA; QL (60 EA per 30 days) |
| ANGIOTENSIN II RECEPTOR BLOCKERS (ARBs) | | |
| <i>candesartan</i> | Tier 1 | |
| <i>irbesartan</i> | Tier 1 | |
| <i>losartan</i> | Tier 1 | |
| <i>olmesartan</i> | Tier 1 | |
| <i>telmisartan</i> | Tier 1 | |
| <i>valsartan oral tablet</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| ANTIANGINAL -
CORONARY
VASODILATORS
(NITRATES) | | |
| <i>isosorbide dinitrate oral
tablet 10 mg, 20 mg, 30
mg, 5 mg</i> | Tier 1 | |
| <i>isosorbide mononitrate</i> | Tier 1 | |
| NITRO-DUR | Tier 2 | |
| <i>nitroglycerin sublingual</i> | Tier 1 | |
| <i>nitroglycerin
transdermal</i> | Tier 1 | |
| <i>nitroglycerin translingual</i> | Tier 1 | |
| NITRO-TIME | Tier 1 | |
| ANTIANGINAL AND
ANTI-ISCHEMIC
AGENTS, NON-
HEMODYNAMIC | | |
| <i>ranolazine</i> | Tier 1 | |
| ANTIARRHYTHMIC -
CLASS IA | | |
| <i>disopyramide
phosphate</i> | Tier 1 | |
| NORPACE CR | Tier 2 | |
| <i>quinidine sulfate</i> | Tier 1 | |
| ANTIARRHYTHMIC -
CLASS IC | | |
| <i>flecainide</i> | Tier 1 | |
| <i>propafenone</i> | Tier 1 | |
| ANTIARRHYTHMIC -
CLASS II | | |
| SOTALOL AF | Tier 1 | |
| <i>sotalol oral</i> | Tier 1 | |
| ANTIARRHYTHMIC -
CLASS III | | |
| <i>amiodarone oral tablet
200 mg, 400 mg</i> | Tier 1 | |
| <i>dofetilide</i> | Tier 1 | |
| PACERONE ORAL
TABLET 200 MG, 400
MG | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| ANTIARRHYTHMIC -
CLASS IV | | |
| <i>verapamil oral tablet
120 mg, 80 mg</i> | Tier 1 | |
| <i>verapamil oral tablet 40
mg</i> | Tier 1 | QL (12 EA per
1 day) |
| ANTIHYPERLIPIDEMI
C - BILE ACID
SEQUESTRANTS | | |
| <i>cholestyramine (with
sugar)</i> | Tier 1 | |
| CHOLESTYRAMINE
LIGHT | Tier 1 | |
| <i>cholestyramine-
aspartame</i> | Tier 1 | |
| <i>colesevelam oral
powder in packet</i> | Tier 1 | QL (30 EA per
30 days) |
| <i>colesevelam oral tablet</i> | Tier 1 | QL (180 EA per
30 days) |
| <i>colestipol oral tablet</i> | Tier 1 | |
| ANTIHYPERLIPIDEMI
C - FIBRIC ACID
DERIVATIVES | | |
| <i>fenofibrate micronized
oral capsule 134 mg,
200 mg, 67 mg</i> | Tier 1 | |
| <i>fenofibrate micronized
oral capsule 90 mg</i> | Tier 2 | ST |
| <i>fenofibrate
nanocrystallized</i> | Tier 1 | |
| <i>fenofibrate oral tablet
160 mg, 54 mg</i> | Tier 1 | |
| <i>gemfibrozil</i> | Tier 1 | |
| ANTIHYPERLIPIDEMI
C - HMG COA
REDUCTASE
INHIBITORS
(STATINS) | | |
| <i>atorvastatin oral tablet
10 mg, 20 mg</i> | Tier 0 | QL (30 EA per
30 days) |
| <i>atorvastatin oral tablet
40 mg, 80 mg</i> | Tier 1 | QL (30 EA per
30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|---------------------------|
| <i>fluvastatin oral capsule 20 mg</i> | Tier 0 | QL (30 EA per 30 days) |
| <i>fluvastatin oral capsule 40 mg</i> | Tier 0 | QL (60 EA per 30 days) |
| <i>fluvastatin oral tablet extended release 24 hr</i> | Tier 0 | QL (30 EA per 30 days) |
| <i>lovastatin oral tablet 10 mg</i> | Tier 0 | QL (30 EA per 30 days) |
| <i>lovastatin oral tablet 20 mg, 40 mg</i> | Tier 0 | QL (60 EA per 30 days) |
| <i>pravastatin</i> | Tier 0 | QL (30 EA per 30 days) |
| <i>rosuvastatin oral tablet 10 mg, 5 mg</i> | Tier 0 | QL (30 EA per 30 days) |
| <i>rosuvastatin oral tablet 20 mg, 40 mg</i> | Tier 1 | QL (30 EA per 30 days) |
| <i>simvastatin oral tablet 10 mg, 20 mg, 40 mg, 5 mg</i> | Tier 0 | QL (30 EA per 30 days) |
| <i>simvastatin oral tablet 80 mg</i> | Tier 1 | QL (30 EA per 30 days) |
| ANTIHYPERTENSIVE
C - NICOTINIC ACID
DERIVATIVES | | |
| <i>niacin oral tablet extended release 24 hr</i> | Tier 1 | |
| ANTIHYPERTENSIVE
C - OMEGA-3 FATTY
ACID TYPE | | |
| <i>omega-3 acid ethyl esters</i> | Tier 1 | |
| ANTIHYPERTENSIVE
C - PCSK9 INHIBITOR,
MONOCLONAL
ANTIBODY (MAB) | | |
| REPATHA
PUSHTRONEX | Tier 2 | PA; QL (1 ML per 28 days) |
| ANTIHYPERTENSIVE
C - PCSK9
INHIBITORS | | |
| REPATHA
PUSHTRONEX | Tier 2 | PA; QL (1 ML per 28 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| ANTIHYPERTENSIVE
C - SELECTIVE
CHOLESTEROL
ABSORPTION
INHIBITOR | | |
| <i>ezetimibe</i> | Tier 1 | |
| ANTIHYPERTENSIVE
C-HMG COA REDUCT
INHIB AND
CHOLESTEROL
ABSORP INHIBIT | | |
| <i>ezetimibe-simvastatin</i> | Tier 1 | ST; QL (30 EA per 30 days) |
| BETA BLOCKERS
CARDIAC SELECTIVE | | |
| <i>atenolol</i> | Tier 1 | |
| <i>bisoprolol fumarate</i> | Tier 1 | |
| <i>metoprolol succinate</i> | Tier 1 | |
| <i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i> | Tier 1 | |
| BETA BLOCKERS
CARDIAC SELECTIVE,
INTRINSIC
SYMPATHOMIMETIC
ACTIVITY | | |
| <i>acebutolol</i> | Tier 1 | |
| BETA BLOCKERS
NON-CARDIAC
SELECTIVE | | |
| <i>nadolol</i> | Tier 1 | |
| <i>propranolol oral</i> | Tier 1 | |
| SOTALOL AF | Tier 1 | |
| <i>sotalol oral</i> | Tier 1 | |
| <i>timolol maleate oral</i> | Tier 1 | |
| CALCIUM CHANNEL
BLOCKERS -
BENZOTHIAZEPINES | | |
| CARDIZEM LA ORAL
TABLET EXTENDED
RELEASE 24 HR 120
MG | Tier 2 | |
| CARTIA XT | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>diltiazem hcl oral capsule,ext.rel 24h degradable</i> | Tier 1 | |
| <i>diltiazem hcl oral capsule,extended release 12 hr</i> | Tier 1 | |
| <i>diltiazem hcl oral capsule,extended release 24 hr</i> | Tier 1 | |
| <i>diltiazem hcl oral capsule,extended release 24hr</i> | Tier 1 | |
| <i>diltiazem hcl oral tablet</i> | Tier 1 | |
| <i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</i> | Tier 1 | |
| DILT-XR | Tier 1 | |
| MATZIM LA | Tier 1 | |
| TAZTIA XT | Tier 1 | |
| CALCIUM CHANNEL BLOCKERS - DIHYDROPYRIDINES | | |
| <i>amlodipine</i> | Tier 1 | |
| <i>felodipine</i> | Tier 1 | |
| <i>nifedipine</i> | Tier 1 | |
| CALCIUM CHANNEL BLOCKERS - PHENYLALKYLAMINES | | |
| <i>verapamil oral capsule,ext rel. pellets 24 hr</i> | Tier 1 | |
| <i>verapamil oral tablet 120 mg, 80 mg</i> | Tier 1 | |
| <i>verapamil oral tablet 40 mg</i> | Tier 1 | QL (12 EA per 1 day) |
| <i>verapamil oral tablet extended release</i> | Tier 1 | |
| CARDIAC SELECTIVE BETA BLOCKER-THIAZIDE DIURETIC AND RELATED COMB. | | |
| <i>atenolol-chlorthalidone</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| <i>bisoprolol-hydrochlorothiazide</i> | Tier 1 | |
| <i>metoprolol ta-hydrochlorothiaz</i> | Tier 1 | |
| CARDIOVASCULAR SYMPATHOMIMETIC - ANAPHYLAXIS THERAPY SINGLE AGENTS | | |
| <i>epinephrine injection auto-injector 0.15 mg/0.15 ml</i> | Tier 2 | QL (2 EA per 30 days) |
| <i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml</i> | Tier 1 | QL (2 EA per 30 days) |
| CARDIOVASCULAR SYMPATHOMIMETICS | | |
| <i>midodrine</i> | Tier 1 | |
| CENTRAL ALPHA-2 RECEPTOR AGONISTS | | |
| <i>clonidine</i> | Tier 1 | QL (4 EA per 30 days) |
| <i>clonidine hcl oral tablet 0.1 mg, 0.2 mg</i> | Tier 1 | QL (10 EA per 1 day) |
| <i>clonidine hcl oral tablet 0.3 mg</i> | Tier 1 | QL (8 EA per 1 day) |
| <i>guanfacine oral tablet</i> | Tier 1 | |
| <i>methyldopa</i> | Tier 1 | |
| DIGITALIS GLYCOSIDES | | |
| DIGITEK | Tier 1 | |
| DIGOX | Tier 1 | |
| <i>digoxin oral solution</i> | Tier 1 | |
| <i>digoxin oral tablet 125 mcg (0.125 mg), 250 mcg (0.25 mg)</i> | Tier 1 | |
| DIRECT ACTING VASODILATORS | | |
| <i>hydralazine oral</i> | Tier 1 | |
| <i>minoxidil oral</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| DIURETIC -
ALDOSTERONE
RECEPTOR
ANTAGONIST, NON-
SELECTIVE | | |
| <i>spironolactone</i> | Tier 1 | |
| DIURETIC -
ALDOSTERONE
RECEPTOR
ANTAGONIST,
SELECTIVE | | |
| <i>eplerenone</i> | Tier 1 | |
| DIURETIC -
CARBONIC
ANHYDRASE
INHIBITORS | | |
| <i>acetazolamide</i> | Tier 1 | |
| <i>methazolamide</i> | Tier 1 | |
| DIURETIC - LOOP | | |
| <i>bumetanide oral</i> | Tier 1 | |
| <i>furosemide oral solution
10 mg/ml, 40 mg/5 ml (8
mg/ml)</i> | Tier 1 | |
| <i>furosemide oral tablet</i> | Tier 1 | |
| <i>torsemide</i> | Tier 1 | |
| DIURETIC -
POTASSIUM SPARING | | |
| <i>amiloride</i> | Tier 1 | |
| DIURETIC -
POTASSIUM
SPARING-THIAZIDE
AND RELATED
COMBINATIONS | | |
| <i>amiloride-
hydrochlorothiazide</i> | Tier 1 | |
| <i>spironolacton-
hydrochlorothiaz</i> | Tier 1 | |
| <i>triamterene-
hydrochlorothiazid oral
capsule</i> | Tier 1 | |
| <i>triamterene-
hydrochlorothiazid oral
tablet 37.5-25 mg</i> | Tier 1 | QL (1 EA per 1
day) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| <i>triamterene-
hydrochlorothiazid oral
tablet 75-50 mg</i> | Tier 1 | |
| DIURETIC -
SELECTIVE ARGININE
VASOPRESSIN V2
RECEPTOR
ANTAGONISTS | | |
| <i>tolvaptan oral tablet 15
mg</i> | Tier 4 | PA; QL (30 EA
per 30 days) |
| <i>tolvaptan oral tablet 30
mg</i> | Tier 4 | PA; QL (60 EA
per 30 days) |
| DIURETIC -
THIAZIDES AND
RELATED | | |
| <i>chlorthalidone</i> | Tier 1 | |
| <i>hydrochlorothiazide</i> | Tier 1 | |
| <i>indapamide</i> | Tier 1 | |
| <i>metolazone</i> | Tier 1 | |
| NON-CARDIAC
SELECTIVE BETA
BLOCKER-THIAZIDE
DIURETIC AND
RELATED COMB. | | |
| <i>propranolol-
hydrochlorothiazid</i> | Tier 1 | |
| PERIPHERAL ALPHA-
1 RECEPTOR
BLOCKERS | | |
| <i>doxazosin oral tablet 1
mg, 2 mg, 4 mg</i> | Tier 1 | QL (30 EA per
30 days) |
| <i>doxazosin oral tablet 8
mg</i> | Tier 1 | QL (60 EA per
30 days) |
| <i>phenoxybenzamine</i> | Tier 1 | |
| <i>prazosin</i> | Tier 1 | |
| <i>terazosin oral capsule 1
mg, 2 mg, 5 mg</i> | Tier 1 | QL (30 EA per
30 days) |
| <i>terazosin oral capsule
10 mg</i> | Tier 1 | QL (60 EA per
30 days) |
| PHEOCHROMOCYTO
MA, AGENTS TO
TREAT | | |
| <i>metyrosine</i> | Tier 1 | PA |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------|
| PULMONARY ANTIHYPERTENSIVE AGENTS - PROSTACYCLIN-TYPE | | |
| ORENITRAM | Tier 4 | PA |
| VENTAVIS | Tier 4 | PA; QL (270 ML per 30 days) |
| PULMONARY ARTERIAL HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS | | |
| <i>ambrisentan</i> | Tier 4 | PA; QL (30 EA per 30 days) |
| <i>bosentan</i> | Tier 4 | PA; QL (2 EA per 1 day) |
| PULMONARY ARTERIAL HYPERTENSION - SELECTIVE CGMP-PDE5 INHIBITORS | | |
| <i>sildenafil (pulm.hypertension) oral tablet</i> | Tier 4 | PA; QL (90 EA per 30 days) |
| CENTRAL NERVOUS SYSTEM AGENTS | | |
| AGENTS TO TREAT EPISODIC CLUSTER HEADACHES | | |
| EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3) | Tier 2 | PA; QL (1 ML per 28 days) |
| ANTIANKXIETY AGENT - ANTIHISTAMINE TYPE | | |
| <i>hydroxyzine hcl oral solution 10 mg/5 ml</i> | Tier 1 | |
| <i>hydroxyzine hcl oral tablet</i> | Tier 1 | |
| <i>hydroxyzine pamoate</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| ANTIANKXIETY AGENT - BENZODIAZEPINES | | |
| <i>alprazolam oral tablet</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>chlordiazepoxide hcl</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>clonazepam oral tablet</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>clorazepate dipotassium</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>diazepam oral tablet</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>lorazepam oral tablet</i> | Tier 1 | QL (3 EA per 1 day) |
| <i>oxazepam</i> | Tier 1 | QL (4 EA per 1 day) |
| ANTIANKXIETY AGENT - DICARBAMATE TYPE | | |
| <i>meprobamate</i> | Tier 1 | |
| ANTIANKXIETY AGENT - NON-BENZODIAZEPINE | | |
| <i>buspirone</i> | Tier 1 | |
| ANTICONVULSANT - AMPA-TYPE GLUTAMATE RECEPTOR ANTAGONISTS | | |
| FYCOMPA | Tier 2 | ST |
| ANTICONVULSANT - BARBITURATES AND DERIVATIVES | | |
| <i>phenobarbital</i> | Tier 1 | |
| <i>primidone oral tablet 250 mg, 50 mg</i> | Tier 1 | |
| ANTICONVULSANT - BENZODIAZEPINES | | |
| <i>clobazam</i> | Tier 1 | PA |
| <i>clonazepam oral tablet</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>diazepam rectal</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|---------------------------|
| NAYZILAM | Tier 2 | PA; QL (2 EA per 30 days) |
| VALTOCO | Tier 2 | PA; QL (2 EA per 30 days) |
| ANTICONVULSANT - CARBAMATES | | |
| <i>felbamate</i> | Tier 1 | |
| ANTICONVULSANT - CARBOXYLIC ACID DERIVATIVES | | |
| <i>divalproex</i> | Tier 1 | |
| <i>valproic acid</i> | Tier 1 | |
| <i>valproic acid (as sodium salt)</i> | Tier 1 | |
| ANTICONVULSANT - FUNCTIONALIZED AMINO ACID | | |
| <i>lacosamide oral tablet</i> | Tier 1 | ST |
| ANTICONVULSANT - GABA ANALOGS | | |
| <i>gabapentin oral capsule 100 mg, 400 mg</i> | Tier 1 | QL (6 EA per 1 day) |
| <i>gabapentin oral capsule 300 mg</i> | Tier 1 | QL (12 EA per 1 day) |
| <i>gabapentin oral solution</i> | Tier 1 | QL (72 ML per 1 day) |
| <i>gabapentin oral tablet 600 mg</i> | Tier 1 | QL (6 EA per 1 day) |
| <i>gabapentin oral tablet 800 mg</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i> | Tier 1 | PA; QL (3 EA per 1 day) |
| <i>pregabalin oral capsule 225 mg, 300 mg</i> | Tier 1 | PA; QL (2 EA per 1 day) |
| <i>pregabalin oral solution</i> | Tier 1 | PA; QL (30 ML per 1 day) |
| ANTICONVULSANT - GABA RE-UP TAKE INHIBITOR, NIPECOTIC ACID DERIVATIVES | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>tiagabine</i> | Tier 1 | |
| ANTICONVULSANT - HYDANTOINS | | |
| DILANTIN | Tier 2 | |
| <i>phenytoin</i> | Tier 1 | |
| <i>phenytoin sodium extended</i> | Tier 1 | |
| ANTICONVULSANT - IMINOSTILBENE DERIVATIVES | | |
| APTOM | Tier 3 | |
| <i>carbamazepine oral capsule, er multiphase 12 hr</i> | Tier 1 | |
| <i>carbamazepine oral suspension 100 mg/5 ml, 200 mg/10 ml</i> | Tier 1 | |
| <i>carbamazepine oral tablet</i> | Tier 1 | |
| <i>carbamazepine oral tablet extended release 12 hr</i> | Tier 1 | |
| <i>carbamazepine oral tablet, chewable</i> | Tier 1 | |
| EPITOL | Tier 1 | |
| <i>oxcarbazepine</i> | Tier 1 | |
| OXTELLAR XR | Tier 2 | ST |
| ANTICONVULSANT - MONOSACCHARIDE DERIVATIVES | | |
| <i>topiramate oral capsule, sprinkle</i> | Tier 1 | |
| <i>topiramate oral tablet</i> | Tier 1 | |
| ANTICONVULSANT - PHENYLTRIAZINE DERIVATIVES | | |
| <i>lamotrigine oral tablet</i> | Tier 1 | |
| <i>lamotrigine oral tablet extended release 24hr</i> | Tier 1 | |
| <i>lamotrigine oral tablet, chewable dispersible</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|---------------------------|
| ANTICONVULSANT -
PYRROLIDINE
DERIVATIVES | | |
| <i>levetiracetam oral</i> | Tier 1 | |
| ROWEEPRA | Tier 1 | |
| ROWEEPRA XR | Tier 1 | |
| ANTICONVULSANT -
SUCCINIMIDES | | |
| CELONTIN | Tier 2 | |
| <i>ethosuximide</i> | Tier 1 | |
| ANTICONVULSANT -
SULFONAMIDE
DERIVATIVES | | |
| <i>zonisamide</i> | Tier 1 | |
| ANTIDEPRESSANT -
ALPHA-2 RECEPTOR
ANTAGONISTS
(NASSA) | | |
| <i>mirtazapine</i> | Tier 1 | |
| ANTIDEPRESSANT -
MAO INHIBITOR
NONSELECTIVE AND
IRREVERSIBLE-
TYPES A,B | | |
| EMSAM | Tier 2 | |
| <i>phenelzine</i> | Tier 1 | |
| <i>tranylcypromine</i> | Tier 1 | |
| ANTIDEPRESSANT -
SELECTIVE
SEROTONIN
REUPTAKE
INHIBITORS (SSRIS) | | |
| <i>citalopram oral solution</i> | Tier 1 | |
| <i>citalopram oral tablet</i> | Tier 1 | QL (30 EA per
30 days) |
| <i>escitalopram oxalate
oral solution</i> | Tier 1 | |
| <i>escitalopram oxalate
oral tablet</i> | Tier 1 | QL (30 EA per
30 days) |
| <i>fluoxetine oral capsule
10 mg</i> | Tier 1 | QL (30 EA per
30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| <i>fluoxetine oral capsule
20 mg</i> | Tier 1 | |
| <i>fluoxetine oral capsule
40 mg</i> | Tier 1 | QL (60 EA per
30 days) |
| <i>fluoxetine oral solution</i> | Tier 1 | |
| <i>fluoxetine oral tablet 10
mg</i> | Tier 1 | ST; QL (30 EA
per 30 days) |
| <i>fluoxetine oral tablet 20
mg, 60 mg</i> | Tier 1 | ST |
| <i>fluvoxamine oral
capsule,extended
release 24hr</i> | Tier 1 | ST; QL (60 EA
per 30 days) |
| <i>fluvoxamine oral tablet
100 mg</i> | Tier 1 | QL (90 EA per
30 days) |
| <i>fluvoxamine oral tablet
25 mg</i> | Tier 1 | QL (30 EA per
30 days) |
| <i>fluvoxamine oral tablet
50 mg</i> | Tier 1 | QL (60 EA per
30 days) |
| <i>paroxetine hcl oral
tablet 10 mg, 40 mg</i> | Tier 1 | QL (30 EA per
30 days) |
| <i>paroxetine hcl oral
tablet 20 mg, 30 mg</i> | Tier 1 | QL (60 EA per
30 days) |
| <i>paroxetine hcl oral
tablet extended release
24 hr</i> | Tier 1 | ST; QL (60 EA
per 30 days) |
| <i>sertraline oral
concentrate</i> | Tier 1 | |
| <i>sertraline oral tablet 100
mg, 50 mg</i> | Tier 1 | QL (60 EA per
30 days) |
| <i>sertraline oral tablet 25
mg</i> | Tier 1 | QL (45 EA per
30 days) |
| ANTIDEPRESSANT -
SEROTONIN-2
ANTAGONIST-
REUPTAKE
INHIBITORS (SARIS) | | |
| <i>nefazodone</i> | Tier 1 | QL (2 EA per 1
day) |
| <i>trazodone</i> | Tier 1 | |
| ANTIDEPRESSANT -
SEROTONIN-
NOREPINEPHRINE
REUPTAKE
INHIBITORS (SNRIS) | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| <i>desvenlafaxine</i> | Tier 2 | ST; QL (30 EA per 30 days) |
| <i>desvenlafaxine succinate</i> | Tier 1 | QL (30 EA per 30 days) |
| <i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 60 mg</i> | Tier 1 | QL (60 EA per 30 days) |
| <i>duloxetine oral capsule, delayed release(dr/ec) 30 mg, 40 mg</i> | Tier 1 | QL (30 EA per 30 days) |
| SAVELLA ORAL TABLET | Tier 2 | ST; QL (60 EA per 30 days) |
| <i>venlafaxine oral capsule, extended release 24hr 150 mg, 37.5 mg</i> | Tier 1 | QL (30 EA per 30 days) |
| <i>venlafaxine oral capsule, extended release 24hr 75 mg</i> | Tier 1 | QL (90 EA per 30 days) |
| <i>venlafaxine oral tablet</i> | Tier 1 | QL (90 EA per 30 days) |
| ANTIDEPRESSANT - SSRI AND 5HT1A PARTIAL AGONIST | | |
| <i>vilazodone</i> | Tier 1 | QL (30 EA per 30 days) |
| ANTIDEPRESSANT - TRICYCLIC AND ANTIPSYCHOTIC, PHENOTHIAZINE COMB | | |
| <i>perphenazine-amitriptyline</i> | Tier 1 | |
| ANTIDEPRESSANT - TRICYCLIC-BENZODIAZEPINE COMBINATIONS | | |
| <i>amitriptyline-chlordiazepoxide</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| ANTIDEPRESSANT-SSRI AND ATYPICAL ANTIPSYCH,DOPAMINE,SEROTONIN ANTAGON | | |
| <i>olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 6-25 mg, 6-50 mg</i> | Tier 1 | ST |
| ANTIDEPRESSANT-NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITORS (NDRIS) | | |
| <i>bupropion hcl oral tablet</i> | Tier 1 | |
| <i>bupropion hcl oral tablet extended release 24 hr 150 mg, 300 mg</i> | Tier 1 | QL (30 EA per 30 days) |
| <i>bupropion hcl oral tablet sustained-release 12 hr</i> | Tier 1 | QL (60 EA per 30 days) |
| ANTIDEPRESSANT-TRICYCLICS AND RELATED (NON-SELECT REUPTAKE INHIBITORS) | | |
| <i>amitriptyline</i> | Tier 1 | |
| <i>amoxapine</i> | Tier 1 | |
| <i>clomipramine</i> | Tier 1 | |
| <i>desipramine</i> | Tier 1 | |
| <i>doxepin oral capsule</i> | Tier 1 | |
| <i>doxepin oral concentrate</i> | Tier 1 | |
| <i>imipramine hcl</i> | Tier 1 | |
| <i>imipramine pamoate</i> | Tier 1 | |
| <i>nortriptyline</i> | Tier 1 | |
| <i>protriptyline</i> | Tier 1 | |
| <i>trimipramine</i> | Tier 1 | |
| ANTIPARKINSON - DOPAMINERGIC-PERIPH COMT-DOPA-DECARBOXYLASE INHIB COMB | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>carbidopa-levodopa-entacapone</i> | Tier 1 | |
| ANTIPARKINSON - DOPAMINERG-PERIPHERAL DOPA-DECARBOXYLASE INHIBIT COMB | | |
| <i>carbidopa-levodopa oral tablet</i> | Tier 1 | |
| <i>carbidopa-levodopa oral tablet extended release</i> | Tier 1 | |
| ANTIPARKINSON ADJUVANT - CENTRAL/PERIPHERAL COMT INHIBITORS | | |
| <i>tolcapone</i> | Tier 1 | |
| ANTIPARKINSON ADJUVANT - PERIPHERAL COMT INHIBITORS | | |
| <i>entacapone</i> | Tier 1 | |
| ANTIPARKINSON ADJUVANT - PERIPHERAL DOPA-DECARBOXYLASE INHIBITORS | | |
| <i>carbidopa</i> | Tier 1 | |
| ANTIPARKINSON THERAPY - ANTICHOLINERGIC AGENTS | | |
| <i>benztropine oral</i> | Tier 1 | |
| <i>trihexyphenidyl</i> | Tier 1 | |
| ANTIPARKINSON THERAPY - ERGOT ALKALOIDS AND DERIVATIVES | | |
| <i>bromocriptine</i> | Tier 1 | |
| ANTIPARKINSON THERAPY - MONOAMINE OXIDASE INHIBITOR(MAO-B) | | |
| <i>rasagiline</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| <i>selegiline hcl</i> | Tier 1 | |
| ANTIPARKINSON THERAPY - NON-ERGOT DOPAMINE AGONIST AGENTS | | |
| <i>amantadine hcl</i> | Tier 1 | |
| NEUPRO
TRANSDERMAL
PATCH 24 HOUR 2
MG/24 HOUR | Tier 2 | ST |
| <i>pramipexole oral tablet</i> | Tier 1 | |
| <i>ropinirole oral tablet</i> | Tier 1 | |
| <i>ropinirole oral tablet extended release 24 hr 2 mg, 4 mg, 8 mg</i> | Tier 1 | ST |
| ANTIPSYCHOTIC - ATYP DOPAMINE-SEROTONIN ANTAG DIBENZO-OXEPINO PYRROLES | | |
| SECUADO | Tier 2 | PA; QL (30 EA per 30 days) |
| ANTIPSYCHOTIC - ATYPICAL DOPAMINE-SEROTONIN ANTAG-BENZISOTHIAZOLON ES | | |
| <i>ziprasidone hcl</i> | Tier 1 | QL (60 EA per 30 days) |
| ANTIPSYCHOTIC - ATYPICAL DOPAMINE-SEROTONIN ANTAG-BENZISOXAZOLE DERIV | | |
| FANAPT ORAL
TABLET | Tier 3 | ST; QL (60 EA per 30 days) |
| INVEGA SUSTENNA | Tier 2 | |
| INVEGA TRINZA
INTRAMUSCULAR
SYRINGE 273 MG/0.88
ML | Tier 2 | QL (1 ML per 90 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|---------------------------|
| INVEGA TRINZA
INTRAMUSCULAR
SYRINGE 410 MG/1.32
ML, 546 MG/1.75 ML | Tier 2 | QL (2 ML per
90 days) |
| INVEGA TRINZA
INTRAMUSCULAR
SYRINGE 819 MG/2.63
ML | Tier 2 | QL (3 ML per
90 days) |
| <i>paliperidone oral tablet
extended release 24hr
1.5 mg, 3 mg, 9 mg</i> | Tier 1 | QL (30 EA per
30 days) |
| <i>paliperidone oral tablet
extended release 24hr 6
mg</i> | Tier 1 | QL (60 EA per
30 days) |
| RISPERDAL CONSTA | Tier 2 | |
| <i>risperidone oral solution</i> | Tier 1 | |
| <i>risperidone oral tablet</i> | Tier 1 | QL (60 EA per
30 days) |
| ANTIPSYCHOTIC -
ATYPICAL
DOPAMINE-
SEROTONIN ANTAG-
DIBENZODIAZEPINE
DER | | |
| <i>clozapine oral tablet</i> | Tier 1 | |
| ANTIPSYCHOTIC -
BUTYROPHENONE
DERIVATIVES | | |
| <i>haloperidol</i> | Tier 1 | |
| <i>haloperidol lactate oral</i> | Tier 1 | |
| ANTIPSYCHOTIC -
DIBENZOXAZEPINE
DERIVATIVES | | |
| <i>loxapine succinate</i> | Tier 1 | |
| ANTIPSYCHOTIC -
DIPHENYLBUTYLPIPE
RIDINE DERIVATIVES | | |
| <i>pimozide</i> | Tier 1 | |
| ANTIPSYCHOTIC -
PHENOTHIAZINES,
ALIPHATIC | | |
| <i>chlorpromazine oral</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|---------------------------|
| ANTIPSYCHOTIC -
PHENOTHIAZINES,
PIPERAZINE | | |
| <i>fluphenazine decanoate</i> | Tier 1 | |
| <i>fluphenazine hcl</i> | Tier 1 | |
| <i>perphenazine</i> | Tier 1 | |
| <i>prochlorperazine
maleate</i> | Tier 1 | |
| <i>trifluoperazine</i> | Tier 1 | |
| ANTIPSYCHOTIC -
PHENOTHIAZINES,
PIPERIDINE | | |
| <i>thioridazine</i> | Tier 1 | |
| ANTIPSYCHOTIC -
THIOXANTHENES | | |
| <i>thiothixene</i> | Tier 1 | |
| ANTIPSYCHOTIC -
ATYPICAL
DOPAMINE-
SEROTONIN ANTAG-
DIBENZODIAZEPINE
DER | | |
| <i>quetiapine oral tablet
100 mg, 200 mg, 25
mg, 50 mg</i> | Tier 1 | QL (90 EA per
30 days) |
| <i>quetiapine oral tablet
300 mg, 400 mg</i> | Tier 1 | QL (60 EA per
30 days) |
| <i>quetiapine oral tablet
extended release 24 hr
150 mg, 200 mg</i> | Tier 1 | QL (30 EA per
30 days) |
| <i>quetiapine oral tablet
extended release 24 hr
300 mg, 400 mg, 50 mg</i> | Tier 1 | QL (60 EA per
30 days) |
| ANTIPSYCHOTIC -
ATYPICAL
DOPAMINE-
SEROTONIN ANTAG-
THIENOBENZODIAZE
PINES | | |
| <i>olanzapine oral tablet</i> | Tier 1 | QL (30 EA per
30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 6-25 mg, 6-50 mg</i> | Tier 1 | ST |
| ANTIPSYCHOTIC-ATYPICAL,D2 RECEPTOR PARTIAL AGONIST-5HT SEROTONIN MIXED | | |
| ABILIFY MAINTENA | Tier 2 | |
| <i>aripiprazole oral tablet</i> | Tier 1 | QL (30 EA per 30 days) |
| ARISTADA INITIO | Tier 2 | QL (3 ML per 180 days) |
| ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML | Tier 2 | QL (4 ML per 60 days) |
| ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML | Tier 2 | QL (2 ML per 30 days) |
| ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML | Tier 2 | QL (3 ML per 30 days) |
| ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML | Tier 2 | QL (3.2 ML per 30 days) |
| ANTIPSYCHOTIC-ATYPICAL,D3/D2 RECEPTOR PARTIAL AGONIST-SEROTONIN MIXED | | |
| VRAYLAR ORAL CAPSULE,DOSE PACK | Tier 2 | QL (1 EA per 365 days) |
| ATTENTION DEFICIT-HYPERACT. DISORDER (ADHD)-ALPHA-2 RECEPTOR AGONIST | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| <i>clonidine hcl oral tablet extended release 12 hr</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>guanfacine oral tablet extended release 24 hr</i> | Tier 1 | QL (1 EA per 1 day) |
| ATTENTION DEFICIT-HYPERACTIVITY (ADHD) THERAPY, STIMULANT-TYPE | | |
| <i>amphetamine sulfate</i> | Tier 1 | |
| <i>dexmethylphenidate oral capsule,er biphasic 50-50</i> | Tier 1 | QL (1 EA per 1 day) |
| <i>dexmethylphenidate oral tablet 10 mg</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>dexmethylphenidate oral tablet 2.5 mg, 5 mg</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>dextroamphetamine sulfate oral capsule, extended release</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>dextroamphetamine sulfate oral tablet 10 mg</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>dextroamphetamine sulfate oral tablet 15 mg, 20 mg, 30 mg</i> | Tier 1 | |
| <i>dextroamphetamine sulfate oral tablet 5 mg</i> | Tier 1 | QL (1 EA per 1 day) |
| <i>dextroamphetamine-amphetamine oral capsule,extended release 24hr 10 mg, 15 mg, 5 mg</i> | Tier 1 | QL (1 EA per 1 day) |
| <i>dextroamphetamine-amphetamine oral capsule,extended release 24hr 20 mg, 25 mg, 30 mg</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>dextroamphetamine-amphetamine oral tablet</i> | Tier 1 | QL (3 EA per 1 day) |
| METADATE ER | Tier 1 | QL (3 EA per 1 day) |
| <i>methamphetamine</i> | Tier 1 | |
| <i>methylphenidate hcl oral capsule, er biphasic 30-70</i> | Tier 1 | QL (1 EA per 1 day) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| <i>methylphenidate hcl oral capsule,er biphasic 50-50 10 mg, 60 mg</i> | Tier 1 | |
| <i>methylphenidate hcl oral capsule,er biphasic 50-50 20 mg, 40 mg</i> | Tier 1 | QL (1 EA per 1 day) |
| <i>methylphenidate hcl oral capsule,er biphasic 50-50 30 mg</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>methylphenidate hcl oral solution 10 mg/5 ml</i> | Tier 1 | QL (30 ML per 1 day) |
| <i>methylphenidate hcl oral solution 5 mg/5 ml</i> | Tier 1 | QL (60 ML per 1 day) |
| <i>methylphenidate hcl oral tablet</i> | Tier 1 | QL (3 EA per 1 day) |
| <i>methylphenidate hcl oral tablet extended release</i> | Tier 1 | QL (3 EA per 1 day) |
| <i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg</i> | Tier 1 | QL (1 EA per 1 day) |
| <i>methylphenidate hcl oral tablet extended release 24hr 36 mg, 54 mg</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>methylphenidate hcl oral tablet extended release 24hr 72 mg</i> | Tier 2 | ST; QL (1 EA per 1 day) |
| <i>methylphenidate hcl oral tablet,chewable</i> | Tier 1 | QL (3 EA per 1 day) |
| RELEXXII | Tier 2 | ST; QL (1 EA per 1 day) |
| ZENZEDI ORAL TABLET 2.5 MG | Tier 2 | QL (1 EA per 1 day) |
| ATTENTION DEFICIT-HYPERACTIVITY DISORDER (ADHD) THERAPY, NRI-TYPE | | |
| <i>atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i> | Tier 1 | QL (1 EA per 1 day) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|---------------------------|
| BENZODIAZEPINES | | |
| <i>alprazolam oral tablet</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>amitriptyline-chlordiazepoxide</i> | Tier 1 | |
| <i>chlordiazepoxide hcl</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>chlordiazepoxide-clidinium</i> | Tier 1 | |
| <i>clobazam</i> | Tier 1 | PA |
| <i>clonazepam oral tablet</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>clorazepate dipotassium</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>diazepam oral tablet</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>diazepam rectal</i> | Tier 1 | |
| <i>estazolam</i> | Tier 1 | QL (15 EA per 30 days) |
| <i>lorazepam oral tablet</i> | Tier 1 | QL (3 EA per 1 day) |
| <i>midazolam (pf) injection solution</i> | Tier 1 | |
| <i>midazolam (pf) injection syringe 2 mg/2 ml (1 mg/ml)</i> | Tier 1 | |
| <i>midazolam injection</i> | Tier 1 | |
| <i>midazolam intravenous syringe 150 mg/30 ml (5 mg/ml)</i> | Tier 2 | |
| NAYZILAM | Tier 2 | PA; QL (2 EA per 30 days) |
| <i>oxazepam</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>quazepam</i> | Tier 1 | QL (15 EA per 30 days) |
| <i>temazepam oral capsule 15 mg, 30 mg</i> | Tier 1 | QL (15 EA per 30 days) |
| <i>triazolam</i> | Tier 1 | QL (15 EA per 30 days) |
| VALTOCO | Tier 2 | PA; QL (2 EA per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| BIPOLAR THERAPY AGENTS - ANTICONVULSANT TYPE | | |
| <i>carbamazepine oral capsule, er multiphase 12 hr</i> | Tier 1 | |
| <i>carbamazepine oral suspension 100 mg/5 ml, 200 mg/10 ml</i> | Tier 1 | |
| <i>carbamazepine oral tablet</i> | Tier 1 | |
| <i>carbamazepine oral tablet extended release 12 hr</i> | Tier 1 | |
| <i>carbamazepine oral tablet, chewable</i> | Tier 1 | |
| <i>divalproex</i> | Tier 1 | |
| EPITOL | Tier 1 | |
| <i>valproic acid</i> | Tier 1 | |
| <i>valproic acid (as sodium salt)</i> | Tier 1 | |
| BIPOLAR THERAPY AGENTS - ATYPICAL ANTIPSYCHOTICS | | |
| <i>aripiprazole oral tablet</i> | Tier 1 | QL (30 EA per 30 days) |
| <i>olanzapine oral tablet</i> | Tier 1 | QL (30 EA per 30 days) |
| <i>olanzapine-fluoxetine oral capsule 12-25 mg, 12-50 mg, 6-25 mg, 6-50 mg</i> | Tier 1 | ST |
| <i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i> | Tier 1 | QL (90 EA per 30 days) |
| <i>quetiapine oral tablet 300 mg, 400 mg</i> | Tier 1 | QL (60 EA per 30 days) |
| <i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i> | Tier 1 | QL (30 EA per 30 days) |
| <i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i> | Tier 1 | QL (60 EA per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>risperidone oral solution</i> | Tier 1 | |
| <i>risperidone oral tablet</i> | Tier 1 | QL (60 EA per 30 days) |
| VRAYLAR ORAL CAPSULE, DOSE PACK | Tier 2 | QL (1 EA per 365 days) |
| <i>ziprasidone hcl</i> | Tier 1 | QL (60 EA per 30 days) |
| BIPOLAR THERAPY AGENTS - LITHIUM | | |
| <i>lithium carbonate</i> | Tier 1 | |
| CANNABIS AND CANNABINOIDS | | |
| <i>dronabinol</i> | Tier 1 | PA |
| CNS STIMULANT - AMPHETAMINE COMBINATIONS | | |
| <i>dextroamphetamine-amphetamine oral capsule, extended release 24hr 10 mg, 15 mg, 5 mg</i> | Tier 1 | QL (1 EA per 1 day) |
| <i>dextroamphetamine-amphetamine oral capsule, extended release 24hr 20 mg, 25 mg, 30 mg</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>dextroamphetamine-amphetamine oral tablet</i> | Tier 1 | QL (3 EA per 1 day) |
| CNS STIMULANT - AMPHETAMINES | | |
| <i>amphetamine sulfate</i> | Tier 1 | |
| <i>dextroamphetamine sulfate oral capsule, extended release</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>dextroamphetamine sulfate oral tablet 10 mg</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>dextroamphetamine sulfate oral tablet 15 mg, 20 mg, 30 mg</i> | Tier 1 | |
| <i>dextroamphetamine sulfate oral tablet 5 mg</i> | Tier 1 | QL (1 EA per 1 day) |
| <i>methamphetamine</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| ZENZEDI ORAL
TABLET 2.5 MG | Tier 2 | QL (1 EA per 1
day) |
| FIBROMYALGIA
AGENTS - GABA
ANALOGS | | |
| <i>pregabalin oral capsule
100 mg, 150 mg, 200
mg, 25 mg, 50 mg, 75
mg</i> | Tier 1 | PA; QL (3 EA
per 1 day) |
| <i>pregabalin oral capsule
225 mg, 300 mg</i> | Tier 1 | PA; QL (2 EA
per 1 day) |
| <i>pregabalin oral solution</i> | Tier 1 | PA; QL (30 ML
per 1 day) |
| FIBROMYALGIA
AGENTS -
SEROTONIN-
NOREPINEPHRINE
REUPTAKE-INHIB
(SNRIS) | | |
| <i>duloxetine oral
capsule, delayed
release(dr/ec) 20 mg,
60 mg</i> | Tier 1 | QL (60 EA per
30 days) |
| <i>duloxetine oral
capsule, delayed
release(dr/ec) 30 mg,
40 mg</i> | Tier 1 | QL (30 EA per
30 days) |
| SAVELLA ORAL
TABLET | Tier 2 | ST; QL (60 EA
per 30 days) |
| HYPNOTICS -
MELATONIN M1/M2
RECEPTOR
AGONISTS | | |
| <i>ramelteon</i> | Tier 1 | QL (15 EA per
30 days) |
| MIGRAINE THERAPY -
CARBOXYLIC ACID
DERIVATIVES | | |
| <i>divalproex oral tablet
extended release 24 hr</i> | Tier 1 | |
| MIGRAINE THERAPY -
CGRP LIGAND
BLOCKER,
MONOCLONAL
ANTIBODY | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|------------------------------|
| EMGALITY PEN | Tier 2 | PA; QL (1 ML
per 28 days) |
| EMGALITY SYRINGE
SUBCUTANEOUS
SYRINGE 120 MG/ML | Tier 2 | PA; QL (1 ML
per 28 days) |
| MIGRAINE THERAPY -
CGRP RECEPTOR
BLOCKERS
(GEPANTS AND MAB) | | |
| AIMOVIG
AUTOINJECTOR | Tier 2 | PA; QL (1 ML
per 28 days) |
| MIGRAINE THERAPY -
ERGOT ALKALOIDS
AND DERIVATIVES | | |
| <i>dihydroergotamine
nasal</i> | Tier 1 | ST; QL (8 ML
per 30 days) |
| MIGRAINE THERAPY -
ERGOT
COMBINATIONS | | |
| <i>ergotamine-caffeine</i> | Tier 1 | |
| MIGRAINE THERAPY -
SELECTIVE
SEROTONIN
AGONISTS 5-HT(1) | | |
| <i>almotriptan malate oral
tablet 12.5 mg</i> | Tier 1 | QL (24 EA per
30 days) |
| <i>almotriptan malate oral
tablet 6.25 mg</i> | Tier 1 | QL (18 EA per
30 days) |
| <i>eletriptan</i> | Tier 1 | QL (18 EA per
30 days) |
| <i>frovatriptan</i> | Tier 1 | QL (27 EA per
30 days) |
| <i>naratriptan</i> | Tier 1 | QL (18 EA per
30 days) |
| <i>rizatriptan</i> | Tier 1 | QL (36 EA per
30 days) |
| <i>sumatriptan nasal
spray, non-aerosol 20
mg/actuation</i> | Tier 1 | QL (18 EA per
30 days) |
| <i>sumatriptan nasal
spray, non-aerosol 5
mg/actuation</i> | Tier 1 | QL (36 EA per
30 days) |
| <i>sumatriptan succinate
oral</i> | Tier 1 | QL (18 EA per
30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-----------------------------|
| <i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i> | Tier 1 | QL (8 ML per 30 days) |
| <i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i> | Tier 1 | QL (8 ML per 30 days) |
| <i>sumatriptan succinate subcutaneous syringe</i> | Tier 1 | QL (8 ML per 30 days) |
| <i>zolmitriptan oral</i> | Tier 1 | QL (18 EA per 30 days) |
| MIGRAINE THERAPY - SEROTONIN AGONIST 5-HT(1) AND NSAID COMB. | | |
| <i>sumatriptan-naproxen</i> | Tier 1 | ST; QL (18 EA per 30 days) |
| MOVEMENT DISORDER DRUG THERAPY | | |
| AUSTEDO ORAL TABLET 12 MG, 9 MG | Tier 4 | PA; QL (120 EA per 30 days) |
| AUSTEDO ORAL TABLET 6 MG | Tier 4 | PA; QL (60 EA per 30 days) |
| <i>tetrabenazine oral tablet 12.5 mg</i> | Tier 4 | PA; QL (120 EA per 30 days) |
| <i>tetrabenazine oral tablet 25 mg</i> | Tier 4 | PA; QL (60 EA per 30 days) |
| MOVEMENT DISORDER THERAPY - HUNTINGTON'S DISEASE | | |
| AUSTEDO ORAL TABLET 12 MG, 9 MG | Tier 4 | PA; QL (120 EA per 30 days) |
| AUSTEDO ORAL TABLET 6 MG | Tier 4 | PA; QL (60 EA per 30 days) |
| <i>tetrabenazine oral tablet 12.5 mg</i> | Tier 4 | PA; QL (120 EA per 30 days) |
| <i>tetrabenazine oral tablet 25 mg</i> | Tier 4 | PA; QL (60 EA per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-----------------------------|
| MOVEMENT DISORDER THERAPY - TARDIVE DYSKINESIA | | |
| AUSTEDO ORAL TABLET 12 MG, 9 MG | Tier 4 | PA; QL (120 EA per 30 days) |
| AUSTEDO ORAL TABLET 6 MG | Tier 4 | PA; QL (60 EA per 30 days) |
| NARCOLEPSY THERAPY AGENTS - H3-RECEPTOR ANTAGONIST/INVERSE AGONIST | | |
| WAKIX ORAL TABLET 17.8 MG | Tier 4 | PA; QL (60 EA per 30 days) |
| WAKIX ORAL TABLET 4.45 MG | Tier 4 | PA; QL (30 EA per 30 days) |
| NARCOLEPSY THERAPY AGENTS - NON-SYMPATHOMIMETIC | | |
| <i>armodafinil</i> | Tier 1 | PA; QL (30 EA per 30 days) |
| <i>modafinil oral tablet 100 mg</i> | Tier 1 | PA; QL (30 EA per 30 days) |
| <i>modafinil oral tablet 200 mg</i> | Tier 1 | PA; QL (60 EA per 30 days) |
| NARCOLEPSY THERAPY AGENTS - STIMULANT-TYPE, PIPERADINE DERIVATIVE | | |
| <i>methylphenidate hcl oral solution 10 mg/5 ml</i> | Tier 1 | QL (30 ML per 1 day) |
| <i>methylphenidate hcl oral solution 5 mg/5 ml</i> | Tier 1 | QL (60 ML per 1 day) |
| <i>methylphenidate hcl oral tablet</i> | Tier 1 | QL (3 EA per 1 day) |
| <i>methylphenidate hcl oral tablet, chewable</i> | Tier 1 | QL (3 EA per 1 day) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| NARCOLEPSY
THERAPY AGENTS-
STIMULANT-
TYPE,SYMPATHOMIM
ETIC,AMPHETAMINES | | |
| <i>amphetamine sulfate</i> | Tier 1 | |
| <i>dextroamphetamine
sulfate oral capsule,
extended release</i> | Tier 1 | QL (2 EA per 1
day) |
| <i>dextroamphetamine
sulfate oral tablet 10 mg</i> | Tier 1 | QL (4 EA per 1
day) |
| <i>dextroamphetamine
sulfate oral tablet 15
mg, 20 mg, 30 mg</i> | Tier 1 | |
| <i>dextroamphetamine
sulfate oral tablet 5 mg</i> | Tier 1 | QL (1 EA per 1
day) |
| <i>dextroamphetamine-
amphetamine oral tablet</i> | Tier 1 | QL (3 EA per 1
day) |
| ZENZEDI ORAL
TABLET 2.5 MG | Tier 2 | QL (1 EA per 1
day) |
| SEDATIVE-HYPNOTIC
- BARBITURATES | | |
| <i>phenobarbital</i> | Tier 1 | |
| SEDATIVE-HYPNOTIC
- BENZODIAZEPINES | | |
| <i>estazolam</i> | Tier 1 | QL (15 EA per
30 days) |
| <i>quazepam</i> | Tier 1 | QL (15 EA per
30 days) |
| <i>temazepam oral
capsule 15 mg, 30 mg</i> | Tier 1 | QL (15 EA per
30 days) |
| <i>triazolam</i> | Tier 1 | QL (15 EA per
30 days) |
| SEDATIVE-HYPNOTIC
- GABA-RECEPTOR
MODULATORS | | |
| <i>eszopiclone</i> | Tier 1 | PA; QL (15 EA
per 30 days) |
| <i>zaleplon</i> | Tier 1 | QL (15 EA per
30 days) |
| <i>zolpidem oral tablet</i> | Tier 1 | QL (15 EA per
30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| SEDATIVE-HYPNOTIC
- TRICYCLIC
ANTIDEPRESSANT
TYPE | | |
| <i>doxepin oral tablet</i> | Tier 1 | ST; QL (15 EA
per 30 days) |
| CHEMICAL
DEPENDENCY,
AGENTS TO TREAT | | |
| AGENTS FOR OPIOID
WITHDRAWAL,
OPIOID-TYPE | | |
| <i>buprenorphine hcl
sublingual</i> | Tier 1 | PA; QL (3 EA
per 1 day) |
| <i>buprenorphine-
naloxone sublingual
tablet 2-0.5 mg</i> | Tier 1 | QL (90 EA per
30 days) |
| <i>buprenorphine-
naloxone sublingual
tablet 8-2 mg</i> | Tier 1 | QL (3 EA per 1
day) |
| ALCOHOL
ABSTINENCE
THERAPY -
GLUTAMATE AND
GABA SYSTEM TYPE | | |
| <i>acamprosate</i> | Tier 1 | |
| ALCOHOL
ABSTINENCE
THERAPY - OPIOID
RECEPTOR
ANTAGONIST-TYPE | | |
| VIVITROL | Tier 4 | QL (1 EA per
30 days) |
| ALCOHOL
DETERRENTS | | |
| <i>disulfiram</i> | Tier 1 | |
| SMOKING
DETERRENTS - NE
AND DOPAMINE
REUPTAKE
INHIBITOR (NDRI)-
TYPE | | |
| <i>bupropion hcl (smoking
deter)</i> | Tier 0 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| SMOKING
DETERRENTS -
NICOTINE-TYPE | | |
| NICOTROL | Tier 0 | QL (180 DAYS
per 365 days) |
| NICOTROL NS | Tier 0 | QL (180 DAYS
per 365 days) |
| SMOKING
DETERRENTS -
NICOTINIC
RECEPTOR PARTIAL
AGONIST,
ALPHA4BETA2 | | |
| CHANTIX | Tier 0 | |
| CHANTIX
CONTINUING MONTH
BOX | Tier 0 | |
| CHANTIX STARTING
MONTH BOX | Tier 0 | |
| <i>varenicline</i> | Tier 0 | |
| CHEMICALS-
PHARMACEUTICAL
ADJUVANTS | | |
| BULK CHEMICALS | | |
| <i>guaiaicol</i> | Tier 2 | |
| CHEMICALS -
CRYOPRESERVATIVE
AGENTS | | |
| CRYOSERV | Tier 1 | |
| CHEMICALS -
SOLVENTS | | |
| MURI-LUBE | Tier 2 | |
| PHARMACEUTICAL
ADJUVANT -
INHALATION
VEHICLES | | |
| NEBUSAL
INHALATION
SOLUTION FOR
NEBULIZATION 3 % | Tier 1 | |
| PULMOSAL | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|---------|--------------------------|
| <i>sodium chloride
inhalation solution for
nebulization 0.9 %, 3 %, 7 %</i> | Tier 1 | |
| <i>sodium chloride
inhalation solution for
nebulization 10 %</i> | Tier 1 | QL (4 ML per 1
day) |
| COGNITIVE
DISORDER
THERAPY | | |
| ALZHEIMER'S
DISEASE THERAPY -
CHOLINESTERASE
INHIBITORS | | |
| <i>donepezil oral tablet 10
mg, 5 mg</i> | Tier 1 | |
| <i>galantamine</i> | Tier 1 | |
| <i>rivastigmine tartrate</i> | Tier 1 | |
| ALZHEIMER'S
DISEASE THERAPY -
NMDA RECEPTOR
ANTAGONISTS | | |
| <i>memantine oral solution</i> | Tier 1 | |
| <i>memantine oral tablet</i> | Tier 1 | |
| <i>memantine oral
tablets,dose pack</i> | Tier 2 | |
| COGNITIVE
DISORDER THERAPY
- CEREBRAL
VASODILATORS | | |
| <i>ergoloid</i> | Tier 1 | |
| CONTRACEPTIVES | | |
| CONTRACEPTIVE
INJECTABLE -
PROGESTIN | | |
| DEPO-SUBQ
PROVERA 104 | Tier 2 | QL (1 ML per
90 days) |
| <i>medroxyprogesterone
intramuscular</i> | Tier 0 | QL (1 ML per
90 days) |
| CONTRACEPTIVE
INTRAUTERINE -
PROGESTERONE IUD | | |
| MIRENA | Tier 10 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| CONTRACEPTIVE ORAL - BIPHASIC | | |
| AMETHIA | Tier 0 | QL (1 EA per 1 day) |
| ASHLYNA | Tier 0 | QL (1 EA per 1 day) |
| AZURETTE (28) | Tier 0 | |
| CAMRESE | Tier 0 | QL (1 EA per 1 day) |
| CAMRESE LO | Tier 0 | QL (1 EA per 1 day) |
| DAYSEE | Tier 0 | QL (1 EA per 1 day) |
| <i>desog-e.estradiol/e.estradiol</i> | Tier 0 | |
| JAIMESS | Tier 0 | QL (1 EA per 1 day) |
| KARIVA (28) | Tier 0 | |
| <i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)</i> | Tier 0 | QL (1 EA per 1 day) |
| LO LOESTRIN FE | Tier 0 | ST |
| LOJAIMESS | Tier 0 | QL (1 EA per 1 day) |
| PIMTREA (28) | Tier 0 | |
| SIMLIYA (28) | Tier 0 | |
| SIMPESSE | Tier 0 | QL (1 EA per 1 day) |
| VIORELE (28) | Tier 0 | |
| VOLNEA (28) | Tier 0 | |
| CONTRACEPTIVE ORAL - MONOPHASIC | | |
| AFIRMELLE | Tier 0 | |
| ALTAVERA (28) | Tier 0 | |
| ALYACEN 1/35 (28) | Tier 0 | |
| AMETHYST (28) | Tier 0 | QL (1 EA per 1 day) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| APRI | Tier 0 | |
| AUBRA | Tier 0 | |
| AUBRA EQ | Tier 0 | |
| AUROVELA 1.5/30 (21) | Tier 0 | |
| AUROVELA 1/20 (21) | Tier 0 | |
| AUROVELA 24 FE | Tier 0 | |
| AUROVELA FE 1.5/30 (28) | Tier 0 | |
| AUROVELA FE 1-20 (28) | Tier 0 | |
| AVIANE | Tier 0 | |
| AYUNA | Tier 0 | |
| BALZIVA (28) | Tier 0 | |
| BLISOVI 24 FE | Tier 0 | |
| BLISOVI FE 1.5/30 (28) | Tier 0 | |
| BLISOVI FE 1/20 (28) | Tier 0 | |
| BRIELLYN | Tier 0 | |
| CHARLOTTE 24 FE | Tier 0 | |
| CHATEAL (28) | Tier 0 | |
| CHATEAL EQ (28) | Tier 0 | |
| CRYSELLE (28) | Tier 0 | |
| CYRED | Tier 0 | |
| CYRED EQ | Tier 0 | |
| DASETTA 1/35 (28) | Tier 0 | |
| <i>desogestrel-ethinyl estradiol</i> | Tier 0 | |
| DOLISHALE | Tier 0 | QL (1 EA per 1 day) |
| <i>drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4)</i> | Tier 0 | |
| <i>drospirenone-ethinyl estradiol</i> | Tier 0 | |
| ELINEST | Tier 0 | |
| ENSKYCE | Tier 0 | |
| ESTARYLLA | Tier 0 | |

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| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>ethynodiol diac-eth estradiol</i> | Tier 0 | |
| FALMINA (28) | Tier 0 | |
| FINZALA | Tier 0 | |
| GEMMILY | Tier 0 | |
| HAILEY | Tier 0 | |
| HAILEY 24 FE | Tier 0 | |
| HAILEY FE 1.5/30 (28) | Tier 0 | |
| HAILEY FE 1/20 (28) | Tier 0 | |
| ICLEVIA | Tier 0 | QL (1 EA per 1 day) |
| ISIBLOOM | Tier 0 | |
| JASMIEL (28) | Tier 0 | |
| JOLESSA | Tier 0 | QL (1 EA per 1 day) |
| JULEBER | Tier 0 | |
| JUNEL 1.5/30 (21) | Tier 0 | |
| JUNEL 1/20 (21) | Tier 0 | |
| JUNEL FE 1.5/30 (28) | Tier 0 | |
| JUNEL FE 1/20 (28) | Tier 0 | |
| JUNEL FE 24 | Tier 0 | |
| KAITLIB FE | Tier 0 | |
| KALLIGA | Tier 0 | |
| KELNOR 1/35 (28) | Tier 0 | |
| KELNOR 1-50 (28) | Tier 0 | |
| KURVELO (28) | Tier 0 | |
| LARIN 1.5/30 (21) | Tier 0 | |
| LARIN 1/20 (21) | Tier 0 | |
| LARIN 24 FE | Tier 0 | |
| LARIN FE 1.5/30 (28) | Tier 0 | |
| LARIN FE 1/20 (28) | Tier 0 | |
| LAYOLIS FE | Tier 0 | |
| LESSINA | Tier 0 | |
| <i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg</i> | Tier 0 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>levonorgestrel-ethinyl estrad oral tablet 90-20 mcg (28)</i> | Tier 0 | QL (1 EA per 1 day) |
| <i>levonorgestrel-ethinyl estrad oral tablets, dose pack, 3 month</i> | Tier 0 | QL (1 EA per 1 day) |
| LEVORA-28 | Tier 0 | |
| LORYNA (28) | Tier 0 | |
| LOW-OGESTREL (28) | Tier 0 | |
| LO-ZUMANDIMINE (28) | Tier 0 | |
| LUTERA (28) | Tier 0 | |
| MARLISSA (28) | Tier 0 | |
| MERZEE | Tier 0 | |
| MIBELAS 24 FE | Tier 0 | |
| MICROGESTIN 1.5/30 (21) | Tier 0 | |
| MICROGESTIN 1/20 (21) | Tier 0 | |
| MICROGESTIN 24 FE | Tier 0 | |
| MICROGESTIN FE 1.5/30 (28) | Tier 0 | |
| MICROGESTIN FE 1/20 (28) | Tier 0 | |
| MILI | Tier 0 | |
| MONO-LINYAH | Tier 0 | |
| NECON 0.5/35 (28) | Tier 0 | |
| NIKKI (28) | Tier 0 | |
| <i>noreth-ethinyl estradiol-iron</i> | Tier 0 | |
| <i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg, 1.5-30 mg-mcg</i> | Tier 0 | |
| <i>norethindrone-e.estradiol-iron oral capsule</i> | Tier 0 | |
| <i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7), 1.5 mg-30 mcg (21)/75 mg (7)</i> | Tier 0 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>norethindrone-
e.estradiol-iron oral
tablet, chewable</i> | Tier 0 | |
| <i>norgestimate-ethinyl
estradiol oral tablet
0.25-35 mg-mcg</i> | Tier 0 | |
| NORTREL 0.5/35 (28) | Tier 0 | |
| NORTREL 1/35 (21) | Tier 0 | |
| NORTREL 1/35 (28) | Tier 0 | |
| NYLIA 1/35 (28) | Tier 0 | |
| NYMYO | Tier 0 | |
| OCELLA | Tier 0 | |
| PHILITH | Tier 0 | |
| PORTIA 28 | Tier 0 | |
| RECLIPSEN (28) | Tier 0 | |
| SETLAKIN | Tier 0 | QL (1 EA per 1
day) |
| SPRINTEC (28) | Tier 0 | |
| SRONYX | Tier 0 | |
| SYEDA | Tier 0 | |
| TARINA 24 FE | Tier 0 | |
| TARINA FE 1/20 (28) | Tier 0 | |
| TARINA FE 1-20 EQ
(28) | Tier 0 | |
| TAYSOFY | Tier 0 | |
| TAYTULLA | Tier 0 | ST |
| TYDEMY | Tier 0 | |
| VESTURA (28) | Tier 0 | |
| VIENVA | Tier 0 | |
| VYFEMLA (28) | Tier 0 | |
| VYLIBRA | Tier 0 | |
| WERA (28) | Tier 0 | |
| WYMZYA FE | Tier 0 | |
| ZARAH | Tier 0 | |
| ZOVIA 1-35 (28) | Tier 0 | |
| ZUMANDIMINE (28) | Tier 0 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| CONTRACEPTIVE
ORAL - PROGESTIN | | |
| CAMILA | Tier 0 | |
| DEBLITANE | Tier 0 | |
| ERRIN | Tier 0 | |
| HEATHER | Tier 0 | |
| INCASSIA | Tier 0 | |
| JENCYCLA | Tier 0 | |
| LYLEQ | Tier 0 | |
| LYZA | Tier 0 | |
| NORA-BE | Tier 0 | |
| <i>norethindrone
(contraceptive)</i> | Tier 0 | |
| SHAROBEL | Tier 0 | |
| TULANA | Tier 0 | |
| CONTRACEPTIVE
ORAL -
QUADRAPHASIC | | |
| <i>l norgest/e.estradiol-
e.estradiol oral
tablets, dose pack, 3
month 0.15 mg-20 mcg/
0.15 mg-25 mcg</i> | Tier 0 | |
| RIVELSA | Tier 0 | |
| CONTRACEPTIVE
ORAL - TRIPHASIC | | |
| ALYACEN 7/7/7 (28) | Tier 0 | |
| ARANELLE (28) | Tier 0 | |
| CAZANT (28) | Tier 0 | |
| DASETTA 7/7/7 (28) | Tier 0 | |
| ENPRESSE | Tier 0 | |
| LEENA 28 | Tier 0 | |
| LEVONEST (28) | Tier 0 | |
| <i>levonorg-eth estrad
triphasic</i> | Tier 0 | |
| <i>norethindrone-
e.estradiol-iron oral
tablet 1-20(5)/1-30(7)
/1mg-35mcg (9)</i> | Tier 0 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| <i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.18/0.215/0.25 mg-35 mcg (28)</i> | Tier 0 | |
| NORTREL 7/7/7 (28) | Tier 0 | |
| NYLIA 7/7/7 (28) | Tier 0 | |
| TILIA FE | Tier 0 | |
| TRI-ESTARYLLA | Tier 0 | |
| TRI-LEGEST FE | Tier 0 | |
| TRI-LINYAH | Tier 0 | |
| TRI-LO-ESTARYLLA | Tier 0 | |
| TRI-LO-MARZIA | Tier 0 | |
| TRI-LO-MILI | Tier 0 | |
| TRI-LO-SPRINTEC | Tier 0 | |
| TRI-MILI | Tier 0 | |
| TRI-NYMYO | Tier 0 | |
| TRI-SPRINTEC (28) | Tier 0 | |
| TRIVORA (28) | Tier 0 | |
| TRI-VYLIBRA | Tier 0 | |
| TRI-VYLIBRA LO | Tier 0 | |
| VELIVET TRIPHASIC REGIMEN (28) | Tier 0 | |
| CONTRACEPTIVE TRANSDERMAL COMBINATIONS - ESTROGEN AND PROGESTIN COMB. | | |
| XULANE | Tier 0 | |
| ZAFEMY | Tier 0 | |
| CONTRACEPTIVES - INTRAVAGINAL, SYSTEMIC - ESTROGEN AND PROGESTIN COMB. | | |
| ELURYNG | Tier 0 | |
| <i>etonogestrel-ethinyl estradiol</i> | Tier 0 | |
| HALOETTE | Tier 0 | |
| NUVARING | Tier 0 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| EMERGENCY CONTRACEPTIVES | | |
| ELLA | Tier 0 | QL (1 EA per 30 days) |
| EMERGENCY CONTRACEPTIVES - PROGESTERONE AGONIST/ANTAGONIST TYPE | | |
| ELLA | Tier 0 | QL (1 EA per 30 days) |
| DERMATOLOGICAL | | |
| ACNE THERAPY SYSTEMIC - RETINOID AND DERIVATIVES | | |
| <i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i> | Tier 1 | |
| ACNE THERAPY TOPICAL - ANTI-INFECTIVE | | |
| CLINDACIN ETZ TOPICAL SWAB | Tier 1 | |
| <i>clindamycin phosphate topical gel</i> | Tier 1 | QL (120 GM per 30 days) |
| <i>clindamycin phosphate topical gel, once daily</i> | Tier 1 | QL (150 ML per 30 days) |
| <i>clindamycin phosphate topical lotion</i> | Tier 1 | QL (120 ML per 30 days) |
| <i>clindamycin phosphate topical solution</i> | Tier 1 | QL (120 ML per 30 days) |
| <i>dapsone topical gel</i> | Tier 1 | |
| ERY PADS | Tier 1 | |
| <i>erythromycin with ethanol</i> | Tier 1 | |
| <i>sulfacetamide sodium (acne)</i> | Tier 1 | QL (118 ML per 30 days) |
| ACNE THERAPY TOPICAL - ANTI-INFECTIVE-KERATOLYTIC COMBINATIONS | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| AVAR | Tier 1 | QL (341 GM per 30 days) |
| AVAR-E | Tier 2 | ST |
| AVAR-E GREEN | Tier 2 | ST |
| AVAR-E LS | Tier 2 | ST; QL (57 GM per 30 days) |
| <i>clindamycin-benzoyl peroxide topical gel</i> | Tier 1 | |
| <i>clindamycin-benzoyl peroxide topical gel with pump 1-5 %</i> | Tier 1 | |
| <i>erythromycin-benzoyl peroxide</i> | Tier 1 | |
| SSS 10-5 TOPICAL CREAM | Tier 1 | |
| <i>sulfacetamide sodium-sulfur topical cleanser 10-5 % (w/w)</i> | Tier 1 | QL (341 GM per 30 days) |
| <i>sulfacetamide sodium-sulfur topical cleanser 9-4 %</i> | Tier 1 | |
| <i>sulfacetamide sodium-sulfur topical cream 10-2 %</i> | Tier 1 | QL (57 GM per 30 days) |
| <i>sulfacetamide sodium-sulfur topical cream 10-5 % (w/w)</i> | Tier 1 | |
| <i>sulfacetamide sodium-sulfur topical lotion 10-5 % (w/v), 10-5 % (w/w)</i> | Tier 1 | |
| <i>sulfacetamide sodium-sulfur topical pads, medicated 10-4 %</i> | Tier 1 | |
| <i>sulfacetamide sodium-sulfur topical suspension 10-5 %, 8-4 %</i> | Tier 1 | |
| <i>sulfacetamide sod-sulfur-urea</i> | Tier 1 | |
| SULFACLEANSE 8-4 | Tier 1 | ST |
| ACNE THERAPY
TOPICAL - ANTI-
INFECTIVE-RETINOID
COMBINATIONS | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| <i>clindamycin-tretinoin</i> | Tier 1 | |
| ACNE THERAPY
TOPICAL - RETINOID
COMBINATIONS
OTHER | | |
| <i>adapalene-benzoyl peroxide topical gel with pump 0.1-2.5 %</i> | Tier 1 | |
| ACNE THERAPY
TOPICAL - RETINOLIDS
AND DERIVATIVES | | |
| <i>adapalene topical lotion</i> | Tier 2 | ST |
| AVITA TOPICAL CREAM | Tier 1 | QL (45 GM per 30 days) |
| AVITA TOPICAL GEL | Tier 2 | QL (45 GM per 30 days) |
| <i>tretinoin</i> | Tier 1 | QL (45 GM per 30 days) |
| ANTIPSORIATIC -
VITAMIN D ANALOG -
GLUCOCORTICOID
COMBINATIONS | | |
| <i>calcipotriene-betamethasone</i> | Tier 1 | QL (60 GM per 30 days) |
| ANTIPSORIATIC
AGENTS -
INTERLEUKIN 12 AND
IL-23 INHIBITORS,MC
ANTIBODY | | |
| STELARA SUBCUTANEOUS SOLUTION | Tier 4 | PA; QL (45 ML per 84 days) |
| STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML | Tier 4 | PA; QL (90 MG per 90 days) |
| STELARA SUBCUTANEOUS SYRINGE 90 MG/ML | Tier 4 | PA; QL (90 ML per 60 days) |
| ANTIPSORIATIC
AGENTS -
INTERLEUKIN-23 (IL-
23) ANTAGONIST, MC
ANTIBODY | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------------|
| SKYRIZI
SUBCUTANEOUS PEN
INJECTOR | Tier 4 | PA; QL (1 ML
per 84 days) |
| SKYRIZI
SUBCUTANEOUS
SYRINGE | Tier 4 | PA; QL (1 ML
per 84 days) |
| TREMFYA | Tier 4 | PA; QL (100
ML per 60
days) |
| ANTIPSORIATIC
AGENTS-
INTERLEUKIN-17 (IL-
17) ANTAGONIST, MC
ANTIBODY | | |
| COSENTYX (2
SYRINGES) | Tier 4 | PA; QL (1 ML
per 30 days) |
| COSENTYX PEN | Tier 4 | PA; QL (1 ML
per 30 days) |
| COSENTYX PEN (2
PENS) | Tier 4 | PA; QL (1 ML
per 30 days) |
| COSENTYX
SUBCUTANEOUS
SYRINGE 150 MG/ML | Tier 4 | PA; QL (1 ML
per 30 days) |
| DERMATITIS - JANUS
KINASE (JAK)
INHIBITORS | | |
| RINVOQ ORAL
TABLET EXTENDED
RELEASE 24 HR 15
MG, 30 MG | Tier 4 | PA; QL (1 EA
per 1 day) |
| DERMATITIS
AGENTS,SYSTEMIC-
IL-4 RECEPTOR
ALPHA ANTAGONIST
(IL-4RA) MAB | | |
| DUPIXENT PEN
SUBCUTANEOUS PEN
INJECTOR 200
MG/1.14 ML | Tier 4 | PA; QL (400
MG per 30
days) |
| DUPIXENT PEN
SUBCUTANEOUS PEN
INJECTOR 300 MG/2
ML | Tier 4 | PA; QL (600
MG per 30
days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|------------------------------------|
| DUPIXENT SYRINGE
SUBCUTANEOUS
SYRINGE 100 MG/0.67
ML | Tier 4 | PA; QL (1.34
ML per 30
days) |
| DUPIXENT SYRINGE
SUBCUTANEOUS
SYRINGE 200 MG/1.14
ML | Tier 4 | PA; QL (400
MG per 30
days) |
| DUPIXENT SYRINGE
SUBCUTANEOUS
SYRINGE 300 MG/2
ML | Tier 4 | PA; QL (600
MG per 30
days) |
| DERMATOLOGICAL -
ANTIBACTERIAL
AMINOGLYCOSIDES | | |
| <i>gentamicin topical</i> | Tier 1 | QL (60 GM per
30 days) |
| DERMATOLOGICAL -
ANTIBACTERIAL
OTHER | | |
| <i>mupirocin</i> | Tier 1 | QL (44 GM per
30 days) |
| DERMATOLOGICAL -
ANTIBACTERIAL
PLEUROMUTILIN
DERIVATIVES | | |
| ALTABAX | Tier 3 | ST; QL (30 GM
per 30 days) |
| DERMATOLOGICAL -
ANTIBACTERIAL
QUINOLONES | | |
| XEPI | Tier 2 | ST; QL (30 GM
per 30 days) |
| DERMATOLOGICAL -
ANTIFUNGAL
ALLYLAMINES | | |
| <i>naftifine topical cream</i> | Tier 1 | PA; QL (60 GM
per 30 days) |
| DERMATOLOGICAL -
ANTIFUNGAL
AMPHOTERIC
POLYENE
MACROLIDES | | |
| NYAMYC | Tier 1 | QL (180 GM
per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| <i>nystatin topical cream</i> | Tier 1 | QL (30 GM per 30 days) |
| <i>nystatin topical ointment</i> | Tier 1 | QL (30 GM per 30 days) |
| <i>nystatin topical powder</i> | Tier 1 | QL (180 GM per 30 days) |
| NYSTOP | Tier 1 | QL (180 GM per 30 days) |
| DERMATOLOGICAL -
ANTIFUNGAL
BENZYLAMINES | | |
| MENTAX | Tier 2 | ST; QL (30 GM per 30 days) |
| DERMATOLOGICAL -
ANTIFUNGAL
HYDROXYPYRIDINON
E | | |
| CICLODAN KIT
TOPICAL COMBO
PACK | Tier 2 | |
| CICLODAN KIT
TOPICAL SOLUTION | Tier 2 | ST |
| CICLODAN TOPICAL
CREAM | Tier 1 | QL (90 GM per 30 days) |
| CICLODAN TOPICAL
SOLUTION | Tier 1 | QL (6.6 ML per 30 days) |
| <i>ciclopirox topical cream</i> | Tier 1 | QL (90 GM per 30 days) |
| <i>ciclopirox topical gel</i> | Tier 1 | QL (45 GM per 30 days) |
| <i>ciclopirox topical shampoo</i> | Tier 1 | QL (120 ML per 30 days) |
| <i>ciclopirox topical solution</i> | Tier 1 | QL (6.6 ML per 30 days) |
| <i>ciclopirox topical suspension</i> | Tier 1 | QL (60 ML per 30 days) |
| <i>ciclopirox-ure-camph-menth-euc</i> | Tier 1 | |
| DERMATOLOGICAL -
ANTIFUNGAL
IMIDAZOLE AND
RELATED AGENTS | | |
| <i>econazole</i> | Tier 1 | QL (85 GM per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------|
| ERTACZO | Tier 2 | QL (60 GM per 30 days) |
| <i>ketoconazole topical cream</i> | Tier 1 | QL (60 GM per 30 days) |
| <i>ketoconazole topical shampoo</i> | Tier 1 | QL (120 ML per 30 days) |
| <i>luliconazole</i> | Tier 2 | PA; QL (60 GM per 30 days) |
| <i>oxiconazole</i> | Tier 1 | PA; QL (60 GM per 30 days) |
| <i>sulconazole</i> | Tier 2 | PA; QL (60 GM per 30 days) |
| DERMATOLOGICAL -
ANTIFUNGAL-
GLUCOCORTICOID
COMBINATIONS | | |
| <i>clotrimazole-
betamethasone topical cream</i> | Tier 1 | QL (45 GM per 30 days) |
| <i>nystatin-triamcinolone</i> | Tier 1 | QL (60 GM per 30 days) |
| DERMATOLOGICAL -
ANTINEOPLASTIC
ANTIMETABOLITES | | |
| <i>fluorouracil topical cream 5 %</i> | Tier 1 | QL (3 GM per 1 day) |
| <i>fluorouracil topical solution</i> | Tier 1 | QL (10 ML per 30 days) |
| DERMATOLOGICAL -
ANTINEOPLASTIC
SELECTIVE RETINOID
X RECEPTOR
AGONIST | | |
| <i>bexarotene topical</i> | Tier 4 | PA; QL (60 GM per 30 days) |
| DERMATOLOGICAL -
ANTIPSORIATIC
AGENTS SYSTEMIC,
VITAMIN A
DERIVATIVES | | |
| <i>acitretin</i> | Tier 1 | |
| DERMATOLOGICAL -
ANTIPSORIATIC
AGENTS TOPICAL | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|---------------------------------|
| <i>calcipotriene scalp</i> | Tier 1 | QL (120 ML per 30 days) |
| <i>calcipotriene topical cream</i> | Tier 1 | QL (120 GM per 30 days) |
| <i>calcipotriene topical ointment</i> | Tier 1 | QL (120 GM per 30 days) |
| <i>calcitriol topical</i> | Tier 1 | |
| <i>halobetasol propionate topical foam</i> | Tier 1 | ST |
| DERMATOLOGICAL - ANTIPSORIATICS SYSTEMIC, PHOSPHODIESTERASE 4 INHIB. | | |
| OTEZLA | Tier 4 | PA; QL (60 EA per 30 days) |
| DERMATOLOGICAL - ANTISEBORRHEIC | | |
| <i>selenium sulfide topical lotion</i> | Tier 1 | |
| DERMATOLOGICAL - ANTIVIRAL, HERPES | | |
| <i>acyclovir topical ointment</i> | Tier 1 | ST; QL (30 GM per 30 days) |
| <i>penciclovir</i> | Tier 1 | ST; QL (5 GM per 30 days) |
| DERMATOLOGICAL - BURN PRODUCTS ANTI-INFECTIVE | | |
| <i>mafenide acetate</i> | Tier 1 | |
| <i>silver sulfadiazine</i> | Tier 1 | |
| SSD | Tier 1 | |
| DERMATOLOGICAL - CALCINEURIN INHIBITORS | | |
| <i>pimecrolimus</i> | Tier 1 | PA; ST; QL (100 GM per 30 days) |
| <i>tacrolimus topical</i> | Tier 1 | QL (100 GM per 30 days) |
| DERMATOLOGICAL - ENZYMES | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------|
| SANTYL | Tier 2 | QL (180 GM per 30 days) |
| DERMATOLOGICAL - GLUCOCORTICOID | | |
| ALA-CORT | Tier 1 | QL (28.35 GM per 30 days) |
| <i>alclometasone</i> | Tier 1 | QL (2 GM per 1 day) |
| BESER | Tier 1 | ST; QL (4 ML per 1 day) |
| <i>betamethasone dipropionate topical cream</i> | Tier 1 | QL (45 GM per 30 days) |
| <i>betamethasone dipropionate topical lotion</i> | Tier 1 | QL (2 ML per 1 day) |
| <i>betamethasone dipropionate topical ointment</i> | Tier 1 | ST; QL (45 GM per 30 days) |
| <i>betamethasone valerate topical cream</i> | Tier 1 | QL (45 GM per 30 days) |
| <i>betamethasone valerate topical lotion</i> | Tier 1 | QL (2 ML per 1 day) |
| <i>betamethasone valerate topical ointment</i> | Tier 1 | QL (45 GM per 30 days) |
| <i>betamethasone, augmented topical cream</i> | Tier 1 | QL (50 GM per 30 days) |
| <i>betamethasone, augmented topical lotion</i> | Tier 1 | QL (2 ML per 1 day) |
| <i>betamethasone, augmented topical ointment</i> | Tier 1 | QL (45 GM per 30 days) |
| <i>clobetasol scalp</i> | Tier 1 | ST; QL (100 ML per 30 days) |
| <i>clobetasol topical cream</i> | Tier 1 | ST; QL (120 GM per 30 days) |
| <i>clobetasol topical gel</i> | Tier 1 | ST; QL (120 GM per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------|
| <i>clobetasol topical ointment</i> | Tier 1 | QL (120 GM per 30 days) |
| <i>clobetasol topical shampoo</i> | Tier 1 | ST; QL (236 ML per 30 days) |
| <i>clobetasol-emollient topical cream</i> | Tier 1 | QL (120 GM per 30 days) |
| CLODAN | Tier 1 | ST; QL (236 ML per 30 days) |
| <i>desonide topical cream</i> | Tier 1 | QL (2 GM per 1 day) |
| <i>desonide topical ointment</i> | Tier 1 | QL (2 GM per 1 day) |
| <i>desoximetasone topical cream 0.05 %</i> | Tier 1 | ST |
| <i>desoximetasone topical cream 0.25 %</i> | Tier 1 | ST; QL (2 GM per 1 day) |
| <i>desoximetasone topical gel</i> | Tier 1 | ST |
| <i>desoximetasone topical ointment</i> | Tier 1 | ST |
| <i>desoximetasone topical spray, non-aerosol</i> | Tier 1 | ST |
| <i>diflorasone</i> | Tier 1 | ST; QL (120 GM per 30 days) |
| <i>fluocinolone and shower cap</i> | Tier 1 | QL (1 ML per 30 days) |
| <i>fluocinolone topical cream 0.01 %</i> | Tier 1 | QL (120 GM per 30 days) |
| <i>fluocinolone topical cream 0.025 %</i> | Tier 1 | QL (2 GM per 1 day) |
| <i>fluocinolone topical oil</i> | Tier 1 | QL (120 ML per 30 days) |
| <i>fluocinolone topical ointment</i> | Tier 1 | QL (2 GM per 1 day) |
| <i>fluocinolone topical solution</i> | Tier 1 | QL (120 ML per 30 days) |
| <i>fluocinonide topical cream 0.05 %</i> | Tier 1 | ST; QL (120 GM per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------|
| <i>fluocinonide topical gel</i> | Tier 1 | PA; QL (120 GM per 30 days) |
| <i>fluocinonide topical ointment</i> | Tier 1 | ST; QL (120 GM per 30 days) |
| <i>fluocinonide topical solution</i> | Tier 1 | QL (120 ML per 30 days) |
| FLUOCINONIDE-E | Tier 1 | QL (120 GM per 30 days) |
| <i>fluocinonide-emollient</i> | Tier 1 | QL (120 GM per 30 days) |
| <i>flurandrenolide topical cream</i> | Tier 1 | ST; QL (120 GM per 30 days) |
| <i>flurandrenolide topical lotion</i> | Tier 1 | ST; QL (120 ML per 30 days) |
| <i>fluticasone propionate topical cream</i> | Tier 1 | QL (2 GM per 1 day) |
| <i>fluticasone propionate topical lotion</i> | Tier 1 | ST; QL (4 ML per 1 day) |
| <i>fluticasone propionate topical ointment</i> | Tier 1 | QL (2 GM per 1 day) |
| <i>halcinonide</i> | Tier 1 | ST |
| <i>halobetasol propionate topical cream</i> | Tier 1 | ST |
| <i>halobetasol propionate topical foam</i> | Tier 1 | ST |
| <i>hydrocortisone butyrate topical cream</i> | Tier 1 | QL (120 GM per 30 days) |
| <i>hydrocortisone butyrate topical ointment</i> | Tier 1 | ST; QL (45 GM per 30 days) |
| <i>hydrocortisone butyrate topical solution</i> | Tier 1 | ST; QL (120 ML per 30 days) |
| <i>hydrocortisone butyr-emollient</i> | Tier 1 | QL (120 GM per 30 days) |
| <i>hydrocortisone topical cream 2.5 %</i> | Tier 1 | QL (1 GM per 1 day) |
| <i>hydrocortisone topical cream with perineal applicator</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-----------------------------|
| <i>hydrocortisone topical lotion 2.5 %</i> | Tier 1 | QL (118 ML per 30 days) |
| <i>hydrocortisone topical ointment 2.5 %</i> | Tier 1 | QL (28.35 GM per 30 days) |
| <i>hydrocortisone valerate topical cream</i> | Tier 1 | QL (2 GM per 1 day) |
| <i>mometasone topical cream</i> | Tier 1 | QL (45 GM per 30 days) |
| <i>mometasone topical ointment</i> | Tier 1 | QL (45 GM per 30 days) |
| <i>mometasone topical solution</i> | Tier 1 | QL (2 ML per 1 day) |
| <i>prednicarbate topical cream</i> | Tier 1 | QL (2 GM per 1 day) |
| <i>prednicarbate topical ointment</i> | Tier 1 | |
| PROCTO-MED HC | Tier 1 | |
| PROCTOSOL HC | Tier 1 | |
| PROCTOZONE-HC | Tier 1 | |
| <i>triamcinolone acetonide topical cream</i> | Tier 1 | QL (454 GM per 30 days) |
| <i>triamcinolone acetonide topical lotion</i> | Tier 1 | QL (2 ML per 1 day) |
| <i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i> | Tier 1 | QL (454 GM per 30 days) |
| <i>triamcinolone acetonide topical ointment 0.05 %</i> | Tier 1 | ST |
| TRIDERM TOPICAL CREAM 0.5 % | Tier 1 | ST; QL (454 GM per 30 days) |
| TRITOCIN | Tier 1 | ST |
| DERMATOLOGICAL - IMMUNOMODULATOR - IMIDAZOQUINOLINAMINES | | |
| <i>imiquimod topical cream in packet 5 %</i> | Tier 1 | PA; QL (24 EA per 30 days) |
| DERMATOLOGICAL - KERATOLYTIC-ANTIMITOTIC SINGLE AGENTS | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| <i>podofilox</i> | Tier 1 | QL (1 ML per 30 days) |
| <i>salicylic acid topical cream</i> | Tier 1 | QL (454 GM per 30 days) |
| <i>salicylic acid topical cream,extended release</i> | Tier 1 | QL (454 GM per 30 days) |
| <i>salicylic acid topical lotion</i> | Tier 1 | QL (473 ML per 30 days) |
| <i>salicylic acid topical lotion,extended release</i> | Tier 1 | QL (473 GM per 30 days) |
| <i>salicylic acid topical shampoo</i> | Tier 1 | QL (177 ML per 30 days) |
| <i>salicylic acid-ceramides no.1</i> | Tier 1 | |
| SALIMEZ | Tier 1 | QL (454 GM per 30 days) |
| TRI-CHLOR | Tier 1 | |
| <i>trichloroacetic acid topical recon soln 30 %, 35 %, 40 %, 50 %, 80 %, 85 %, 90 %</i> | Tier 2 | |
| DERMATOLOGICAL - LOCAL ANESTHETIC COMBINATIONS | | |
| DERMACINRX PRIZOPAK | Tier 1 | |
| <i>lidocaine-prilocaine topical cream</i> | Tier 1 | QL (30 GM per 30 days) |
| <i>lidocaine-prilocaine topical kit</i> | Tier 1 | |
| DERMATOLOGICAL - MAMMALIAN TARGET OF RAPAMYCIN (MTOR) INHIBITORS | | |
| HYFTOR | Tier 4 | PA; QL (20 GM per 21 days) |
| DERMATOLOGICAL - PROTECTANTS | | |
| <i>zinc oxide topical paste</i> | Tier 2 | |
| DERMATOLOGICAL - RETINIDS (VITAMIN A DERIVATIVES) - TOPICAL COSMETIC | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| <i>tretinoin (emollient)</i> | Tier 1 | |
| DERMATOLOGICAL -
ROSACEA THERAPY,
TOPICAL | | |
| <i>brimonidine topical</i> | Tier 1 | |
| <i>metronidazole topical
cream</i> | Tier 1 | QL (45 GM per
30 days) |
| <i>metronidazole topical
gel 0.75 %</i> | Tier 1 | QL (45 GM per
30 days) |
| <i>metronidazole topical
lotion</i> | Tier 1 | QL (59 ML per
30 days) |
| ROSADAN TOPICAL
CREAM | Tier 1 | QL (45 GM per
30 days) |
| ROSADAN TOPICAL
GEL | Tier 1 | QL (45 GM per
30 days) |
| <i>sulfacetamide sod-
sulfur-urea</i> | Tier 1 | |
| DERMATOLOGICAL -
TOPICAL LOCAL
ANESTHETIC AMIDES | | |
| <i>lidocaine topical
adhesive
patch,medicated 5 %</i> | Tier 1 | PA; QL (1 EA
per 1 day) |
| LIDOPIN TOPICAL
CREAM 3 % | Tier 1 | QL (30 GM per
30 days) |
| DERMATOLOGICAL
ANTIPRURITICS -
ANTI HISTAMINES | | |
| <i>doxepin topical</i> | Tier 1 | ST; QL (45 GM
per 30 days) |
| SCABICIDE AND
PEDICULICIDE
SINGLE AGENTS | | |
| <i>lindane</i> | Tier 1 | QL (2 ML per 1
day) |
| <i>malathion</i> | Tier 1 | QL (59 ML per
30 days) |
| <i>permethrin</i> | Tier 1 | QL (2 GM per 1
day) |
| <i>spinosad</i> | Tier 1 | PA; QL (4 ML
per 1 day) |
| ULESFIA | Tier 2 | QL (227 GM
per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| DIAGNOSTIC
AGENTS | | |
| CONTRAST MEDIA -
IODINATED IONIC | | |
| MD-GASTROVIEW | Tier 1 | |
| DIAGNOSTIC DRUGS -
GASTROINTESTINAL
RADIOLOGICAL
ADJUNCT | | |
| GLUCAGEN
DIAGNOSTIC KIT | Tier 2 | |
| <i>glucagon hcl injection
recon soln 1 mg/ml</i> | Tier 2 | |
| DIAGNOSTIC DRUGS -
GLUCOSE
TOLERANCE TEST,
ORAL | | |
| GLUTOL GEL | Tier 2 | |
| EATING DISORDER
THERAPY | | |
| APPETITE
STIMULANTS -
CANNABINOIDS | | |
| <i>dronabinol</i> | Tier 1 | PA |
| APPETITE
STIMULANTS -
PROGESTIN
HORMONE TYPE | | |
| <i>megestrol oral
suspension 400 mg/10
ml (10 ml), 400 mg/10
ml (40 mg/ml), 625
mg/5 ml (125 mg/ml)</i> | Tier 1 | |
| ELECTROLYTE
BALANCE-
NUTRITIONAL
PRODUCTS | | |
| B-COMPLEX VITAMIN
COMBINATIONS | | |
| B COMPLEX 1 (WITH
FOLIC ACID) | Tier 0 | |
| <i>b complex-vitamin c-
folic acid oral tablet</i> | Tier 0 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| BALANCE B-100
(FOLIC ACID) | Tier 0 | |
| BALANCE B-50 (WITH
FOLIC ACID) | Tier 0 | |
| BALANCED B-100
ORAL TABLET | Tier 0 | |
| B-COMPLEX WITH
VITAMIN C ORAL
TABLET 400-500 MCG-
MG | Tier 0 | |
| DIALYVITE 800 ORAL
TABLET | Tier 0 | |
| FULL SPECTRUM B-
VITAMIN C | Tier 0 | |
| KOBEE | Tier 0 | |
| RENA-VITE | Tier 0 | |
| STRESS FORMULA
WITH IRON | Tier 0 | |
| STRESS FORMULA
WITH IRON(SULF) | Tier 0 | |
| SUPER B MAXI
COMPLEX | Tier 0 | |
| SUPER QUINTS | Tier 0 | |
| <i>vitamin b complex-folic
acid oral tablet</i> | Tier 0 | |
| ELECTROLYTE
DEPLETERS - ION
EXCHANGE RESIN | | |
| <i>sodium polystyrene
sulfonate</i> | Tier 1 | |
| SPS (WITH
SORBITOL) | Tier 1 | |
| MINERALS AND
ELECTROLYTES -
IODINE | | |
| <i>potassium iodide oral
solution</i> | Tier 1 | |
| SSKI | Tier 2 | |
| MINERALS AND
ELECTROLYTES -
IRON | | |
| AURYXIA | Tier 2 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| MINERALS AND
ELECTROLYTES -
POTASSIUM, ORAL | | |
| EFFER-K ORAL
TABLET,
EFFERVESCENT 25
MEQ | Tier 1 | |
| KLOR-CON 10 | Tier 1 | |
| KLOR-CON 8 | Tier 1 | |
| KLOR-CON M10 | Tier 1 | |
| KLOR-CON M15 | Tier 1 | |
| KLOR-CON M20 | Tier 1 | |
| KLOR-CON/EF | Tier 1 | |
| <i>potassium chloride oral
capsule, extended
release</i> | Tier 1 | |
| <i>potassium chloride oral
liquid</i> | Tier 1 | |
| <i>potassium chloride oral
tablet extended release</i> | Tier 1 | |
| <i>potassium chloride oral
tablet,er
particles/crystals 10
meq, 20 meq</i> | Tier 1 | |
| MULTIVITAMIN AND
MINERAL
COMBINATIONS | | |
| WESCAP-C DHA | Tier 1 | |
| NUTRITIONAL
PRODUCT -
CARBOHYDRATES,
ORAL | | |
| ENFAMIL GLUCOSE | Tier 2 | |
| PEDIATRIC VITAMINS
WITH FLUORIDE AND
MINERALS
COMBINATIONS | | |
| MULTI-VIT WITH
FLUORIDE-IRON | Tier 1 | |
| PEDIATRIC VITAMINS
WITH FLUORIDE
COMBINATIONS | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| MULTI-VIT WITH FLUORIDE-IRON | Tier 1 | |
| MULTIVITAMIN WITH FLUORIDE | Tier 0 | |
| MULTI-VITAMIN WITH FLUORIDE | Tier 0 | |
| MULTIVITAMINS WITH FLUORIDE | Tier 0 | |
| MVC-FLUORIDE | Tier 0 | |
| TRI-VITAMIN WITH FLUORIDE | Tier 0 | |
| TRI-VITE WITH FLUORIDE | Tier 0 | |
| VITAMINS A,C,D AND FLUORIDE | Tier 0 | |
| PRENATAL VITAMINS AND MINERALS | | |
| CLASSIC PRENATAL | Tier 0 | |
| ONE DAILY PRENATAL | Tier 0 | |
| <i>pnv cmb#95-ferrous fumarate-fa</i> | Tier 0 | |
| PRENATAL COMPLETE | Tier 0 | |
| PRENATAL MULTI-DHA (ALGAL OIL) | Tier 0 | |
| PRENATAL MULTIVITAMINS | Tier 0 | |
| PRENATAL ONE DAILY | Tier 0 | |
| PRENATAL ORAL TABLET 28 MG IRON-800 MCG | Tier 0 | |
| PRENATAL TABLET | Tier 0 | |
| <i>prenatal vit no. 179-iron-folic</i> | Tier 0 | |
| PRENATAL VITAMIN ORAL TABLET 27 MG IRON- 0.8 MG | Tier 0 | |
| PRENATAL VITAMIN WITH MINERALS | Tier 0 | |
| <i>prenatal vit-iron fum-folic ac</i> | Tier 0 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| SODIUM CHLORIDE FLUSHES | | |
| BD POSIFLUSH NORMAL SALINE 0.9 | Tier 1 | |
| MONOJECT 0.9% SODIUM CHLORIDE | Tier 1 | |
| MONOJECT PREFILL ADVANCED NS | Tier 1 | |
| NORMAL SALINE FLUSH | Tier 1 | |
| VITAMINS - B PREPARATION COMBINATIONS | | |
| FOLTABS 800 | Tier 0 | |
| VITAMINS - B-12, CYANOCOBALAMIN AND DERIVATIVES | | |
| <i>cyanocobalamin (vitamin b-12) injection</i> | Tier 1 | |
| VITAMINS - D DERIVATIVES | | |
| <i>calcitriol oral</i> | Tier 1 | |
| <i>ergocalciferol (vitamin d2) oral capsule 1,250 mcg (50,000 unit)</i> | Tier 1 | |
| VITAMIN D2 | Tier 1 | |
| VITAMINS - FOLIC ACID AND DERIVATIVES | | |
| <i>folic acid oral tablet 400 mcg, 800 mcg</i> | Tier 0 | |
| VITAMINS - FOLIC ACID COMBINATIONS | | |
| FOLTABS 800 | Tier 0 | |
| VITAMINS - K, PHYTONADIONE AND DERIVATIVES | | |
| <i>phytonadione (vitamin k1) injection solution 1 mg/0.5 ml</i> | Tier 2 | |
| <i>phytonadione (vitamin k1) injection solution 10 mg/ml</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------|
| <i>phytonadione (vitamin k1) oral tablet 5 mg</i> | Tier 1 | QL (10 EA per 30 days) |
| ENDOCRINE | | |
| ADRENAL STEROID INHIBITORS | | |
| ISTURISA ORAL TABLET 1 MG | Tier 4 | PA; QL (240 EA per 30 days) |
| ISTURISA ORAL TABLET 5 MG | Tier 4 | PA; QL (60 EA per 30 days) |
| AGENTS TO TREAT HYPOGLYCEMIA (HYPERGLYCEMICS) | | |
| BAQSIMI | Tier 2 | ST; QL (2 EA per 30 days) |
| DEX4 GLUCOSE BITS | Tier 1 | |
| DEX4 GLUCOSE ORAL TABLET,CHEWABLE | Tier 1 | |
| DEX4 GLUCOSE POUCH PACK | Tier 1 | |
| DEX4 GLUCOSE QUICK DISSOLVE | Tier 1 | |
| <i>dextrose oral gel</i> | Tier 1 | |
| GLUCAGEN HYPOKIT | Tier 2 | QL (2 EA per 30 days) |
| GLUCAGON (HCL) EMERGENCY KIT | Tier 2 | QL (2 EA per 30 days) |
| GLUCAGON EMERGENCY KIT (HUMAN) | Tier 1 | QL (2 EA per 30 days) |
| GLUCO BURST | Tier 1 | |
| GLUCOSE BITS | Tier 1 | |
| GLUCOSE GEL | Tier 1 | |
| <i>glucose oral tablet,chewable 4 gram</i> | Tier 1 | |
| GLUTOSE-5 | Tier 1 | |
| RELION GLUCOSE | Tier 1 | |
| ANDROGEN - SINGLE AGENTS | | |
| <i>methyltestosterone</i> | Tier 1 | |
| <i>testosterone cypionate</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------|
| <i>testosterone enanthate</i> | Tier 1 | |
| <i>testosterone transdermal gel</i> | Tier 1 | PA; QL (60 GM per 30 days) |
| <i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i> | Tier 1 | PA; QL (150 GM per 30 days) |
| <i>testosterone transdermal gel in packet 1 % (25 mg/2.5gram)</i> | Tier 1 | PA; QL (75 GM per 30 days) |
| <i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i> | Tier 1 | PA; QL (30 GM per 30 days) |
| ANTIDIURETIC AND VASOPRESSOR HORMONES | | |
| <i>desmopressin injection</i> | Tier 4 | |
| <i>desmopressin nasal spray with pump</i> | Tier 1 | |
| <i>desmopressin oral</i> | Tier 1 | |
| ANTIHYPERGLYCEMI C - ALPHA-GLUCOSIDASE INHIBITORS | | |
| <i>acarbose</i> | Tier 1 | |
| <i>miglitol</i> | Tier 1 | |
| ANTIHYPERGLYCEMI C - AMYLIN ANALOG-TYPE | | |
| SYMLINPEN 120 | Tier 2 | ST; QL (19 ML per 30 days) |
| SYMLINPEN 60 | Tier 2 | ST; QL (11 ML per 30 days) |
| ANTIHYPERGLYCEMI C - DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS | | |
| <i>alogliptin</i> | Tier 1 | ST; QL (30 EA per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------|
| ANTIHYPERGLYCEMIC - DUAL GIP AND GLP-1 RECEPTOR AGONISTS | | |
| MOUNJARO | Tier 2 | PA; QL (2 ML per 28 days) |
| ANTIHYPERGLYCEMIC - GLUCAGON-LIKE PEPTIDE-1 (GLP-1) RECEPTOR AGONISTS | | |
| RYBELSUS | Tier 2 | PA; QL (30 EA per 30 days) |
| TRULICITY | Tier 2 | PA; QL (2 ML per 22 days) |
| ANTIHYPERGLYCEMIC - MEGLITINIDE ANALOGS | | |
| <i>nateglinide</i> | Tier 1 | |
| <i>repaglinide</i> | Tier 1 | |
| ANTIHYPERGLYCEMIC - SGLT-2 INHIBITOR AND BIGUANIDE COMBINATIONS | | |
| SEGLUROMET | Tier 2 | ST; QL (60 EA per 30 days) |
| SYNJARDY | Tier 2 | ST; QL (60 EA per 30 days) |
| SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG | Tier 2 | ST; QL (60 EA per 30 days) |
| SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG | Tier 2 | ST; QL (30 EA per 30 days) |
| ANTIHYPERGLYCEMIC - SODIUM GLUCOSE COTRANSPORTER-2 (SGLT2) INHIBITORS | | |
| FARXIGA | Tier 2 | QL (30 EA per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------|
| JARDIANCE | Tier 2 | ST; QL (30 EA per 30 days) |
| STEGLATRO | Tier 2 | ST; QL (30 EA per 30 days) |
| ANTIHYPERGLYCEMIC - SULFONYLUREA AND BIGUANIDE COMBINATIONS | | |
| <i>glipizide-metformin</i> | Tier 1 | |
| <i>glyburide-metformin oral tablet 1.25-250 mg</i> | Tier 1 | QL (260 EA per 30 days) |
| <i>glyburide-metformin oral tablet 2.5-500 mg, 5-500 mg</i> | Tier 1 | QL (5 EA per 1 day) |
| ANTIHYPERGLYCEMIC - SULFONYLUREA DERIVATIVES | | |
| <i>glimepiride</i> | Tier 1 | |
| <i>glipizide</i> | Tier 1 | |
| <i>glyburide micronized oral tablet 1.5 mg</i> | Tier 1 | QL (8 EA per 1 day) |
| <i>glyburide micronized oral tablet 3 mg</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>glyburide micronized oral tablet 6 mg</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>glyburide oral tablet 1.25 mg</i> | Tier 1 | QL (16 EA per 1 day) |
| <i>glyburide oral tablet 2.5 mg</i> | Tier 1 | QL (8 EA per 1 day) |
| <i>glyburide oral tablet 5 mg</i> | Tier 1 | QL (4 EA per 1 day) |
| ANTIHYPERGLYCEMIC - THIAZOLIDINEDIONE AND BIGUANIDE COMBINATIONS | | |
| <i>pioglitazone-metformin</i> | Tier 1 | QL (90 EA per 30 days) |
| ANTIHYPERGLYCEMIC - THIAZOLIDINEDIONE AND SULFONYLUREA COMBINATIONS | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|--------------------------------|
| <i>pioglitazone-glimepiride</i> | Tier 1 | ST; QL (30 EA per 30 days) |
| ANTIHYPERGLYCEMI
C-DIPEPTIDYL
PEPTIDASE-4 INHIBIT
AND
THIAZOLIDINEDIONE | | |
| <i>alogliptin-pioglitazone</i> | Tier 2 | ST; QL (30 EA per 30 days) |
| ANTIHYPERGLYCEMI
C-DIPEPTIDYL
PEPTIDASE-4(DPP-
4)INHIBITOR AND
BIGUANIDE | | |
| <i>alogliptin-metformin</i> | Tier 2 | ST; QL (60 EA per 30 days) |
| ANTIHYPERGLYCEMI
C-INSULIN, LONG
ACTING AND GLP-1
RECEPTOR AGONIST
COMB | | |
| SOLIQUA 100/33 | Tier 2 | ST; QL (15 ML per 30 days) |
| XULTOPHY 100/3.6 | Tier 2 | PA; ST; QL (15 ML per 30 days) |
| ANTITHYROID
AGENTS,
THIONAMIDES -
IMIDAZOLE
DERIVATIVES | | |
| <i>methimazole</i> | Tier 1 | |
| ANTITHYROID
AGENTS,
THIONAMIDES -
THIOURACIL
DERIVATIVES | | |
| <i>propylthiouracil</i> | Tier 1 | |
| BONE FORMATION
STIMULATING
AGENTS -
PARATHYROID
HORMONE-TYPE | | |
| <i>teriparatide</i> | Tier 4 | PA; QL (1 ML per 28 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| BONE RESORPTION
INHIBITORS -
BISPHOSPHONATES | | |
| <i>alendronate oral tablet
10 mg, 5 mg</i> | Tier 1 | QL (30 EA per 30 days) |
| <i>alendronate oral tablet
35 mg, 70 mg</i> | Tier 1 | QL (4 EA per 30 days) |
| <i>ibandronate oral</i> | Tier 1 | QL (1 EA per 28 days) |
| <i>risedronate oral tablet
150 mg</i> | Tier 1 | QL (1 EA per 28 days) |
| <i>risedronate oral tablet
30 mg, 5 mg</i> | Tier 1 | QL (30 EA per 30 days) |
| <i>risedronate oral tablet
35 mg</i> | Tier 1 | QL (4 EA per 30 days) |
| <i>risedronate oral
tablet, delayed release
(dr/ec)</i> | Tier 1 | QL (4 EA per 30 days) |
| CALCIMIMETIC,
PARATHYROID
CALCIUM RECEPTOR
SENSITIVITY
ENHANCER | | |
| <i>cinacalcet</i> | Tier 1 | PA |
| CALCITONINS | | |
| <i>calcitonin (salmon)
nasal</i> | Tier 1 | |
| ESTROGEN-
ANDROGEN | | |
| COVARYX | Tier 1 | |
| COVARYX H.S. | Tier 1 | |
| EEMT | Tier 1 | |
| EEMT HS | Tier 1 | |
| <i>estrogens-
methyltestosterone</i> | Tier 1 | |
| ESTROGEN-
PROGESTIN | | |
| COMBIPATCH | Tier 2 | |
| <i>estradiol-norethindrone
acet</i> | Tier 1 | |
| FYAVOLV | Tier 1 | |
| MIMVEY | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|--------------------------|
| <i>norethindrone ac-eth
estradiol oral tablet 0.5-
2.5 mg-mcg, 1-5 mg-
mcg</i> | Tier 1 | |
| ESTROGENS | | |
| DOTTI
TRANSDERMAL
PATCH SEMIWEEKLY
0.025 MG/24 HR, 0.05
MG/24 HR, 0.075
MG/24 HR, 0.1 MG/24
HR | Tier 1 | QL (8 EA per
30 days) |
| <i>estradiol oral</i> | Tier 1 | |
| <i>estradiol transdermal
patch semiweekly</i> | Tier 1 | QL (8 EA per
30 days) |
| <i>estradiol transdermal
patch weekly</i> | Tier 1 | QL (4 EA per
30 days) |
| FERTILITY
ENHANCER - LUTEAL
PHASE SUPPORTING,
PROGESTERONE-
TYPE | | |
| CRINONE VAGINAL
GEL 8 % | Tier 4 | |
| FERTILITY
ENHANCER -
OVULATION
STIMULANT -
SYNTHETIC (NON-
FSH) | | |
| CLOMID | Tier 1 | |
| <i>clomiphene citrate</i> | Tier 1 | |
| GLUCOCORTICOIDS | | |
| <i>cortisone</i> | Tier 1 | |
| DEXAMETHASONE
INTENSOL | Tier 1 | |
| <i>dexamethasone oral
elixir</i> | Tier 1 | |
| <i>dexamethasone oral
solution</i> | Tier 1 | |
| <i>dexamethasone oral
tablet</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------------|
| EMFLAZA ORAL
SUSPENSION | Tier 4 | PA; QL (117
ML per 30
days) |
| EMFLAZA ORAL
TABLET 18 MG | Tier 4 | PA; QL (30 EA
per 30 days) |
| EMFLAZA ORAL
TABLET 30 MG, 36 MG | Tier 4 | PA; QL (90 EA
per 30 days) |
| EMFLAZA ORAL
TABLET 6 MG | Tier 4 | PA; QL (60 EA
per 30 days) |
| <i>hydrocortisone oral</i> | Tier 1 | |
| <i>methylprednisolone</i> | Tier 1 | |
| <i>prednisolone oral
solution</i> | Tier 1 | |
| <i>prednisolone sodium
phosphate oral solution
15 mg/5 ml (3 mg/ml),
15 mg/5 ml (5 ml), 5 mg
base/5 ml (6.7 mg/5 ml)</i> | Tier 1 | |
| <i>prednisolone sodium
phosphate oral
tablet, disintegrating</i> | Tier 1 | |
| <i>prednisone</i> | Tier 1 | |
| PREDNISONE
INTENSOL | Tier 1 | |
| GONADOTROPIN
INHIBITOR PITUITARY
SUPPRESSANTS | | |
| <i>danazol</i> | Tier 1 | |
| GROWTH HORMONES | | |
| OMNITROPE
SUBCUTANEOUS
CARTRIDGE | Tier 4 | |
| OMNITROPE
SUBCUTANEOUS
RECON SOLN | Tier 4 | PA |
| SKYTROFA | Tier 4 | PA |
| HUMAN INSULINS -
SHORT ACTING | | |
| HUMULIN R U-500
(CONC) INSULIN | Tier 2 | |
| HUMULIN R U-500
(CONC) KWIKPEN | Tier 2 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| INSULIN ANALOGS - FIXED COMBINATIONS | | |
| <i>insulin asp prt-insulin aspart subcutaneous insulin pen</i> | Tier 2 | QL (45 ML per 30 days) |
| <i>insulin asp prt-insulin aspart subcutaneous solution</i> | Tier 2 | QL (40 ML per 30 days) |
| <i>insulin lispro protamin-lispro</i> | Tier 2 | QL (1 ML per 1 day) |
| INSULIN ANALOGS - LONG ACTING | | |
| BASAGLAR KWIKPEN U-100 INSULIN | Tier 2 | QL (45 ML per 30 days) |
| TRESIBA FLEXTOUCH U-100 | Tier 2 | QL (45 ML per 30 days) |
| TRESIBA FLEXTOUCH U-200 | Tier 2 | QL (27 ML per 30 days) |
| TRESIBA U-100 INSULIN | Tier 2 | QL (40 ML per 30 days) |
| INSULIN ANALOGS - RAPID ACTING | | |
| <i>insulin aspart u-100 subcutaneous insulin pen</i> | Tier 2 | |
| <i>insulin aspart u-100 subcutaneous solution</i> | Tier 2 | |
| <i>insulin lispro subcutaneous insulin pen</i> | Tier 2 | QL (45 ML per 30 days) |
| <i>insulin lispro subcutaneous insulin pen, half-unit</i> | Tier 2 | QL (1 ML per 1 day) |
| <i>insulin lispro subcutaneous solution</i> | Tier 2 | QL (45 ML per 30 days) |
| INSULIN RESPONSE ENHANCERS - BIGUANIDES | | |
| <i>metformin oral solution</i> | Tier 1 | ST |
| <i>metformin oral tablet 1,000 mg, 500 mg, 850 mg</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-----------------------------|
| <i>metformin oral tablet extended release 24 hr 500 mg</i> | Tier 1 | QL (120 EA per 30 days) |
| <i>metformin oral tablet extended release 24 hr 750 mg</i> | Tier 1 | QL (60 EA per 30 days) |
| INSULIN RESPONSE ENHANCERS - THIAZOLIDINEDIONE S (PPAR-GAMMA AGONISTS) | | |
| <i>pioglitazone</i> | Tier 1 | QL (30 EA per 30 days) |
| INSULIN-LIKE GROWTH FACTOR-1 (IGF-1) | | |
| INCRELEX | Tier 4 | |
| LHRH (GNRH) AGONIST ANALOG PITUITARY SUPPRESSANTS | | |
| SYNAREL | Tier 2 | |
| MINERALOCORTICOID S | | |
| <i>fludrocortisone</i> | Tier 1 | |
| OXYTOCIC - ERGOT ALKALOIDS | | |
| METHERGINE | Tier 1 | ST; QL (240 EA per 30 days) |
| <i>methylergonovine oral</i> | Tier 1 | QL (240 EA per 30 days) |
| PROGESTINS | | |
| <i>medroxyprogesterone oral</i> | Tier 1 | |
| <i>norethindrone acetate</i> | Tier 1 | |
| <i>progesterone micronized</i> | Tier 1 | |
| PROLACTIN INHIBITOR - ERGOT DERIVATIVE DOPAMINE RECEPTOR AGONISTS | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| <i>cabergoline</i> | Tier 1 | QL (8 EA per 30 days) |
| SELECTIVE ESTROGEN RECEPTOR MODULATORS (SERMS) | | |
| <i>raloxifene</i> | Tier 0 | |
| THYROID HORMONES - ANIMAL SOURCE (PORCINE) | | |
| NP THYROID | Tier 1 | |
| THYROID HORMONES - SYNTHETIC T3 (TRIIODOTHYRONINE) | | |
| <i>liothyronine oral</i> | Tier 1 | |
| THYROID HORMONES - SYNTHETIC T4 (THYROXINE) | | |
| EUTHYROX | Tier 1 | |
| <i>levothyroxine oral tablet</i> | Tier 1 | |
| LEVOXYL | Tier 1 | |
| UNITHROID | Tier 1 | |
| GASTROINTESTINAL THERAPY AGENTS | | |
| ANTIDIARRHEAL - ANTIPERISTALTIC AGENTS | | |
| <i>loperamide oral capsule</i> | Tier 1 | QL (2 EA per 1 day) |
| ANTIDIARRHEAL ANTIPERISTALTIC-ANTICHOLINERGIC COMBINATIONS | | |
| <i>diphenoxylate-atropine oral tablet</i> | Tier 1 | |
| ANTIEMETIC - ANTICHOLINERGICS | | |
| <i>scopolamine base</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-----------------------------|
| ANTIEMETIC - ANTIHISTAMINE-VITAMIN COMBINATIONS | | |
| <i>doxylamine-pyridoxine (vit b6)</i> | Tier 1 | PA; QL (120 EA per 30 days) |
| ANTIEMETIC - CANNABINOID TYPE | | |
| <i>dronabinol</i> | Tier 1 | PA |
| ANTIEMETIC - DOPAMINE (D2)/5-HT3 ANTAGONISTS | | |
| <i>trimethobenzamide</i> | Tier 1 | |
| ANTIEMETIC - PHENOTHIAZINES | | |
| <i>prochlorperazine maleate</i> | Tier 1 | |
| <i>promethazine oral</i> | Tier 1 | |
| <i>promethazine rectal</i> | Tier 1 | |
| PROMETHEGAN | Tier 1 | |
| ANTIEMETIC - SELECTIVE SEROTONIN 5-HT3 ANTAGONISTS | | |
| <i>granisetron hcl oral</i> | Tier 1 | QL (6 EA per 30 days) |
| <i>ondansetron</i> | Tier 1 | QL (9 EA per 30 days) |
| <i>ondansetron hcl oral solution</i> | Tier 1 | QL (100 ML per 30 days) |
| <i>ondansetron hcl oral tablet</i> | Tier 1 | QL (9 EA per 30 days) |
| ANTIEMETIC - SUBSTANCE P-NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS | | |
| <i>aprepitant oral capsule 125 mg, 40 mg</i> | Tier 1 | PA; QL (1 EA per 30 days) |
| <i>aprepitant oral capsule 80 mg</i> | Tier 1 | PA; QL (2 EA per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| ANTIEMETIC -
SUBSTANCE P-
NEUROKININ 1 AND 5-
HT3 RECEPT
ANTAGONIST COMB | | |
| AKYNZEO
(NETUPITANT) | Tier 3 | QL (1 EA per
30 days) |
| CHRONIC IDIOPATHIC
CONST. AGENTS -
GUANYLATE
CYCLASE-C (GC-C)
AGONISTS | | |
| TRULANCE | Tier 2 | PA; QL (1 EA
per 1 day) |
| COLONIC ACIDIFIER
(AMMONIA
INHIBITOR) | | |
| ENULOSE | Tier 1 | |
| GENERLAC | Tier 1 | |
| <i>lactulose oral solution
10 gram/15 ml, 10
gram/15 ml (15 ml)</i> | Tier 1 | |
| DIGESTIVE ENZYME
MIXTURES | | |
| CREON | Tier 2 | |
| VIOKACE | Tier 2 | |
| GALLSTONE
SOLUBILIZING
(LITHOLYSIS)
AGENTS | | |
| <i>ursodiol</i> | Tier 1 | |
| GASTRIC ACID
SECRETION
REDUCER -
HISTAMINE H2-
RECEPTOR
ANTAGONISTS | | |
| <i>cimetidine oral tablet
300 mg, 400 mg, 800
mg</i> | Tier 1 | |
| <i>famotidine oral
suspension</i> | Tier 1 | |
| <i>famotidine oral tablet 40
mg</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------------|
| <i>nizatidine</i> | Tier 1 | |
| GASTRIC ACID
SECRETION
REDUCER - PROTON
PUMP INHIBITORS
(PPIS) | | |
| <i>dexlansoprazole oral
capsule,biphase
delayed releas 30 mg</i> | Tier 1 | QL (60 EA per
30 days) |
| <i>dexlansoprazole oral
capsule,biphase
delayed releas 60 mg</i> | Tier 1 | ST; QL (60 EA
per 30 days) |
| <i>esomeprazole
magnesium oral
capsule,delayed
release(dr/ec) 40 mg</i> | Tier 1 | |
| <i>esomeprazole
magnesium oral
granules dr for susp in
packet 10 mg, 20 mg</i> | Tier 1 | ST; QL (30 EA
per 30 days) |
| <i>esomeprazole
magnesium oral
granules dr for susp in
packet 40 mg</i> | Tier 1 | ST |
| <i>lansoprazole oral
capsule,delayed
release(dr/ec) 30 mg</i> | Tier 1 | |
| <i>omeprazole oral
capsule,delayed
release(dr/ec) 10 mg</i> | Tier 1 | QL (30 EA per
30 days) |
| <i>omeprazole oral
capsule,delayed
release(dr/ec) 20 mg,
40 mg</i> | Tier 1 | QL (2 EA per 1
day) |
| <i>pantoprazole oral
tablet,delayed release
(dr/ec) 20 mg</i> | Tier 1 | QL (30 EA per
30 days) |
| <i>pantoprazole oral
tablet,delayed release
(dr/ec) 40 mg</i> | Tier 1 | QL (6 EA per 1
day) |
| <i>rabeprazole oral
tablet,delayed release
(dr/ec)</i> | Tier 1 | ST; QL (60 EA
per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------|
| GASTRIC ACID SECRETION REDUCER-PROTON PUMP INHIBITOR AND ANTACID COMB | | |
| <i>omeprazole-sodium bicarbonate oral packet 20-1,680 mg</i> | Tier 1 | PA; QL (30 EA per 30 days) |
| <i>omeprazole-sodium bicarbonate oral packet 40-1,680 mg</i> | Tier 1 | PA |
| GASTRIC MUCOSA - CYTOPROTECTIVE PROSTAGLANDIN ANALOGS | | |
| <i>misoprostol</i> | Tier 1 | QL (4 EA per 1 day) |
| GASTROINTESTINAL PROKINETIC AGENTS - D2 ANTAGONIST/5-HT4 AGONISTS | | |
| <i>metoclopramide hcl oral</i> | Tier 1 | |
| GI ANTISPASMODIC - BELLADONNA ALKALOIDS | | |
| ED-SPAZ | Tier 1 | |
| <i>hyoscyamine sulfate oral</i> | Tier 1 | |
| <i>hyoscyamine sulfate sublingual</i> | Tier 1 | |
| HYOSYNE | Tier 1 | |
| <i>methscopolamine</i> | Tier 1 | |
| OSCIMIN | Tier 1 | |
| OSCIMIN SL | Tier 1 | |
| SYMAX-SR | Tier 1 | |
| GI ANTISPASMODIC - QUATERNARY AMMONIUM COMPOUNDS | | |
| <i>glycopyrrolate oral tablet 1 mg, 2 mg</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| GI ANTISPASMODIC - SYNTHETIC TERTIARY AMINES | | |
| <i>dicyclomine oral</i> | Tier 1 | |
| GI ANTISPASMODIC AND BENZODIAZEPINE COMBINATIONS | | |
| <i>chlordiazepoxide-clidinium</i> | Tier 1 | |
| GI ANTISPASMODIC COMBINATIONS OTHER | | |
| <i>chlordiazepoxide-clidinium</i> | Tier 1 | |
| H. PYLORI THERAPY - PROTON PUMP INHIBITOR AND ANTIBIOTICS COMBINATIONS | | |
| <i>amoxicil-clarithromy-lansopraz</i> | Tier 1 | QL (112 EA per 30 days) |
| IBS AGENT - GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATOR AGENTS | | |
| <i>lubiprostone</i> | Tier 1 | QL (60 EA per 30 days) |
| IBS AGENT - GUANYLATE CYCLASE-C (GC-C) AGONISTS | | |
| TRULANCE | Tier 2 | PA; QL (1 EA per 1 day) |
| IBS AGENT - SELECTIVE 5-HT3 RECEPTOR ANTAGONISTS | | |
| <i>alosetron</i> | Tier 1 | |
| INFLAMMATORY BOWEL AGENT - INTERLEUKIN-12 AND IL-23 INHIBITORS, MC AB | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|------------------------------------|
| STELARA
INTRAVENOUS | Tier 4 | PA; QL (104
ML per 365
days) |
| STELARA
SUBCUTANEOUS
SOLUTION | Tier 4 | PA; QL (45 ML
per 84 days) |
| STELARA
SUBCUTANEOUS
SYRINGE 90 MG/ML | Tier 4 | PA; QL (90 ML
per 60 days) |
| INFLAMMATORY
BOWEL AGENT -
INTERLEUKIN-23 (IL-
23) INHIBITOR, MC AB | | |
| SKYRIZI
SUBCUTANEOUS
WEARABLE
INJECTOR 180 MG/1.2
ML (150 MG/ML) | Tier 4 | PA |
| SKYRIZI
SUBCUTANEOUS
WEARABLE
INJECTOR 360 MG/2.4
ML (150 MG/ML) | Tier 4 | PA; QL (1 ML
per 84 days) |
| INFLAMMATORY
BOWEL AGENT -
AMINOSALICYLATES
AND RELATED
AGENTS | | |
| <i>balsalazide</i> | Tier 1 | |
| DIPENTUM | Tier 2 | |
| <i>mesalamine oral
capsule (with del rel
tablets)</i> | Tier 1 | |
| <i>mesalamine oral
capsule,extended
release 24hr</i> | Tier 1 | |
| <i>mesalamine oral
tablet, delayed release
(dr/ec)</i> | Tier 1 | |
| <i>mesalamine rectal
enema</i> | Tier 1 | |
| <i>mesalamine with
cleansing wipe</i> | Tier 1 | |
| <i>sulfasalazine</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| INFLAMMATORY
BOWEL AGENT -
GLUCOCORTICOIDS | | |
| <i>budesonide oral
capsule, delayed, extend.
release</i> | Tier 1 | |
| CORTIFOAM | Tier 2 | |
| <i>hydrocortisone rectal</i> | Tier 1 | |
| INFLAMMATORY
BOWEL AGENT -
JANUS KINASE (JAK)
INHIBITORS | | |
| RINVOQ ORAL
TABLET EXTENDED
RELEASE 24 HR 45
MG | Tier 4 | PA; QL (1 EA
per 1 day) |
| INFLAMMATORY
BOWEL AGENT -
SPHINGOSINE 1-
PHOSPHATE
RECEPTOR
MODULATOR | | |
| ZEPOSIA | Tier 4 | PA |
| ZEPOSIA STARTER
PACK (7-DAY) | Tier 4 | PA; QL (1 EA
per 365 days) |
| INFLAMMATORY
BOWEL AGENT -
TUMOR NECROSIS
FACTOR ALPHA
BLOCKERS | | |
| <i>adalimumab-adaz</i> | Tier 4 | PA |
| <i>adalimumab-fkjp</i> | Tier 4 | PA |
| CIMZIA | Tier 4 | PA; QL (2 EA
per 28 days) |
| CIMZIA POWDER FOR
RECONST | Tier 4 | PA; QL (1 EA
per 28 days) |
| CIMZIA STARTER KIT | Tier 4 | PA; QL (6 EA
per 365 days) |
| HADLIMA | Tier 4 | PA |
| HADLIMA
PUSHTOUCH | Tier 4 | PA |
| HADLIMA(CF) | Tier 4 | PA |
| HADLIMA(CF)
PUSHTOUCH | Tier 4 | PA |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| HUMIRA | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA PEN | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA PEN CROHNS-UC-HS START | Tier 4 | PA; QL (6 EA per 365 days) |
| HUMIRA PEN PSOR-UVEITS-ADOL HS | Tier 4 | PA; QL (4 EA per 365 days) |
| HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML | Tier 4 | PA; QL (3 EA per 365 days) |
| HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML | Tier 4 | PA; QL (2 EA per 365 days) |
| HUMIRA(CF) PEN | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA(CF) PEN CROHNS-UC-HS | Tier 4 | PA; QL (3 EA per 365 days) |
| HUMIRA(CF) PEN PEDIATRIC UC | Tier 4 | PA; QL (2 EA per 28 days) |
| HUMIRA(CF) PEN PSOR-UV-ADOL HS | Tier 4 | PA; QL (3 EA per 365 days) |
| HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML, 40 MG/0.4 ML | Tier 4 | PA; QL (2 EA per 28 days) |
| IRRITABLE BOWEL SYNDROME (IBS) AGENTS | | |
| <i>alosetron</i> | Tier 1 | |
| <i>lubiprostone</i> | Tier 1 | QL (60 EA per 30 days) |
| LAXATIVE - SALINE AND OSMOTIC | | |
| <i>lactulose oral solution 10 gram/15 ml, 20 gram/30 ml</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| LAXATIVE - SALINE/OSMOTIC MIXTURES | | |
| GAVILYTE-C | Tier 0 | |
| GAVILYTE-G | Tier 0 | |
| <i>peg 3350-electrolytes</i> | Tier 0 | |
| <i>peg-electrolyte soln</i> | Tier 0 | |
| <i>sodium,potassium,mag sulfates</i> | Tier 0 | |
| LAXATIVE - STIMULANT AND SALINE/OSMOTIC COMBINATIONS | | |
| CLENPIQ ORAL SOLUTION 10 MG-3.5 GRAM- 12 GRAM/160 ML | Tier 0 | |
| PEPTIC ULCER - GASTRIC LUMEN ADHERENT CYTOPROTECTIVES | | |
| <i>sucralfate oral suspension</i> | Tier 1 | |
| <i>sucralfate oral tablet</i> | Tier 1 | QL (4 EA per 1 day) |
| GENITOURINARY THERAPY | | |
| BPH AGENT- 5-ALPHA REDUCTASE INHIB AND ALPHA-1 ADRENOCEPTOR ANTAG COMB | | |
| <i>dutasteride-tamsulosin</i> | Tier 1 | ST |
| CYSTINOSIS THERAPY (CYSTINE DEPLETING AGENTS) | | |
| CYSTAGON | Tier 4 | |
| G.U. IRRIGANTS | | |
| GLYCINE UROLOGIC | Tier 1 | |
| <i>glycine urologic solution</i> | Tier 1 | |
| INTERSTITIAL CYSTITIS AGENTS | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------------|
| ELMIRON | Tier 2 | |
| OVERACTIVE
BLADDER AGENTS -
BETA -3
ADRENERGIC
RECEPTOR AGONIST | | |
| MYRBETRIQ ORAL
TABLET EXTENDED
RELEASE 24 HR | Tier 2 | ST |
| PHOSPHATE
BINDERS | | |
| AURYXIA | Tier 2 | |
| <i>calcium
acetate(phosphat bind)</i> | Tier 1 | QL (360 EA per
30 days) |
| <i>lanthanum</i> | Tier 1 | PA; QL (90 EA
per 30 days) |
| <i>sevelamer carbonate
oral tablet</i> | Tier 1 | PA; QL (270
EA per 30
days) |
| <i>sevelamer hcl oral
tablet 400 mg</i> | Tier 1 | PA; QL (90 EA
per 30 days) |
| PHOSPHATE
BINDERS - CALCIUM-
BASED | | |
| <i>calcium
acetate(phosphat bind)</i> | Tier 1 | QL (360 EA per
30 days) |
| PHOSPHATE
BINDERS - IRON-
BASED | | |
| AURYXIA | Tier 2 | |
| POLYCYSTIC KIDNEY
DISEASE -
VASOPRESSIN V2
RECEPTOR
ANTAGONISTS | | |
| JYNARQUE ORAL
TABLET 15 MG | Tier 4 | PA; QL (60 EA
per 30 days) |
| JYNARQUE ORAL
TABLET 30 MG | Tier 4 | PA; QL (30 EA
per 30 days) |
| PROSTATIC
HYPERTROPHY
AGENT - ALPHA-1-
ADRENOCEPTOR
ANTAGONISTS | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|------------------------------|
| <i>alfuzosin</i> | Tier 1 | |
| <i>silodosin</i> | Tier 1 | |
| <i>tamsulosin</i> | Tier 1 | |
| PROSTATIC
HYPERTROPHY
AGENT - TYPE II 5-
ALPHA REDUCTASE
INHIBITORS | | |
| <i>finasteride oral tablet 5
mg</i> | Tier 1 | |
| PROSTATIC
HYPERTROPHY
AGENT-SEL.CGMP
PHOSPHODIESTERAS
E TYPE5 INHIBITOR | | |
| <i>tadalafil oral tablet 5 mg</i> | Tier 1 | PA; QL (8 EA
per 30 days) |
| PROSTATIC
HYPERTROPHY
AGENT-TYPE I AND II
5-ALPHA
REDUCTASE
INHIBITORS | | |
| <i>dutasteride</i> | Tier 1 | ST |
| URINARY
ALKALINIZER -
CITRATES | | |
| <i>potassium citrate oral
tablet extended release</i> | Tier 1 | |
| URINARY
ANALGESICS | | |
| <i>phenazopyridine</i> | Tier 1 | |
| URINARY
ANTIBACTERIAL -
NITROFURAN
DERIVATIVES | | |
| <i>nitrofurantoin
macrocrystal</i> | Tier 1 | |
| <i>nitrofurantoin
monohyd/m-cryst</i> | Tier 1 | |
| <i>nitrofurantoin oral
suspension 25 mg/5 ml</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| URINARY ANTI-
INFECTIVE
METHENAMINE-
ANTISPAS-ANALG
COMBINATIONS | | |
| URETRON D-S | Tier 1 | |
| URO-SP | Tier 1 | |
| UTIRA-C | Tier 1 | |
| URINARY
ANTISPASMODIC -
ANTICHOL., M(3)
MUSCARINIC
SELECTIVE
(BLADDER) | | |
| <i>darifenacin</i> | Tier 1 | |
| <i>solifenacin</i> | Tier 1 | |
| URINARY
ANTISPASMODIC -
ANTICHOLINERGICS,
NON-SELECTIVE | | |
| ED-SPAZ | Tier 1 | |
| <i>hyoscyamine sulfate
oral</i> | Tier 1 | |
| <i>hyoscyamine sulfate
sublingual</i> | Tier 1 | |
| HYOSYNE | Tier 1 | |
| OSCIMIN | Tier 1 | |
| OSCIMIN SL | Tier 1 | |
| SYMAX-SR | Tier 1 | |
| URINARY
ANTISPASMODIC -
SMOOTH MUSCLE
RELAXANTS | | |
| <i>flavoxate</i> | Tier 1 | |
| <i>oxybutynin chloride oral
syrup</i> | Tier 1 | |
| <i>oxybutynin chloride oral
tablet 5 mg</i> | Tier 1 | |
| <i>oxybutynin chloride oral
tablet extended release
24hr</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>tolterodine oral
capsule, extended
release 24hr</i> | Tier 1 | ST |
| <i>tolterodine oral tablet</i> | Tier 1 | |
| <i>trospium</i> | Tier 1 | |
| URINARY RETENTION
THERAPY -
PARASYMPATHOMIM
ETIC AGENTS | | |
| <i>bethanechol chloride</i> | Tier 1 | |
| GOUT AND
HYPERURICEMIA
THERAPY | | |
| GOUT ACUTE
THERAPY -
ANTIMITOTICS | | |
| <i>colchicine (gout) oral
tablet</i> | Tier 1 | QL (1 EA per 1
day) |
| GOUT AND
HYPERURICEMIA -
ANTIMITOTIC-
URICOSURIC
COMBINATIONS | | |
| <i>probenecid-colchicine</i> | Tier 1 | ST |
| HYPERURICEMIA
THERAPY -
URICOSURICS | | |
| <i>probenecid</i> | Tier 1 | |
| HYPERURICEMIA
THERAPY - XANTHINE
OXIDASE INHIBITORS | | |
| <i>allopurinol oral tablet
100 mg, 300 mg</i> | Tier 1 | |
| <i>febuxostat</i> | Tier 1 | ST |
| HEMATOLOGICAL
AGENTS | | |
| ANTICOAGULANTS -
CITRATE-BASED | | |
| ACD SOLUTION A | Tier 2 | |
| ACD-A | Tier 2 | |
| <i>anticoag citrate phos
dextrose</i> | Tier 2 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| ANTICOAGULANTS - COUMARIN | | |
| JANTOVEN | Tier 1 | |
| <i>warfarin</i> | Tier 1 | |
| DIRECT FACTOR XA INHIBITORS | | |
| ELIQUIS | Tier 2 | |
| ELIQUIS DVT-PE TREAT 30D START | Tier 2 | |
| XARELTO DVT-PE TREAT 30D START | Tier 2 | QL (51 EA per 30 days) |
| XARELTO ORAL SUSPENSION FOR RECONSTITUTION | Tier 2 | PA |
| XARELTO ORAL TABLET | Tier 2 | |
| GRANULOCYTE COLONY-STIMULATING FACTOR (G-CSF) | | |
| ZARXIO | Tier 4 | PA |
| HEMATORHEOLOGIC AGENTS | | |
| <i>pentoxifylline</i> | Tier 1 | |
| HEMOSTATIC SYSTEMIC - ANTIFIBRINOLYTIC AGENTS | | |
| <i>tranexamic acid oral</i> | Tier 1 | |
| HEMOSTATIC TOPICAL AGENTS | | |
| MONSEL'S | Tier 2 | |
| SURGIFOAM TOPICAL SPONGE 12-7 MM | Tier 1 | |
| HEPARINS | | |
| <i>heparin (porcine) injection solution 5,000 unit/ml</i> | Tier 1 | |
| INDIRECT FACTOR XA INHIBITORS | | |
| <i>fondaparinux</i> | Tier 4 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| LOW MOLECULAR WEIGHT HEPARINS | | |
| <i>enoxaparin</i> | Tier 4 | |
| PLATELET AGGREGATION INHIB - CYCLOPENTYL-TRIAZOLO-PYRIMIDINES (CPTPS) | | |
| BRILINTA | Tier 2 | ST |
| PLATELET AGGREGATION INHIBITOR COMBINATIONS | | |
| <i>aspirin-dipyridamole</i> | Tier 1 | ST |
| PLATELET AGGREGATION INHIBITORS - PHOSPHODIESTERASE III INHIBITORS | | |
| <i>cilostazol</i> | Tier 1 | |
| PLATELET AGGREGATION INHIBITORS - QUINAZOLINE AGENTS | | |
| <i>anagrelide</i> | Tier 1 | |
| PLATELET AGGREGATION INHIBITORS - THIENOPYRIDINE AGENTS | | |
| <i>clopidogrel oral tablet 75 mg</i> | Tier 1 | |
| <i>prasugrel</i> | Tier 1 | |
| PLATELET AGGREGATION INHIB-PDESTERASE AND ADENOSINE DEAMINASE INHIBITR | | |
| <i>dipyridamole oral</i> | Tier 1 | |
| THROMBOPOIETIN RECEPTOR AGONISTS | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------------|
| PROMACTA ORAL
TABLET 12.5 MG | Tier 4 | PA; QL (90 EA
per 30 days) |
| PROMACTA ORAL
TABLET 25 MG | Tier 4 | PA; QL (30 EA
per 30 days) |
| PROMACTA ORAL
TABLET 50 MG, 75 MG | Tier 4 | PA; QL (60 EA
per 30 days) |
| IMMUNOSUPPRESSIVE AGENTS | | |
| IMMUNOSUPPRESSIVE - CALCINEURIN INHIBITORS | | |
| <i>cyclosporine modified</i> | Tier 1 | |
| <i>cyclosporine oral</i> | Tier 1 | |
| GENGRAF | Tier 1 | |
| <i>tacrolimus oral</i> | Tier 1 | |
| IMMUNOSUPPRESSIVE - INOSINE MONOPHOSPHATE DEHYDROGENASE INHIBITORS | | |
| <i>mycophenolate mofetil</i> | Tier 1 | |
| <i>mycophenolate sodium</i> | Tier 1 | |
| IMMUNOSUPPRESSIVE - MAMMALIAN TARGET OF RAPAMYCIN (MTOR) INHIBITORS | | |
| <i>everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg, 0.75 mg</i> | Tier 1 | |
| <i>sirolimus oral tablet</i> | Tier 1 | |
| IMMUNOSUPPRESSIVE - PURINE ANALOGS | | |
| <i>azathioprine</i> | Tier 1 | |
| LOCOMOTOR SYSTEM | | |
| ANTIMYASTHENIC AGENT - REVERSIBLE CHOLINESTERASE INHIBITORS | | |
| <i>pyridostigmine bromide oral syrup</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| <i>pyridostigmine bromide oral tablet 60 mg</i> | Tier 1 | |
| <i>pyridostigmine bromide oral tablet extended release</i> | Tier 1 | |
| SKELETAL MUSCLE RELAXANT - CENTRAL MUSCLE RELAXANTS | | |
| <i>baclofen oral tablet</i> | Tier 1 | |
| <i>carisoprodol oral tablet 350 mg</i> | Tier 1 | |
| <i>chlorzoxazone oral tablet 500 mg</i> | Tier 1 | |
| <i>cyclobenzaprine oral tablet 10 mg, 5 mg</i> | Tier 1 | |
| CYCLOTENS
STARTER | Tier 2 | |
| <i>metaxalone oral tablet 800 mg</i> | Tier 1 | |
| <i>methocarbamol oral tablet 500 mg, 750 mg</i> | Tier 1 | |
| <i>orphenadrine citrate oral</i> | Tier 1 | |
| <i>tizanidine oral tablet</i> | Tier 1 | |
| SKELETAL MUSCLE RELAXANT - DIRECT MUSCLE RELAXANTS | | |
| <i>dantrolene oral</i> | Tier 1 | |
| SKELETAL MUSCLE RELAXANT - OPIOID ANALGESIC COMBINATIONS | | |
| <i>carisoprodol-aspirin-codeine</i> | Tier 1 | |
| SKELETAL MUSCLE RELAXANT, SALICYLATE, AND OPIOID ANALGESIC COMB. | | |
| <i>carisoprodol-aspirin-codeine</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|------------------------------------|
| MEDICAL SUPPLIES
AND DURABLE
MEDICAL
EQUIPMENT (DME) | | |
| MEDICAL SUPPLIES
AND DME - BLOOD
COLLECTION
NEEDLES | | |
| MONOJECT BLOOD
COLLECTION | Tier 2 | |
| MEDICAL SUPPLIES
AND DME - CERVICAL
CAPS | | |
| FEMCAP | Tier 0 | QL (1 EA per
365 days) |
| MEDICAL SUPPLIES
AND DME -
DIAPHRAGMS | | |
| CAYA CONTOURED | Tier 0 | QL (1 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 60 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 65 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 70 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 75 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 80 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 85 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 90 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 95 | Tier 0 | QL (2 EA per
365 days) |
| MEDICAL SUPPLIES
AND DME - GLUCOSE
MONITORING TEST
SUPPLIES | | |
| DEXCOM G6
RECEIVER | Tier 2 | PA; QL (1 EA
per 1
LIFETIME) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|--|
| DEXCOM G6 SENSOR | Tier 2 | PA; QL (3 EA
per 30 days) |
| DEXCOM G6
TRANSMITTER | Tier 2 | PA; QL (1 EA
per 90 days) |
| FREESTYLE LIBRE 14
DAY READER | Tier 2 | PA; ST; QL (1
EA per 1
Lifetime) |
| FREESTYLE LIBRE 14
DAY SENSOR | Tier 2 | PA; ST; QL (2
EA per 28
days) |
| FREESTYLE LIBRE 2
READER | Tier 2 | PA; ST; QL (1
EA per 1
Lifetime) |
| FREESTYLE LIBRE 2
SENSOR | Tier 2 | PA; ST; QL (2
EA per 28
days) |
| MEDICAL SUPPLIES
AND DME - INSULIN
NEEDLES-SYRINGES
AND ADMIN
SUPPLIES | | |
| BD INSULIN SYRINGE
U-500 | Tier 2 | QL (400 EA per
30 days) |
| MEDICAL SUPPLIES
AND DME - NEEDLES
AND SYRINGES | | |
| BD FILTER NEEDLE-5
MICRON | Tier 2 | |
| <i>blunt needle, disposable
needle 18 x 1 1/2 "</i> | Tier 2 | |
| ECLIPSE SYRINGE
SYRINGE 3 ML 21
GAUGE X 1", 3 ML 25
GAUGE X 1" | Tier 2 | QL (400 EA per
30 days) |
| INTEGRA SYRINGE | Tier 2 | QL (400 EA per
30 days) |
| MAGELLAN SAFETY
SYRINGE | Tier 2 | QL (400 EA per
30 days) |
| MAGELLAN SYRINGE
SYRINGE 1 ML 27
GAUGE X 1/2" | Tier 2 | QL (400 EA per
30 days) |
| MAGELLAN
TUBERCULIN SAFETY
SYR | Tier 2 | QL (400 EA per
30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| MONOJECT CONTROL SYRINGE LUER | Tier 2 | QL (400 EA per 30 days) |
| MONOJECT HYPODERMIC NEEDLES NEEDLE 25 GAUGE X 1 1/2", 25 GAUGE X 1", 26 GAUGE X 1 1/2", 30 GAUGE X 3/4" | Tier 2 | |
| MONOJECT MAGELLAN SYRINGE | Tier 2 | QL (400 EA per 30 days) |
| MONOJECT REGULAR LUER SYRINGE 12 ML | Tier 2 | QL (400 EA per 30 days) |
| MONOJECT SAFETY SYRINGES SYRINGE 12 ML 21X 1 1/2", 3 ML 22 GAUGE X 1 1/2", 6 ML | Tier 2 | QL (400 EA per 30 days) |
| MONOJECT SYRINGE SYRINGE 3 ML, 6 ML, 6 ML 22 X 1 1/2" | Tier 2 | QL (400 EA per 30 days) |
| MONOJECT TB LUER LOK | Tier 2 | QL (400 EA per 30 days) |
| <i>safety needles</i> | Tier 2 | |
| SURGUARD2 SAFETY NEEDLE 18 GAUGE X 1 1/2", 18 GAUGE X 1", 19 GAUGE X 1 1/2", 19 GAUGE X 1", 20 GAUGE X 1 1/2", 20 GAUGE X 1", 21 GAUGE X 1 1/2", 21 GAUGE X 1", 22 GAUGE X 1 1/2", 22 GAUGE X 1", 23 GAUGE X 1 1/2", 25 GAUGE X 1 1/2", 25 GAUGE X 1", 25 GAUGE X 5/8", 26 GAUGE X 1/2", 27 GAUGE X 1/2", 30 GAUGE X 1 1/2" | Tier 2 | |
| SURGUARD2 SAFETY SYRINGE | Tier 2 | QL (400 EA per 30 days) |
| TOOMEY SYRINGE | Tier 2 | QL (400 EA per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| TUBERCULIN SYRINGE SYRINGE 1 ML 25 GAUGE X 1" | Tier 2 | QL (400 EA per 30 days) |
| ULTICARE SYRINGE 1 ML 25 GAUGE X 5/8" | Tier 2 | QL (400 EA per 30 days) |
| MEDICAL SUPPLIES AND DME - RESPIRATORY THERAPY SUPPLIES | | |
| AEROCHAMBER PLUS FLOW-VU,L MSK | Tier 2 | |
| AEROCHAMBER PLUS FLOW-VU,M MSK | Tier 2 | |
| AEROCHAMBER PLUS FLOW-VU,S MSK | Tier 2 | |
| AEROCHAMBER PLUS Z STAT LG MSK | Tier 2 | |
| AEROCHAMBER PLUS Z STAT MD MSK | Tier 2 | |
| AEROCHAMBER PLUS Z STAT SM MSK | Tier 2 | |
| BREATHERITE SPACER-MASK, NEO. | Tier 2 | |
| BREATHERITE SPACER-MASK,ADULT | Tier 2 | |
| BREATHERITE SPACER-MASK,CHILD | Tier 2 | |
| BREATHERITE SPACER-MASK,INFANT | Tier 2 | |
| BREATHERITE SPACER-MASK,S.CHLD | Tier 2 | |
| CLEVER CHOICE CHAMBER-LRG MASK | Tier 2 | |
| CLEVER CHOICE CHAMBER-MED MASK | Tier 2 | |
| CLEVER CHOICE CHAMBER-SM MASK | Tier 2 | |
| COMPACT SPACE CHAMBER-LRG MASK | Tier 2 | |
| COMPACT SPACE CHAMBER-MED MASK | Tier 2 | |

| Drug Name | Tier | Restrictions/
Limits |
|--------------------------------|--------|-------------------------|
| COMPACT SPACE CHAMBER-SM MASK | Tier 2 | |
| EASIVENT MASK LARGE | Tier 2 | |
| EASIVENT MASK MEDIUM | Tier 2 | |
| EASIVENT MASK SMALL | Tier 2 | |
| FLEXICHAMBER-LG CHILD MASK | Tier 2 | |
| FLEXICHAMBER-SM ADULT MASK | Tier 2 | |
| FLEXICHAMBER-SM CHILD MASK | Tier 2 | |
| LITE TOUCH-MEDIUM MASK | Tier 2 | |
| LITETOUCH-LARGE MASK | Tier 2 | |
| LITETOUCH-SMALL MASK | Tier 2 | |
| OPTICHAMBER ADULT MASK-LARGE | Tier 2 | |
| OPTICHAMBER DIAMOND LG MASK | Tier 2 | |
| OPTICHAMBER DIAMOND-MED MSK | Tier 2 | |
| OPTICHAMBER DIAMOND-SML MASK | Tier 2 | |
| PROCARE SPACER WITH ADULT MASK | Tier 2 | |
| PROCARE SPACER WITH CHILD MASK | Tier 2 | |
| SILICONE MASK - INFANT | Tier 2 | |
| SPACE CHAMBER WITH LARGE MASK | Tier 2 | |
| SPACE CHAMBER WITH MEDIUM MASK | Tier 2 | |
| SPACE CHAMBER WITH SMALL MASK | Tier 2 | |
| VORTEX VHC FROG MASK-CHILD | Tier 2 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| VORTEX VHC LADYBUG MASK-TODDLR | Tier 2 | |
| MEDICAL SUPPLY, FDB SUPERSET | | |
| MEDICAL SUPPLY, FDB SUPERSET | | |
| AEROCHAMBER PLUS FLOW-VU,L MSK | Tier 2 | |
| AEROCHAMBER PLUS FLOW-VU,M MSK | Tier 2 | |
| AEROCHAMBER PLUS FLOW-VU,S MSK | Tier 2 | |
| AEROCHAMBER PLUS Z STAT LG MSK | Tier 2 | |
| AEROCHAMBER PLUS Z STAT MD MSK | Tier 2 | |
| AEROCHAMBER PLUS Z STAT SM MSK | Tier 2 | |
| BD FILTER NEEDLE-5 MICRON | Tier 2 | |
| BD INSULIN SYRINGE U-500 | Tier 2 | QL (400 EA per 30 days) |
| <i>blunt needle, disposable needle 18 x 1 1/2 "</i> | Tier 2 | |
| BREATHERITE SPACER-MASK, NEO. | Tier 2 | |
| BREATHERITE SPACER-MASK,ADULT | Tier 2 | |
| BREATHERITE SPACER-MASK,CHILD | Tier 2 | |
| BREATHERITE SPACER-MASK,INFANT | Tier 2 | |
| BREATHERITE SPACER-MASK,S.CHLD | Tier 2 | |
| CAYA CONTOURED | Tier 0 | QL (1 EA per 365 days) |
| CLEVER CHOICE CHAMBER-LRG MASK | Tier 2 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------------|
| CLEVER CHOICE CHAMBER-MED MASK | Tier 2 | |
| CLEVER CHOICE CHAMBER-SM MASK | Tier 2 | |
| COMPACT SPACE CHAMBER-LRG MASK | Tier 2 | |
| COMPACT SPACE CHAMBER-MED MASK | Tier 2 | |
| COMPACT SPACE CHAMBER-SM MASK | Tier 2 | |
| DEXCOM G6 RECEIVER | Tier 2 | PA; QL (1 EA per 1 LIFETIME) |
| DEXCOM G6 SENSOR | Tier 2 | PA; QL (3 EA per 30 days) |
| DEXCOM G6 TRANSMITTER | Tier 2 | PA; QL (1 EA per 90 days) |
| EASIVENT MASK LARGE | Tier 2 | |
| EASIVENT MASK MEDIUM | Tier 2 | |
| EASIVENT MASK SMALL | Tier 2 | |
| ECLIPSE SYRINGE SYRINGE 3 ML 21 GAUGE X 1", 3 ML 25 GAUGE X 1" | Tier 2 | QL (400 EA per 30 days) |
| FEMCAP | Tier 0 | QL (1 EA per 365 days) |
| FLEXICHAMBER-LG CHILD MASK | Tier 2 | |
| FLEXICHAMBER-SM ADULT MASK | Tier 2 | |
| FLEXICHAMBER-SM CHILD MASK | Tier 2 | |
| FREESTYLE LIBRE 14 DAY READER | Tier 2 | PA; ST; QL (1 EA per 1 Lifetime) |
| FREESTYLE LIBRE 14 DAY SENSOR | Tier 2 | PA; ST; QL (2 EA per 28 days) |
| FREESTYLE LIBRE 2 READER | Tier 2 | PA; ST; QL (1 EA per 1 Lifetime) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------------|
| FREESTYLE LIBRE 2 SENSOR | Tier 2 | PA; ST; QL (2 EA per 28 days) |
| INTEGRA SYRINGE | Tier 2 | QL (400 EA per 30 days) |
| LITE TOUCH-MEDIUM MASK | Tier 2 | |
| LITETOUCH-LARGE MASK | Tier 2 | |
| LITETOUCH-SMALL MASK | Tier 2 | |
| MAGELLAN SAFETY SYRINGE | Tier 2 | QL (400 EA per 30 days) |
| MAGELLAN SYRINGE SYRINGE 1 ML 27 GAUGE X 1/2" | Tier 2 | QL (400 EA per 30 days) |
| MAGELLAN TUBERCULIN SAFETY SYR | Tier 2 | QL (400 EA per 30 days) |
| MONOJECT BLOOD COLLECTION | Tier 2 | |
| MONOJECT CONTROL SYRINGE LUER | Tier 2 | QL (400 EA per 30 days) |
| MONOJECT HYPODERMIC NEEDLES NEEDLE 25 GAUGE X 1 1/2", 25 GAUGE X 1", 26 GAUGE X 1 1/2", 30 GAUGE X 3/4" | Tier 2 | |
| MONOJECT MAGELLAN SYRINGE | Tier 2 | QL (400 EA per 30 days) |
| MONOJECT REGULAR LUER SYRINGE 12 ML | Tier 2 | QL (400 EA per 30 days) |
| MONOJECT SAFETY SYRINGES SYRINGE 12 ML 21X 1 1/2", 3 ML 22 GAUGE X 1 1/2", 6 ML | Tier 2 | QL (400 EA per 30 days) |
| MONOJECT SYRINGE SYRINGE 3 ML, 6 ML, 6 ML 22 X 1 1/2" | Tier 2 | QL (400 EA per 30 days) |
| MONOJECT TB LUER LOK | Tier 2 | QL (400 EA per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------|
| OPTICHAMBER
ADULT MASK-LARGE | Tier 2 | |
| OPTICHAMBER
DIAMOND LG MASK | Tier 2 | |
| OPTICHAMBER
DIAMOND-MED MSK | Tier 2 | |
| OPTICHAMBER
DIAMOND-SML MASK | Tier 2 | |
| PROCARE SPACER
WITH ADULT MASK | Tier 2 | |
| PROCARE SPACER
WITH CHILD MASK | Tier 2 | |
| <i>safety needles</i> | Tier 2 | |
| SILICONE MASK -
INFANT | Tier 2 | |
| SPACE CHAMBER
WITH LARGE MASK | Tier 2 | |
| SPACE CHAMBER
WITH MEDIUM MASK | Tier 2 | |
| SPACE CHAMBER
WITH SMALL MASK | Tier 2 | |
| SURGUARD2 SAFETY
NEEDLE 18 GAUGE X
1 1/2", 18 GAUGE X 1",
19 GAUGE X 1 1/2", 19
GAUGE X 1", 20
GAUGE X 1 1/2", 20
GAUGE X 1", 21
GAUGE X 1 1/2", 21
GAUGE X 1", 22
GAUGE X 1 1/2", 22
GAUGE X 1", 23
GAUGE X 1 1/2", 25
GAUGE X 1 1/2", 25
GAUGE X 1", 25
GAUGE X 5/8", 26
GAUGE X 1/2", 27
GAUGE X 1/2", 30
GAUGE X 1 1/2" | Tier 2 | |
| SURGUARD2 SAFETY
SYRINGE | Tier 2 | QL (400 EA per
30 days) |
| TOOMEY SYRINGE | Tier 2 | QL (400 EA per
30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------|
| TUBERCULIN
SYRINGE SYRINGE 1
ML 25 GAUGE X 1" | Tier 2 | QL (400 EA per
30 days) |
| ULTICARE SYRINGE 1
ML 25 GAUGE X 5/8" | Tier 2 | QL (400 EA per
30 days) |
| VORTEX VHC FROG
MASK-CHILD | Tier 2 | |
| VORTEX VHC
LADYBUG MASK-
TODDLR | Tier 2 | |
| WIDE-SEAL
DIAPHRAGM 60 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 65 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 70 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 75 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 80 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 85 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 90 | Tier 0 | QL (2 EA per
365 days) |
| WIDE-SEAL
DIAPHRAGM 95 | Tier 0 | QL (2 EA per
365 days) |
| METABOLIC
MODIFIERS | | |
| HYPERPARATHYROID
TREATMENT AGENTS
- VITAMIN D ANALOG-
TYPE | | |
| <i>calcitriol oral</i> | Tier 1 | |
| <i>doxercalciferol oral
capsule 0.5 mcg, 1 mcg</i> | Tier 1 | ST |
| PHARMACOEHNANC
ER - CYTOCHROME
P450 INHIBITORS | | |
| TYBOST | Tier 2 | |
| PHENYLKETONURIA(
PKU) TX AGENTS -
COFACTOR OF
PHENYLALANINE
HYDROXYLASE | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| <i>sapropterin</i> | Tier 4 | |
| MOUTH-THROAT-DENTAL - PREPARATIONS | | |
| DENTAL PRODUCT - FLUORIDE PREPARATIONS | | |
| DETA 5000 PLUS | Tier 1 | |
| <i>fluoride (sodium) dental cream</i> | Tier 1 | |
| <i>fluoride (sodium) dental gel</i> | Tier 1 | |
| <i>fluoride (sodium) dental paste</i> | Tier 1 | |
| <i>fluoride (sodium) oral</i> | Tier 0 | |
| LUDENT FLUORIDE | Tier 0 | |
| SF | Tier 1 | |
| SF 5000 PLUS | Tier 1 | |
| SODIUM FLUORIDE 5000 DRY MOUTH | Tier 1 | |
| SODIUM FLUORIDE 5000 PLUS | Tier 1 | |
| MOUTH AND THROAT - ANTIFUNGALS | | |
| <i>clotrimazole mucous membrane</i> | Tier 1 | |
| <i>nystatin oral suspension</i> | Tier 1 | |
| MOUTH AND THROAT - ANTISEPTICS | | |
| <i>chlorhexidine gluconate mucous membrane</i> | Tier 1 | |
| PAROEX ORAL RINSE | Tier 1 | |
| PERIOGARD | Tier 1 | |
| MOUTH AND THROAT - GLUCOCORTICOIDS | | |
| ORALONE | Tier 1 | |
| <i>triamcinolone acetonide dental</i> | Tier 1 | |
| MOUTH AND THROAT - LOCAL ANESTHETIC AMIDES | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------|
| <i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i> | Tier 1 | |
| LIDOCAINE VISCOUS | Tier 1 | QL (100 ML per 30 days) |
| MOUTH AND THROAT - SALIVA STIMULANTS | | |
| <i>cevimeline</i> | Tier 1 | ST |
| <i>pilocarpine hcl oral</i> | Tier 1 | |
| PERIODONTAL PRODUCT - TETRACYCLINE-TYPE, COLLAGENASE INHIBITORS | | |
| <i>doxycycline hyclate oral tablet 20 mg</i> | Tier 1 | |
| THERAPY FOR DROOLING- PRIMARY OR SECONDARY SIALORRHEA-ANTICHOLINERGIC | | |
| <i>glycopyrrolate oral solution</i> | Tier 1 | |
| MULTIPLE SCLEROSIS AGENTS | | |
| MULTIPLE SCLEROSIS AGENT - INTERFERONS | | |
| AVONEX INTRAMUSCULAR PEN INJECTOR KIT | Tier 4 | PA; QL (1 EA per 28 days) |
| AVONEX INTRAMUSCULAR SYRINGE KIT | Tier 4 | PA; QL (1 EA per 28 days) |
| EXTAVIA | Tier 4 | PA; QL (15 EA per 30 days) |
| REBIF (WITH ALBUMIN) | Tier 4 | PA; QL (6 ML per 30 days) |
| REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML | Tier 4 | PA; QL (6 ML per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-----------------------------------|
| REBIF REBIDOSE
SUBCUTANEOUS PEN
INJECTOR
8.8MCG/0.2ML-22
MCG/0.5ML (6) | Tier 4 | PA; QL (5 ML
per 30 days) |
| MULTIPLE
SCLEROSIS AGENT -
OTHERS | | |
| <i>dimethyl fumarate oral
capsule, delayed
release(dr/ec) 120 mg,
240 mg</i> | Tier 4 | PA; QL (60 EA
per 30 days) |
| <i>glatiramer
subcutaneous syringe
20 mg/ml</i> | Tier 4 | PA; QL (1 ML
per 28 days) |
| <i>glatiramer
subcutaneous syringe
40 mg/ml</i> | Tier 4 | PA; QL (12 ML
per 28 days) |
| GLATOPA
SUBCUTANEOUS
SYRINGE 20 MG/ML | Tier 4 | PA; QL (1 ML
per 28 days) |
| GLATOPA
SUBCUTANEOUS
SYRINGE 40 MG/ML | Tier 4 | PA; QL (12 ML
per 28 days) |
| VUMERITY | Tier 4 | PA; QL (120
EA per 30
days) |
| MULTIPLE
SCLEROSIS AGENT -
POTASSIUM
CHANNEL BLOCKER | | |
| <i>dalfampridine</i> | Tier 4 | PA; QL (60 EA
per 30 days) |
| MULTIPLE
SCLEROSIS AGENT -
PYRIMIDINE
SYNTHESIS
INHIBITORS | | |
| AUBAGIO | Tier 4 | PA; QL (30 EA
per 30 days) |
| MULTIPLE
SCLEROSIS AGENT -
SPHINGOSINE 1-
PHOSPHATE
RECEPTOR
MODULATOR | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------------|
| <i> fingolimod</i> | Tier 4 | PA; QL (30 EA
per 30 days) |
| ZEPOSIA | Tier 4 | PA |
| ZEPOSIA STARTER
PACK (7-DAY) | Tier 4 | PA; QL (1 EA
per 365 days) |
| OPHTHALMIC
AGENTS | | |
| MIOTICS -
CHOLINESTERASE
INHIBITORS | | |
| PHOSPHOLINE
IODIDE | Tier 4 | |
| MIOTICS - DIRECT
ACTING | | |
| <i>pilocarpine hcl
ophthalmic (eye)</i> | Tier 1 | |
| OPHTHALMIC -
ANTIBACTERIAL-
GLUCOCORTICOID
COMBINATIONS | | |
| <i>neomycin-bacitracin-
poly-hc</i> | Tier 1 | |
| <i>neomycin-polymyxin b-
dexameth</i> | Tier 1 | |
| <i>neomycin-polymyxin-hc
ophthalmic (eye)</i> | Tier 1 | |
| NEO-POLYCIN HC | Tier 1 | |
| <i>sulfacetamide-
prednisolone</i> | Tier 1 | |
| <i>tobramycin-
dexamethasone</i> | Tier 1 | |
| OPHTHALMIC -
ANTICHOLINERGICS | | |
| <i>atropine ophthalmic
(eye) drops</i> | Tier 1 | |
| <i>atropine ophthalmic
(eye) ointment</i> | Tier 1 | |
| <i>cyclopentolate</i> | Tier 1 | |
| HOMATROPAIRE | Tier 1 | |
| <i>tropicamide</i> | Tier 1 | |
| OPHTHALMIC -
ANTI-HISTAMINES | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| <i>azelastine ophthalmic (eye)</i> | Tier 1 | |
| <i>epinastine</i> | Tier 1 | |
| ZERVIAE | Tier 2 | |
| OPHTHALMIC - ANTI-INFLAMMATORY, GLUCOCORTICOIDS | | |
| <i>dexamethasone sodium phosphate ophthalmic (eye)</i> | Tier 1 | |
| <i>fluorometholone</i> | Tier 1 | |
| <i>loteprednol etabonate ophthalmic (eye) drops, suspension</i> | Tier 1 | |
| <i>prednisolone acetate</i> | Tier 1 | |
| <i>prednisolone sodium phosphate ophthalmic (eye)</i> | Tier 1 | |
| OPHTHALMIC - ANTI-INFLAMMATORY, IMMUNOMODULATORS | | |
| <i>cyclosporine ophthalmic (eye)</i> | Tier 1 | QL (60 EA per 30 days) |
| OPHTHALMIC - ANTI-INFLAMMATORY, NSAIDS | | |
| <i>bromfenac</i> | Tier 1 | |
| <i>diclofenac sodium ophthalmic (eye)</i> | Tier 1 | |
| <i>flurbiprofen sodium</i> | Tier 1 | |
| <i>ketorolac ophthalmic (eye) drops 0.4 %</i> | Tier 1 | QL (5 ML per 30 days) |
| <i>ketorolac ophthalmic (eye) drops 0.5 %</i> | Tier 1 | |
| OPHTHALMIC - BETA BLOCKERS-ADRENERGIC COMBINATIONS | | |
| <i>brimonidine-timolol</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|-------------------------|
| OPHTHALMIC - BETA BLOCKERS-CARBONIC ANHYDRASE INHIBITOR COMBINATIONS | | |
| <i>dorzolamide-timolol</i> | Tier 1 | |
| <i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i> | Tier 1 | |
| OPHTHALMIC - CARBONIC ANHYDRASE INHIBITORS | | |
| <i>dorzolamide</i> | Tier 1 | |
| OPHTHALMIC - DIAGNOSTIC AGENTS | | |
| BIOGLO | Tier 1 | |
| GLOSTRIPS
OPHTHALMIC (EYE)
STRIP 1 MG | Tier 1 | |
| OPHTHALMIC - INTRAOCULAR PRESSURE REDUCING AGENTS, BETA-BLOCKERS | | |
| <i>betaxolol ophthalmic (eye)</i> | Tier 1 | |
| <i>carteolol</i> | Tier 1 | |
| <i>levobunolol</i> | Tier 1 | |
| <i>timolol maleate (pf) ophthalmic (eye) dropperette 0.25 %</i> | Tier 1 | |
| <i>timolol maleate ophthalmic (eye) drops</i> | Tier 1 | |
| <i>timolol maleate ophthalmic (eye) gel forming solution</i> | Tier 1 | |
| TIMOPTIC OCUDOSE (PF) OPHTHALMIC (EYE) DROPPERETTE 0.25 % | Tier 2 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| OPHTHALMIC -
IRRIGATION
SOLUTIONS | | |
| BALANCED SALT | Tier 1 | |
| BSS | Tier 1 | |
| OPHTHALMIC -
LOCAL ANESTHETIC
ESTERS | | |
| <i>proparacaine</i> | Tier 1 | |
| OPHTHALMIC - MAST
CELL STABILIZERS | | |
| ALOMIDE | Tier 2 | |
| <i>cromolyn ophthalmic
(eye)</i> | Tier 1 | |
| OPHTHALMIC -
SURGICAL AIDS
OTHER | | |
| OCUCOAT | Tier 1 | |
| OPHTHALMIC -
VISCOELASTIC
AGENTS | | |
| BIOLON | Tier 1 | |
| OPHTHALMIC
ANTIBACTERIAL
MIXTURES | | |
| <i>bacitracin-polymyxin b</i> | Tier 1 | |
| <i>neomycin-bacitracin-
polymyxin</i> | Tier 1 | |
| <i>neomycin-polymyxin-
gramicidin</i> | Tier 1 | |
| NEO-POLYCIN | Tier 1 | |
| POLYCIN | Tier 1 | |
| <i>polymyxin b sulf-
trimethoprim</i> | Tier 1 | |
| OPHTHALMIC
ANTIBIOTIC -
AMINOGLYCOSIDES | | |
| <i>gentamicin ophthalmic
(eye)</i> | Tier 1 | |
| <i>tobramycin ophthalmic
(eye)</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|---------------------------|
| OPHTHALMIC
ANTIBIOTIC -
DEHYDROPEPTIDASE
INHIBITORS | | |
| <i>bacitracin ophthalmic
(eye)</i> | Tier 1 | |
| OPHTHALMIC
ANTIBIOTIC -
FLUOROQUINOLONE
S | | |
| <i>ciprofloxacin hcl
ophthalmic (eye)</i> | Tier 1 | |
| <i>gatifloxacin</i> | Tier 1 | |
| <i>levofloxacin ophthalmic
(eye)</i> | Tier 1 | |
| <i>moxifloxacin ophthalmic
(eye)</i> | Tier 1 | |
| <i>ofloxacin ophthalmic
(eye)</i> | Tier 1 | QL (10 ML per
30 days) |
| OPHTHALMIC
ANTIBIOTIC -
MACROLIDES | | |
| AZASITE | Tier 2 | |
| <i>erythromycin
ophthalmic (eye)</i> | Tier 1 | |
| OPHTHALMIC
ANTIBIOTIC -
SULFONAMIDES | | |
| <i>sulfacetamide sodium
ophthalmic (eye) drops</i> | Tier 1 | |
| OPHTHALMIC
ANTIFUNGALS | | |
| NATACYN | Tier 2 | QL (15 ML per
30 days) |
| OPHTHALMIC
ANTIFUNGALS -
TETRAENE POLYENE-
TYPE | | |
| NATACYN | Tier 2 | QL (15 ML per
30 days) |
| OPHTHALMIC
ANTIVIRALS | | |
| <i>trifluridine</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| OPHTHALMIC-
INTRAOCULAR
PRESS. REDUCING,
SEL. ALPHA
ADRENERGIC
AGONISTS | | |
| <i>apraclonidine</i> | Tier 1 | |
| <i>brimonidine ophthalmic
(eye) drops 0.15 %, 0.2
%</i> | Tier 1 | |
| IOPIDINE | Tier 2 | |
| OPHTHALMIC-
INTRAOCULAR
PRESSURE
REDUCING AGENTS,
PROSTAGLANDIN
ANALOGS | | |
| <i>bimatoprost ophthalmic
(eye)</i> | Tier 1 | ST |
| <i>latanoprost</i> | Tier 1 | |
| <i>tafluprost (pf)</i> | Tier 1 | ST |
| <i>travoprost</i> | Tier 1 | ST |
| ORGAN
PRESERVATION
SOLUTIONS | | |
| CARDIOPLEGIC
SOLUTIONS | | |
| <i>cardioplegic soln</i> | Tier 1 | |
| OTIC (EAR) | | |
| OTIC (EAR) - ANTI-
INFECTIVE-
GLUCOCORTICOID
COMBINATIONS | | |
| CIPRO HC | Tier 3 | |
| <i>ciprofloxacin-
dexamethasone</i> | Tier 1 | ST |
| <i>ciprofloxacin-
fluocinolone</i> | Tier 2 | |
| <i>neomycin-polymyxin-hc
otic (ear)</i> | Tier 1 | |
| OTIC (EAR) - ANTI-
INFECTIVES OTHER | | |
| <i>acetic acid otic (ear)</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|---------------------------|
| OTIC (EAR) -
FLUOROQUINOLONE
S | | |
| <i>ciprofloxacin hcl otic
(ear)</i> | Tier 1 | |
| <i>ofloxacin otic (ear)</i> | Tier 1 | |
| OTIC (EAR) -
GLUCOCORTICIDS | | |
| <i>fluocinolone acetonide
oil</i> | Tier 1 | |
| <i>hydrocortisone-acetic
acid</i> | Tier 1 | QL (10 ML per
30 days) |
| RENAL
REPLACEMENT
THERAPY | | |
| PERITONEAL
DIALYSIS SOLUTIONS | | |
| DELFLEX WITH 2.5 %
DEXTROSE | Tier 1 | |
| DELFLEX-LC/1.5%
DEXTROSE | Tier 1 | |
| DELFLEX-LC/2.5%
DEXTROSE | Tier 1 | |
| DELFLEX-LC/4.25%
DEXTROSE | Tier 1 | |
| EXTRANAL 7.5 % | Tier 2 | |
| RESPIRATORY
THERAPY AGENTS | | |
| 1ST GENERATION
ANTIHISTAMINE-
DECONGESTANT
COMBINATIONS | | |
| PROMETHAZINE VC | Tier 1 | |
| ANTIHISTAMINE - 1ST
GENERATION -
ALKYLAMINES | | |
| <i>dexchlorpheniramine
maleate</i> | Tier 1 | |
| ANTIHISTAMINE - 1ST
GENERATION -
ETHANOLAMINES | | |
| <i>carbinoxamine maleate
oral liquid</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------|
| <i>carbinoxamine maleate oral tablet 4 mg</i> | Tier 1 | |
| <i>carbinoxamine maleate oral tablet 6 mg</i> | Tier 1 | ST |
| <i>clemastine oral tablet 2.68 mg</i> | Tier 1 | |
| ANTIHISTAMINE - 1ST GENERATION - PHENOTHIAZINES | | |
| <i>promethazine oral</i> | Tier 1 | |
| <i>promethazine rectal</i> | Tier 1 | |
| PROMETHEGAN | Tier 1 | |
| ANTIHISTAMINE - 1ST GENERATION - PIPERIDINES | | |
| <i>ciproheptadine</i> | Tier 1 | |
| ANTIHISTAMINES - 1ST GENERATION | | |
| <i>carbinoxamine maleate oral liquid</i> | Tier 1 | |
| <i>carbinoxamine maleate oral tablet 4 mg</i> | Tier 1 | |
| <i>carbinoxamine maleate oral tablet 6 mg</i> | Tier 1 | ST |
| <i>clemastine oral tablet 2.68 mg</i> | Tier 1 | |
| <i>ciproheptadine</i> | Tier 1 | |
| <i>dexchlorpheniramine maleate</i> | Tier 1 | |
| <i>promethazine oral</i> | Tier 1 | |
| <i>promethazine rectal</i> | Tier 1 | |
| PROMETHEGAN | Tier 1 | |
| ANTIHISTAMINES - 2ND GENERATION | | |
| <i>desloratadine oral tablet</i> | Tier 1 | ST; QL (30 EA per 30 days) |
| <i>levocetirizine oral solution</i> | Tier 1 | |
| ANTIHISTAMINES - 2ND GENERATION - PIPERAZINES | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| <i>levocetirizine oral solution</i> | Tier 1 | |
| ANTIHISTAMINES - 2ND GENERATION - PIPERIDINES | | |
| <i>desloratadine oral tablet</i> | Tier 1 | ST; QL (30 EA per 30 days) |
| ANTITUSSIVES - NON-OPIOID | | |
| <i>benzonatate oral capsule 100 mg, 200 mg</i> | Tier 1 | QL (4 EA per 1 day) |
| <i>benzonatate oral capsule 150 mg</i> | Tier 1 | |
| ASTHMA THERAPY - 5-LIPOXYGENASE INHIBITORS | | |
| <i>zileuton</i> | Tier 1 | ST |
| ASTHMA THERAPY - INHALED CORTICOSTEROIDS (GLUCOCORTICOIDS) | | |
| ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION | Tier 3 | QL (13 GM per 30 days) |
| ALVESCO INHALATION HFA AEROSOL INHALER 80 MCG/ACTUATION | Tier 3 | QL (7 GM per 30 days) |
| ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION | Tier 2 | QL (1 EA per 30 days) |
| ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 50 MCG/ACTUATION | Tier 2 | QL (30 EA per 30 days) |
| ASMANEX HFA | Tier 2 | QL (13 GM per 30 days) |
| <i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i> | Tier 1 | QL (120 ML per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>budesonide inhalation suspension for nebulization 1 mg/2 ml</i> | Tier 1 | QL (60 ML per 30 days) |
| FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION | Tier 2 | QL (1 EA per 30 days) |
| FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION | Tier 2 | QL (4 EA per 30 days) |
| FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 50 MCG/ACTUATION | Tier 2 | QL (60 EA per 30 days) |
| FLOVENT HFA INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION | Tier 2 | QL (12 GM per 30 days) |
| FLOVENT HFA INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION | Tier 2 | QL (24 GM per 30 days) |
| FLOVENT HFA INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION | Tier 2 | QL (11 GM per 30 days) |
| <i>fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation</i> | Tier 2 | QL (12 GM per 30 days) |
| <i>fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation</i> | Tier 2 | QL (24 GM per 30 days) |
| <i>fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation</i> | Tier 2 | QL (11 GM per 30 days) |
| QVAR REDHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION | Tier 2 | QL (11 GM per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|------------------------------|
| QVAR REDHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION | Tier 2 | QL (22 GM per 30 days) |
| ASTHMA THERAPY - INTERLEUKIN-4 (IL-4) RECEPTOR ALPHA ANTAGONISTS, MAB | | |
| DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML | Tier 4 | PA; QL (400 MG per 30 days) |
| DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML | Tier 4 | PA; QL (600 MG per 30 days) |
| DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML | Tier 4 | PA; QL (1.34 ML per 30 days) |
| DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML | Tier 4 | PA; QL (400 MG per 30 days) |
| DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML | Tier 4 | PA; QL (600 MG per 30 days) |
| ASTHMA THERAPY - LEUKOTRIENE RECEPTOR ANTAGONISTS | | |
| <i>montelukast</i> | Tier 1 | |
| <i>zafirlukast</i> | Tier 1 | ST |
| ASTHMA THERAPY - MAST CELL STABILIZERS | | |
| <i>cromolyn inhalation</i> | Tier 1 | QL (8 ML per 1 day) |
| ASTHMA THERAPY - XANTHINES | | |
| ELIXOPHYLLIN | Tier 2 | |
| THEO-24 | Tier 2 | |
| <i>theophylline oral elixir</i> | Tier 1 | |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-------------------------|
| <i>theophylline oral solution</i> | Tier 1 | |
| <i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i> | Tier 1 | |
| <i>theophylline oral tablet extended release 24 hr</i> | Tier 1 | |
| ASTHMA/COPD - ANTICHOLINERGIC AGENTS, INHALED LONG ACTING | | |
| SPIRIVA RESPIMAT | Tier 2 | QL (4 GM per 30 days) |
| ASTHMA/COPD - ANTICHOLINERGIC AGENTS, INHALED SHORT ACTING | | |
| ATROVENT HFA | Tier 2 | QL (26 GM per 30 days) |
| <i>ipratropium bromide inhalation</i> | Tier 1 | QL (10 ML per 1 day) |
| ASTHMA/COPD - BETA 2-ADRENERGIC AGENTS, INHALED, ULTRA-LONG ACTING | | |
| STRIVERDI RESPIMAT | Tier 2 | QL (4 GM per 30 days) |
| ASTHMA/COPD THERAPY - BETA 2-ADRENERGIC AGENTS, INHALED, LONG ACTING | | |
| SEREVENT DISKUS | Tier 2 | QL (60 EA per 30 days) |
| ASTHMA/COPD THERAPY - BETA 2-ADRENERGIC AGENTS, INHALED, SHORT ACTING | | |
| <i>albuterol sulfate inhalation hfa aerosol inhaler</i> | Tier 1 | QL (17 GM per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|----------------------------|
| <i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %)</i> | Tier 1 | QL (375 ML per 30 days) |
| <i>albuterol sulfate inhalation solution for nebulization 2.5 mg/0.5 ml</i> | Tier 1 | QL (2 EA per 1 day) |
| <i>albuterol sulfate inhalation solution for nebulization 5 mg/ml</i> | Tier 1 | QL (2 ML per 1 day) |
| <i>levalbuterol tartrate</i> | Tier 2 | QL (30 GM per 30 days) |
| ASTHMA/COPD THERAPY - BETA ADRENERGIC AGENTS | | |
| <i>albuterol sulfate oral</i> | Tier 1 | |
| <i>terbutaline oral</i> | Tier 1 | |
| ASTHMA/COPD THERAPY - BETA ADRENERGIC-ANTICHOLINERGIC COMBINATIONS | | |
| COMBIVENT RESPIMAT | Tier 2 | QL (8 GM per 30 days) |
| <i>ipratropium-albuterol</i> | Tier 1 | QL (540 ML per 30 days) |
| STIOLTO RESPIMAT | Tier 2 | QL (4 GM per 30 days) |
| ASTHMA/COPD THERAPY - BETA ADRENERGIC-GLUCOCORTICOID COMBINATIONS | | |
| BREO ELLIPTA INHALATION BLISTER WITH DEVICE 100-25 MCG/DOSE, 200-25 MCG/DOSE | Tier 3 | PA; QL (60 EA per 30 days) |
| <i>budesonide-formoterol</i> | Tier 2 | PA; QL (11 GM per 30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|--|--------|-----------------------------------|
| DULERA INHALATION
HFA AEROSOL
INHALER 100-5
MCG/ACTUATION | Tier 2 | PA; QL (1 GM
per 30 days) |
| DULERA INHALATION
HFA AEROSOL
INHALER 200-5
MCG/ACTUATION, 50-
5 MCG/ACTUATION | Tier 2 | PA; QL (13 GM
per 30 days) |
| <i>fluticasone propion-
salmeterol inhalation
aerosol powdr breath
activated</i> | Tier 2 | QL (1 EA per
30 days) |
| <i>fluticasone propion-
salmeterol inhalation
blister with device</i> | Tier 1 | QL (1 EA per
30 days) |
| ASTHMA/COPD TX -
BETA-ADRENERGIC-
ANTICHOLINERGIC-
GLUCOCORTICOID
COMB, | | |
| TRELEGY ELLIPTA | Tier 2 | QL (60 EA per
30 days) |
| CYSTIC FIBROSIS -
INHALED
AMINOGLYCOSIDES | | |
| <i>tobramycin in 0.225 %
nacl</i> | Tier 4 | PA; QL (280
ML per 30
days) |
| <i>tobramycin inhalation</i> | Tier 4 | PA; QL (224
ML per 30
days) |
| <i>tobramycin with
nebulizer</i> | Tier 4 | PA; QL (280
ML per 30
days) |
| CYSTIC FIBROSIS -
INHALED
MONOBACTAMS | | |
| CAYSTON | Tier 4 | PA; QL (84 ML
per 30 days) |
| CYSTIC FIBROSIS-
TRANSMEMBRANE
CONDUCTANCE
REGULATOR (CFTR)
POTENTIATOR | | |

| Drug Name | Tier | Restrictions/
Limits |
|--|---------|-----------------------------------|
| KALYDECO ORAL
GRANULES IN
PACKET 25 MG, 50
MG, 75 MG | Tier 4 | PA; QL (56 EA
per 30 days) |
| KALYDECO ORAL
TABLET | Tier 4 | PA; QL (60 EA
per 30 days) |
| CYSTIC FIB-
TRANSMEMB
CONDUCT.
REG.(CFTR)
POTENTIATOR AND
CORRECTOR CMB | | |
| ORKAMBI ORAL
GRANULES IN
PACKET 100-125 MG,
150-188 MG | Tier 4 | PA; QL (56 EA
per 30 days) |
| ORKAMBI ORAL
GRANULES IN
PACKET 75-94 MG | Tier 4 | PA |
| ORKAMBI ORAL
TABLET | Tier 4 | PA; QL (112
EA per 30
days) |
| TRIKAFTA ORAL
TABLETS,
SEQUENTIAL 100-50-
75 MG(D) /150 MG (N) | Tier 4 | PA; QL (84 EA
per 30 days) |
| TRIKAFTA ORAL
TABLETS,
SEQUENTIAL 50-25-
37.5 MG (D)/75 MG (N) | Tier 4 | PA |
| ELASTASE
INHIBITORS | | |
| PROLASTIN-C | Tier 10 | |
| MUCOLYTICS | | |
| <i>acetylcysteine</i> | Tier 1 | |
| PULMOZYME | Tier 4 | PA; QL (2.5 ML
per 1 day) |
| NASAL
ANTICHOLINERGICS | | |
| <i>ipratropium bromide
nasal</i> | Tier 1 | QL (30 ML per
30 days) |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| NASAL ANTIHISTAMINE AND ANTI-INFLAMMATORY STEROID COMBINATIONS | | |
| <i>azelastine-fluticasone</i> | Tier 1 | ST; QL (23 GM per 30 days) |
| NASAL ANTIHISTAMINES | | |
| <i>azelastine nasal aerosol, spray</i> | Tier 1 | QL (60 ML per 30 days) |
| <i>azelastine nasal spray, non-aerosol</i> | Tier 1 | |
| <i>olopatadine nasal</i> | Tier 1 | QL (31 GM per 30 days) |
| NASAL CORTICOSTEROIDS | | |
| <i>flunisolide</i> | Tier 1 | ST; QL (50 ML per 30 days) |
| <i>mometasone nasal</i> | Tier 1 | ST; QL (17 GM per 30 days) |
| NON-OPIOID ANTITUSSIVE-1ST GEN.ANTIHISTAMINE-DECONGESTANT COMBINATIONS | | |
| <i>brompheniramine-pseudoeph-dm</i> | Tier 1 | |
| NON-OPIOID ANTITUSSIVE-ANTIHISTAMINE COMBINATIONS | | |
| <i>promethazine-dm</i> | Tier 1 | |
| OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE COMBINATIONS | | |
| <i>hydrocodone-chlorpheniramine</i> | Tier 1 | |
| <i>promethazine-codeine</i> | Tier 1 | |
| OPIOID ANTITUSSIVE-1ST GENERATION ANTIHISTAMINE-DECONGESTANT COMB. | | |

| Drug Name | Tier | Restrictions/
Limits |
|---|--------|----------------------------|
| PROMETHAZINE VC-CODEINE | Tier 1 | |
| OPIOID ANTITUSSIVE-ANTICHOLINERGIC COMBINATIONS | | |
| HYDROMET | Tier 1 | QL (4 ML per 1 day) |
| PULMONARY FIBROSIS TREATMENT AGENTS - MULTIKINASE INHIBITORS | | |
| OFEV | Tier 4 | PA; QL (60 EA per 30 days) |
| VAGINAL PRODUCTS | | |
| VAGINAL ANTIBACTERIAL - LINCOSAMIDES | | |
| CLEOCIN VAGINAL SUPPOSITORY | Tier 2 | |
| <i>clindamycin phosphate vaginal</i> | Tier 1 | |
| VAGINAL ANTIFUNGAL - TRIAZOLES | | |
| <i>terconazole</i> | Tier 1 | |
| VAGINAL ANTIPROTOZOAL-ANTIBACTERIAL - NITROIMIDAZOLE DERIVATIVES | | |
| <i>metronidazole vaginal</i> | Tier 1 | QL (70 GM per 30 days) |
| VANDAZOLE | Tier 1 | QL (70 GM per 30 days) |
| VAGINAL ESTROGENS | | |
| <i>estradiol vaginal tablet</i> | Tier 1 | |
| VAGINAL PROGESTINS | | |
| CRINONE VAGINAL GEL 4 % | Tier 2 | |

| Drug Name | Tier | Restrictions/
Limits |
|-----------|---------|-------------------------|
| BEYFORTUS | Tier 10 | PA |
| FASENRA | Tier 10 | PA |

| Drug Name | Tier | Restrictions/
Limits |
|-------------|---------|------------------------------|
| FASENRA PEN | Tier 10 | PA |
| SYNAGIS | Tier 10 | PA; QL (2 ML
per 28 days) |

A

| | | | | | |
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| <i>abacavir</i> | 11 | <i>alogliptin-pioglitazone</i> | 54 | <i>atenolol-chlorthalidone</i> | 24 |
| <i>abacavir-lamivudine</i> | 12 | ALOMIDE | 74 | <i>atomoxetine</i> | 33 |
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| <i>adapalene-benzoyl peroxide</i> | 43 | <i>amoxicil-clarithromy-lansopraz</i> | 59 | AYUNA | 39 |
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ENGLISH - Language assistance services, free of charge, are available to you. Call: **1-833-230-2099** (TTY: 711).



SPANISH - Servicios gratuitos de asistencia lingüística, sin cargo, disponibles para usted. Llame al: 1-833-230-2099 (TTY: 711).

NEPALI - तपाईंका निम्ति निःशुल्क भाषा सहायता सेवाहरू उपलब्ध छन् । फोन गर्नुहोस्: 1-833-230-2099 (TTY: 711).

KOREAN - 언어 지원 서비스가 무료로 제공됩니다. 전화: 1-833-230-2099 (TTY: 711).

FRENCH - Services d'aide linguistique offerts sans frais. Composez le 1-833-230-2099 (TTY: 711).

GERMAN - Es stehen Ihnen kostenlose Sprachassistenzen zur Verfügung. Anrufen unter: 1-833-230-2099 (TTY: 711).

SIMPLIFIED CHINESE -

可为您提供免费的语言协助服务。请致电: 1-833-230-2099 (TTY: 711).

TELUGU - భాషా సాయం సర్వీసులు, మీకు ఉచితంగా లభ్యమవుతాయి. కాల్ చేయండి: 1-833-230-2099 (TTY: 711).

BURMESE - ဘာသာစကားဆိုင်ရာအကူအညီဝန်ဆောင်မှုများအား သင့်အတွက် အခမဲ့ ရရှိနိုင်ပါသည်။ ဖုန်းခေါ်ရန်: 1-833-230-2099 (TTY: 711).

ARABIC - تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل على الرقم: 1-833-230-2099 (هاتف نصي: 711).

URDU - زبان کی معاونتی ترجمانی خدمات، آپ کے لیے بالکل مفت یا - فری آف چارج دستیاب ہیں۔ کال کریں: 1-833-230-2099 (TTY: 711)

PENNSYLVANIA DUTCH - Mir kenne dich Hilf griege mit Deutsch, unni as es dich ennich eppes koschte zellt. Ruf 1-833-230-2099 (TTY: 711) uff.

RUSSIAN - Вам доступны бесплатно услуги языкового сопровождения. Позвоните по номеру: 1-833-230-2099 (TTY: 711).

TAGALOG - May mga serbisyong tulong sa wika, na walang bayad, na magagamit mo. Tumawag sa: 1-833-230-2099 (TTY: 711).

VIETNAMESE - Dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi: 1-833-230-2099 (TTY: 711).

GUJARATI - ભાષા સહાય સેવાઓ તમારા માટે નિઃશુલ્ક છે. 1-833-230-2099 (TTY: 711) પર કોલ કરો.

PORTUGUESE - Serviços linguísticos gratuitos disponíveis para você. Ligue para: 1-833-230-2099 (TTY: 711).

MARSHALLESE - Jerbal in jibañ ikijen kajin, ejelok onean, ej bellok ñan eok. Kurlok: 1-833-230-2099 (TTY: 711).

NOTICE OF NON-DISCRIMINATION

CareSource complies with applicable state and federal civil rights laws. We do not discriminate, exclude people, or treat them differently because of age, gender, gender identity, color, race, disability, national origin, ethnicity, marital status, sexual preference, sexual orientation, religious affiliation, health status, or public assistance status.

CareSource offers free aids and services to people with disabilities or those whose primary language is not English. We can get sign language interpreters or interpreters in other languages so they can communicate effectively with us or their providers. Printed materials are also available in large print, braille, or audio at no charge. Please call Member Services at the number on your CareSource ID card if you need any of these services.

If you believe we have not provided these services to you or discriminated in another way, you may file a grievance.

Mail: CareSource, Attn: Civil Rights Coordinator
P.O. Box 1947, Dayton, Ohio 45401

Email: CivilRightsCoordinator@CareSource.com

Phone: 1-844-539-1732

Fax: 1-844-417-6254

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights.

Mail: U.S. Dept. of Health and Human Services
200 Independence Ave, SW Room 509F

HHH Building Washington, D.C. 20201

Phone: 1-800-368-1019 (TTY: 1-800-537-7697)

Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are found at:

www.hhs.gov/ocr/office/file/index.html





Administrative Policy Statement MARKETPLACE

| Policy Name | Policy Number | Date Effective |
|---------------------------|----------------|------------------------|
| Non-Formulary Medications | PAD-0028-MPP | 7/13/2023 |
| Policy Type | | |
| Medical | ADMINISTRATIVE | Pharmacy Reimbursement |

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Clinically appropriate services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Clinically appropriate services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

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A. Subject

Non-Formulary Medications

B. Background

CareSource uses a Marketplace Formulary Drug List that is established, reviewed, and approved by a Pharmacy and Therapeutics (P&T) Committee and applicable state and federal regulatory agencies. Drugs on the Marketplace Formulary Drug List are classified into tiers as explained in the Member's Evidence of Coverage (EOC). The Marketplace Formulary Drug List is reviewed routinely for addition or deletion of drugs and for movement of drugs from one tier to another. Drugs may be added to or deleted from the Marketplace Formulary Drug List in response to new clinical evidence related to safety or efficacy for the drug in question or for a comparable drug with the same indication for use. CareSource will follow the guidance of the state Marketplace programs in the states that it services to enforce clinically appropriate, low cost drugs as first line therapy through the use of the Marketplace Formulary Drug List.

The intent of CareSource Pharmacy Policy Statements is to encourage clinically appropriate and cost-effective selection of drug therapy for members according to product labeling, clinical guidelines, and/or clinical studies as well as to encourage use of drugs on the Marketplace Formulary Drug List.

NOTE: *The Introduction section is for your general knowledge and is not to be construed as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals and is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider can also be a place where medical care is given, like a hospital, clinic or lab. This policy informs providers about when a service may be covered.*

C. Definitions

- **Clinical Judgment** – Decisions made within the scope of the expertise of a pharmacist following the review of subjective and objective medical data for a member. A pharmacist can use Clinical Judgment for a benefit determination for an exception request for a Non-Formulary Drug. If the request is outside the scope of a pharmacist's expertise, a benefit determination will be made in collaboration with a medical director.
- **Clinically Adequate Trials** – Trials of prior drug therapies indicated to treat a member's condition based on FDA-approved indications, evidence-based guidelines, evidence-based clinical literature, and peer-reviewed studies, and benefit design on the Marketplace Formulary Drug List. A clinically adequate trial must be of a sufficient duration and/or dose for treatment of the member's condition based on appropriate FDA labeling and/or compendia guidance as determined by a licensed physician or pharmacist engaged in utilization management reviews on behalf of CareSource.
- **Marketplace Formulary Drug List** (i.e., Marketplace Drug Formulary, Formulary) – A list of prescription drugs which includes a group of selected generic and brand-name drugs which are covered by CareSource at the designated member cost share in the member's EOC. The Marketplace Formulary Drug List is based on evidence based guidelines, FDA-approved indications, evidence-based clinical literature, and peer-reviewed studies, and benefit design. The Marketplace Formulary Drug List is reviewed and approved by the Pharmacy & Therapeutics Committee composed of practicing physicians, pharmacists and other health care professionals as required by 45 CFR §156.122(a)(3)(i)(B).



- **Potential Covered Alternatives** – Drugs that share the same clinical indication or are positioned similarly in FDA labelling, clinical guidelines, and/or clinical trials.
- **Submitted Documentation** – Information provided by the prescriber that includes, but is not limited to, chart notes specific to member's condition, previous treatments, and the provider's rationale. Documentation of previous treatments must include the dates of the treatment trial.
- **Therapeutic Failure** – Failure to accomplish the goals of treatment following a clinically adequate trial. Therapeutic failure can include an allergic reaction, lack of physiologic response, and/or intolerable adverse reaction to a drug.

D. Policy

CareSource will approve the use of non-formulary drugs (i.e. drugs that are not on the Marketplace Formulary Drug List) when the criteria below have been met. This policy will not supersede drug-specific criteria developed and approved by the P&T Committee nor drug or therapeutic category benefit exclusions. Drug and therapeutic category benefit exclusions can be found in the member's EOC. Formulary exception requests should be submitted for each non-formulary medication and should include chart notes and documentation.

Use of non-formulary drugs will be approved when the following criteria are met:

- I. The drug is being used for an FDA approved indication or meets the criteria laid out in the **Off Label** policy, AND
- II. The requested dose of the drug is based on FDA approved labeling for the member's age and indication, AND
- III. The submitted documentation includes ONE of the following:
 - A. Documentation of clinically adequate trial and therapeutic failure of:
 1. At least 3 potential covered alternatives that are included on the Marketplace Formulary Drug List, OR
 2. If fewer than 3 potential covered alternatives are available on the Marketplace Formulary Drug List, then all of the available alternatives must be tried, AND
 - B. If the member was enrolled with CareSource at the time of the treatment trial, the documentation must be supported by paid claims, OR
 - C. Documentation of contraindication to ALL of the alternative drugs on the Marketplace Formulary Drug List based on the member's diagnosis, medical conditions, and/or other medication therapies, OR
 - D. In the absence of a clinically adequate trial, documentation of clinical reasons why the alternative drugs on the Marketplace Formulary Drug List are expected to be ineffective or less effective than the non-formulary drug. Documented clinical reasons are subject to the clinical judgement of the reviewing pharmacist or physician, AND



If the request is for a combination product, the submitted documentation includes a clinical reason why the member is unable to take the active ingredients of the combination product separately as individually prescribed medications, AND **NOTE:** *This criteria is waived if the separate active ingredients are not included on the Marketplace Formulary Drug List.*

- IV. If the request is for a long-acting formulation, the submitted documentation includes a clinical reason why the member is unable to use the immediate-release formulation of the drug, AND
NOTE: *This criteria is waived if the immediate-release formulation is not included on the Marketplace Formulary Drug List.*
- V. If the request is for a multi-source branded drug, the submitted documentation includes trial and therapeutic failure of a minimum of two generic manufacturers of the requested brand name medication. The submitted documentation must include information about the therapeutic failure that was experienced by the member for each generic manufacturer and is subject to the clinical judgement of the reviewing pharmacist or physician.

Limitations of Scope:

- Requests for drugs that are provider administered or that are otherwise billed through the medical benefit should meet the criteria in the Marketplace **Medical Benefit Medications** policy.

E. Conditions of Coverage

Applicable NDCs

AUTHORIZATION PERIOD – 1 year unless otherwise determined by the clinical judgement of the reviewer

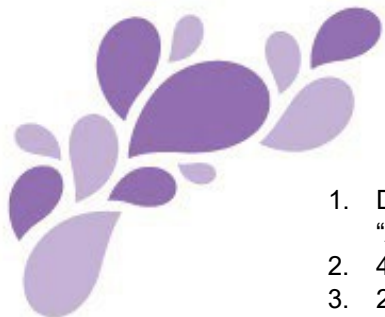
F. Related Policies/Rules

Any applicable drug-specific clinical policies
Medical Benefit Medications
Off Label

G. Review/Revision History

| DATES | | ACTION |
|----------------|------------|--|
| Date Issued | 12/06/2013 | |
| Date Revised | 09/01/2021 | |
| | 04/20/2017 | Policy separated by State/LOB. |
| | 06/19/2018 | Definitions added. All sections updated. |
| | 06/11/2020 | Policy moved to the new template. |
| | 09/16/2021 | Annual review |
| | 11/08/2022 | Annual review |
| | 6/6/2023 | Removed “medical necessity” |
| Date Effective | 7/13/2023 | Approved by P&T |
| Date Archived | | |

H. References



1. Definitions for Clinical Judgement: Ombudsman Saskatchewan, Canada; “Administrative versus Clinical Decisions” January 2016.
2. 45 CFR - Chapter A - Subchapter B - §156.122 - Prescription drug benefits.
3. 2021 NCQA Standards and Guidelines for the Accreditation of Health Plans.



Administrative Policy Statement MARKETPLACE PLANS

| Policy Name | | Policy Number | Date Effective |
|---|----------------|---------------|----------------|
| Utilization Management of Formulary Medications | | PAD-0067-MPP | 01/01/2023 |
| Policy Type | | | |
| Medical | ADMINISTRATIVE | Pharmacy | Reimbursement |

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

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A. Subject

Utilization Management of Formulary Medications

B. Background

CareSource uses a Marketplace Formulary Drug List (i.e., Marketplace Formulary) that is established, reviewed and approved by the Pharmacy and Therapeutics (P&T) Committee and applicable state and federal regulatory agencies. Drugs on the Marketplace Formulary are classified into tiers as explained in the Member's Evidence of Coverage (EOC) including: Preventive, Preferred, Non-preferred, and/or Specialty. The Marketplace Formulary is reviewed routinely for addition or deletion of drugs and for tier selection of formulary drugs.

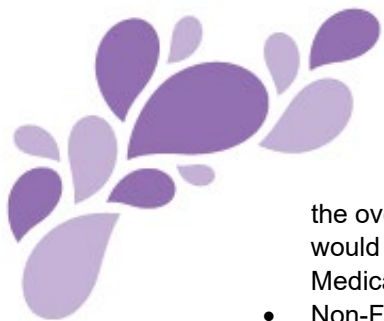
Drugs that have been added to the Marketplace Formulary under any tier may be subject to Utilization Management. Utilization Management could include a Prior Authorization, Quantity or Dose Limit, or Step Therapy. Any applicable Utilization Management associated with a specific drug will be indicated on the Marketplace Formulary. Drugs that have been added to the Marketplace Formulary under any tier that are not subject to Utilization Management are available to members at the appropriate cost share as described in the member's EOC.

The intent of CareSource Pharmacy Policy Statements is to encourage appropriate selection of drug therapy for members according to product labeling, clinical guidelines, and/or clinical studies as well as to encourage use of Marketplace Formulary drugs. The CareSource Pharmacy Policy Statement is a guideline for determining health care coverage for our members with benefit plans covering prescription drugs. The Pharmacy Policy Statement is used as a tool to be interpreted in conjunction with the member's specific benefit plan.

NOTE: *The Introduction section is for your general knowledge and is not to be construed as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals and is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider can also be a place where medical care is given, like a hospital, clinic or lab. This policy informs providers about when a service may be covered.*

C. Definitions

- **Administrative Review/Approval/Denial:** A decision for coverage or non-coverage of a drug which is made regarding the organization and delivery of the drugs according to a member's benefits, policies & procedures and/or legislature & regulation which do not require clinical expertise or subject knowledge.
- **Clinical Judgment:** Decisions made within the scope of the expertise of a pharmacist following the review of subjective and objective medical data for a member. A pharmacist can use Clinical Judgment for a benefit determination for an exception request for a Non-Formulary Drug. If the request is outside the scope of a pharmacist's expertise, a benefit determination will be made in collaboration with a medical director.
- **Drug:** A medication or substance which induces a physiologic effect on the body of a member (i.e., medication, agent, drug therapy, treatment, product, biosimilar drugs, etc.).
- **Marketplace Formulary Drug List (i.e., Marketplace Drug Formulary, Formulary):** A list of prescription drugs which includes a group of selected generic and brand-name drugs which are covered by CareSource at the designated member cost share in the member's Evidence of Coverage (EOC).
- **Medical Necessity:** Health care services, supplies, or drugs needed to diagnose, treat or prevent illness, injury, conditions, diseases or the associated symptoms in accordance with accepted standards in the practice of medicine. Medical necessity will be evaluated based on



the overall health and well-being of the member and when the member's day-to-day health would be impacted. Prescription Drugs, unless otherwise stated in the EOC, must be Medically Necessary in order to be Covered Services.

- Non-Formulary Drug: A drug not on the Marketplace Formulary Drug List.
- Non-Preferred Drug: A drug on the Marketplace Formulary Drug List placed at a higher member cost share than Preferred Drugs as explained on the member's EOC (e.g., tier 3 and tier 5).
- Preferred Drug: A drug on the Marketplace Formulary Drug List placed at a lower member cost share as explained on the member's EOC (e.g., tier 2 and tier 4).
- Preventive Drug/Service: Routine drug or service which prevents illnesses, disease or other health problems from occurring. These drugs are identified through guidance of the The Affordable Care Act (ACA) as essential health benefits and may be subject to prior authorization or other limitations.
- Prior Authorization: Requirement for medical necessity review for a Formulary drug that may not be clinically appropriate for all members or may be associated with risk to the member if used inappropriately. A provider will be required to submit additional clinical information to CareSource for review and approval prior to the drug being available to the member.
- Quantity Limit or Dosage Limit: Limits that may restrict the amount dispensed per prescription order, refill, time period, total quantity or total dose.
- Specialty Drug: A drug which treats complex diseases and/or requires special handling or distribution and is usually high cost. Many of these drugs require prior authorization and may be dispensed at limited locations. Please see CareSource's Specialty Drug List on the CareSource website.
- Step Therapy: A member may need to use a medication or a series of medications before the requested medication.
- Utilization Management: Use of Prior Authorization, Quantity or Dose Limits, or Step Therapy to ensure that coverage of a Formulary Medication is consistent with Medical Necessity, clinical best practice, and cost-effective care

D. Policy

- I. A Formulary drug that is subject to a Prior Authorization will be denied at the point of purchase unless CareSource receives a request for Clinical Judgement for coverage. Requests for Clinical Judgement for Formulary drugs that are subject to a Prior Authorization will be reviewed against drug-specific criteria that has been developed and approved by the P&T Committee. When CareSource approves coverage of a Formulary drug that is subject to a Prior Authorization, the member's cost share will reflect the appropriate tier as indicated on the Marketplace Drug Formulary and explained in the Member's EOC.
 - A. Prior Authorization requests should be submitted for each Formulary drug that is subject to a Prior Authorization with chart notes and member-specific documentation which supports Medical Necessity for Clinical Judgement.
 - B. Prior Authorization requests can be submitted via fax, phone, or mail or electronically.
 - C. Prior Authorization requests will be reviewed and notification of the determination made according to the Prescription Drug Exception Process outlined in the Member's EOC.
- II. A Formulary drug that is subject to Step Therapy will be denied at the point of purchase unless the member has previously had a paid claim for the prerequisite drug(s) required by the Step Therapy criteria or CareSource receives and approves a Prescription Drug Exception request. When CareSource approves an Exception request for a Formulary drug that is subject to Step Therapy, the member's cost share will be the appropriate tier as indicated



on the Marketplace Drug Formulary and explained in the Member's EOC. An Exception request will be approved in the following cases:

- A. The member has previously used the prerequisite drug(s) or a drug in the same therapeutic class or with the same mechanism of action as the prerequisite drug(s) but discontinued the drug due to lack of efficacy, diminished effect, or adverse event based on submitted documentation and medical history. (If the member does not have previous paid claims for the prerequisite or related drug(s), documentation of the previous trials will be required for an exception request to be approved.) OR
 - B. The member is currently using and is stable on the requested drug and is expected to experience adverse outcomes (e.g. worsening of a comorbid condition, decreased ability to achieve or maintain reasonable functional ability in performing daily activities, etc.) as a result of switching drug therapy based on submitted documentation and medical history, OR
 - C. The member has an allergy or intolerance to one or more of the prerequisite drug(s) required by the Step Therapy criteria based on submitted documentation and medical history, OR
 - D. The prerequisite drug(s) required by the Step Therapy criteria is/are expected to cause an adverse effect based on submitted documentation and medical history, OR
 - E. The prerequisite drug(s) required by the Step Therapy criteria is/are expected to be ineffective or less effective for the member based on submitted documentation and medical history, OR
 - F. The prerequisite drug(s) required by the Step Therapy criteria is/are expected to cause a significant barrier to the member's adherence or compliance with the plan of care based on submitted documentation and medical history.
- III. A Formulary drug that is subject to Quantity or Dose Limits will be denied at the point of service for any claim that exceeds these limits unless CareSource receives and approves a Prescription Drug Exception request. When CareSource approves an Exception request for a Formulary drug that is subject to Quantity or Dose Limits, the member's cost share will be the appropriate tier as indicated on the Marketplace Drug Formulary and explained in the Member's EOC. An Exception request will be approved in the following cases:
- EITHER
- A. The requested quantity or dose of the drug does not exceed the maximum recommended dose approved by the FDA and is medically necessary based on submitted documentation and medical history AND
 - B. The requested quantity or dose of the drug does not exceed the limits as covered by the plan or applicable State and Federal laws
- OR
- C. The provider has submitted clinical documentation supporting the use of an off-label quantity or dose in accordance with the **CareSource Medical Necessity – Off Label, Approved Orphan and Compassionate Use Drugs Policy**, and the requested quantity or dose of the drug is medically necessary based on submitted documentation and medical history.

Conditions of Coverage:

NDC
HCPCS
CPT



AUTHORIZATION PERIOD: through the end of the member's plan year unless otherwise indicated in drug-specific policies or criteria

IV. Related Policies/Rules

Medical Necessity - Off Label, Approved Orphan and Compassionate Use Drugs

Other drug-specific Clinical Criteria may apply.

V. Review/Revision History

| DATES | | ACTION |
|----------------|------------|---|
| Date Issued | 10/01/2020 | |
| Date Revised | 12/19/2022 | Removed mention of turn around times (TAT). |
| Date Effective | 01/01/2023 | |
| | | |
| Date Archived | | |

VI. References

1. Definitions for Formulary, Non-Formulary, Medical Necessity, Preventive Drug: Healthcare.gov.
2. Definitions for Administrative Review or Clinical Judgement: Ombudsman Saskatchewan, Canada; "Administrative versus Clinical Decisions" January 2016.
3. 45 CFR - Chapter A - Subchapter B - §156.122 - Prescription drug benefits.
4. 2018 NCQA Standards and Guidelines for the Accreditation of Health Plans.



Pharmacy and Therapeutic (P&T) Charter Updated 06/2023

Purpose: To establish a clinically sound and high-quality formulary(ies) to promote appropriate use of pharmaceuticals in the care of CareSource members.

Responsibilities:

The P&T Committee is responsible for the following functions:

- Develop and maintain formulary(ies) to ensure the pharmaceuticals covered are effective and safe
- Review the formulary(ies) in their entirety at least annually
- Review new drugs and chemical entities, drug classes, new clinical indications, therapeutic advantages, and new safety information within six (6) months of any new market launch or change
- Make recommendations to the Value Assessment Committee (VAC) for placement determination on the formulary using FDA-approved prescribing information, evidence-based literature, drug compendia, and treatment guidelines. The committee will denote each pharmaceutical as: Include, Optional, and Exclude (see Process)
- Complete final review of the VAC formulary placement determinations

Committee Structure:

The P&T Committee reports decisions to the Quality Enterprise Committee (QEC) for final approval. The P&T Committee is co-chaired by the Chief Clinical Officer and the Manager of Formulary. The membership consists of internal and external physicians and pharmacists with broad primary care and specialty expertise (see Table 1. Committee Membership).

Membership Requirements for Internal Members:

Internal members of the P&T Committee shall complete a conflict-of-interest statement annually. Any internal member with a conflict of interest should take action to resolve the conflict, recuse themselves from decisions for which they are in conflict, or step down from their position. In addition, voting members should not engage in direct contact with representatives of the pharmaceutical industry. This policy does not apply to non-voting members that work for CareSource that must have regular contact with pharmaceutical industry personnel in order to perform their assigned duties. All members should refrain from accepting any gift from a pharmaceutical company, including meals, books, office supplies, and sample drugs. It is also important that all information, including pre-decisional sensitive information, discussed by P&T be considered confidential until the meeting minutes are completed, and the release of information approved by the CareSource RX Innovations leadership. As such, voting members, non-voting members, invited subject matter experts and speakers, and invited guests (residents, students/interns, etc.) will be asked to sign a non-disclosure agreement, annually, which prevents them from releasing information and decisions discussed during the P&T Committee meetings until approved to release.

Membership Requirements for External Voting Members:

The committee shall consist of nine voting members, appointed by the committee chairs. Voting members must have an active professional medical or pharmacy license in good standing and be experienced with responsibilities including prescribing, dispensing, or monitoring of drugs, quality assurance, disease state management, or evidence-based medicine.

Each term of appointment will be in place for two years, and members may be eligible for subsequent terms. Membership may be terminated at any time at the discretion of the committee chairs. Attendance and/or participation in greater than 50% of P&T committee meetings/electronic votes (E-votes) in a rolling 12 months is required to maintain the rights of a voting member. Every two years, members will be asked to confirm their willingness to continue participation as a voting member. Attendance to every meeting is strongly encouraged in order to ensure that a quorum is present. If a member is unable to attend a meeting, one must notify the committee chairs as soon as possible. Failure to regularly attend may result in termination from the committee.

At the time of appointment, each member must sign a consultant agreement. Actions contrary to the contents of the agreement may result in termination from the committee. A confidentiality statement must also be signed.

Voting members shall not be employed by a pharmaceutical manufacturer and may not have financial or other conflicts of interest that could detract from the integrity of the committee. Any potential conflict of interest must be disclosed. A conflict-of-interest form must be completed annually, or more often if individual circumstances change. A member must recuse oneself from voting on any matter for which they identify a possible conflict of interest. Repeated incidences may result in termination if prohibitive to the function, progress, or effectiveness of the committee. Voting members do not have access to any information regarding rebates, negotiated discounts, or the net cost of a drug after discounts. The P&T committee does not use price to make formulary placement decisions.

Voting members receive a stipend for preparation and participation in the meetings. This stipend is based on a reasonable estimate of revenue lost by not seeing patients or while out of the office for P&T committee meeting attendance and preparation.

Meetings:

The P&T Committee meets at least quarterly in person or virtually. Minutes will reflect the members in attendance, items discussed, and decisions reached. The meeting minutes are forwarded to QEC and will be maintained for a period of not less than 10 years.

At all meetings of the P&T Committee must have a quorum (defined as one-third of voting members) for the transaction of business consisting of members present either telephonically or in-person. For voting purposes, the present voting members are the decision-making body at the P&T Committee. In case of a tie vote by the majority present members, the Chair or Vice Chair will render the tie breaking vote, either electronically or in person. Voting members may send a delegate to attend in his/her place if unable to attend.

Electronic votes (e-votes) will be sent between meetings only for medications with significant clinical impact that require an urgent decision. Voting members will be given five business days to reply, for standard votes, with any concerns, acceptance, or denial. For expedited votes, voting members will be given three business days. Changes may be made depending on that feedback. Lack of response constitutes acceptance of the proposed designation of the medication.

Process:

Formulary requests, new drugs, class reviews and potential changes to existing formularies are first reviewed by the Clinical Pharmacists within CareSource RxInnovations. The Clinical Pharmacists will prepare a policy or criteria proposal and suggest a formulary coverage option after doing a comprehensive review from the following sources as appropriate: clinical literature, FDA-approved prescribing information, treatment guidelines, medical associations, national commissions, peer-reviewed journals, authoritative compendia, and government agencies. The P&T Committee considers the proposed drug criteria, literature, and the monograph for each medication and determines if a drug should or should not be included on the formulary with the proposed clinical criteria for utilization. The P&T Committee will vote on the formulary coverage options for each of the pharmaceuticals using one of the following:

Formulary Coverage Options:

- Include: Medication must be covered on all formularies, as preferred or non-preferred. The medication has a unique indication addressing a clinically significant unmet treatment need and/or superior efficacy or safety to alternatives.
- Optional: Medication may be included as preferred or non-preferred. The medication is safe and effective for its indicated use. Medications denoted as optional may be clinically similar to alternatives and/or is only marginally better than alternatives or placebo. Designated optional medications are referred to the VAC committee to be reviewed for formulary placement based on non-clinical business considerations including cost, utilization, and market share.
- Exclude: Medication should not be added to formulary. The medication has inferior efficacy or safety risks compared to alternatives or insufficient data is available for evaluation. Coverage of this medication is only permitted with medical necessity review on a case by case basis. Medications denoted as Exclude may also receive this designation if they are required to be excluded based upon Federal or State regulation or requirement.

The P&T Committee will forward the recommendations for each of the pharmaceuticals to the Value Assessment Committee for review and formulary determination of the optional agents. The VAC will also review and approve the use of the utilization management criteria approved by P&T such as prior authorization, step therapy, quantity limits, age, and gender edits. The VAC may not select a final formulary placement that is inconsistent with the drug designation made by the P&T Committee.

The final recommendations made by VAC will be sent back to the P&T Committee via an e-vote. The P&T will review the final positions of each drug reviewed and move to the QEC for final approval before implementation. Direction from federal or state agencies will take precedence over formulary coverage options determined by the P&T Committee. The following may be implemented without requiring committee review and approval:

- Updates in vaccination coverage to align with the Advisory Committee on Immunization Practices (ACIP) recommendations coordinated with market and/or line of business regulatory required coverage without requiring committee review and approval
- Quantity limits that align with Food and Drug Administration (FDA) approved dosing
- Dose optimization determined by VAC

For existing drugs with new indications or changes to existing criteria, the P&T committee will only be reviewing the clinical changes of those criteria or indications for approval. The Clinical Pharmacists will not

be making a recommendation (Include, Optional, or Exclude) for these drugs, unless there is any new clinical information since the previous review that warrants a change in the recommendation.

Table 1. Committee Membership

| ROLE | RESPONSIBILITIES | REPRESENTING | VOTING MEMBER? |
|---|--|-----------------------------------|----------------|
| Vice President, Market Chief Clinical Officer | Chairperson
Clinical
Executive
Leadership
Quality | Individual Markets | Yes |
| Clinical Formulary Pharmacist | Clinical
Quality | Pharmacy | No |
| Manager, Clinical Formulary Strategy | Chairperson
Clinical
Quality
Leadership | Pharmacy | No |
| Associate Vice President, Pharmacy Market | Clinical
Quality
Leadership
Strategy Execution | Individual Markets | Yes |
| Director, Pharmacy Operations | Clinical
Leadership
Strategy Execution | Pharmacy | No |
| Formulary and Strategy Pharmacist | Clinical
Implementation
Quality
Strategy Development | Pharmacy | No |
| Director, Pharmacy Clinical Strategy | Chairperson
Clinical
Leadership
Quality
Strategy Execution | Pharmacy | No |
| Manager, Formulary Design and Strategy | Clinical
Leadership
Strategy Development | Pharmacy | No |
| Manager, Specialty Pharmacy Prior Authorization | Clinical
Leadership
Strategy Development | Pharmacy | No |
| Medical Directors | Clinical
Leadership
Medical Management
Quality | Enterprise and Individual Markets | Yes |

| ROLE | RESPONSIBILITIES | REPRESENTING | VOTING MEMBER? |
|--------------------------------------|---|-----------------|----------------|
| Physicians and Pharmacists, External | Clinical Leadership
Medical Management
Quality | Health Partners | Yes |
| Senior Vice President, Pharmacy | Executive Leadership
Quality
Strategy Execution | Pharmacy | No |

Table 2. Document Revision History

| DATE | REVISION NUMBER | DESCRIPTION OF CHANGE | AUTHOR |
|------------|-----------------|--|--------------------|
| 08/1/2012 | 1 | UPDATED TO NEW FORMAT | KAREN HUDSON |
| 08/07/2013 | 2 | UPDATED TO NEW FORMAT | KAREN HUDSON |
| 02/14/2014 | 3 | UPDATED TO NEW FORMAT | KAREN HUDSON |
| 10/30/2014 | 4 | NEEDED TO ADD NEW THERAPY STATEMENT FOR NCQA | WENDY NULL |
| 01/29/2015 | 5 | UPDATED DATE FOR 2015 | OWEN NEFF |
| 01/21/2016 | 6 | UPDATED FOR 2016 | OWEN NEFF |
| 01/21/2017 | 7 | UPDATED FOR 2017 | OWEN NEFF |
| 02/28/2018 | 8 | UPDATED FOR 2018 | DAVID HARTZELL |
| 12/13/2018 | 9 | UPDATED FOR 2019 | DAVID HARTZELL |
| 05/6/2019 | 10 | UPDATED FOR 2020 | JENNIFER SZUMOWICZ |
| 11/8/2019 | 11 | ADDITIONAL 2020 UPDATES | JENNIFER SZUMOWICZ |
| 8/25/2020 | 12 | UPDATED TO NEW FORMAT AND UPDATED PROCESS FOR DESIGNATION AND RECOMMENDATION TO VAC AND FINAL P&T APPROVAL | JESSICA HATTON |
| 11/30/2020 | 13 | UPDATED THE POST VAC PROCESS. UPDATED THE VOTING PROCESS AND RECOMMENDATION FOR NON-NEW DRUGS | PHUONG LUU |
| 12/1/2021 | 14 | UPDATED COMMITTEE MEMBERS | ANDREA ENTERLINE |
| 11/8/2022 | 15 | ADDED ADDITIONAL SOURCES UTILIZED TO MAKE RECOMMENDATIONS, ADDED INFORMATION ON FEDERAL OR STATE DIRECTION TAKING PRECEDENCE OVER P&T VOTES, ADDED ACIP RECOMMENDATIONS WILL DEFAULT TO INCLUDE COVERAGE OPTION. | ANDREA ENTERLINE |
| 06/05/2023 | 16 | REVISED CHARTER AND MEMBERSHIP RESPONSIBILITIES TO REFLECT EXTERNAL | ANDREA ENTERLINE |



| | | | |
|--|--|--|--|
| | | VOTING MEMBERS. ADDED STATEMENT ON
FDA QLS. | |
|--|--|--|--|



Pharmacy and Therapeutic (P&T) Charter Updated 11/2022

Purpose: To establish a clinically sound and high-quality formulary(ies) to promote appropriate use of pharmaceuticals in the care of CareSource members.

Responsibilities:

The P&T Committee is responsible for the following functions:

- Develop and maintain formulary(ies) to ensure the pharmaceuticals covered are effective and safe.
- Review the formulary(ies) in their entirety at least annually.
- Review new drugs and chemical entities, drug classes, new clinical indications, therapeutic advantages, and new safety information within six (6) months of any new market launch or change.
- Make recommendations to the Value Assessment Committee (VAC) for placement determination on the formulary using FDA-approved prescribing information, evidence-based literature, drug compendia, and treatment guidelines. The committee will denote each pharmaceutical as: Include, Optional, and Exclude (see Process).
- Complete final review of the VAC formulary placement determinations.

Committee Structure:

The P&T Committee reports decisions to the Quality Enterprise Committee (QEC) for final approval. The P&T Committee is co-chaired by the Chief Clinical Officer and the Manager of Formulary. The membership consists of internal and external physicians and pharmacists with broad primary care and specialty expertise (see Table 1. Committee Membership).

Members of the P&T Committee shall complete a conflict-of-interest statement annually. Any member with a conflict of interest should take action to resolve the conflict, recuse themselves from decisions for which they are in conflict, or step down from their position. In addition, voting members should not engage in direct contact with representatives of the pharmaceutical industry. This policy does not apply to non-voting members that work for CareSource that must have regular contact with pharmaceutical industry personnel in order to perform their assigned duties. All members should refrain from accepting any gift from a pharmaceutical company, including meals, books, office supplies, and sample drugs. It is also important that all information, including pre-decisional sensitive information, discussed by P&T be considered confidential until the meeting minutes are completed, and the release of information approved by the CareSource RX Innovations leadership. As such, voting members, non-voting members, invited subject matter experts and speakers, and invited guests (residents, students/interns, etc.) will be asked to sign a non-disclosure agreement, annually, which prevents them from releasing information and decisions discussed during the P&T Committee meetings until approved to release.

Meetings:

The P&T Committee meets at least quarterly in person or telephonically. Minutes will reflect the members in attendance, items discussed, and decisions reached. The meeting minutes are forwarded to QEC and will be maintained for a period of not less than 10 years.

At all meetings of the P&T Committee must have a quorum (defined as one-third of voting members) for the transaction of business consisting of members present either telephonically or in-person. For voting purposes, the present voting members are the decision-making body at the P&T Committee. In case of a

tie vote by the majority present members, the Chair or Vice Chair will render the tie breaking vote, either telephonically or in person. Voting members may send a delegate to attend in his/her place if unable to attend.

Electronic votes (e-votes) will be sent between meetings only for medications with significant clinical impact that require an urgent decision. Voting members will be given one week to reply with any concerns, acceptance, or denial. Changes may be made depending on that feedback. Lack of response constitutes acceptance of the proposed designation of the medication.

Process:

Formulary requests, new drugs, class reviews and potential changes to existing formularies are first reviewed by the Clinical Pharmacists within CareSource RxInnovations. The Clinical Pharmacists will prepare a policy or criteria proposal and suggest a formulary coverage option after doing a comprehensive review from the following sources as appropriate: clinical literature, FDA-approved prescribing information, treatment guidelines, medical associations, national commissions, peer-reviewed journals, authoritative compendia, and government agencies. The P&T Committee considers the proposed drug criteria, literature, and the monograph for each medication and determines if a drug should or should not be included on the formulary with the proposed clinical criteria for utilization. The P&T Committee will vote on the formulary coverage options for each of the pharmaceuticals using one of the following:

Formulary Coverage Options:

- **Include**: Medication must be covered on all formularies, as preferred or non-preferred. The medication has a unique indication addressing a clinically significant unmet treatment need and/or superior efficacy or safety to alternatives.
- **Optional**: Medication may be included as preferred or non-preferred. The medication is safe and effective for its indicated use. Medications denoted as optional may be clinically similar to alternatives and/or is only marginally better than alternatives or placebo. Designated optional medications are referred to the VAC committee to be reviewed for formulary placement based on non-clinical business considerations including cost, utilization, and market share.
- **Exclude**: Medication should not be added to formulary. The medication has inferior efficacy or safety risks compared to alternatives or insufficient data is available for evaluation. Coverage of this medication is only permitted with medical necessity review on a case by case basis. Medications denoted as Exclude may also receive this designation if they are required to be excluded based upon Federal or State regulation or requirement.

The P&T Committee will forward the recommendations for each of the pharmaceuticals to the Value Assessment Committee for review and formulary determination of the optional agents. The VAC will also review and approve the use of the utilization management criteria approved by P&T such as prior authorization, step therapy, quantity limits, age, and gender edits. The VAC may not select a final formulary placement that is inconsistent with the drug designation made by the P&T Committee.

The final recommendations made by VAC will be sent back to the P&T Committee via an e-vote. The P&T will review the final positions of each drug reviewed and move to the QEC for final approval before implementation. Direction from federal or state agencies will take precedence over formulary coverage options determined by the P&T Committee.

For existing drugs with new indications or changes to existing criteria, the P&T committee will only be reviewing the clinical changes of those criteria or indications for approval. The Clinical Pharmacists will not be making a recommendation (Include, Optional, or Exclude) for these drugs, unless there is any new clinical information since the previous review that warrants a change in the recommendation.

Review exclusions:

- **Vaccinations** - CareSource's Formulary team will initiate updates in vaccination coverage to align with ACIP recommendations, coordinated with market/line of business (LOB) regulatorily required coverage, without requiring Committee review and approval
- **Dose Optimization** - The P&T Committee will review clinical dose limits. Dose optimization may be implemented where able by the Formulary team without requiring Committee review and approval

Confidentiality Statement

All information presented in the P&T Committee meeting and all related communications are considered proprietary and confidential. Participation in, or attendance of, the P&T Committee constitutes an agreement to not share presented or distributed information.

Table 1. Committee Membership

| ROLE | RESPONSIBILITIES | REPRESENTING | VOTING MEMBER? |
|---|---|--------------------|----------------|
| Vice President, Market Chief Clinical Officer | Chairperson
Clinical
Executive
Leadership
Quality | Individual Markets | Yes |
| Clinical Formulary Pharmacist | Clinical
Quality | Pharmacy | No |
| Manager, Clinical Formulary Strategy | Clinical
Quality
Leadership | Pharmacy | No |
| Associate Vice President, Pharmacy Market | Clinical
Quality
Leadership
Strategy Execution | Individual Markets | Yes |
| Director, Pharmacy Operations | Clinical
Leadership
Strategy Execution | Pharmacy | No |
| Formulary and Strategy Pharmacist | Clinical
Implementation
Quality
Strategy Development | Pharmacy | No |

| ROLE | RESPONSIBILITIES | REPRESENTING | VOTING MEMBER? |
|---|---|-----------------------------------|----------------|
| Director, Pharmacy Clinical Strategy | Chairperson
Clinical Leadership
Quality
Strategy Execution | Pharmacy | No |
| Manager, Formulary Design and Strategy | Clinical Leadership
Strategy Development | Pharmacy | No |
| Manager, Specialty Pharmacy Prior Authorization | Clinical Leadership
Strategy Development | Pharmacy | No |
| Medical Directors | Clinical Leadership
Medical Management
Quality | Enterprise and Individual Markets | Yes |
| Physicians and Pharmacists, External | Clinical Leadership
Medical Management
Quality | Health Partners | Yes |
| Senior Vice President, Pharmacy | Executive Leadership
Quality
Strategy Execution | Pharmacy | No |

Table 2. Document Revision History

| DATE | REVISION NUMBER | DESCRIPTION OF CHANGE | AUTHOR |
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| 08/1/2012 | 1 | UPDATED TO NEW FORMAT | KAREN HUDSON |
| 08/07/2013 | 2 | UPDATED TO NEW FORMAT | KAREN HUDSON |
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| 02/28/2018 | 8 | UPDATED FOR 2018 | DAVID HARTZELL |
| 12/13/2018 | 9 | UPDATED FOR 2019 | DAVID HARTZELL |
| 05/6/2019 | 10 | UPDATED FOR 2020 | JENNIFER SZUMOWICZ |
| 11/8/2019 | 11 | ADDITIONAL 2020 UPDATES | JENNIFER SZUMOWICZ |
| 8/25/2020 | 12 | UPDATED TO NEW FORMAT AND UPDATED PROCESS FOR DESIGNATION AND | JESSICA HATTON |

| | | | |
|------------|----|---|------------------|
| | | RECOMMENDATION TO VAC AND FINAL P&T APPROVAL | |
| 11/30/2020 | 13 | UPDATED THE POST VAC PROCESS.
UPDATED THE VOTING PROCESS AND
RECOMMENDATION FOR NON-NEW DRUGS | PHUONG LUU |
| 12/1/2021 | 14 | UPDATED COMMITTEE MEMBERS | ANDREA ENTERLINE |
| 11/8/2022 | 15 | ADDED ADDITIONAL SOURCES UTILIZED TO
MAKE RECOMMENDATIONS, ADDED
INFORMATION ON FEDERAL OR STATE
DIRECTION TAKING PRECEDENCE OVER
P&T VOTES. ADDED REVIEW EXCLUSIONS.
ADDED CONFIDENTIALITY STATEMENT. | ANDREA ENTERLINE |



RxInnovations Value Assessment Committee (VAC) Charter **Updated 01/2023**

Purpose: To establish financially sound and cost-effective formulary(ies) and preferred drug lists to promote responsible use of pharmaceuticals in the care of CareSource members

Responsibilities:

The VAC is responsible for evaluating the actual or predicted net cost, market share, and/or drug utilization trends of clinically similar drugs/products, new-to-market drugs/products, and other formulary-related strategy opportunities to make a value assessment and recommend final formulary and/or preferred drug list placement of the drugs/products

The VAC will make recommendations regarding:

- Drug formulary and/or preferred drug list placement and coverage determinations for new and existing drugs/products and new line extensions
 - Drug placement on or off the formulary(ies) or Preferred Drug List (if applicable)
- Use of Clinical criteria approved by the CareSource Pharmacy and Therapeutics (P&T) Committee for formulary, preferred, and non-preferred drugs (e.g. Prior Authorization, Step Therapy, and/or Quantity Limits)
 - Unless otherwise stated in the VAC meeting or voting documentation, clinical criteria will remain as approved at the corresponding quarter's P&T Committee meeting and existing drug status will remain as is
- Approval of delegated formularies at least annually or as needed on an ad hoc basis
- Any additional formulary-related strategy opportunities

Committee Structure:

All drugs, products, or classes reviewed through P&T are reviewed through the VAC process. The VAC also reviews any strategy-related opportunities not covered in P&T. The VAC reports recommendations back to the P&T Committee for review and acceptance. The Formulary team then sends decisions to the Quality Enterprise Committee (QEC) for final acceptance.

The VAC is co-chaired by the CareSource Vice President of Actuarial Science and the RxInnovations Manager of Formulary Design and Strategy.

The membership consists of Market and Enterprise staff; see Table 1. Committee Membership. The voting membership of VAC will be composed of the Market President and the Market Finance Director from each Market served by CareSource. The Market President and/or Market Finance Director may appoint a designee to vote on his/her behalf provided advance notice is given to the co-chairs. Only committee members designated as voting members will have voting privileges.

All voting members must attend a minimum of 75% of scheduled VAC meetings or send a designee to attend in his/her absence. If a voting member does not attend two subsequent meetings and/or fails to send a designee in his/her place, the Senior Vice President of Markets will be asked to replace the voting member.

Voting members of VAC are prohibited from serving as voting members on the CareSource P&T Committee or any subcommittee thereof. Likewise, voting members of the CareSource P&T Committee are prohibited from serving as voting members on VAC.



RxInnovations Value Assessment Committee (VAC) Charter

Updated 01/2023

The non-voting membership of VAC will include:

- Market Medical Director from each Market
- Market Pharmacy Director from each Market
- Members of RxInnovations leadership
- Designated member(s) of the RxInnovations Clinical Strategy team
- Designated member of the RxInnovations Analytics team
- Designated member of the CareSource Enterprise Finance team
- Director, Pharmacy Clinical Strategy

Meetings:

The VAC meets at least quarterly in person or virtually following a meeting of the CareSource P&T Committee. Minutes will reflect the members in attendance, items discussed, and decisions reached. The meeting minutes will be maintained for a period of not less than 10 years.

Process:

Prior to VAC, market representatives will receive modeling scenarios prepared by the Formulary, Analytics, Finance, and/or Actuarial teams. These scenarios will take into account the CareSource P&T Committee's evaluation of the drugs designating them as include, optional, or exclude. The VAC may not recommend a final formulary placement that is inconsistent with the drug designation made by the P&T Committee.

During VAC, the modeling scenarios, as well as other information including, for example, drug pipelines, drug shortages, and delegated market reports will be presented to the Committee.

Applicable market may be indicated but external factors may override market application (examples- delegated formulary updates, state/market decisioning). Market representatives will have the opportunity to ask questions or discuss any of the information presented.

The vote will be collected electronically following the VAC meeting. Voting members will be given a minimum of 24 hours to reply with acceptance or denial of the items discussed in the meeting. The votes collected from each market will apply only to that market. Lack of response by requested deadline will constitute acceptance of the proposal(s).

Additional electronic votes may be sent between meetings in response to a CareSource P&T Committee electronic vote for drugs/products with significant clinical impact that require an urgent decision. Voting members will be given one week to reply with any concerns, acceptance, or denial. Changes may be made depending on that feedback. Lack of response by requested deadline will constitute acceptance of the proposal(s).

Following collected votes, the Formulary team will send final positions/recommendations for each reviewed drug/strategy opportunity to the P&T Committee for final review and approval. Once accepted by P&T Committee voting members, final decisions will move to the QEC.



RxInnovations Value Assessment Committee (VAC) Charter Updated 01/2023

Review exclusions:

- **Vaccinations-** CareSource's Formulary team will initiate updates in preventative vaccination coverage to align with ACIP recommendations, coordinated with market/LOB regulatorily required coverage, without requiring Committee review and approval
- **Dose Optimization-** The P&T Committee will review clinical dose limits. Dose optimization may be implemented where able by the Formulary team without requiring Committee review and approval

Confidentiality Statement

All information presented in the VAC meeting and all related communications are considered proprietary and confidential. Participation in, or attendance of, the VAC constitutes an agreement to not share presented or distributed information.

Definitions

- **Coverage (Covered/Non-covered)- Coverage is not a determination made by the VAC Committee.** Coverage is specific to the program in question (Medicaid vs. Marketplace) and defined by law or contract. Non-covered drugs do not have a path to medical necessity, while covered drugs may be available to a member through the formulary or if/when the member meets medical necessity. Non-covered drugs can also be referred to as "benefit exclusions."
- **Formulary/Non-Formulary-** Refers to whether a drug is included on our prescription drug formulary. In Medicaid, formulary drugs are covered drugs. In Marketplace, formulary drugs are a subset of covered drugs.
- **Preferred/Non-preferred-** Refers to relative access to a drug. In Medicaid, a preferred drug will be included on the preferred drug list. In Marketplace, a preferred drug may fall in a lower tier than a non-preferred drug. For both Marketplace and Medicaid, preferred drugs are a subset of formulary drugs.



RxInnovations Value Assessment Committee (VAC) Charter
Updated 01/2023

Table 1. Committee Membership

| ROLE | RESPONSIBILITIES | REPRESENTING | VOTING MEMBER? |
|---|---|-----------------------------------|----------------|
| Market President | Executive Leadership
Quality | Individual Markets | Yes |
| Market Finance Director | Leadership
Quality
Financial Strategy | Individual Markets | Yes |
| Medical Directors | Clinical Leadership
Medical Management
Quality | Enterprise and Individual Markets | No |
| Director or Associate Vice President, Pharmacy Market | Clinical
Quality
Leadership
Strategy Execution | Individual Markets | No |
| Formulary and Strategy Pharmacist | Clinical Implementation
Quality
Strategy Development | Pharmacy | No |
| Clinical Pharmacist | Clinical
Quality | Pharmacy | No |
| Pharmacy Analysts | Data Analytics | Pharmacy | No |
| Manager of Formulary Design and Strategy | Chairperson
Clinical Leadership
Quality
Strategy Execution | Pharmacy | No |
| Senior Vice President, Pharmacy | Executive Leadership
Quality
Strategy Execution | Pharmacy | No |
| Vice President of Actuarial Science | Chairperson
Leadership
Modeling | Enterprise | No |



RxInnovations Value Assessment Committee (VAC) Charter
Updated 01/2023

Table 2. Document Revision History

| DATE | REVISION NUMBER | DESCRIPTION OF CHANGE | AUTHOR |
|------------|-----------------|--|-----------------|
| 10/20/2020 | 1 | INITIAL CHARTER | JESSICA HATTON |
| 01/20/2022 | 2 | UPDATE TO VOTING PROCEDURE | JESSICA HATTON |
| 01/2023 | 3 | UPDATES WITHIN RESPONSIBILITIES, COMMITTEE STRUCTURE, MEETINGS, AND PROCESS SECTIONS. ADDED REVIEW EXCLUSIONS, CONFIDENTIALITY STATEMENT, AND DEFINITIONS SECTIONS. UPDATED CO-CHAIR TO VICE PRESIDENT OF ACTUARIAL SCIENCE. SEE RED-LINED VERSION FOR ALL CHARTER UPDATES | JENNIFER CHAPIN |



RxInnovations Value Assessment Committee (VAC) Charter

Updated 06/2023

Purpose: To establish financially sound and cost-effective formulary(ies) and preferred drug lists to promote responsible use of pharmaceuticals in the care of CareSource members

Responsibilities:

The VAC is responsible for evaluating the actual or predicted net cost, market share, and/or drug utilization trends of clinically similar drugs/products, new-to-market drugs/products, and other formulary-related strategy opportunities to make a value assessment and recommend final formulary and/or preferred drug list placement of the drugs/products

The VAC will make recommendations regarding:

- Drug formulary and/or preferred drug list placement and coverage determinations for new and existing drugs/products and new line extensions
 - Drug placement on or off the formulary(ies) or Preferred Drug List (if applicable)
- Use of Clinical criteria approved by the CareSource Pharmacy and Therapeutics (P&T) Committee for formulary, preferred, and non-preferred drugs (e.g. Prior Authorization, Step Therapy, and/or Quantity Limits)
 - Unless otherwise stated in the VAC meeting or voting documentation, clinical criteria will remain as approved at the corresponding quarter's P&T Committee meeting and existing drug status will remain as is
- Approval of delegated formularies at least annually or as needed on an ad hoc basis
- Any additional formulary-related strategy opportunities

Committee Structure:

All drugs, products, or classes reviewed through P&T are reviewed through the VAC process. The VAC also reviews any strategy-related opportunities not covered in P&T. The VAC reports recommendations back to the P&T Committee for review and acceptance. The Formulary team then sends decisions to the Quality Enterprise Committee (QEC) for final acceptance.

The VAC is co-chaired by the CareSource Vice President of Actuarial Science and the RxInnovations Manager of Formulary Design and Strategy.

The membership consists of Market and Enterprise staff; see Table 1. Committee Membership. The voting membership of VAC will be composed of the Market President and the Market Finance Director from each Market served by CareSource. The Market President and/or Market Finance Director may appoint a designee to vote on his/her behalf provided advance notice is given to the co-chairs. Only committee members designated as voting members will have voting privileges.

All voting members must attend a minimum of 75% of scheduled VAC meetings or send a designee to attend in his/her absence. If a voting member does not attend two subsequent meetings and/or fails to send a designee in his/her place, the Senior Vice President of Markets will be asked to replace the voting member.

Voting members of VAC are prohibited from serving as voting members on the CareSource P&T Committee or any subcommittee thereof. Likewise, voting members of the CareSource P&T Committee are prohibited from serving as voting members on VAC.



RxInnovations Value Assessment Committee (VAC) Charter

Updated 06/2023

The non-voting membership of VAC will include:

- Market Medical Director from each Market
- Market Pharmacy Director from each Market
- Members of RxInnovations leadership
- Designated member(s) of the RxInnovations Clinical Strategy team
- Designated member of the RxInnovations Analytics team
- Designated member of the CareSource Enterprise Finance team
- Director, Pharmacy Clinical Strategy

Meetings:

The VAC meets at least quarterly in person or virtually following a meeting of the CareSource P&T Committee. Minutes will reflect the members in attendance, items discussed, and decisions reached. The meeting minutes will be maintained for a period of not less than 10 years.

Process:

Prior to VAC, market representatives will receive modeling scenarios prepared by the Formulary, Analytics, Finance, and/or Actuarial teams. These scenarios will take into account the CareSource P&T Committee's evaluation of the drugs designating them as include, optional, or exclude. The VAC may not recommend a final formulary placement that is inconsistent with the drug designation made by the P&T Committee.

During VAC, the modeling scenarios, as well as other information including, for example, drug pipelines, drug shortages, and delegated market reports will be presented to the Committee.

Applicable market may be indicated but external factors may override market application (examples-delegated formulary updates, state/market decisioning). Market representatives will have the opportunity to ask questions or discuss any of the information presented.

The vote will be collected electronically following the VAC meeting. Voting members will be given five business days to reply, for standard votes, with any concerns, acceptance, or denial. For expedited votes, voting members will be given three business days. Changes may be made depending on that feedback. The votes collected from each market will apply only to that market. Lack of response by requested deadline will constitute acceptance of the proposal(s).

Additional electronic votes may be sent between meetings in response to a CareSource P&T Committee electronic vote for drugs/products with significant clinical impact that require an urgent decision. Voting members will be given five business days to reply, for standard votes, with any concerns, acceptance, or denial. For expedited votes, voting members will be given three business days. Changes may be made depending on that feedback. Lack of response by requested deadline will constitute acceptance of the proposal(s).

Following collected votes, the Formulary team will send final positions/recommendations for each reviewed drug/strategy opportunity to the P&T Committee for final review and approval. Once accepted by P&T Committee voting members, final decisions will move to the QEC.



RxInnovations Value Assessment Committee (VAC) Charter Updated 06/2023

Review exclusions:

- **Vaccinations-** CareSource's Formulary team will initiate updates in preventative vaccination coverage to align with ACIP recommendations, coordinated with market/LOB regulatorily required coverage, without requiring Committee review and approval
- **Dose Optimization-** The P&T Committee will review clinical dose limits. Dose optimization may be implemented where able by the Formulary team without requiring Committee review and approval
- **Quantity Limits-** CareSource's Formulary team will apply quantity limits that align with Food and Drug Administration (FDA) approved dosing without requiring Committee review and approval

Confidentiality Statement

All information presented in the VAC meeting and all related communications are considered proprietary and confidential. Participation in, or attendance of, the VAC constitutes an agreement to not share presented or distributed information.

Definitions

- **Coverage (Covered/Non-covered)- Coverage is not a determination made by the VAC Committee.** Coverage is specific to the program in question (Medicaid vs. Marketplace) and defined by law or contract. Non-covered drugs do not have a path to medical necessity, while covered drugs may be available to a member through the formulary or if/when the member meets medical necessity. Non-covered drugs can also be referred to as "benefit exclusions."
- **Formulary/Non-Formulary-** Refers to whether a drug is included on our prescription drug formulary. In Medicaid, formulary drugs are covered drugs. In Marketplace, formulary drugs are a subset of covered drugs.
- **Preferred/Non-preferred-** Refers to relative access to a drug. In Medicaid, a preferred drug will be included on the preferred drug list. In Marketplace, a preferred drug may fall in a lower tier than a non-preferred drug. For both Marketplace and Medicaid, preferred drugs are a subset of formulary drugs.



RxInnovations Value Assessment Committee (VAC) Charter
Updated 06/2023

Table 1. Committee Membership

| ROLE | RESPONSIBILITIES | REPRESENTING | VOTING MEMBER? |
|---|---|-----------------------------------|----------------|
| Market President | Executive Leadership
Quality | Individual Markets | Yes |
| Market Finance Director | Leadership
Quality
Financial Strategy | Individual Markets | Yes |
| Medical Directors | Clinical Leadership
Medical Management
Quality | Enterprise and Individual Markets | No |
| Director or Associate Vice President, Pharmacy Market | Clinical Quality
Leadership
Strategy Execution | Individual Markets | No |
| Formulary and Strategy Pharmacist | Clinical Implementation
Quality
Strategy Development | Pharmacy | No |
| Clinical Pharmacist | Clinical Quality | Pharmacy | No |
| Pharmacy Analysts | Data Analytics | Pharmacy | No |
| Manager of Formulary Design and Strategy | Chairperson
Clinical Leadership
Quality
Strategy Execution | Pharmacy | No |
| Senior Vice President, Pharmacy | Executive Leadership
Quality
Strategy Execution | Pharmacy | No |
| Vice President of Actuarial Science | Chairperson
Leadership
Modeling | Enterprise | No |



RxInnovations Value Assessment Committee (VAC) Charter
Updated 06/2023

Table 2. Document Revision History

| DATE | REVISION
NUMBER | DESCRIPTION OF CHANGE | AUTHOR |
|------------|--------------------|--|--------------------|
| 10/20/2020 | 1 | INITIAL CHARTER | JESSICA
HATTON |
| 01/20/2022 | 2 | UPDATE TO VOTING PROCEDURE | JESSICA
HATTON |
| 01/2023 | 3 | UPDATES WITHIN
RESPONSIBILITIES, COMMITTEE
STRUCTURE, MEETINGS, AND
PROCESS SECTIONS. ADDED
REVIEW EXCLUSIONS,
CONFIDENTIALITY STATEMENT,
AND DEFINITIONS SECTIONS.
UPDATED CO-CHAIR TO VICE
PRESIDENT OF ACTUARIAL
SCIENCE. SEE RED-LINED VERSION
FOR ALL CHARTER UPDATES | JENNIFER
CHAPIN |
| 06/2023 | 4 | CLARIFIED VOTING TURNAROUND
TIMES AND ADDED QUANTITY
LIMITS PER FDA LABELING AS
COMMITTEE REVIEW EXCLUSION | JENNIFER
CHAPIN |



POLICY - PROCEDURE

1411 - Clinical Criteria Policy-Procedure - GA Marketplace

Effective Date: 03/08/2023

| | | | |
|--------------------------|------------------------|-----------------------|------------|
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | GA - Marketplace | | |
| Department: | Utilization Management | Policy Number: | 1411 |

Scope:

This Policy and Procedure document applies to all CareSource business operations as necessary to comply with all local, state and federal regulations, as well as contractual and accreditation standards.

Purpose:

To outline the criteria used for Utilization Management (UM) determinations related to medical necessity.

Policy Statement:

CareSource verifies the status of license and or certifications at least annually for associates within

UM whose position requires a license or certification.

CareSource's Clinical Care Reviewer's (CCR) utilize clinical criteria for making UM determinations related to Medical Necessity (UM Medical Necessity Criteria) that is objective, measurable, and based on sound clinical evidence. Clinical criteria are developed, adopted and reviewed by appropriate practitioners. The criteria are reviewed and updated as necessary and approved by the Clinical Policy Governance Committee at least annually and as otherwise required by applicable regulatory agencies.

When a request for a service, procedure or product is under review, the review criteria is based on the following hierarchy:

1. Benefit contract language
2. Federal and/or State Regulation, including state waiver regulations when applicable
3. Nationally accepted evidence-based clinical guidelines (i.e.: MCG, ASAM)
4. CareSource Medical Policy Statements

Process Steps:

- i. CCR's use contract benefit, State/Federal regulations and approved clinical criteria to determine medical necessity for covered services that require authorization.
- ii. Prior to the application of the UM Medical Necessity criteria, UM staff request, from the ordering practitioner and/or servicing provider, sufficient clinical information to render a determination. The minimum necessary information to ensure appropriate clinical decision making is collected. Information may include (but is not limited to):
 - Name and date of birth
 - Primary Care Provider (PCP) or Specialty Providers
 - Diagnosis(s)
 - Procedural codes (if available)
 - Medical history
 - History of present illness
 - Presenting symptoms
 - Prior treatment outcomes
 - Current clinical status
 - Plan of care
 - ER treatment
 - Current treatment
 - Discharge Plan
 - Information regarding condition and instructions at prior discharge if readmission within thirty (30) calendar days.
- iii. When applying UM medical necessity criteria UM staff also consider the individual member factors and the characteristics of the local health care delivery system, including:
 - Member considerations.
 - Age, comorbidities, complications, progress of treatment, psychosocial situations, home environment.
 - Local Delivery System.
 - Availability of sub-acute care facilities or home care in the CareSource service area for post discharge support,
 - Ability of local hospitals to provide all recommended services within the estimated length of stay.
- iv. When UM medical necessity criteria are identified as not appropriate for an individual member based upon any of the above considerations, or when the UM criteria is not met, the case is referred to the CareSource medical director, Behavioral Health medical director or designee for completion. As part of the medical director or designee review process, the medical director/designee reviews the clinical information submitted in support of the request.
- v. Criteria utilized for UM determinations are available upon request to all CareSource practitioners, providers (including non-participating providers) and members free of

charge. Members, practitioners and providers are made aware of the availability of review criteria and how to obtain clinical criteria used for an UM determination through the provider and member handbooks and written UM determination. Criteria is provided to the requestor via the avenue of their choice including, but not limited to telephonically, via fax, or email.

Definitions:

Clinical Care Reviewer (CCR) – Registered Nurses (RN), Licensed Practical Nurses (LPN), or Licensed Social Workers (LSW) with active unrestricted and current licenses in a state of the United States in which CareSource operates. CCR's conduct initial clinical reviews and may approve services using established criteria. They do not make adverse determinations. They have access to consultation with a licensed Doctor of Medicine or Doctor of Osteopathic Medicine; a licensed Psychiatrist or licensed health professional in the same licensure category as an ordering provider, or health professional with the same clinical education as an ordering provider in clinical specialties where licensure is not issued.

Clinical Review Criteria: The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by CareSource to determine the Medical Necessity and appropriateness of Health Care Services

Medically Necessary Services: Services provided that address the prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability, in order for a member to achieve age-appropriate growth and development and attain, maintain or regain functional capacity and provide the opportunity for members to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

Utilization Management Staff (UM Staff): Administrative and Professional Staff members with titles such as Intake Specialist or Clinical Care Reviewer

Related Document(s):

- i. 42 CFR 438.2010
- ii. CareSource Provider Handbook
- iii. Evidence of Coverage and Health Insurance Contract - Georgia
- iv. Health Plan Standards for Accreditation – National Committee for Quality Assurance (NCQA) Standards and Guidelines for Health Plans, Utilization Management Standards

| REVIEW/REVISION HISTORY | |
|-------------------------|----------------------------|
| Date | Description of changes |
| 04/2021 | Initial Release |
| 04/2022 | Miscellaneous Change - CCA |

| | |
|---------|---|
| 03/2023 | Update to template, move to Georgia Marketplace specific document, update for current processes |
|---------|---|

— 907 KAR 1:360

— 0690.04 – UM – Continuity of Care Policy

| REVIEW/REVISION HISTORY | |
|--------------------------------|--|
| Date | Description of changes |
| 04/2011 | 2011 Annual Review – Added NCQA reference under Source Document |
| 04/2012 | 2012 Annual Review |
| 10/2012 | Updated Kentucky (KY) References and PCP definition for KY |
| 04/2103 | 2013 Annual Review |
| 03/2014 | Added Section E1 |
| 04/2014 | 2014 Annual Review |
| 04/2015 | 2015 Annual Review |
| 04/2016 | 2016 Annual Review – Added Definitions |
| 12/2016 | Updated for Indiana Readiness Review. Changes to Procedure section. Change to BO. |
| 03/2017 | Changed Medical Management to Utilization Management and minor spelling corrections. |
| 05/2017 | Updated to new template. |
| 10/2017 | Updated to new template. |
| 05/2018 | Annual Review – Removed other lines of business than Medicaid |
| 07/2018 | Added Purpose/Description |
| 09/2018 | Miscellaneous changes |
| 04/2019 | Updated to new template. Updates for P&P Refresh. New number. Replaces MM-04. |
| 12/2020 | BO Updated- Reviewed |
| 04/2022 | Update to BO, remove Ohio Medicaid |
| 01/2023 | 2023 Annual Review |



| PROCEDURE |
|---|
| 0690.04 - Continuity of Care Procedure |
| Effective Date: 01/09/2023 |

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| | | | |
|--------------------------|--|--------------------------|------------|
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | GA – Marketplace, IN – Marketplace, KY – Marketplace, OH – Marketplace, WV – Marketplace | | |
| Department: | Utilization Management | Procedure Number: | 0690.04 |

Purpose:

Members are expected to seek medical services from participating providers within the network. Continuity of care occurs when members request continuation of care from the provider who was treating them at the time of the provider's termination, when a newly enrolled member requests continuation of care from the provider who was treating them prior to their enrollment, or when a newly enrolled member is or will be receiving services for which a prior authorization was received from another payer. If the member's circumstances fall within the guidelines in this document, the member would be eligible for continuity of care by his/her current provider for a period of time following the termination of the provider or to transfer to a participating provider.

Definitions:

Acute Condition - A medical or behavioral condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.

Active Course of Treatment - A medical or behavioral health condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Chronic Condition - A medical or behavioral health condition due to a disease, illness, or other medical problem that is complex in nature and that persists without cure or worsens over an extended period of time or requires ongoing treatment to maintain remission of prevent deterioration.

Continuity of Care (COC) - The process of authorizing continuation of services with a termination or non-participating provider under specific conditions and for a limited period of time with a plan of care to transition the member to a network provider.

Covered Person - A policyholder, subscriber, enrollee, or member.

Evidence of Individual and Health Insurance Contract (EOC) - The contract document between CareSource Just4Me and the member outlining the members rights, responsibilities and obligations.

Fee for Service (FFS) - A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Network health partner - A health partner who has entered into a contractual arrangement with CareSource or is being used by CareSource, or another organization that has an agreement with CareSource to provide certain Covered Services or certain administration

functions for the Network associated with this EOC. A Network health partner may also be a Non-Network health partner for other services or products that are not covered by the contractual arrangement with us as Covered Services.

Network Provider - A Provider who has entered into a contractual arrangement with CareSource or is being used by CareSource, or another organization that has an agreement with CareSource to provide certain Covered Services or certain administration functions for the Network associated with this EOC. A Network Provider may also be a Non-Network Provider for other services or products that are not covered by the contractual arrangement with us as Covered Services.

Primary Care Provider (PCP) - A network physician, network physician group, advanced practice nurse or advanced practice nurse group trained in family medicine (general practice), internal medicine, or pediatrics that are responsible for providing or coordinating all Covered Services for Network Benefits.

Primary Care Provider PCP (KY Plan) - Licensed or certified health care practitioner, including a doctor of medicine, doctor of Osteopathy, advanced practice registered nurse, physician assistant, advanced nurse practitioner or health clinic, including an Federal Qualified Health Center (FQHC), primary care center or Rural Health Center (RHC) that functions within the scope of licensure of certification, has admitting privileges at a hospital or formal referral agreement with a provider processing admitting privileges and agrees to provide twenty-four (24) hours a day, seven (7) days a week primary health care services to individuals, and for Members who have a gynecological or obstetrical health care need, disability or chronic illness, is a specialist who agrees to provide and arrange for all appropriate primary and preventive care.

Non-Network Provider - An individual physician, hospital or ancillary provider who is not contracted with the preferred provider network affiliated with the covered person's health plan.

Serious Chronic Condition - A medical or behavioral health condition due to a disease, illness, or other medical problem that is complex in nature and that persists without cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Terminal Illness - Is an incurable or irreversible condition that has a high probability of causing death.

Process Steps:

1. Continuity of care occurs when members request continuation of care from a health partner who was treating them at the time of:
 - A. The health partner's termination from the network and that termination was not related to a Fraud or Quality of Care issue; or
 - B. A new member is enrolled with the plan and the health partner is treating the member for an acute or serious chronic condition; or

- C. A new member is enrolled with the plan and is or will be receiving services for which a prior authorization was received from another payer.
- 2. New Members: CareSource will provide coverage for Services provided by the members existing Physician or nurse practitioner if he or she is a Non-Network health partner for up to 30 calendar days after the coverage effective date if:
 - A. The health partner or nurse practitioner does not participate in another Marketplace Plan for which the Member is eligible through the Marketplace;
 - B. The health partner or nurse practitioner is providing the Member an ongoing course of treatment or is the Member's PCP;
 - C. Through the Member's postpartum period, if it is a new Member in their second or third trimester of Pregnancy; or
 - D. Until death, if it is a new Member with a Terminal Illness.
- 3. Existing Members
 - A. CareSource makes every effort to notify the Member at least 30 days prior to the date the Member's PCP leaves the network.
 - B. CareSource continues to pay for Covered Services for 60 calendar days after the date the PCP leaves the CareSource Marketplace Network. Unless the Member's PCP was terminated from the CareSource Network for reasons related to Fraud or quality of care,
 - C. If a Member is undergoing an active course of treatment for sickness or injury, CareSource may authorize continuing coverage with that PCP from the date the health partner left the CareSource Network through the acute phase of Sickness or up to 90 calendar days (whichever is shorter).
 - D. If a Member is a woman in the second or third trimester of Pregnancy, and the Network health partner the member is seeing in connection with the pregnancy involuntarily leaves the CareSource Network coverage will continue through the postpartum period, unless the health partner is terminated for reasons related to fraud or quality of care.
 - E. If a Member has a Terminal Illness, and the health partner treating the Member in connection with a Terminal Illness, is involuntarily disenrolled from CareSource, coverage will continue through the passing of the member, unless the health partner is terminated for reasons related to fraud or quality of care.
- 4. Health Care Services rendered by a health partner who is disenrolled from the Network or a Non-Network health partner will only be covered when the Health Care Services would otherwise be Covered Services if provided by a Network health partner, and the health partner agrees to:
 - A. Accept payment from CareSource at the rates that are paid to network CareSource health partners of the same specialty or sub-specialty;

- B. Accept payment as payment in full and not charge the member more than they would have paid if the health partner was in the CareSource network;
- C. Comply with the quality assurance Standards of CareSource;
- D. Provide CareSource with the necessary medical information related to the care provided; and
- E. Comply with the CareSource policies and procedures including but not limited to procedures regarding referrals, obtaining prior authorization and providing covered services pursuant to a treatment, approved by CareSource.

Related Document(s):

- CFR 438.206
- CareSource Marketplace Evidence of Coverage and Health Insurance Contract
- NCQA QI 10 A-F
- 0690 – UM – Continuity of Care Policy

| REVIEW/REVISION HISTORY | |
|--------------------------------|---|
| Date | Description of changes |
| 01/2014 | Initial Release |
| 04/2014 | Additional definitions added for clarification of active course of treatment, acute condition, chronic condition and continuity of care. Updates to source documents. Formatting changes. |
| 07/2014 | Updated to Kentucky and Indiana lines of business effective 01/01/2015. |
| 12/2014 | Reviewed/Updated to reflect changes in product line. |
| 04/2015 | 2015 Annual Review |
| 10/2015 | Addition of WV Product Line |
| 04/2016 | 2016 Annual Review, added health partner and The Plan |
| 05/2017 | Updated to new template. |
| 10/2017 | Updated to new templates. |
| 05/2018 | Annual Review, updated department name. |
| 07/2018 | Added Purpose/Description |
| 09/2018 | Miscellaneous changes. |
| 04/2019 | Updated to new template. Updates for P&P Refresh. New number. Replaces MM-04. |
| 12/2020 | BO Updated- Reviewed |
| 04/2022 | Update BO |
| 01/2023 | 2023 Annual Review |



POLICY - PROCEDURE

1413 - Notice of Adverse Benefit Determination Policy-Procedure - GA Marketplace

Effective Date: 04/11/2023

| | | | |
|--------------------------|------------------------|-----------------------|------------|
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | GA - Marketplace | | |
| Department: | Utilization Management | Policy Number: | 1413 |

Scope:

This Policy and Procedure document applies to all CareSource business operations as necessary to comply with all local, state and federal regulations, as well as contractual and accreditation standards.

Purpose:

To define a consistent process for issuing written Notice of Adverse Benefit (NOA) Determination for Utilization Management (UM) determinations.

Policy Statement:

The decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, is made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. CareSource does not arbitrarily deny or reduce the amount, duration, or scope of a required services solely because of the diagnosis, type of illness, or condition of the member.

CareSource offers medically necessary services to correct and/or ameliorate physical and behavioral health disorders and defects or conditions with select services having defined benefit limits. When a member's benefits have been exhausted, they are provided contact information for Care Management in their NOA letter. The Care Management team support includes but is not limited to assisting member in finding care alternatives, providing alternate resources for continuing their care, and referring members to CareSource Care Management. The NOA is issued by the Clinical Care Reviewer (CCR) and delegated entities any time a request for coverage of services/items has a decision to deny coverage for a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

The written NOA determination is issued within timeframes specified by state contracts, state or federal regulations, or accreditation bodies such as the National Committee for Quality Assurance (NCQA) and complies with all relevant regulations regarding appropriate denials or

reductions in care. The written NOA determination is sent to the Member and Practitioner/Provider. Written language used in the notice to the member is written to be easily understood by the member and worded at, or below, the regulatory required reading level. Notice of Adverse Benefit Determination letters are available in alternate format including but not limited to:

- Regular and large print
- In alternative formats, upon request, free of charge
- In the prevalent non-English languages in CareSource service area
- With taglines in the prevalent non-English languages in the area of coverage

A quality assurance review is completed for all NOA Determinations prior to mailing.

Process Steps:

- I. Adverse benefit determination notices utilize the letter template provided by regulatory agencies and include the following information:
 - a. Member name;
 - b. Member address;
 - c. Date of birth;
 - d. CareSource ID number;
 - e. Provider Name and License Number, if required by regulatory agency;
 - f. Requested service including CPT/service code and service code description;
 - g. The amount, frequency and duration of the requested services, including the amount of service requested, denied and approved for each requested service.
 - h. Effective date of the decision;
 - i. The specific reason(s) for the decision, in easily understood language, including the detailed clinical rationale and any information that was requested and not provided for each service that is denied or partially denied;
 - j. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the decision was based;
 - k. Notification that the member, upon request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the decision was based, free of charge and provided in the format of their choosing
- I. Notification that the treating provider has the opportunity to discuss a medical necessity denial;

- m. Written explanation of the right to, and the process for appealing the determination, including associated timeframes;
 - n. Written explanation of the appeal process, including whom to contact to initiate an appeal, the associated timeframe and how to exercise appeal rights;
 - o. The circumstances under which expedited appeal resolution is available and how to request it;
 - p. Written explanation of the member's right to request a State Fair Hearing, when applicable, after the CareSource appeal process has been exhausted;
 - q. Written explanation of the member's right to have benefits continued pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to repay the costs of these services; and
 - r. The availability of oral interpretation for all languages and how to access interpretation services.
- II. When CareSource identifies exhausted benefits during the authorization review process the clinical reviewer denies the request for exceeding benefit limits.
- a. The NOA is sent by the clinical reviewer on the date of the determination
 - i. The clinical reviewer includes in the NOA the following statement:
 CareSource is unable to approve your request for <service/benefit requested> at this time because you have exceeded your benefit limit for <service/benefit requested>. This does not mean that you do not continue to require care, but that you have used all of your allowed benefit. Please call 1-844-417-6256 to speak to a member of our outreach team. They can assist you with finding alternatives and resources for continuing care and how to receive it. Please leave a message and we will return your call within 4 business days
 - b. The Care Management team returns the call within a 4-business day SLA and works with the member to resolve outstanding concerns that includes but is not limited to: assisting member in finding care alternatives, providing alternate resources for continuing their care, and referring/handing off members to CareSource market specific Case Management.
- III. The NOA determination is reviewed for quality, including physician reviewer rationale, criteria used for determination, spelling, and the use of abbreviations.
- IV. The NOA determination is mailed to the member, or the parent or guardian of the member (if the member is under age 21), the member's authorized representative, and the requesting Practitioner/ Provider in accordance with the timeframes outlined in Policy # 0806, *Timeliness of Decision and Notification*.
- V. For members under the age of 21 the notice of adverse benefit determination includes relevant rationale related to the individualized EPSDT review performed.

- VI. In cases for which the member has no known address or has no forwarding address on file the staff make their best effort to gain contact information through:
- a. Review of CareSource medical management information systems for alternate/updated address on file.
 - b. Outreach to the requesting provider to obtain current address and/or contact information the office has on file for the member.

Definitions:

Adverse Action/ Non-Certification/Denial: A determination that an admission, extension of stay, or other health care service has been reviewed and based on the information provided, does not meet the clinical requirements for medical necessity, (as defined in State/Commonwealth Administrative Regulation or Code) appropriateness, level of care, or effectiveness; or the requested service is an exclusion as determined by state regulations.

Clinical Care Review (CCR) – Registered Nurses (RN), Licensed Practical Nurses (LPN), or Licensed Social Workers (LSW) with active unrestricted and current licenses in a state of the United States in which CareSource operates. CCR's conduct initial clinical reviews and may approve services using established criteria. They do not make adverse determinations. They have access to consultation with a licensed Doctor of Medicine or Doctor of Osteopathic Medicine; a licensed Psychiatrist or licensed health professional in the same licensure category as an ordering provider, or health professional with the same clinical education as an ordering provider in clinical specialties where licensure is not issued.

Determination: Any decision made by CareSource regarding:

- i. Receipt of, or payment for, a managed care item or service;
- ii. The amount CareSource requires an enrollee to pay for an item or service; or
- iii. A limit on the quantity of items or services.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): EPSDT is a federally mandated program of comprehensive preventive health services available to Medicaid-eligible persons from birth through twenty years of age. EPSDT is designed to maintain health by providing early intervention to discover and treat health problems. EPSDT provides screening and diagnostic services to determine physical or mental defects in recipients under the age of twenty-one and to provide health care treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. All services must be medically necessary.

Inter-Rater Reliability Assessment ("IRR"): A performance measurement audit involving a comparison of responses for a control group with a standard. IRR Assessments minimize variation in the application of clinical guidelines; evaluate the rater's ability to identify potentially avoidable utilization and/or quality of care issues, identify areas or individuals in need of remediation and to avoid litigation due to inconsistently applied guidelines.

Nationally Recognized Evidence Based Criteria: Criteria developed by specialty organizations, national policy committees (clinical practice guidelines), industry recognized review organizations, State or Federal criteria or regulations (as appropriate to product), medical policy or internally developed criteria, physician, and clinician judgment are all used to objectively evaluate the necessity of medical and behavioral health services requested for both initial determinations and clinical appeals.

Notice of Adverse Benefit Determination: A written notice from the Contractor to a member to advise the member of an Adverse Benefit Determination

Utilization Management/Utilization Review (UM): The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, medication, procedures,

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and facilities under the provisions of the applicable health benefits plan. It aids clinicians or members, in cooperation with other parties, to ensure appropriate use of resources. Utilization management is sometimes called “utilization review” or “medical management”.

Related Citation(s):

- i. 42 CFR 438.404

Related Document(s):

- i. Care management Exhaustion of Benefits Policy and Procedure Document
- ii. Evidence of Coverage and Health Insurance Contract - Georgia
- iii. Health Plan Standards for Accreditation – National Committee for Quality Assurance (NCQA) Standards and Guidelines for Health Plans, Utilization Management Standards
- iv. Policy #0805 EPSDT
- v. Policy # 0806, *Timeliness of Decision and Notification*

| REVIEW/REVISION HISTORY | |
|-------------------------|--|
| Date | Description of changes |
| 04/2023 | Initial Release; Update to template; update for current processes, move to Georgia Marketplace specific document split from 0815 |



POLICY - PROCEDURE

1414 - Out of Network Referrals Policy-Procedure - GA Marketplace

Effective Date: 04/11/2023

| | | | |
|--------------------------|------------------------|-----------------------|------------|
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | GA - Marketplace | | |
| Department: | Utilization Management | Policy Number: | 1414 |

Scope:

This Policy and Procedure document applies to all CareSource business operations, referred to in this document as CareSource Georgia Marketplace, as necessary to comply with all local, state and federal regulations, as well as contractual and accreditation standards.

Purpose:

To ensure a consistent process for making and communicating utilization management determinations when out of network care is required.

Policy Statement:

CareSource credential's sufficient numbers and types of providers to promote member access to services within the CareSource network. CareSource is committed to promoting the delivery of high-quality care in the most appropriate setting and recognizes that there are occasions when it is medically necessary for members to obtain care outside of the CareSource's provider network and, therefore, has established processes and criteria for authorizing referrals to out of network providers. All non-participating providers must have prior authorization of services. When authorization is approved for an out of network provider, the member is held responsible for in network out of pocket amounts, including annual deductible, copay, or coinsurance as specified in the member's evidence of coverage.

Process Steps:

1. The Clinical Care Reviewer (CCR) receives a request for services with a non-participating health partner and obtains pertinent clinical information, maintaining turnaround times included in Policy #0806, *Timeliness of Decision and Notification*.
 - A. The review process begins after obtaining and reviewing applicable clinical

information from the medical record, hospital/utilization nurse, referring/attending health partner, or the member and/or family. The CCR contacts the source of the information when clarification is needed and obtains relevant information to:

- Verify that the proposed service is a covered benefit under the member's policy
 - Determine if the proposed service is medically necessary
 - Assess the most appropriate level of care
 - Verify that the requested provider is currently participating with the applicable state/product
 - Identify at least one participating health partner within the member's geographic area qualified to provide the requested medical services for the specific medical condition outlined in the request
 - Non-par approval is based on CMS mileage guidelines and provider types. Members are given a choice of two participating providers for direct member care and one participating provider for non-direct member service such as DME and hospital/ambulatory surgical center providers within specified mileage per provider type
 - Apply quality indicators to identify potential quality issues
 - Identify and refer cases requiring case management
2. The CCR, in accordance with this procedure and applicable SOP, issues authorizations to a non-participating health partner in the following situations:
- A. New Member Continuity of Care (COC)
 - B. Network Disruption COC
 - C. There is no participating health partner to address the member's needs after considering the member's individual situation including but not limited to;
 - The medical condition of the member at the time the service is requested including factors such as intractable pain, risk for deterioration or permanent impairment of health
 - Delay of treatment would likely result in a significant decline in the member's health
 - Geographic distance to health partner from member's residence (rural versus urban setting)
 - Emergent/Urgent hospitalization services were required. Non-participating health partners are notified that they must submit clinical information for review by a CCR before inpatient services can be authorized.

- All other requests for out of network care are reviewed by a medical director/dental consultant for authorization or adverse determinations
3. When the requested health care service is approved, the CCR follows the notification requirements as outlined in the Out of Network SOP.
 4. When the requested service is denied, the member and/or the member's authorized representative and health partner are notified of the reason for the denial as well as instructed on how to file an appeal, per Policy #1413, *Notice of Adverse Determination*
 - A. The CCR concurrently reviews the authorized stay, identifying discharge and/or transition of care needs of the member.
 - B. The CCR works closely with the health partner to transfer the member to a participating provider when medically stable as appropriate on a case-by-case basis.
 5. Any potential quality of care issues that are identified during the review process are referred to Quality Improvement for investigation and resolution. The non-participating health partner is obligated to adhere to Quality Improvement requirements of CareSource.
 6. Inter-rater reliability audits are conducted to evaluate the consistency, accuracy, and timeliness of out-of-network review activities according to Utilization Management- Inter-rater Reliability Studies.

Definitions:

Clinical Care Reviewer (CCR) - Registered Nurses (RN), Licensed Practical Nurses (LPN), or Licensed Social Workers (LSW) with active unrestricted and current licenses in a state of the United States in which CareSource operates. CCR's conduct initial clinical reviews and may approve services using established criteria. They do not make adverse determinations. They have access to consultation with a licensed Doctor of Medicine or Doctor of Osteopathic Medicine; a licensed Psychiatrist or licensed health professional in the same licensure category as an ordering provider, or health professional with the same clinical education as an ordering provider in clinical specialties where licensure is not issued

Covered Person - Policyholder, subscriber, enrollee, member, or other individual participating with CareSource.

Emergent Medical Condition - or Emergency means the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health, or to a Pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An Emergency means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson

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who possesses an average knowledge of health and medicine to result in placing the health of a Member or another person, or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of anybody organ or part; or, with respect to a pregnant woman, as further defined in section 1867e(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B). Examples of Emergencies are heart attack or suspected heart attack, stroke, shock, major blood loss, choking, severe head trauma, loss of consciousness, seizures, and convulsions.

Health Care Services - Services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease.

Inpatient Services - Health Care Services relating to Covered Person admitted to a hospital, skilled nursing facility, or Inpatient Rehabilitation Facility.

Out of Network (OON) Health Partner - An Individual physician, hospital or ancillary health partner who is not contracted within the preferred health partner network affiliated with the member's health plan. The Out of Network Health Partner may be in the same community as the "in network" health partners or geographically remote.

Participating or Network health partner - a facility, hospital, doctor, or other health care professional that has been credentialed and has a contract with CareSource to provide services for CareSource's product.

Single Case Agreement- A contract between CareSource and a non-network provider allowing a member to use their network benefits with a non-network provider.

Utilization Management Staff ("UM Staff") - Administrative and Professional Staff members with titles such as; Prior Authorization Specialist ("APAS"), Prior Authorization Specialist ("PAS"), Prior Authorization Coach (PAC), Patient Care Coordinator ("PCC") or Case Manager ("CM").

Utilization Management ("UM") - the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, medication, procedures, and facilities under the provisions of the applicable health benefits plan. It aids clinicians or members, in cooperation with other parties, to ensure appropriate use of resources. Utilization management is sometimes called "utilization review" or "Utilization Management".

Related Citation(s):

N/A

Related Document(s):

- i. CareSource Provider Handbook
- ii. Evidence of Coverage and Health Insurance Contract - Georgia
- iii. Health Plan Standards for Accreditation – National Committee for Quality Assurance (NCQA) Standards and Guidelines for Health Plans, Utilization Management Standards

- iv. Policy 0806, Timeliness of Decision and Notification
- v. Policy 1413, Notice of Adverse Benefit Determination

| REVIEW/REVISION HISTORY | |
|-------------------------|--|
| Date | Description of changes |
| 04/2023 | Initial Release; Update to template, updated for current processes, move to Georgia Marketplace specific document split from 0690.17 |



POLICY - PROCEDURE

1417 - Standard and Urgent Prior Authorization Policy-Procedure - GA Marketplace

Effective Date: 04/11/2023

| | | | |
|--------------------------|------------------------|-----------------------|------------|
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | GA - Marketplace | | |
| Department: | Utilization Management | Policy Number: | 1417 |

Scope:

This Policy and Procedure document applies to all CareSource business operations as necessary to comply with all local, state and federal regulations, as well as contractual and accreditation standards.

Purpose:

To define a consistent process for Non-Urgent and Urgent service requests requiring prior authorization including a list of services/service categories that require prior authorization

Policy Statement:

Healthcare coverage is limited to items and services that are included in a defined benefit package and that are medically necessary. A determination of whether a covered benefit or service is medically necessary is based on an individualized assessment of the member's medical needs and may be expedited if the member's healthcare needs warrant it. CareSource follows federal, state and NCQA decision and notification timeframes for all utilization review determinations. Where regulatory and accreditation bodies differ, the strictest/shortest timeframe is used to assure compliance with all requirements.

Services requiring Prior Authorization are selected on the basis of:

- i. Availability of evidenced based guidelines to evaluate the medical necessity of services.
- ii. Recognition that unexplained variation exists among practitioners in the utilization of selected services.

Neither the member nor the provider is required to obtain prior authorization for Emergency Services. Emergency services or emergency care includes health care services that are provided for a mental health condition or substance use disorder and include post-stabilization

health care services.

Authorizations are based on a comprehensive and individualized needs assessment that addresses all needs including social determinants of health and a subsequent person-centered planning process.

CareSource Prior Authorization requirements comply with all Mental Health parity rules and regulations.

Providers may submit prior authorization requests via telephone, fax, in writing or electronically through the provider portal.

Prior Authorization review is performed by UM staff including nurses and licensed behavioral health (BH) and substance use disorder (SUD) clinicians who are supported by licensed physicians.

Utilization Management (UM) responsibilities are assigned to appropriately licensed clinicians, including but not limited to physicians, nurses, therapists, and behavioral health clinicians (including substance use disorder professionals).

Compensation to individuals or entities that conduct UM activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Member.

Prior Authorization decisions are based on nationally accepted guidelines (UM Medical Necessity Criteria) as outlined in Policy #1411, *Clinical Criteria*. Clinical Care Reviewer (CCR) staff approve requested services when UM medical necessity criteria are met.

Any decision to deny, alter or approve coverage for an admission, service, procedure or extension of stay in an amount, duration or scope that is less than requested is made by a CareSource medical director, Behavioral Health medical director or physician designee after evaluating the individual health needs of the member such as age, comorbidities, complications, progress of treatment, psychological situation and home environment when applicable, characteristics of the local delivery system and, as needed, consultation with the treating physician.

Assessment of the local delivery system and their ability to meet a member's health care needs include:

- i. Availability of inpatient, outpatient and transitional facilities;
- ii. Availability of outpatient services in lieu of inpatient services;
- iii. Availability of highly specialized services;
- iv. Availability of skilled nursing facilities, subacute care facilities or home care in the Plan's service area to support the member post discharge; and
- v. The local hospital's ability to provide all recommended services within the estimated length of stay.

Prior authorization determinations are documented in the appropriate medical management

information system (MMIS) to facilitate claim payment and are communicated to the provider and member in accordance with Policy #0806, *Timeliness of Decision and Notification*.

CareSource's MMIS generates and stores an authorization number and the effective dates of the authorization to servicing and requesting Practitioners/Providers, regardless of contracted status.

Any decision to deny or limit coverage is communicated in writing to the provider/practitioner, and/or member in accordance with Policy #1413, *Notice of Adverse Benefit Determination*. A provider's failure to adhere to CareSource's contractual requirements may result in an administrative denial in accordance with Policy #1410, *Administrative Denial*. Administrative denials do not require a review by a CareSource Medical Director.

Service Limits:

- i. CareSource may place appropriate limits on a service on the basis of criteria such as medical necessity or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.
- ii. CareSource may place appropriate limits on a service for utilization control, provided:
 - Services supporting Members with ongoing or Chronic Conditions are authorized in a manner that reflects the Member's ongoing need for such services and supports
 - Family Planning Services are provided in a manner that protects and enables the Member's freedom to choose the method of Family Planning to be used.

CCR staff review supporting clinical information received via telephone, fax, in writing or electronically through the provider portal, per the provider's preference. CareSource Providers are able, in many instances, to receive a real time determination when they enter their notification/continued stay request through Cite Auto Auth. All determinations are made in accordance with timeliness standards by line of business

Process Steps:

- i. Requests for prior authorization are submitted via telephone, fax or in writing, utilizing the standard prior authorization form, or electronically, through the provider portal to the CareSource UM department. Prior authorization requests may be submitted by the practitioner/provider ordering the service or performing the service or by the member.
- ii. Health care practitioners/providers complete the designated prior authorization form with the information to have the service considered for authorization which includes but is not limited to diagnosis code and requested item/procedure (applicable codes should be included).
- iii. UM staff review the request to determine if the item/service is covered under CareSource benefits.

- iv. For services covered by CareSource, the CCR reviews the information submitted in support of the request against the definition of medical necessity and applicable UM medical necessity criteria (See Policy #1411, *Clinical Criteria*). Both non-urgent and urgent prior (Pre- Service) authorization requests are reviewed in accordance with the timeframes outlined in Policy #0806, *Timeliness of Decision and Notification*.
- v. CareSource gathers the minimum information needed to complete the medical necessity review, the information gathered for use in a prior authorization determination includes some or all of the following:
 - a. Medical history
 - b. Mental Health and Substance Abuse History
 - c. History of present illness
 - d. Presenting symptoms
 - e. Prior treatment outcomes
 - f. Current clinical status
 - g. Plan of care
 - h. ER treatment
 - i. Current treatment
 - j. Discharge plan
 - k. Information regarding condition and instructions at prior discharge if readmission is at the same contracted facility
 - l. Special communication needs
 - When special communication needs are identified during the determination process, UM staff communicate the identified needs through the Streamline Customer Service Application to all CareSource staff. All special communications needs are considered during the determination process.
- vi. When there is insufficient information to make a determination, the CCR requests additional information in accordance with the procedure outlined in Policy #0806, *Timeliness of Decision and Notification*. All attempts to collect information are documented in the MMIS. Lack of sufficient information is defined as, but not limited to:
 - a. Lack of information indicating that the service is medically necessary
 - b. Lack of consultant findings
 - c. Lack of therapy evaluations
- vii. The CCR may make a determination that coverage for the requested service(s) is medically necessary based on CareSource's accepted UM medical necessity criteria (See Policy #1411, *Clinical Criteria*). The requesting practitioner/provider, facility and/or member are notified of this determination as outlined in Policy #0806, *Timeliness of Decision and Notification*.
- viii. When the CCR is not able to approve the requested service(s) he/she refers the case to the medical director, BH medical director or physician designee for review.
 - b. In the instance where the medical director gives verbal approval after discussion with the CCR, the CCR documents the approval, along with the reason for the approval, within the specific case notes in the MMIS.

- c. The medical director documents the decision rationale within 1 business day.
- ix. Under no circumstances does the CCR deny, alter or approve a lower or different level of care or scope of services than requested; any such denial or downgrade is made by either the medical director, BH medical director or physician designee.
 - The CCR can process and administrative denial which *is not* based on medical necessity or medical review.
- x. The medical director/BH medical director or physician designee reviews the clinical information submitted in support of the request. When needed, He/She may also consult a specialty Practitioner/Provider for input into the determination.
- xi. The review clinician is responsible for communicating the medical director, BH medical director or physician designee's determination to the requesting Practitioner/Provider, facility and/or Member as outlined in Policy #0806, *Timeliness of Decision and Notification*.
 - a. When the medical director, BH medical director or physician designee's determination is to deny, alter or approve a lower or different level of care or scope of services other than requested, the requesting Practitioner/Provider and/or Member are notified of the determination and applicable appeal rights as outlined in Policy #1413, *Notice of Adverse Benefit Determination*.
 - b. At the time of the notification of the adverse benefit determination, the Practitioner/ Provider is informed of the opportunity to call and discuss the adverse benefit determination with the medical director/physician designee who made the determination within five (5) business days of the denial notification. (See Policy #1415, *Peer-to-Peer Discussion*).
 - c. When the adverse determination is based on a lack of sufficient clinical information, the provider/practitioner are informed a reconsideration of the decision is performed if the necessary clinical information is received into the UM department within 1 business day of the denial notification.
- xii. Members, or Practitioners acting on behalf of the member with the member's consent, may appeal or file a grievance of an adverse benefit determination in accordance with the CareSource Appeal and Grievance policy.

Definitions:

Adverse Action/ Non-Certification/Denial: A determination that an admission, extension of stay, or other health care service has been reviewed and based on the information provided, does not meet the clinical requirements for medical necessity, (as defined in State/Commonwealth Administrative Regulation or Code) appropriateness, level of care, or effectiveness; or the requested service is an exclusion as determined by state regulations.

Approval/Authorization/Fully Favorable: A determination that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided,

meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness.

Clinical Care Review (CCR) – Registered Nurses (RN), Licensed Practical Nurses (LPN), or Licensed Social Workers (LSW) with active unrestricted and current licenses in a state of the United States in which CareSource operates. CCR's conduct initial clinical reviews and may approve services using established criteria. They do not make adverse determinations. They have access to consultation with a licensed Doctor of Medicine or Doctor of Osteopathic Medicine; a licensed Psychiatrist or licensed health professional in the same licensure category as an ordering provider, or health professional with the same clinical education as an ordering provider in clinical specialties where licensure is not issued.

Clinical Guidelines: A clinical guideline is a document with the aim of guiding decisions and clinical criteria regarding diagnosis, management, and treatment in specific areas of healthcare, based on an examination of current evidence within the paradigm of evidence-based medicine and include summarized consensus statements on best practice in healthcare. The objectives of clinical guidelines are to standardize medical care, to raise quality of care, to reduce several kinds of risk (to the patient, to the healthcare provider, to medical insurers and health plans) and to achieve the best balance between cost and medical parameters.

Covered Benefit/Service: Health Care Services to which a Covered Person is legally entitled under the terms of their CareSource plan and Evidence of Coverage.

Health Care Professional: A physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with applicable state and federal law.

Health Care Services: Services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury, or disease.

Medical Management Information System (MMIS): an electronic data system used by CareSource to document the utilization review authorization and determination process from intake through notification. Access is limited to users with approved log-in (username and password protected). Information entered into the system is automatically stamped with date, time and user identification

Medical Necessity (includes concepts of Medically Necessary and Medically Necessary Services):

- i. For individuals covered by early and periodic screening, diagnosis and treatment (EPSDT) is defined as procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
- ii. For individuals not covered by EPSDT is defined as procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without

which the person can be expected to suffer prolonged, increased or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.

Nationally Recognized Evidence Based Criteria: Criteria developed by specialty organizations, national policy committees (clinical practice guidelines), industry recognized review organizations, State or Federal criteria or regulations (as appropriate to product), medical policy or internally developed criteria, physician, and clinician judgment are all used to objectively evaluate the necessity of medical and behavioral health services requested for both initial determinations and clinical appeals.

Pre-Certification: Review conducted prior to a member's admission, stay or other service or course of treatment in a hospital or other facility

Prior Authorization: Utilization review conducted prior to an admission or the provision of a Health Care Service or a course of treatment in accordance with CareSource's requirement that the Health Care Service or course of treatment, in whole or in part, be approved prior to its provision. Also known as Pre-Authorization or Prior Approval.

Review Clinician: Registered Nurses (RN), Licensed Practical Nurses (LPN), or Licensed Mental Health Professionals such as Behavioral Health Autism Specialist and Behavioral Health UM Specialist, with active unrestricted and current licenses. First Level Reviewers conduct initial clinical reviews and may approve services using established criteria. They do not make adverse determinations. They have access to consultation with a licensed Doctor of Medicine or Doctor of Osteopathic Medicine; a licensed psychiatrist or licensed health professional in the same licensure category as the ordering provider, or health professional with the same clinical education as the ordering provider in clinical specialties where licensure is not issued.

Urgent care (Expedited): Any request for medical or behavioral health care or treatment with respect to which the application of time periods for non-urgent care determinations:

- i. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- ii. In the opinion of an attending health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
- iii. Except as provided below in (d), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the issuer shall apply the judgement of a prudent layperson who possesses an average knowledge of health and medicine.
- iv. Any request that an attending health care professional, with knowledge of the covered person's medical condition, determines is an urgent care request within the meaning of (a) or (b), is treated as an urgent care request.
- v. Urgent care includes all requests for hospitalization and outpatient surgery that also meet criteria indicated in (i) and (ii).

Utilization Management/Utilization Review (UM): The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, medication, procedures, and facilities under the provisions of the applicable health benefits plan. It aids clinicians or members, in cooperation with other parties, to ensure appropriate use of resources. Utilization management is sometimes called “utilization review” or “medical management”.

Related Citation(s):

- i. 42 CFR 422.568
- ii. 42 CFR 4.570
- iii. 42 CFR 422.572
- iv. 42 CFR 438.210(a)(2)
- v. 42 CFR 438.210(a)(3)(i)
- vi. 42 CFR 438.210(a)(4)(ii)(A)
- vii. 42 CFR 438.210(a)(4)(ii)(B)
- viii. 42 CFR 438.210(b)(2)(iii)
- ix. 42 CFR 438.210(e)

Related Document(s):

- x. GA Senate Bill 566
- xi. CareSource Appeal and Grievance Policy
- xii. Policy 1410, *Administrative Denial*
- xiii. Policy 1411, *Clinical Criteria*
- xiv. Policy 1413, *Notice of Adverse Benefit Determination*
- xv. Policy 1415, *Peer-to-Peer Discussion*
- xvi. Policy 0806, *Timeliness of Decision and Notification*

| REVIEW/REVISION HISTORY | |
|-------------------------|--|
| Date | Description of changes |
| 04/2023 | Initial Release; Georgia Marketplace specific document split from 0816 |



POLICY - PROCEDURE

1416 - Post Service Review Policy-Procedure - GA Marketplace

Effective Date: 04/11/2023

| | | | |
|--------------------------|------------------------|-----------------------|------------|
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | GA - Marketplace | | |
| Department: | Utilization Management | Policy Number: | 1416 |

Scope:

This Policy and Procedure document applies to all CareSource business operations as necessary to comply with all local, state and federal regulations, as well as contractual and accreditation standards.

Purpose:

To outline the process for Post Service Review of services that require prior authorization, where an authorization was not obtained prior to delivery of the service.

Policy Statement:

At certain times CareSource conducts Post Service Reviews of medical services received by members when the request is received within thirty (30) calendar days of the date of service, of retrospective enrollment into the plan or in compliance with a specific provider contract. In these instances, the member's medical record is reviewed, and a decision is rendered within thirty (30) calendar days of receiving all information reasonably necessary to make a determination. In the case of an adverse determination, the attending or treating health care Practitioner, institutional Provider and/or Member are notified of the decision and the reason for the decision.

Post Service Reviews which are requested greater than 30 days past date of service or date of retrospective enrollment are administratively denied.

When a provider/practitioner submits a claim related to the delivery of retrospective/post service authorization prior to the review and determination of the request, the claim is denied as the case is pending and no authorization is on file.

A retrospective/post-service review is performed under the following circumstances:

- When a CareSource member is unable to advise the provider, what plan they are enrolled in due to a condition that renders them unresponsive or incapacitated.
- The Member is retrospectively enrolled and covers the date of service.

- When urgent service(s), requiring authorization, was/were performed and it would have been to the member's detriment to take the time to request authorization.
- The new service was not known to be needed at the time the original prior authorized service was performed.
 - The need for the new service was revealed at the time the original authorized service was performed.
- The service is directly related to another service for which prior approval has already been obtained and that has already been performed.
- For services provided to a dual eligible member and the provider is notified that Medicare benefits have been exhausted after delivery of service.
- Based on specific provider contract terms.

Post Service Review is performed by licensed clinicians who are supported by licensed physicians. Post Service Review decisions are based on nationally accepted guidelines or internal Medical Policy as outlined in Policy #1411, Clinical Criteria. Clinical Care Reviewers (CCR) approve requested services when Utilization Management (UM) criteria have been met. Any decision to deny, alter or approve coverage for an admission, service, procedure or extension of stay in an amount, duration or scope that is less than requested is made by the CareSource medical director, BH medical director or designee after evaluating the individual health needs of the Member, characteristics of the local delivery system and, as needed, consultation with the treating physician/practitioner. Incidents of provider's failure to adhere to CareSource contractual requirements may result in an administrative denial in accordance with policy #1410, Administrative Denial. Administrative denials do not require a review by a CareSource Medical Director.

Post Service Review determinations are documented in the appropriate information system to facilitate claim payment and are communicated to the requesting Practitioner/Provider and Member in accordance with Policy #0806, Timeliness of Decision and Notification and/or #1410, Administrative Denial. The medical management documentation system (MMIS) generates and stores an authorization number and the effective dates of the authorization to servicing and requesting providers, regardless of contracted status. Any decision to deny or limit coverage is communicated in writing to the provider, facility/attending physician, and/or member in accordance with Policy #1413, Notice of Adverse Benefit Determination.

Process Steps:

1. Requests for Post Service Review are submitted via telephone, fax, in writing or electronically through the provider portal to the CareSource UM department. Members may request, orally or in writing, a Post Service review of initial services, or continuation of previously requested services in the event a provider does not request a service within appropriate timelines. Practitioners/ Providers must submit a request for Post Service Review in writing via telephone, fax, in writing or electronically through the provider portal.

2. Healthcare Practitioners/Providers are required to submit the numerical diagnosis and procedure codes in order for the service to be considered for authorization.

3. The information gathered for use in a Post Service Review determination includes some, or all, of the following:

- Reason for the Post Service request
- Medical history
- Mental Health and Substance Abuse History
- History of present illness
- Presenting symptoms
- Prior treatment outcomes
- Current clinical status
- Plan of care
- Emergency Room treatment
- Current treatment
- Discharge Plan
- Information regarding condition and instructions at prior discharge if a readmission

4. When the Post Service request meets criteria for review, the UM review clinician may make a determination that coverage for the requested service(s) is medically necessary based on CareSource's accepted UM criteria (See Policy #1411, *Clinical Criteria*). The requesting Practitioner/Provider is notified of this determination as outlined in Policy #0806, *Timeliness of Decision and Notification*.

- When the request does not meet the criteria for Post Service review an Administrative Denial is issued in accordance with Policy #1410, *Administrative Denial*.

5. When the CCR is not able to approve the requested service(s), he/she refers the case to the medical director, BH medical director, or designee for review.

6. In an instance where the medical director gives verbal approval after discussion with the UM review clinician the review clinician documents the approval, along with the reason for the approval, within the specific case notes in the medical management information system.

- The medical director documents in the MMIS no later than the next business day.

7. Except in instances of failure to follow the contractual or policy requirements (i.e., Administrative Denials), a licensed clinician is prohibited from denying, altering or approving a lower or different level of care or scope of services than requested; any such denial or downgrade is made by the medical director, BH medical director or physician designee.

8. The UM review clinician is responsible for communicating the determination to the requesting Practitioner/Provider as outlined in Policy #0806, *Timeliness of Decision and Notification*.

9. When the determination is to deny, alter or approve a lower or different level of care or scope of services than requested, the requesting Practitioner/Provider and/or Member are notified of the determination and applicable appeal rights as outlined in Policy #1413, *Notice of Adverse Benefit Determination*.

Definitions:

Clinical Care Review (CCR) – Registered Nurses (RN), Licensed Practical Nurses (LPN), or Licensed Social Workers (LSW) with active unrestricted and current licenses in a state of the United States in which CareSource operates. CCR's conduct initial clinical reviews and may approve services using established criteria. They do not make adverse determinations. They have access to consultation with a licensed Doctor of Medicine or Doctor of Osteopathic Medicine; a licensed Psychiatrist or licensed health professional in the same licensure category as an ordering provider, or health professional with the same clinical education as an ordering provider in clinical specialties where licensure is not issued.

Clinical Review Criteria: The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by CareSource to determine the Medical Necessity and appropriateness of Health Care Services

Medical Management Information System (MMIS): an electronic data system used by CareSource to document the utilization review authorization and determination process from intake through notification. Access is limited to users with approved log-in (username and password protected). Information entered into the system is automatically stamped with date, time and user identification.

Post Service (retrospective) Review: The process of reviewing and making a coverage decision for care or services that have already been received (e.g., post service decision) or any review of a request for a benefit that is not a prospective review request

Prior Authorization: Utilization review conducted prior to an admission or the provision of a Health Care Service or a course of treatment in accordance with CareSource's requirement that the Health Care Service or course of treatment, in whole or in part, be approved prior to its provision. Also known as Pre-Authorization or Prior Approval.

Utilization Management ("UM"): The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, medication, procedures, and facilities under the provisions of the applicable health benefits plan. It aids clinicians or members, in cooperation with other parties, to ensure appropriate use of resources. Utilization management is sometimes called "utilization review" or "medical management".

Utilization Review: A formal evaluation (pre-service, concurrent or post service) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment.

Related Document(s):

- i. 42 CFR 438.210
- ii. CareSource Provider Handbook
- iii. Evidence of Coverage and Health Insurance Contract - Georgia
- iv. Health Plan Standards for Accreditation – National Committee for Quality Assurance (NCQA) Standards and Guidelines for Health Plans, Utilization Management Standards
- v. Policy #1410, *Administrative Denial*

- vi. Policy #0806, *Timelines of Decision and Notification*
- vii. Policy #1413, *Notice of Adverse Benefit Determination*
- viii. Policy #1411, *Clinical Criteria*

| REVIEW/REVISION HISTORY | |
|-------------------------|--|
| Date | Description of changes |
| 04/2023 | Initial Release; Update to template, update for current processes, definition changes for No Surprise Act, move to Georgia Marketplace specific document split from 0825 |



| PROCEDURE | | | |
|---|--|-------------------|------------|
| 0690.14 - Quality Monitoring of UM Activities Procedure | | | |
| Effective Date: 01/06/2023 | | | |
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | AR - PASSE, GA - D-SNP, GA - Marketplace, GA - Medicaid, GA - Medicare Advantage, IN - D-SNP, IN - Marketplace, IN - Medicaid, IN - Medicare Advantage, KY - D-SNP, KY - Marketplace, KY - Medicare Advantage, OH - D-SNP, OH - Marketplace, OH - Medicaid, OH - Medicare Advantage, OH - MyCare, WV - Marketplace | | |
| Department: | Utilization Management | Procedure Number: | 0690.14 |

Scope:

This Policy and Procedure document applies to all CareSource Utilization Management business operations as necessary to comply with all local, state and federal regulations, as well as all contractual and accreditation standards. The contents of this policy may be copied into a stand-alone document for a specific business operation.

Purpose:

The purpose of the Utilization Management (UM) Clinical audit is to:

- Identify opportunities to address individual performance by providing feedback and training opportunities to staff not meeting the benchmark
- Identify appropriate documentation of service date request and notification of decisions for accuracy in Clinical Operations turnaround time reports
- Determine utilization and application of appropriate medical criteria used by clinical staff is in association with outcomes for services requested
- Identify consistency and suitable routing of cases to the medical directors/BH medical directors/physician designees

Policy Statement:

CareSource assures and monitors continuous quality of utilization management activities performed by UM Staff and the quality of utilization management activities performed by non-clinical utilization management support staff by performing quality assurance reviews and developing standards by which activities are measured.

Process Steps:

- i. 1 Documentation and Inter-rater Reliability Quality Assurance Reviews are mechanisms by which CareSource monitors UM activity for accuracy, consistency, completeness, and compliance.
- ii. Quality assurance reviews for clinical and non-clinical UM Staff are performed on a monthly basis, or more often as needed.
 - A. The process is outlined in the UM Clinical Audit and IRR Process Document
- iii. Quality assurance reviews for the Clinical Care Reviewer (CCR) staff include documentation and Inter-Rater Reliability cases.
- iv. Quality assurance reviews for the UM Intake Specialist staff include documentation, Inter-Rater Reliability and phone calls.
- v. Results of each quality assurance review are tallied on an individual basis. The goal score of the quality assurance reviews is 95% for each UM Staff member.
 - A. When the results of a quality assurance review are below the threshold score, an action plan is developed. The action plan includes direct follow up with the team lead and employee. The action plan may include retraining and retesting to determine understanding of the guideline.
- vi. The results of each quality assurance review are:
 - A. Shared with the UM Staff members in a confidential manner;
 - B. Placed in the UM Staff's employee file; and
 - C. Included in the annual performance evaluation.
- vii. Results of each quality assurance review are compiled and are presented to UM Leadership upon completion.

Definitions:

Inter-rater reliability Quality Assurance Reviews - Evaluate the consistent application of standardized medical and behavioral health criteria when the same case scenario is presented to staff members for review.

Clinical Review Criteria - The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by CareSource to determine the Medical Necessity and appropriateness of Health Care Services

Intake Specialist - Non-clinical staff responsible for the pre-review screening of authorization requests. The Intake Specialists review requests for completeness of information. They collect and transfer non-clinical data and structured clinical data and perform activities that do not require evaluation or interpretation of clinical information. They assist or refer members and/or providers with questions regarding authorizations, authorization process and/or benefit information.

Utilization Management Staff (UM Staff) – Administrative and Professional Staff members with titles such as Intake Specialist or Clinical Care Reviewer

Related Document(s):

- i. Health Plan Standards for Accreditation - Nation Committee for Quality Assurance (NCQA) Standards and Guidelines for Health Plans, Utilization Management Standards
- ii. Policy XXXX, *Application of Clinical Criteria*
- iii. W. Va. Code § 33-25A-17a - *Quality Assurance*
- iv. W. Va. CSR 114-95-1, et seq. – *Utilization Review and Benefit Determination*
- v. W. Va. CSR 114-51-1, et seq. (Only to the extent not Contrary to W. Va. CSR 114-95-1, et seq) - *Quality Assurance*
- vi. W. Va. CSR 114-53-1, et seq. - *Quality Assurance*

| REVIEW/REVISION HISTORY | |
|--------------------------------|--|
| Date | Description of changes |
| 04/2011 | 2011 Annual Review. Added NCQA reference under Source Document and changed to the name of the policy from Quality Audit of Med Mgmt. |
| 06/2011 | Changed language to reference quality assurance/monitoring review rather than quality audit review |
| 09/2011 | Added Behavioral Health Committee. |
| 04/2012 | 2012 Annual Review. Deleted Behavioral Health Committee. |
| 11/2012 | Added KY for KY line of business. |
| 04/2013 | 2013 Annual Review |
| 04/2014 | 2014 Annual Review |
| 04/2015 | 2015 Annual Review |
| 04/2016 | 2016 Annual Review |
| 03/2017 | Changed Beth McIntire to Juan Abreu, changed Medical Management to Utilization Management, and minor spelling corrections. Updated to new P&P template. |
| 08/2017 | Miscellaneous changes. Moved to new templates. |
| 05/2018 | 2018 Annual review |
| 01/2019 | Updated to New Template. Consolidate all separate procedures into on “All States All Lines” procedure. Deleted non-applicable definitions. Minor grammatical revisions. Replace references to “The Plan” with “CareSource”. Updated the Purpose statement. |
| 10/2019 | Miscellaneous changes for P&P Refresh. |
| 10/2020 | 2020 Annual Review; BO Updated |
| 06/2022 | 2022 Annual Review |

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|---------|---|
| 01/2023 | 2023 Annual Review; Update to combined Policy and Procedure document, updated BO, updated for current processes |
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| POLICY | | | |
|---|---|----------------|------------|
| 0690 - UM - Utilization Management Policy | | | |
| Effective Date: 07/06/2022 | | | |
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | AR - PASSE, GA - D-SNP, GA - Marketplace, GA - Medicaid, GA - Medicare Advantage, IN - D-SNP, IN - Marketplace, IN - Medicaid, IN - Medicare Advantage, KY - D-SNP, KY - Marketplace, KY - Medicare Advantage, OH - D-SNP, OH - Marketplace, OH - Medicare Advantage, OH - MyCare, WV - Marketplace | | |
| Department: | Utilization Management | Policy Number: | 0690 |

Purpose:

Utilization Management (UM) is a comprehensive program designed to maximize the effectiveness of the care provided to CareSource members by employing various strategies to monitor and evaluate services delivered by healthcare providers to CareSource members.

The Utilization Management program is designed to achieve the following objectives for all members:

- Assure effective and efficient utilization of facilities and services through an ongoing monitoring and educational program. The program is designed to identify patterns of utilization, such as overutilization, underutilization and inefficient scheduling of resources.
- Assure fair and consistent Utilization Management decision-making by applying consistent, evidence-based criteria and clinical practice guidelines to all medical necessity and coverage determinations.
- Identify members who could benefit from care management and link to appropriate programs
- Assure timely notification of service authorization decisions
- Assist in the promotion and maintenance of optimally achievable quality of care.
- Educate medical providers and other health care professionals on appropriate and cost-effective use of health care resources.

This document outlines CareSource's policy regarding its Utilization Management program, procedures and processes.

Policy Statement:

The UM program encompasses activities associated with the review and authorization of medical, dental and behavioral health care services, appropriate resource utilization, and oversight of delegated activities, and includes prior approval, precertification, prospective, concurrent and retrospective review, discharge planning, case management, and utilization review activities. CareSource's UM program, including the processes outlined herein are reviewed by the Quality Enterprise Committee and the Quality Assurance Committee on an annual basis. It is the policy of CareSource that all Utilization Management activities occur in accordance with applicable federal and state laws, rules and regulations, and accreditation standards. CareSource uses the utilization management strategies below, at a minimum, in meeting UM program standards.

Utilization Management Strategies

1. *Medical Necessity*

Healthcare coverage is limited to items and services that are included in a defined benefit package and are medically necessary. It is the policy of CareSource that all health care services requiring authorization are reviewed for Medical Necessity. CareSource follows federal, state and NCQA decision and notification timeframes for all Utilization Review determinations. Where regulatory and accreditation bodies differ, the strictest/shortest timeframe will be used to assure compliance with all requirements. A determination of whether a covered benefit or service is medically necessary is based on an individualized assessment of the patient's medical needs, and may be expedited if the member's healthcare needs warrant it. CareSource establishes processes and procedures to process expedited requests according to federal and state laws, rules and regulations, and accreditation standards.

Nationally accepted, evidence-based criteria, developed by specialty organizations, national policy committees (clinical practice guidelines) and industry recognized review organizations in addition to State or Federal criteria or regulations are used to assist in making medical necessity decisions. The criteria are based on current clinical principles and processes; and are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria or scripts under review, and updated if necessary. To ensure that clinical guidelines are uniformly and equitably applied in all medical necessity determinations qualified licensed health professionals make UM decisions that require clinical judgement.

All medical necessity determinations that cannot be authorized are reviewed by a Clinical Peer Reviewer with a current medical license and preferably who is board certified in his/her specialty. The Clinical Peer Reviewer is a health care professional, who has appropriate clinical expertise in treating the member's medical condition, could perform

the procedure, or provide the treatment requested. Neither UM staff, nor do Providers, receive compensation or any other incentive which would have the effect of encouraging the denial, limited authorization or reduction suspension or termination of medically necessary services to members.

When a determination is made to authorize or deny all or part of any service requested by a member or provider, the member and provider(s) are notified in writing of the behavioral and Utilization Management determination in accordance with the requirements set forth by regulatory and accrediting bodies. CareSource does not retaliate against any member, or provider who on behalf of a member, exercises a right to appeal an adverse benefit determination. Utilization Management activities comply with all applicable federal, state and local laws including the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA).

2. Prior Authorization

CareSource may determine that certain services must obtain prior approval before a service may be provided to a member in order to control utilization and ensure members receive the right care in the right setting and at the right time. CareSource establishes and follows processes and protocols for ensuring decisions to amend a prior authorization requirement are properly vetted, documented and approved. CareSource does not retroactively deny a service that was previously approved.

3. Prospective (Pre-service) Decisions

For services that do not require prior authorization, members and providers may request a coverage decision request for medical necessity in advance of delivering or receiving a service.

4. Concurrent Review

CareSource uses concurrent reviews to determine whether a current or ongoing course of treatment continues to be medically necessary. Concurrent reviews may occur for both inpatient and outpatient care.

5. Retrospective Review

CareSource uses retrospective reviews to determine whether care or services already received were medically necessary when received. CareSource will allow retrospective reviews in certain circumstances.

6. Use of In-of-Network providers

Caresource works with its contracted provider network to provide high quality care to CareSource members in accordance with evidence-based practices and clinical guidelines. It is always preferable for members to receive care from an In-Network provider; however, CareSource recognizes that there are occasions when it is medically necessary for members to obtain care outside of the provider network. Therefore,

CareSource will follow established processes and criteria for authorizing referrals to out of network providers. If authorization is approved for an out of network provider, the member will be held responsible for in network out of pocket amounts including, annual deductible, copay, or coinsurance as specified in the member's evidence of coverage.

7. Monitoring of Utilization Management Activities

CareSource evaluates the effectiveness of the Utilization Management Program through the evaluation of utilization data gathered from various activities such as authorizations, appeals, clinical practice guidelines, claims and member and provider satisfaction surveys. CareSource monitors utilization data by reviewing the turnaround times, types of determinations, timely notifications, and any other prior authorization monitoring required by State and/or Federal requirements. The UM program is evaluated on an ongoing and annual basis based on reporting of data, outcomes and policy changes for approval by the Quality Enterprise Committee and acceptance by the Quality Assurance Committee, which are multidisciplinary committees. Process improvement activities and adjustments to the UM Program are made as needed. CareSource provides reports and data on the effectiveness and efficiency of the UM program as required by federal, state and accrediting authorities. UM staff members are trained on the clinical practice guidelines for utilization management processes.

CareSource assures and monitors continuous quality of utilization management activities performed by first and second level reviewers and the quality of utilization management activities performed by non-clinical utilization management support staff by performing Standards of Excellence Quality Assurance Reviews. These reviews monitor utilization management activity for accuracy, consistency, completeness, compliance and inter-rater reliability.

The Integrated Management Solutions Committee (IMSC) annually reviews and approves the UM Program, policies and procedures and the use of clinical criteria for alignment with all Federal, State and accreditation standards.

Related Documents:

0690.01 – Desk Reference and Quick Tools Procedure

0690.02 – Post Stabilization Procedure

0690.03 – Accessibility of Review Services Procedure

0690.04 – Continuity of Care Procedure

0690.05 – Medical Necessity Determination Procedure

0690.06 – Requests Services Beyond Defined Benefit Limits Procedure

0690.07 – Request for Clinical Rationale Procedure

0690.08 Application of Clinical Criteria in UM Reviews
0690.10 – Updating the Prior Authorization List

- 0690.11 – Mailing Determination Letters
- 0690.12 – Back Transfers Procedures
- 0690.13 – Monitoring and Evaluating Procedure
- 0690.14 – Quality Monitoring of UM Activities Procedure
- 0690.15 – Pregnancy Termination Procedure
- 0690.16 – Organization Determinations Procedure
- 0690.17 – Out of Network Referrals Procedure
- 0690.18 – Notification of Initial Determination Procedure
- 0690.19 – Transplant Services Procedure
- 0690.21 – BH and Diversionary Services Procedure
- 0690.22 – Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) Procedure
- 0690.23 – Monitoring of Determinations Procedure

| REVIEW/REVISION HISTORY | |
|--------------------------------|--|
| Date | Description of changes |
| 03/2019 | Initial release to P&P Committee |
| 06/2019 | Added language from procedure 0690.13 |
| 12/2019 | Miscellaneous Changes |
| 03/2020 | 2020 Annual Review; BO Updated |
| 05/2020 | Miscellaneous Edits |
| 12/2020 | BO Updated- Reviewed |
| 07/2022 | 2022 Annual Review; BO Updated and removed OH Medicaid |



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| POLICY | | | |
|---|---|----------------|------------|
| 0690 - UM - Utilization Management Policy | | | |
| Effective Date: 07/06/2022 | | | |
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | AR - PASSE, GA - D-SNP, GA - Marketplace, GA - Medicaid, GA - Medicare Advantage, IN - D-SNP, IN - Marketplace, IN - Medicaid, IN - Medicare Advantage, KY - D-SNP, KY - Marketplace, KY - Medicare Advantage, OH - D-SNP, OH - Marketplace, OH - Medicare Advantage, OH - MyCare, WV - Marketplace | | |
| Department: | Utilization Management | Policy Number: | 0690 |

Purpose:

Utilization Management (UM) is a comprehensive program designed to maximize the effectiveness of the care provided to CareSource members by employing various strategies to monitor and evaluate services delivered by healthcare providers to CareSource members.

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- Assure effective and efficient utilization of facilities and services through an ongoing monitoring and educational program. The program is designed to identify patterns of utilization, such as overutilization, underutilization and inefficient scheduling of resources.
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- Identify members who could benefit from care management and link to appropriate programs
- Assure timely notification of service authorization decisions
- Assist in the promotion and maintenance of optimally achievable quality of care.
- Educate medical providers and other health care professionals on appropriate and cost-effective use of health care resources.

This document outlines CareSource's policy regarding its Utilization Management program, procedures and processes.

Policy Statement:

The UM program encompasses activities associated with the review and authorization of medical, dental and behavioral health care services, appropriate resource utilization, and oversight of delegated activities, and includes prior approval, precertification, prospective, concurrent and retrospective review, discharge planning, case management, and utilization review activities. CareSource's UM program, including the processes outlined herein are reviewed by the Quality Enterprise Committee and the Quality Assurance Committee on an annual basis. It is the policy of CareSource that all Utilization Management activities occur in accordance with applicable federal and state laws, rules and regulations, and accreditation standards. CareSource uses the utilization management strategies below, at a minimum, in meeting UM program standards.

Utilization Management Strategies

1. *Medical Necessity*

Healthcare coverage is limited to items and services that are included in a defined benefit package and are medically necessary. It is the policy of CareSource that all health care services requiring authorization are reviewed for Medical Necessity. CareSource follows federal, state and NCQA decision and notification timeframes for all Utilization Review determinations. Where regulatory and accreditation bodies differ, the strictest/shortest timeframe will be used to assure compliance with all requirements. A determination of whether a covered benefit or service is medically necessary is based on an individualized assessment of the patient's medical needs, and may be expedited if the member's healthcare needs warrant it. CareSource establishes processes and procedures to process expedited requests according to federal and state laws, rules and regulations, and accreditation standards.

Nationally accepted, evidence-based criteria, developed by specialty organizations, national policy committees (clinical practice guidelines) and industry recognized review organizations in addition to State or Federal criteria or regulations are used to assist in making medical necessity decisions. The criteria are based on current clinical principles and processes; and are evaluated at least annually by appropriate, actively practicing physicians and other providers with current knowledge relevant to the criteria or scripts under review, and updated if necessary. To ensure that clinical guidelines are uniformly and equitably applied in all medical necessity determinations qualified licensed health professionals make UM decisions that require clinical judgement.

All medical necessity determinations that cannot be authorized are reviewed by a Clinical Peer Reviewer with a current medical license and preferably who is board certified in his/her specialty. The Clinical Peer Reviewer is a health care professional, who has appropriate clinical expertise in treating the member's medical condition, could perform

the procedure, or provide the treatment requested. Neither UM staff, nor do Providers, receive compensation or any other incentive which would have the effect of encouraging the denial, limited authorization or reduction suspension or termination of medically necessary services to members.

When a determination is made to authorize or deny all or part of any service requested by a member or provider, the member and provider(s) are notified in writing of the behavioral and Utilization Management determination in accordance with the requirements set forth by regulatory and accrediting bodies. CareSource does not retaliate against any member, or provider who on behalf of a member, exercises a right to appeal an adverse benefit determination. Utilization Management activities comply with all applicable federal, state and local laws including the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA).

2. Prior Authorization

CareSource may determine that certain services must obtain prior approval before a service may be provided to a member in order to control utilization and ensure members receive the right care in the right setting and at the right time. CareSource establishes and follows processes and protocols for ensuring decisions to amend a prior authorization requirement are properly vetted, documented and approved. CareSource does not retroactively deny a service that was previously approved.

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For services that do not require prior authorization, members and providers may request a coverage decision request for medical necessity in advance of delivering or receiving a service.

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CareSource uses concurrent reviews to determine whether a current or ongoing course of treatment continues to be medically necessary. Concurrent reviews may occur for both inpatient and outpatient care.

5. Retrospective Review

CareSource uses retrospective reviews to determine whether care or services already received were medically necessary when received. CareSource will allow retrospective reviews in certain circumstances.

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Caresource works with its contracted provider network to provide high quality care to CareSource members in accordance with evidence-based practices and clinical guidelines. It is always preferable for members to receive care from an In-Network provider; however, CareSource recognizes that there are occasions when it is medically necessary for members to obtain care outside of the provider network. Therefore,

CareSource will follow established processes and criteria for authorizing referrals to out of network providers. If authorization is approved for an out of network provider, the member will be held responsible for in network out of pocket amounts including, annual deductible, copay, or coinsurance as specified in the member's evidence of coverage.

7. Monitoring of Utilization Management Activities

CareSource evaluates the effectiveness of the Utilization Management Program through the evaluation of utilization data gathered from various activities such as authorizations, appeals, clinical practice guidelines, claims and member and provider satisfaction surveys. CareSource monitors utilization data by reviewing the turnaround times, types of determinations, timely notifications, and any other prior authorization monitoring required by State and/or Federal requirements. The UM program is evaluated on an ongoing and annual basis based on reporting of data, outcomes and policy changes for approval by the Quality Enterprise Committee and acceptance by the Quality Assurance Committee, which are multidisciplinary committees. Process improvement activities and adjustments to the UM Program are made as needed. CareSource provides reports and data on the effectiveness and efficiency of the UM program as required by federal, state and accrediting authorities. UM staff members are trained on the clinical practice guidelines for utilization management processes.

CareSource assures and monitors continuous quality of utilization management activities performed by first and second level reviewers and the quality of utilization management activities performed by non-clinical utilization management support staff by performing Standards of Excellence Quality Assurance Reviews. These reviews monitor utilization management activity for accuracy, consistency, completeness, compliance and inter-rater reliability.

The Integrated Management Solutions Committee (IMSC) annually reviews and approves the UM Program, policies and procedures and the use of clinical criteria for alignment with all Federal, State and accreditation standards.

Related Documents:

0690.01 – Desk Reference and Quick Tools Procedure

0690.02 – Post Stabilization Procedure

0690.03 – Accessibility of Review Services Procedure

0690.04 – Continuity of Care Procedure

0690.05 – Medical Necessity Determination Procedure

0690.06 – Requests Services Beyond Defined Benefit Limits Procedure

0690.07 – Request for Clinical Rationale Procedure

0690.08 Application of Clinical Criteria in UM Reviews
0690.10 – Updating the Prior Authorization List

- 0690.11 – Mailing Determination Letters
- 0690.12 – Back Transfers Procedures
- 0690.13 – Monitoring and Evaluating Procedure
- 0690.14 – Quality Monitoring of UM Activities Procedure
- 0690.15 – Pregnancy Termination Procedure
- 0690.16 – Organization Determinations Procedure
- 0690.17 – Out of Network Referrals Procedure
- 0690.18 – Notification of Initial Determination Procedure
- 0690.19 – Transplant Services Procedure
- 0690.21 – BH and Diversionary Services Procedure
- 0690.22 – Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) Procedure
- 0690.23 – Monitoring of Determinations Procedure

| REVIEW/REVISION HISTORY | |
|--------------------------------|--|
| Date | Description of changes |
| 03/2019 | Initial release to P&P Committee |
| 06/2019 | Added language from procedure 0690.13 |
| 12/2019 | Miscellaneous Changes |
| 03/2020 | 2020 Annual Review; BO Updated |
| 05/2020 | Miscellaneous Edits |
| 12/2020 | BO Updated- Reviewed |
| 07/2022 | 2022 Annual Review; BO Updated and removed OH Medicaid |



POLICY - PROCEDURE

1068 - UM Application of Clinical Criteria Reviews Policy-Procedure

Effective Date: 05/05/2023

| | | | |
|--------------------------|---|-----------------------|------------|
| Business Owner: | Honig, Deronda | Approver: | Russo, Amy |
| Line of Business: | AR - PASSE, GA - D-SNP, GA - Marketplace, GA - Medicaid, GA - Medicare Advantage, IN - D-SNP, IN - Marketplace, IN - Medicaid, IN - Medicare Advantage, KY - D-SNP, KY - Marketplace, KY - Medicaid, KY - Medicare Advantage, NC - Marketplace, OH - D-SNP, OH - Marketplace, OH - Medicaid, OH - Medicare Advantage, OH - MyCare, WV - Marketplace | | |
| Department: | Utilization Management | Policy Number: | 1068 |

Scope:

This Policy and Procedure document applies to all CareSource business operations as necessary to comply with all local, state and federal regulations, as well as contractual and accreditation standards.

Purpose:

CareSource evaluates the consistency among the Utilization Management (UM) staff in application of established criteria, standards and CareSource Medical Policy in utilization review and clinical processes. This document outlines CareSource's policy regarding Inter-Rater Reliability (IRR) procedures established to meet the needs of members, regulators and stakeholders.

Policy Statement:

The Clinical Operations Training and Auditing team conducts, at a minimum, semi-annual IRR assessments of the UM staff. The purpose for IRR assessment is to:

- Determine consistency in staff adherence to organizational clinical criteria and/or standards;
- Minimize variation in application of clinical guidelines;
- Identify areas of improvement and staff in need of additional training; and
- Eliminate and/or minimize litigation due to inconsistently applied guidelines.

Process Steps:

1. All Clinical Care Reviewers (CCR) are required to complete a minimum of two IRR review assessments on a semi-annual basis. Factually based scenarios are applied to determinations made as part of the review criteria (i.e., MCG, CareSource Policy, and regulatory guidelines).
 - a. Each IRR assessment includes a minimum of five multiple choice questions.
 - b. Each individual reviewer must score 95% or greater to pass the IRR assessment.
2. Each individual reviewer failing to meet the minimum passing threshold of 95% or greater retakes the IRR assessment once within the same testing period, within four weeks of the initial IRR failed assessment. The average of both test scores, conducted within the same testing period, is reported as the individual's final score. Individuals noted to score below 95% on their first and subsequent attempts are subject to a defined action plan.
3. Action plans for staff who do not meet the minimum passing threshold of 95% or greater are as follows:
 - a. First failed attempt: coaching/training, self-study, and documentation within employee file.
 - i. The Team Lead/Manager performs IRR coaching/training.
 - ii. Coaching/training is completed within two weeks of failed IRR assessment.
 - b. Second consecutive failed attempt: written warning and employee file documentation.
 - c. Third consecutive failed attempt: final written warning, employee file documentation and possible further action, up to and including termination.
4. The UM Directors and/or designees are responsible for actioning upon identified deficiencies.
5. The UM Directors and/or designees report all IRR results, including opportunities for improvement to the UM Senior Director and UM Vice President for discussion during quarterly UMCM Committee meetings.
 - a. The Senior Director and Vice President of UM for discussion during quarterly UMCM Committee meetings.

Definitions:

Clinical Care Reviewer (CCR) – Also referred to as Service Determination Specialists; CCRs include Registered Nurses (RN), Licensed Practical Nurses (LPN), Licensed Social Workers (LSW), and Licensed Psychological Examiners (LPE) and master's level clinicians with experience with HCBS services, with active, unrestricted and current licenses in the state of Arkansas. CCR's conduct initial clinical reviews and may approve services using established criteria. They do not make adverse determinations. When unable to approve, they have access to consultation with a licensed Doctor of Medicine or Doctor of Osteopathic Medicine; a

licensed Psychiatrist or licensed health professional in the same licensure category as an ordering/treating provider. In clinical specialties where licensure is not issued, or health professional with the same clinical education as an ordering/treating provider is consulted. in clinical specialties where licensure is not issued.

Clinical Review Criteria – The written screening procedures, decision abstracts, clinical protocols and practice guidelines used by CareSource to determine medical necessity and appropriateness of Health Care Services.

Inter-Rater Reliability Assessment (“IRR”) - A performance measurement audit involving a comparison of responses for a control group with a standard. IRR Assessments minimize variation in the application of clinical guidelines; evaluate the rater’s ability to identify potentially avoidable utilization and/or quality of care issues, identify areas or individuals in need of remediation and to avoid litigation due to inconsistently applied guidelines.

MCG® - Annually updated, evidence-based clinical guidelines that cover the continuum of care, including chronic care and behavioral health management. In addition to the Guidelines, several tools are included such as care pathway tables, flagged quality measures, and integrated medical evidence.

Utilization Review - A formal evaluation (pre-service, concurrent or post service) of the coverage, medical necessity, efficiency or appropriateness of health care services and treatment.

Related Citation(s):

- i. Health Plan Standards for Accreditation - National Committee for Quality Assurance (NCQA) Standards and Guidelines for Health Plans, Utilization Management Standards

Related Document(s):

N/A

| REVIEW/REVISION HISTORY | |
|-------------------------|---|
| Date | Description of changes |
| 01/2014 | Initial Release to P&P Committee |
| 04/2014 | No Changes |
| 12/2014 | Updated with to include Kentucky and Indiana lines of business effective 01/01/2015. |
| 04/2015 | 2015 Annual Review |
| 04/2016 | 2016 Annual Review; Combined Corporate and Exchange policies, with exclusion of KY Medicaid. Retired MM-19-M to create MM-36. |
| 07/2016 | Miscellaneous revisions. |
| 03/2017 | Changed Beth McIntire to Juan Abreu, changed Medical Management to Utilization Management, and minor spelling corrections. Updated to new P&P template. |
| 10/2017 | Updated to new templates. |

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|---------|---|
| 04/2018 | Removed comment to Indiana within the Medical Necessity description |
| 07/2018 | Added Purpose/Description |
| 09/2018 | Miscellaneous Changes. |
| 04/2019 | Updated for P&P Refresh. New Template. New Number. Replaces MM-36. |
| 08/2019 | P&P ownership changed/updated, all business areas performing IRR assessment now under one standardized IRR process included/updated and a defined action plan created/updated; Replaces 0690.08 |
| 12/2020 | 2020 Annual review; BO Updated |
| 02/2022 | Updated to new templates, miscellaneous revisions, BO update |
| 05/2022 | Update to reflect current processes, move to combined Policy and Procedure document |
| 03/2023 | Move to UM specific document, updated for current processes |