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Prior Authorization Guideline

Guideline ID	GL-144743
Guideline Name	Acetaminophen (Dose > 4 gm)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/21/2024

1 . Criteria

Product Name:Acetaminophen (Dose > 4gm)	
Diagnosis	DUR Reject 88 (Total APAP > 4 g)
Guideline Type	DUR Reject 88
Approval Criteria **1** - Requests for acetaminophen dosages greater than 4000mg per day should be denied. The total dose of acetaminophen (cumulative total daily dose of 4000mg) is not supported by the Food and Drug Administration (FDA).	
Notes	Note: Reject message: "DUR1:APAP = Total APAP >4g; Verify dose; EnterO/R -"

2 . Revision History

Date	Notes
3/21/2024	Guideline type changed from Administrative to DUR Reject 88

Prior Authorization Guideline

Guideline ID	GL-224208
Guideline Name	Acthar Gel, Cortrophin Gel
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:Acthar Gel vial	
Diagnosis	Infantile spasm (i.e., West Syndrome)*
Approval Length	4 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of infantile spasms (i.e., West Syndrome)*

AND

2 - Patient is less than 2 years old

AND

3 - Both of following:

3.1 Initial dose: 75 units per meters squared intramuscular (IM) twice daily for 2 weeks

AND

3.2 After 2 weeks, dose should be tapered according to the following schedule: 30 units per meters squared IM in the morning for 3 days; 15 units per meters squared IM in the morning for 3 days; 10 units per meters squared IM in the morning for 3 days; 10 units per meters squared IM every other morning for 6 days (3 doses)

Notes	*Note: Acthar Gel is not medically necessary for treatment of acute ex acerbations of multiple sclerosis.

Product Name:Acthar Gel, Cortrophin	
Diagnosis	Opsoclonus-myoclonus syndrome (i.e., OMS, Kinsbourne Syndrome)*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Opsoclonus-myoclonus syndrome (i.e., OMS, Kinsbourne Syndrome)*

AND

2 - For Cortrophin requests ONLY: Trial and failure or intolerance to Acthar Gel (verified via paid pharmacy claims or submission of medical records/chart notes)

Notes	*Note: Acthar Gel is not medically necessary for treatment of acute ex acerbations of multiple sclerosis.

2 . Revision History

Date	Notes
3/26/2025	Added new GPIs for Acthar and Cortrophin

Prior Authorization Guideline

Guideline ID	GL-99673
Guideline Name	Actimmune
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Actimmune	
Diagnosis	Chronic Granulomatous Disease (CGD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic granulomatous disease	

Product Name:Actimmune	
Diagnosis	Chronic Granulomatous Disease (CGD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Actimmune

Product Name:Actimmune	
Diagnosis	Severe, Malignant Osteopetrosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe, malignant osteopetrosis

Product Name:Actimmune	
Diagnosis	Severe, Malignant Osteopetrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Actimmune

Product Name:Actimmune	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Mycosis fungoides (MF)
- Sézary syndrome (SS)

Product Name:Actimmune	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Actimmune

Product Name:Actimmune	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Actimmune will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Actimmune	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Actimmune therapy

2 . Revision History

Date	Notes
6/7/2021	7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-124866
Guideline Name	Adacel TDAP vaccine
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2023

1 . Criteria

Product Name:Adacel	
Diagnosis	Pregnant Patients 19 years of age and older*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

2 - Vaccine is being used to prevent pertussis in infants younger than 2 months of age

AND

1 - Patient is 19 years of age or older **AND** **3** - Both of the following: • Patient is pregnant • Vaccine is being administered during 3rd trimester of pregnancy

Notes	*Note: Patients under 19 years of age must get immunization from PCP or pediatrician through the VFC (Vaccines For Children) Program

2 . Revision History

Date	Notes
4/20/2023	New program

Prior Authorization Guideline

Guideline ID	GL-226191
Guideline Name	Adakveo (crizanlizumab-tmca)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:Adakveo	
Diagnosis	Sickle cell disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of sickle cell disease, identified by any genotype

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Age 16 to 20 years
- Prescriber attests the service is medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness in an eligible patient

OR

2.2 Age greater than or equal to 21 years

AND

3 - Patient has experienced at least two vaso-occlusive crises within the past 12 months

AND

4 - Trial and failure or inadequate response, contraindication, or intolerance to hydroxyurea

Product Name:Adakveo	
Diagnosis	Sickle cell disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., reduction in annual rate of vaso-occlusive events, increased time between each vaso-occlusive event)

2 . Revision History

Date	Notes
3/26/2025	Added step through HXU to initial auth, added reauth criteria.

Prior Authorization Guideline

Guideline ID	GL-525274
Guideline Name	Adalimumab
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderately to severely active rheumatoid arthritis	

AND

2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming a history of failure to a minimum duration of a 6-week trial, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:

- leflunomide
- methotrexate

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis (AS)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to TWO NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Ankylosing Spondylitis (AS)

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis (PsA)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

3 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

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

- Rheumatologist
- Dermatologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe chronic plaque psoriasis (PsO)

AND

2 - Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

3 - Both of the following:

3.1 Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Vtama
- Zoryve 0.3% cream

AND

3.2 Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

4 - Prescribed by or in consultation with a dermatologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to at least ONE oral antibiotic (e.g., doxycycline, clindamycin, rifampin) at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

3 - Prescribed by or in consultation with a dermatologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Plaque Psoriasis (PsO), Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a dermatologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Adult Crohn's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease

AND

2 - ONE of the following:

2.1 Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- Azathioprine (Imuran)
- 6-mercaptopurine (Purinethol)
- Methotrexate (Rheumatrex, Trexall)

OR

2.2 Patient has lost response or intolerant to infliximab (e.g., Remicade, Inflectra, Renflexis)

AND

3 - Prescribed by or in consultation with a gastroenterologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Pediatric Crohn's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn's disease

AND

2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- Azathioprine (Imuran)
- 6-mercaptopurine (Purinethol)
- Methotrexate (Rheumatrex, Trexall)

AND

3 - Prescribed by or in consultation with a gastroenterologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis

AND

2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Aminosalicylates (e.g., mesalamine, sulfasalazine)

AND

3 - Prescribed by or in consultation with a gastroenterologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Adult Crohn’s Disease, Pediatric Crohn’s Disease, Ulcerative Colitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a gastroenterologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Uveitis (UV)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-infectious uveitis

AND

2 - Uveitis is classified as ONE of the following:

- intermediate
- posterior
- panuveitis

AND

3 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to at least ONE corticosteroid (e.g., prednisolone, prednisone) at maximally indicated

dose within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

4 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to at least ONE systemic non-biologic immunosuppressant (e.g., methotrexate, cyclosporine, azathioprine, mycophenolate) at a maximally indicated dose within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

5 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Ophthalmologist

Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Preferred*: Unbranded Adalimumab-fkjp (Biocon manufacturer), Hadlima, Adalimumab-adbm 10mg/0.2ml	
Diagnosis	Uveitis (UV)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

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

- Rheumatologist

• Ophthalmologist	
Notes	*NOTE: Please approve at NDC level (refer to background table for lis t of preferred adalimumab biosimilars).

Product Name:Non-Preferred*: Brand Humira, Abrilada, Amjevita, Cyltezo, Brand Adalimumab-adbm, Hulio, Hyrimoz, Brand Adalimumab-adaz, Idacio, Brand Adalimumab-aacf, Brand Adalimumab-ryvk, Simlandi, Yuflyma, Brand Adalimumab-aaty, Yusimry, and newly launched adalimumab products	
Approval Length	Requests for Non-Preferred biosimilars are not approved at this time
Guideline Type	Prior Authorization
Approval Criteria **1** - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred products are Unbranded Adalimumab-fkjp, Hadlima, and Adalimumab-adbm 10mg/0.2ml. **Please note: The drug(s) listed above may require additional review.	
Notes	*Patients must use preferred adalimumab biosimilar (refer to backgrou nd table for list of preferred adalimumab biosimilars).

2 . Background

Benefit/Coverage/Program Information

Preferred Adalimumab Biosimilars

NDC	Product Label	GPI-14	GPI-14 Description
49502041602	ADALIMU-FKJP KIT 40/0.8ML	6627001535F520	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML
83257002232	ADALIMU-FKJP KIT 40/0.8ML	6627001535F520	ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40 MG/0.8ML
49502041702	ADALIMU-FKJP KIT 20/0.4ML	6627001535F810	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML

83257002042	ADALIMU-FKJP KIT 20/0.4ML	6627001535F810	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 20 MG/0.4ML
49502041802	ADALIMU-FKJP KIT 40/0.8ML	6627001535F820	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML
83257002142	ADALIMU-FKJP KIT 40/0.8ML	6627001535F820	ADALIMUMAB-FKJP PREFILLED SYRINGE KIT 40 MG/0.8ML
78206018701	HADLIMA PUSH INJ 40/0.4ML	6627001520D510	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.4ML
78206018401	HADLIMA PUSH INJ 40/0.8ML	6627001520D520	ADALIMUMAB-BWWD SOLN AUTO-INJECTOR 40 MG/0.8ML
78206018601	HADLIMA INJ 40/0.4ML	6627001520E510	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.4ML
78206018301	HADLIMA INJ 40/0.8ML	6627001520E520	ADALIMUMAB-BWWD SOLN PREFILLED SYRINGE 40 MG/0.8ML
00597058589	ADALIMU-ADBM KIT 10/0.2ML	6627001505F805	ADALIMUMAB-ADBM PREFILLED SYRINGE KIT 10 MG/0.2ML

3 . Revision History

Date	Notes
2/26/2026	Added GPI for adalimumab-ryvk

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-739228
Guideline Name	Adbry (tralokinumab-ldrm)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Adbry	
Diagnosis	Atopic Dermatitis
Approval Length	6 Months*
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderate to severe atopic dermatitis	

AND

2 - Submission of documentation (e.g., chart notes) demonstrating one of the following:

- Involvement of at least 10% body surface area (BSA)
- SCORing Atopic Dermatitis (SCORAD) index value of at least 25 [A]

AND

3 - Patient is 12 years of age or older

AND

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

- Dermatologist
- Allergist/Immunologist

AND

5 - History of failure, contraindication, or intolerance to TWO of the following: (document drug, date of trial, and/or contraindication to medication)**

- Opzelura (ruxolitinib)
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.15% cream

Notes	*QL Override (For new starts only): Enter 2 PAs as follows: First PA: Approve 6 syringes per 28 days for one month; Second PA: Approve 4 syringes per 28 days (no overrides needed) for the remaining 11 mo nths. (Adbry is hard-coded with a quantity of 4 syringes per 28 days). **Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication

Product Name:Adbry	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) demonstrating positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in body surface area involvement from baseline
- Reduction in SCORing Atopic Dermatitis (SCORAD) index value from baseline [A]

AND

2 - History of failure, contraindication, or intolerance to TWO of the following: (document drug, date of trial, and/or contraindication to medication)*

- Opzelura (ruxolitinib)
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.15% cream

AND

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

- Dermatologist
- Allergist/Immunologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication

2 . Revision History

Date	Notes
9/30/2026	Updated step through first line therapies, added step and prescriber r eq to reauth.

Prior Authorization Guideline

Guideline ID	GL-669262
Guideline Name	ADHD Agents - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Brand Adderall, generic amphetamine/dextroamphetamine tablets, Brand Adderall XR, generic amphetamine/dextroamphetamine ER capsules, Brand Aptensio XR, generic atomoxetine, Brand Concerta, generic methylphenidate ER OSM tablets, generic dexmethylphenidate tablets, generic dexmethylphenidate ER, generic dextroamphetamine tablets, Brand Focalin, Brand Focalin XR, generic lisdexamfetamine capsules and chewables, Brand Methylin solution, generic methylphenidate solution, generic methylphenidate tablets, generic methylphenidate ER tablets, generic methylphenidate ER (CD) capsules, generic methylphenidate ER (LA) capsules, generic methylphenidate ER (XR) capsules, generic methylphenidate patch, Brand Ritalin, Brand Ritalin LA, Brand Strattera, Brand Vyvanse capsules and chewables, Brand Zenzedi	
Diagnosis	PA Required for Children Under 6 Years Old
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The requesting clinician has documented that the child has a diagnosis of attention deficit hyperactivity disorder (ADHD)

AND

2 - The requesting clinician has documented that psychosocial issues have been evaluated before request for ADHD medications

AND

3 - The requesting clinician has documented non-medication alternatives that have been attempted before request for ADHD medications

AND

4 - The requested dose does NOT exceed the Food and Drug Administration (FDA) recommended maximum daily dosage unless the provider has submitted clinical justification for the dose exceeding the FDA maximum

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:Brand Intuniv, generic guanfacine IR/ER, Brand Kapvay, generic clonidine IR/ER	
Diagnosis	PA Required for Children Under 6 Years Old
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 The requesting clinician has documented that the child has a diagnosis of attention deficit hyperactivity disorder (ADHD)

AND

1.1.2 The requesting clinician has documented that psychosocial issues have been evaluated before request for ADHD medications

AND

1.1.3 The requesting clinician has documented non-medication alternatives that have been attempted before request for ADHD medications

AND

1.1.4 The requested dose does NOT exceed the Food and Drug Administration (FDA) recommended maximum daily dosage unless the provider has submitted clinical justification for the dose exceeding the FDA maximum

OR

1.2 Both of the following:

1.2.1 Diagnosis of insomnia

AND

1.2.2 Trial and failure, contraindication, or intolerance to melatonin

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:NON-PREFERRED DRUGS: Arynta

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a history of failure, contraindication, or intolerance to BOTH of the following:

- generic lisdexamfetamine capsules (opened/mixed with yogurt, water, or orange juice per PI)
- generic lisdexamfetamine chewables

Notes	*Alternatives may require prior authorization

Product Name:NON-PREFERRED DRUGS: Atoncy, atomoxetine oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a history of failure, contraindication, or intolerance to a trial to THREE of the following preferred products*:

- Brand Adderall
- generic amphetamine/dextroamphetamine tablets
- generic methylphenidate ER OSM release tablets (generic for Concerta)
- generic dexmethylphenidate IR tablets or ER capsules
- generic methylphenidate solution
- generic methylphenidate tablets
- Brand Ritalin LA or generic methylphenidate LA capsules
- generic methylphenidate ER (CD) capsules
- generic clonidine ER
- generic guanfacine ER
- generic dextroamphetamine tablets
- generic lisdexamfetamine capsules or chewables (generic for Vyvanse)

AND

2 - The patient has a history of failure, contraindication, or intolerance to generic atomoxetine capsules

Notes	*Alternatives may require prior authorization

Product Name:NON-PREFERRED DRUGS: Onyda XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a history of failure, contraindication, or intolerance to a trial to THREE of the following preferred products*:

- Brand Adderall
- generic amphetamine/dextroamphetamine tablets
- generic methylphenidate ER OSM release tablets (generic for Concerta)
- generic dexmethylphenidate IR tablets or ER capsules
- generic methylphenidate solution
- generic methylphenidate tablets
- Brand Ritalin LA or generic methylphenidate LA capsules
- generic methylphenidate ER (CD) capsules
- generic lisdexamfetamine capsules or chewables (generic for Vyvanse)
- generic atomoxetine
- generic clonidine ER
- generic guanfacine ER
- generic dextroamphetamine tablets

AND

2 - The patient has a history of failure, contraindication, or intolerance to generic clonidine patch

Notes	*Alternatives may require prior authorization

Product Name:NON-PREFERRED DRUGS: Xelstrym patch	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a history of failure, contraindication, or intolerance to a trial to THREE of the following preferred products*:

- Brand Adderall
- generic amphetamine/dextroamphetamine tablets
- generic methylphenidate ER OSM release tablets (generic for Concerta)
- generic dexmethylphenidate IR tablets or ER capsules
- generic methylphenidate solution
- generic methylphenidate tablets
- Brand Ritalin LA or generic methylphenidate LA capsules
- generic methylphenidate ER (CD) capsules
- generic lisdexamfetamine capsules or chewables (generic for Vyvanse)
- generic atomoxetine
- generic clonidine ER
- generic guanfacine ER
- generic dextroamphetamine tablets

AND

2 - The patient has a history of failure, contraindication, or intolerance to generic methylphenidate patch

Notes	*Alternatives may require prior authorization

Product Name:NON-PREFERRED DRUGS: Brand Adderall XR, Brand Adhansia XR, Adzenys XR-ODT, Amphetamine ER ODT, generic amphetamine IR tablets, generic amphetamine ER suspension, generic amphetamine/dextroamphetamine ER capsules, Brand Aptensio XR, Brand Azstarys, Brand Concerta, Brand Cotempla XR-ODT, generic methylphenidate ER-ODT, Brand Desoxyn, Brand Dexedrine, generic dextroamphetamine oral solution, generic dextroamphetamine ER, Brand Dyanavel XR (oral suspension and chewable tablets), Brand Evekeo, Brand Evekeo ODT, Brand Focalin, Brand Focalin XR, Brand Intuniv, Brand Jornay PM, Brand Kapvay, generic methamphetamine, generic methylphenidate chewable, Brand Methylin solution, generic methylphenidate ER tablets, generic methylphenidate ER (XR) capsules, Brand Mydayis, Brand Procentra, Brand Qelbree, Brand Quillichew ER, Brand Quillivant XR, Relexxii, Brand Ritalin, Brand Strattera, Brand Vyvanse capsules, Brand Vyvanse chewables, Brand Zenzedi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a history of failure, contraindication, or intolerance to a trial to FOUR of the following preferred products*:

- Brand Adderall
- generic amphetamine/dextroamphetamine tablets
- generic methylphenidate ER OSM release tablets (generic for Concerta)
- generic methylphenidate patch
- generic dexmethylphenidate IR tablets or ER capsules
- generic methylphenidate solution
- generic methylphenidate tablets
- Brand Ritalin LA or generic methylphenidate LA capsules
- generic methylphenidate ER (CD) capsules
- generic lisdexamfetamine capsules or chewables (generic for Vyvanse)
- generic atomoxetine
- generic clonidine ER
- generic guanfacine ER
- generic dextroamphetamine tablets

AND

2 - If the request is for a multi-source brand medication (i.e., MSC O) ONE of the following:

2.1 BOTH of the following:

- The brand is being requested because of an adverse reaction, allergy or sensitivity to the generic and the prescriber must attest to submitting the FDA MedWatch Form for allergic reactions to the medications
- The patient has tried three generic formulations (if available) of the requested brand product

OR

2.2 ONE of the following:

- The brand is being requested due to a therapeutic failure with the generic (please provide reason for therapeutic failure)
- The brand is being requested because transition to the generic could result in destabilization of the patient (rationale must be provided)

• Special clinical circumstances exist that preclude the use of the generic equivalent of the multi-source brand medication for the patient (rationale must be provided)	
Notes	*Alternatives may require prior authorization

2 . Revision History

Date	Notes
7/28/2026	Brand Vyvanse to NPD effective 8/1/26; updated preferred prereqs. Updated Arynta step, Added generic atomoxetine soln and generic m ethylphenidate ER-ODT as NPD targets.

Prior Authorization Guideline

Guideline ID	GL-756213
Guideline Name	Adquey (difamilast)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Adquey	
Diagnosis	Atopic Dermatitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of mild to moderate atopic dermatitis

AND

2 - Patient is 2 years of age or older

AND

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

- Dermatologist
- Allergist/Immunologist

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming a trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to ALL of the following:

- Medium or higher potency topical corticosteroid
- Generic topical calcineurin inhibitor (e.g., tacrolimus ointment)
- Eucrisa (crisaborole)
- Opzelura (ruxolitinib)
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.05% or 0.15% cream

AND

5 - Not used in combination with other nonsteroidal topical agents or systemic therapies for atopic dermatitis

Product Name:Adquey	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by ONE of the following:

- Reduction in body surface area involvement from baseline
- Reduction in pruritus severity from baseline
- Improvement in quality of life from baseline

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to ALL of the following:

- Medium or higher potency topical corticosteroid
- Generic topical calcineurin inhibitor (e.g., tacrolimus ointment)
- Eucrisa (crisaborole)
- Opzelura (ruxolitinib)
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.05% or 0.15% cream

AND

3 - Not used in combination with other nonsteroidal topical agents or systemic therapies for atopic dermatitis

2 . Background

Benefit/Coverage/Program Information

Table 1. Relative potencies of topical corticosteroids [2]

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment	0.05

	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream	0.1
	Triamcinolone acetonide	Cream, ointment	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
10/28/2026	New program

Prior Authorization Guideline

Guideline ID	GL-143519
Guideline Name	Adzynma (ADAMTS13, recombinant-krhn)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2024

1 . Criteria

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

Approval Criteria

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

1.1 Diagnosis of congenital thrombotic thrombocytopenic purpura (cTTP)

AND

1.2 Molecular genetic testing confirms mutations in the ADAMTS13 gene

AND

1.3 Trial and inadequate response, contraindication or intolerance to plasma-based infusions

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

2 - Trial and inadequate response, contraindication or intolerance to plasma-based infusions [B, 11]

2 . Revision History

Date	Notes
2/23/2024	New program

Prior Authorization Guideline

Guideline ID	GL-99426
Guideline Name	Aemcolo
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Aemcolo	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of travelers' diarrhea

AND

2 - History of failure, contraindication, or intolerance to ONE of the following:

- Azithromycin (generic Zithromax)
- Ciprofloxacin (generic Cipro)
- Levofloxacin (generic Levaquin)
- Ofloxacin (generic Floxin)

2 . Revision History

Date	Notes
3/10/2021	Bulk Copy C&S Arizona to Arizona Standard

Prior Authorization Guideline

Guideline ID	GL-642191
Guideline Name	Afrezza
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Afrezza	
Diagnosis	Type 1 or Type 2 diabetes mellitus
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Diagnosis of type 1 diabetes mellitus and used in combination with a basal insulin or continuous insulin pump

OR

1.2 Diagnosis of type 2 diabetes mellitus

AND

2 - Patient is 6 years of age or older

AND

3 - Patient is unable to self-inject medications (e.g. Humalog, Lantus, Levemir) due to ONE of the following:

- Physical impairment
- Visual impairment
- Lipohypertrophy
- Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria)

AND

4 - Forced Expiratory Volume (FEV1) within the last 60 days is greater than or equal to 70% of expected normal as determined by the physician

AND

5 - Afrezza will not be approved in patients with ONE of the following:

- Who smoke cigarettes
- Who recently quit smoking (within the past 6 months)
- With chronic lung disease (e.g. asthma, chronic obstructive pulmonary disease)

Product Name:Afrezza	
Diagnosis	Type 1 or Type 2 diabetes mellitus

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

Approval Criteria

1 - Repeat pulmonary function test confirms that patient has NOT experienced a decline of 20% or more in Forced Expiratory Volume (FEV1)

AND

2 - Patient continues to be unable to self-inject short-acting insulin due to ONE of the following:

- Physical impairment
- Visual impairment
- Lipohypertrophy
- Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria)

AND

3 - Patient continues to not smoke cigarettes

2 . Revision History

Date	Notes
6/25/2026	Added age criterion due to expanded approval.

Prior Authorization Guideline

Guideline ID	GL-749234
Guideline Name	Agamree (vamorolone)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of Duchenne muscular dystrophy (DMD)

AND

2 - Patient is 2 years of age or older

AND

3 - Patient has received genetic testing for a mutation of the dystrophin gene

AND

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

4.1 Patient has a confirmed mutation of the dystrophin gene

OR

4.2 Muscle biopsy confirmed an absence of dystrophin protein

AND

5 - Submission of medical records (e.g., chart notes) or paid claims confirming patient has had a trial and failure or intolerance to prednisone or prednisolone given at a dose of 0.75 mg/kg/day or 10 mg/kg/weekend

AND

6 - Prescribed by or in consultation with a neurologist who has experience treating children

AND

7 - One of the following:

7.1 For patients less than or equal to 50kg, dose will not exceed 6mg/kg of body weight once daily

OR

7.2 For patients greater than 50kg, dose will not exceed 300mg/day

AND

8 - Requested medication will not be used in combination with deflazacort products (approval will not be granted for both agents)

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting patient has experienced a benefit from therapy (e.g., improvement in preservation of muscle strength)

AND

2 - One of the following:

2.1 For patients less than or equal to 50kg, dose will not exceed 6mg/kg of body weight once daily

OR

2.2 For patients greater than 50kg, dose will not exceed 300mg/day

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming patient has had a trial and failure or intolerance to prednisone or prednisolone given at a dose of 0.75 mg/kg/day or 10 mg/kg/weekend

AND

4 - Requested medication will not be used in combination with deflazacort products (approval will not be granted for both agents)

2 . Revision History

Date	Notes
10/28/2026	Added deflazacort concomitant use criteria to initial and reauth (approval will not be granted for both agents)

Prior Authorization Guideline

Guideline ID	GL-589202
Guideline Name	Aldurazyme - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Aldurazyme	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Confirmed diagnosis of Hurler or Hurler-Scheie forms of Mucopolysaccharidosis I (MPS I)

OR

1.2 Both the following:

1.2.1 Confirmed diagnosis of Scheie form of Mucopolysaccharidosis I (MPS I)

AND

1.2.2 Have moderate to severe symptoms

2 . Revision History

Date	Notes
4/30/2026	Changed "and" to "or" criterion 1.1: Confirmed diagnosis of Hurler "OR" Hurler-Scheie forms of Mucopolysaccharidosis I (MPS I)

Prior Authorization Guideline

Guideline ID	GL-99429
Guideline Name	Alinia
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Alinia, generic nitazoxanide	
Diagnosis	Diarrhea caused by Giardia lamblia
Approval Length	3 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of giardiasis

AND

2 - History of failure, contraindication, or intolerance to metronidazole

Product Name:Brand Alinia, generic nitazoxanide	
Diagnosis	Diarrhea caused by Cryptosporidium parvum
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cryptosporidiosis	

2 . Revision History

Date	Notes
3/10/2021	Bulk Copy C&S Arizona to Arizona Standard

Prior Authorization Guideline

Guideline ID	GL-525282
Guideline Name	Alkindi Sprinkle, Khindivi Oral Solution (hydrocortisone)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Alkindi Sprinkle, Khindivi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of adrenocortical insufficiency

AND

2 - Patient is between 5 and 18 years of age (applies to KHINDIVI requests ONLY)

AND

3 - One of the following:

3.1 Patient has a contraindication (e.g., age) or intolerance to other corticosteroids (e.g., prednisolone, prednisone)

OR

3.2 Patient is unable to swallow a solid dosage form (e.g., age, physical impairment, dysphagia, patient is using a feeding tube or nasal gastric tube)

OR

3.3 Dosage requirements cannot be met with a solid dosage form

AND

4 - Prescribed by or in consultation with an endocrinologist

Product Name:Alkindi Sprinkle, Khindivi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

2 . Revision History

Date	Notes
2/26/2026	Added Alkindi Sprinkle as target, updated age criterion (applies only t o Khindivi), updated guideline name.

Prior Authorization Guideline

Guideline ID	GL-105169
Guideline Name	Alpha Interferons - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2022

1 . Criteria

Product Name:Intron A	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of hairy cell leukemia

OR

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of condylomata acuminata (genital or perianal)

OR

3 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of AIDS-related Kaposi's sarcoma

OR

4 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of leptomeningeal metastases

OR

5 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of meningiomas

OR

6 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of kidney cancer

OR

7 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting treatment of myeloproliferative neoplasms (MPNs) such as essential thrombocythemia (ET), polycythemia vera (PV), or primary myelofibrosis (PM)

OR

8 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of follicular lymphoma

OR

9 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of adult T-cell leukemia, lymphoma

OR

10 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of mycosis fungoides, Sézary syndrome

OR

11 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of desmoid tumors/aggressive fibromatosis

OR

12 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of giant cell tumor of the bone

OR

13 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of malignant melanoma

Product Name:Alferon N	
Approval Length	8 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting

treatment of refractory or recurring external condylomata acuminata (genital or venereal warts) due to the human papillomavirus (HPV) infection

2 . Revision History

Date	Notes
3/24/2022	Removed Sylatron from guideline, Added Submission of Medical Records

Prior Authorization Guideline

Guideline ID	GL-731221
Guideline Name	Alpha-1 Proteinase Inhibitors
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Aralast NP, Glassia, Prolastin-C, Prolastin-C liquid, Zemaira	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has clinically evident emphysema

AND

2 - Submission of medical records (e.g., chart notes) documenting a diagnosis of severe congenital deficiency of Alpha1- proteinase inhibitor (alpha1 antitrypsin deficiency)

Product Name:Aralast NP, Glassia, Prolastin-C, Prolastin-C liquid, Zemaira	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has positive clinical response to therapy

2 . Revision History

Date	Notes
9/23/2026	Glassia to preferred (removed step) and added reauth criteria

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-589214
Guideline Name	Alyftrek (vanzacaftor/tezacaftor/deutivacaftor)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Alyftrek	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of cystic fibrosis (CF)

AND

2 - Submission of medical records (e.g., chart notes) or laboratory results confirming the presence of at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

AND

3 - One of the following:

3.1 CFTR mutation is responsive based on clinical or in vitro data

OR

3.2 CFTR mutation results in the production of CFTR protein

AND

4 - Patient is 6 years of age or older

AND

5 - Prescribed by or in consultation with a specialist affiliated with a CF care center

AND

6 - One of the following:

6.1 Submission of medical records (e.g., chart notes) or paid claims documenting history of failure or inadequate response to Trikafta (elexacaftor/tezacaftor/ivacaftor)

OR

6.2 Submission of medical records (e.g., chart notes) demonstrating that patient has a

documented CFTR gene mutation that is responsive to Alyftrek but is not responsive to Trikafta (a complete up to date list of responsive mutations can be referenced in the Trikafta Prescribing Information)

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates demonstrates positive clinical response to therapy (e.g., stable or improved lung function [percent predicted forced expiratory volume in one second {PPFEV1}], decreased number of pulmonary exacerbations)

AND

2 - Prescribed by or in consultation with a specialist affiliated with a CF care center

2 . Revision History

Date	Notes
4/30/2026	Updated dx confirmation criterion due to expanded indication. Updated embedded step through Trikafta (step bypass for pts with Alyftrek-only mutations)

Prior Authorization Guideline

Guideline ID	GL-749232
Guideline Name	Alzheimer's Agents - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Brand Aricept, generic donepezil, Brand Namenda/Namenda XR, generic memantine/memantine XR, Brand Razadyne, generic galantamine hydrobromide, Brand Razadyne ER, generic galantamine ER	
Diagnosis	Alzheimer’s Dementia
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of dementia of the Alzheimer’s type	

Product Name:Brand Exelon, generic rivastigmine	
Diagnosis	Alzheimer's Dementia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of dementia of the Alzheimer's type

OR

2 - Diagnosis of dementia associated with Parkinson's disease

Product Name:Adlarity	
Diagnosis	Alzheimer's Dementia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of dementia of the Alzheimer's type

AND

2 - One of the following:

2.1 History of failure, contraindication or intolerance to ALL of the following preferred drugs* (verified via paid pharmacy claims):

- generic donepezil
- generic galantamine IR/ER
- generic memantine
- generic oral rivastigmine

OR

2.2 Both of the following:

2.2.1 History of failure, contraindication or intolerance to generic rivastigmine patch* (verified via paid pharmacy claims)

AND

2.2.2 Patient is unable to swallow oral formulations or has documented swallowing difficulties

Notes	*PA may be required

Product Name:generic memantine IR	
Diagnosis	Migraine Prophylaxis [off-label]
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Requested medication is being used for migraine prophylaxis

2 . Revision History

Date	Notes
10/28/2026	Added criteria for off label indication of migraine prophylaxis for mem antine IR

Prior Authorization Guideline

Guideline ID	GL-530189
Guideline Name	Amondys 45 (casimersen)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Amondys 45	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of Duchenne muscular dystrophy (DMD)

AND

1.2 Disease is confirmed by the presence of a mutation of the dystrophin gene amenable to exon 45 skipping

AND

2 - Patient is 7 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

5 - Submission of medical records including results of baseline North Star Ambulatory Assessment (NSAA) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) as evidenced by NSAA scoring

AND

6 - Patient will not receive Amondys 45 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

Product Name:Amondys 45	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is tolerating therapy

AND

2 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

3 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

4 - Submission of medical records including results of recent North Star Ambulatory Assessment (NSAA) confirming patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) as evidenced by NSAA scoring

AND

5 - Patient will not receive Amondys 45 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

2 . Revision History

Date	Notes
2/26/2026	Added submission of NSAA testing for confirmation of ambulatory sta tus.

Prior Authorization Guideline

Guideline ID	GL-240226
Guideline Name	Amvuttra (vutrisiran)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Amvuttra	
Diagnosis	Hereditary transthyretin-mediated amyloidosis with polyneuropathy (hATTR-PN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of documentation (e.g., chart notes) confirming diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) with polyneuropathy	

AND

2 - Patient has a transthyretin (TTR) mutation (e.g., V30M)

AND

3 - Two of the following:

- Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb
- Patient has a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2
- Patient has a baseline neuropathy impairment score (NIS) greater than or equal to 5 and less than or equal to 130
- Patient has a baseline Karnofsky Performance Status score greater than or equal to 60%

AND

4 - Presence of clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy, walking ability, quality of life)

AND

5 - Patient has not had a liver transplant

AND

6 - Requested drug is not used in combination with a TTR silencer (e.g.,Tegsedi) or a TTR stabilizer (e.g., Vyndaqel)

AND

7 - Prescribed by or in consultation with a neurologist

Product Name:Amvuttra

Diagnosis	Hereditary transthyretin-mediated amyloidosis with polyneuropathy (hATTR-PN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to therapy as evidenced by an improvement in clinical signs and symptoms from baseline (e.g., neuropathy, quality of life, gait speed, nutritional status, decrease in serum TTR level)

AND

2 - Two of the following:

- Patient continues to have a polyneuropathy disability (PND) score less than or equal to IIIb
- Patient continues to have a familial amyloidotic polyneuropathy (FAP) stage of 1 or 2
- Patient continues to have a neuropathy impairment score (NIS) greater than or equal to 5 and less than or equal to 130
- Patient continues to have a Karnofsky Performance Status score greater than or equal to 60%

AND

3 - Requested drug is not used in combination with a TTR silencer (e.g.,Tegsedi) or a TTR stabilizer (e.g., Vyndaqel)

Product Name:Amvuttra	
Diagnosis	Transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming diagnosis of transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM)

AND

2 - One of the following:

2.1 Patient has a transthyretin (TTR) mutation (e.g., V122I)

OR

2.2 Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of TTR amyloid deposits

OR

2.3 Both of the following:

- Cardiac magnetic resonance imaging or scintigraphy scan suggestive of amyloidosis
- Absence of light-chain amyloidosis

AND

3 - Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

4 - Requested drug is not used in combination with a TTR silencer (e.g.,Onpattro)

AND

5 - Prescribed by or in consultation with a cardiologist

Product Name:Amvuttra	
Diagnosis	Transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

2 - Requested drug is not used in combination with a TTR silencer (e.g.,Onpattro)

2 . Revision History

Date	Notes
4/24/2025	Added criteria for new ATTR-CM indication. Added criterion regarding concomitant use of TTR silencer/stabilizer to hATTR-PN sections.

Prior Authorization Guideline

Guideline ID	GL-99431
Guideline Name	Anthelmintics - Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Albenza, generic albendazole	
Diagnosis	See Note section*
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Enterobius vermicularis (pinworm)

OR

2 - Diagnosis of Hydatid Disease [Echinococcosis (Tapeworm)]

OR

3 - Diagnosis of Ancylostoma/Necatoriasis (Hookworm)

OR

4 - Diagnosis of Ascariasis (Roundworm)

OR

5 - Diagnosis of Mansonella perstans (Filariasis)

OR

6 - Diagnosis of Toxocariasis (Roundworm)

OR

7 - Diagnosis of Trichinellosis

OR

8 - Diagnosis of Trichuriasis (Whipworm)

OR

9 - Diagnosis of Capillariasis

Notes	* Enterobius vermicularis (pinworm), Hydatid Disease [Echinococcosis (Tapeworm)] Ancylostoma/Necatoriasis (Hookworm), Ascariasis (Roundworm), Ma

	nsonella perstans (Filariasis), Toxocariasis (Roundworm), Trichinellosis, Trichuriasis (Whipworm), Capillariasis

Product Name:Brand Albenza, generic albendazole	
Diagnosis	Neurocysticercosis
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of neurocysticercosis

Product Name:Brand Stromectol, generic ivermectin	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of intestinal strongyloidiasis due to the nematode parasite Strongyloides stercoralis

OR

2 - Diagnosis of onchocerciasis due to the nematode parasite Onchocerca volvulus

2 . Revision History

Date	Notes
3/10/2021	Bulk Copy C&S Arizona to Arizona Standard

Prior Authorization Guideline

Guideline ID	GL-450245
Guideline Name	Anti-Parkinson’s Agents (Crexont, Duopa, Rytary, Vyalev)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Crexont, Brand Rytary, Brand Carbidopa/Levodopa ER capsule	
Diagnosis	Parkinson's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Parkinson's disease
- Post-encephalitic parkinsonism

- Symptomatic parkinsonism that may follow carbon monoxide and/or manganese intoxication

AND

2 - History of failure (after a minimum 30 day trial) or adverse reaction to one of the following:

- Generic carbidopa-levodopa immediate release
- Generic carbidopa-levodopa extended release tablets

Product Name:Duopa	
Diagnosis	Parkinson's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of advanced Parkinson's disease

AND

2 - Patient is levodopa-responsive

AND

3 - Patient experiences disabling “off” periods for a minimum of 3 hours per day

AND

4 - Disabling “off" periods occur despite therapy with BOTH of the following:

- Oral levodopa-carbidopa

- One drug from a different class of anti-Parkinson's disease therapy (e.g., COMT [catechol-O-methyltransferase] inhibitor [entacapone, tolcapone], MAO-B [monoamine oxidase-B] inhibitor [selegiline, rasagiline], dopamine agonist [pramipexole, ropinirole])

AND

5 - Has undergone or has planned placement of a procedurally-placed tube

AND

6 - Prescribed by or in consultation with a neurologist

Product Name:Vyalev	
Diagnosis	Parkinson's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of advanced Parkinson's disease

AND

2 - Patient is levodopa-responsive

AND

3 - Patient experiences disabling “off” periods for a minimum of 2.5 hours per day

AND

4 - Disabling “off" periods occur despite therapy with BOTH of the following:

- Oral levodopa-carbidopa
- One drug from a different class of anti-Parkinson's disease therapy (e.g., COMT [catechol-O-methyltransferase] inhibitor [entacapone, tolcapone], MAO-B [monoamine oxidase-B] inhibitor [selegiline, rasagiline], dopamine agonist [pramipexole, ropinirole])

AND

5 - Prescribed by or in consultation with a neurologist

Product Name:Crexont, Brand Rytary, Brand Carbidopa/Levodopa ER capsule, Duopa, Vyalev	
Diagnosis	Parkinson's disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

2 . Revision History

Date	Notes
12/17/2025	Added Brand Rytary and Brand Carbidopa/Levodopa ER capsule (A BA for Rytary) as targets.

Prior Authorization Guideline

Guideline ID	GL-545202
Guideline Name	Anticonvulsants - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:PREFERRED: Brand Briviact, generic lacosamide, Xcopri; NON-PREFERRED: Brand Aptiom, generic brivaracetam, generic eslicarbazepine, Brand Vimpat	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 All of the following:

1.1.1 One of the following diagnoses:

- partial-onset seizures
- primary generalized tonic-clonic seizures (Applies to Brand Vimpat and generic lacosamide only)

AND

1.1.2 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies)*: (APPLIES TO BRAND APTIOM, GENERIC BRIVARACETAM, GENERIC ESLICARBAZEPINE, AND BRAND VIMPAT ONLY)

- Brand Briviact
- Carbamazepine
- Divalproex
- Gabapentin
- Fycompa
- generic lacosamide
- Lamotrigine
- Levetiracetam
- Oxcarbazepine
- Phenytoin
- Pregabalin
- Topiramate
- Valproic acid
- Xcopri
- Zonisamide

AND

1.1.3 One of the following: APPLIES TO BRAND APTIOM, GENERIC BRIVARACETAM, GENERIC ESLICARBAZEPINE, AND BRAND VIMPAT ONLY)

1.1.3.1 Both of the following:

- Documented history of persisting seizures after titration to the highest tolerated dose with each medication trial of preferred formulary alternatives
- Lack of compliance as a reason for treatment failure has been ruled out

OR

1.1.3.2 Both of the following:

- Documentation of failure of preferred formulary alternatives due to intolerable side effects
- Reasonable efforts were made to minimize the side effect (e.g. change timing of dosing, divide dose out for more frequent but smaller doses, etc.)

AND

1.1.4 Trial and failure, contraindication, or intolerance to generic lacosamide (APPLIES TO BRAND VIMPAT ONLY)

OR

1.2 For continuation of prior therapy for a seizure disorder

Notes	*Preferred Drugs may require PA

Product Name:Motpoly XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 Both of the following:

1.1.1 Diagnosis of one of the following:

- partial-onset seizures
- primary generalized tonic-clonic seizures

AND

1.1.2 Patient weighs at least 50 kg

OR

1.2 For continuation of prior therapy for a seizure disorder

Product Name:PREFERRED: Brand Fycompa; NON-PREFERRED: generic perampanel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 BOTH of the following:

- Diagnosis of partial-onset or primary generalized tonic-clonic seizures
- Trial and failure, contraindication, or intolerance to Brand Fycompa (APPLIES TO GENERIC PERAMPANEL REQUESTS ONLY)

OR

1.2 For continuation of prior therapy for a seizure disorder

Product Name:Epidiolex	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 Diagnosis of seizures associated with Dravet syndrome

OR

1.2 Diagnosis of seizures associated with Lennox-Gastaut syndrome

OR

1.3 Diagnosis of seizures associated with tuberous sclerosis complex (TSC)

OR

1.4 For continuation of prior therapy for a seizure disorder

Notes	*Drug may require PA

Product Name:Diacomit	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of Dravet syndrome and currently taking clobazam

OR

2 - For continuation of prior therapy for a seizure disorder

Product Name:Fintepla	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of seizures associated with Dravet syndrome

AND

1.2 History of greater than or equal to 8-week trial of at least TWO of the following (any release formulation qualifies)*:

- Divalproex (e.g., generic Depakote)
- Epidiolex
- Levetiracetam (e.g., generic Keppra)
- Topiramate (e.g., generic Topamax)
- Valproic acid (e.g., generic Depakene)
- Zonisamide (generic Zonegran)

AND

1.3 ONE of the following:

1.3.1 BOTH of the following:

1.3.1.1 Documented history of persisting seizures after titration to the highest tolerated dose with each medication trial of preferred formulary alternatives

AND

1.3.1.2 Lack of compliance as a reason for treatment failure has been ruled out

OR

1.3.2 BOTH of the following:

1.3.2.1 Documentation of failure of preferred formulary alternatives due to intolerable side effects

AND

1.3.2.2 Reasonable efforts were made to minimize the side effect (e.g., change timing of dosing, divide dose out for more frequent but smaller doses, etc.)

OR

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ALL of the following:

2.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

2.2 History of greater than or equal to 8 week trial, contraindication or intolerance of at least TWO of the following (any release formulation qualifies)*:

- Banzel (rufinamide)
- Clobazam
- Divalproex
- Epidiolex
- Felbamate
- Lamotrigine
- Topiramate
- Valproic Acid

AND

2.3 ONE of the following:

2.3.1 BOTH of the following:

- Documented history of persisting seizures after titration to the highest tolerated dose with each medication trial of preferred formulary alternatives
- Lack of compliance as a reason for treatment failure has been ruled out

OR

2.3.2 BOTH of the following:

- Documentation of failure of preferred formulary alternatives due to intolerable side effects
- Lack of compliance as a reason for treatment failure has been ruled out

OR

3 - For continuation of prior therapy for a seizure disorder

Notes	*Drug may require PA

Product Name:PREFERRED: generic rufinamide tablets, generic rufinamide solution; NON-PREFERRED: Brand Banzel tablets and suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Submission of medical records (e.g., chart notes, lab work, imaging) documenting both of the following:

1.1.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome

AND

1.1.2 Trial and failure, contraindication, or intolerance to generic rufinamide (APPLIES TO BRAND BANZEL REQUESTS ONLY)

OR

1.2 For continuation of prior therapy for a seizure disorder

Product Name:PREFERRED: generic clobazam; NON-PREFERRED: Brand Onfi

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting one of the following:

1.1 Both of the following:

- Diagnosis of seizures associated with Lennox-Gastaut syndrome
- Trial and failure, contraindication, or intolerance to generic clobazam (APPLIES TO BRAND ONFI ONLY)

OR

1.2 All of the following:

- Diagnosis of Dravet syndrome
- Patient is currently taking Diacomit
- Trial and failure, contraindication, or intolerance to generic clobazam (APPLIES TO BRAND ONFI ONLY)

OR

2 - For continuation of prior therapy for a seizure disorder

Product Name:Sympazan	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 ALL of the following:

1.1.1 Diagnosis of seizures associated with Lennox-Gastaut syndrome (LGS)

AND

1.1.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment.)
- Not used as primary treatment

AND

1.1.3 History of greater than or equal to 8 week trial, contraindication or intolerance of at least TWO of the following (any release formulation qualifies)*:

- Brand Banzel suspension/tablets or runfinamide tablets
- Divalproex
- Felbamate
- Lamotrigine
- Topiramate
- Valproic acid

AND

1.1.4 Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

OR

1.2 ALL of the following:

1.2.1 Diagnosis of refractory partial onset seizures (four or more uncontrolled seizures per month after an adequate trial of at least two antiepileptic drugs)

AND

1.2.2 BOTH of the following:

- Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment.)
- Not used as primary treatment

AND

1.2.3 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies)*:

- Carbamazepine
- Divalproex
- Fycompa
- Gabapentin
- Lacosamide
- Lamotrigine
- Levetiracetam
- Oxcarbazepine
- Phenytoin
- Pregabalin
- Topiramate
- Valproic acid
- Xcopri
- Zonisamide

AND

1.2.4 Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

OR

1.3 ALL of the following:

1.3.1 Diagnosis of Dravet syndrome

AND

1.3.2 Patient is currently taking Diacomit

AND

1.3.3 Prescriber provides a reason or special circumstance the patient cannot use generic clobazam tablets or suspension

OR

1.4 For continuation of prior therapy for a seizure disorder

Notes	*Drug may require PA

Product Name:PREFERRED: generic tiagabine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 All of the following:

1.1.1 Diagnosis of partial-onset seizures

AND

1.1.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

1.1.3 Not used as primary treatment

OR

1.2 For continuation of prior therapy for a seizure disorder

Product Name:Brand Sabril Tablets, generic vigabatrin tablets, vigadrone tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 All of the following:

1.1.1 Diagnosis of complex partial seizures

AND

1.1.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

1.1.3 Not used as primary treatment

AND

1.1.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies)*:

- Carbamazepine
- Divalproex
- Fycompa
- Gabapentin

- Lacosamide
- Lamotrigine
- Levetiracetam
- Oxcarbazepine
- Phenytoin
- Pregabalin
- Topiramate
- Valproic acid
- Xcopri
- Zonisamide

OR

1.2 For continuation of prior therapy for a seizure disorder

Notes	*Drug may require PA

Product Name:Brand Sabril Oral Solution, generic vigabatrin oral solution, generic vigadrone oral solution, Vigafyde	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of infantile spasms

OR

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting all of the following:

2.1 Diagnosis of complex partial seizures

AND

2.2 Used as adjunctive therapy (defined as accessory treatment used in combination to enhance primary treatment)

AND

2.3 Not used as primary treatment

AND

2.4 History of greater than or equal to 8 week trial of at least TWO of the following (any release formulation qualifies)*:

- Carbamazepine
- Divalproex
- Fycompa
- Gabapentin
- Lacosamide
- Lamotrigine
- Levetiracetam
- Oxcarbazepine
- Phenytoin
- Pregabalin
- Topiramate
- Valproic acid
- Xcopri
- Zonisamide

OR

3 - For continuation of prior therapy for a seizure disorder

Notes	*Drug may require PA

Product Name:PREFERRED: Brand Trokendi XR; NON-PREFERRED: generic topiramate ER, generic topiramate 50 mg sprinkle, Brand Qudexy XR, generic topiramate ER sprinkle	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 All of the following:

1.1.1 Diagnosis of partial-onset seizures

AND

1.1.2 Trial and failure, contraindication, or intolerance to generic topiramate immediate-release (IR) tablet or preferred topiramate IR sprinkle capsule (APPLIES TO GENERIC TOPIRAMATE ER, GENERIC TOPIRAMATE 50 MG SPRINKLE, BRAND QUDEXY XR, AND GENERIC TOPIRAMATE ER SPRINKLE ONLY)

AND

1.1.3 Trial and failure, contraindication, or intolerance to Brand Trokendi XR (APPLIES TO GENERIC TOPIRAMATE ER, BRAND QUDEXY XR, AND GENERIC TOPIRAMATE ER SPRINKLE ONLY)

OR

1.2 For continuation of prior therapy for a seizure disorder

Product Name:Gabarone	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

- Patient is 3 years of age or older
- Submission of medical records (e.g., chart notes) documenting diagnosis of partial onset seizures

• Trial and failure or intolerance to generic immediate-release gabapentin (generic for Neurontin) **OR** **1.2** All of the following • Patient is 18 years of age or older • Submission of medical records (e.g., chart notes) documenting diagnosis of postherpetic neuralgia (PHN) • Trial and failure or intolerance to generic immediate-release gabapentin (generic for Neurontin) • Trial and failure or intolerance to Brand Gralise*	
Notes	*Drug may require PA

2 . Revision History

Date	Notes
3/24/2026	Added generic Briviact (tabs/soln) as NP target (Brand Preferred)

Prior Authorization Guideline

Guideline ID	GL-731218
Guideline Name	Antidepressants - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:generic citalopram oral solution, generic fluoxetine oral solution, generic sertraline oral conc for solution	
Diagnosis	Requests for Patients greater than 12 years of age
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The member is unable to swallow the oral tablet/capsule	

Product Name:Amitriptyline, amoxapine, bupropion tabs/SR tabs/XL tabs (150 and 300mg), citalopram tabs/oral soln, clomipramine, desipramine, generic desvenlafaxine ER, doxepin caps/oral conc for solution, duloxetine capsules (20, 30, 60mg), escitalopram tablets, fluoxetine caps/oral soln, fluvoxamine IR, generic mirtazapine tabs/ODT, imipramine tabs/caps, nortriptyline caps/oral soln, paroxetine tabs, protriptyline, sertraline tabs/oral soln, trazodone 50mg/100mg/150mg/300mg tabs, trimipramine, venlafaxine tabs/ER capsules	
Diagnosis	PREFERRED DRUG Requests for patient 6 years of age or younger
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e. other medications or behavioral modification attempted)

AND

2 - The physician attests that the requested medication is medically necessary. (Document rationale for use)

Notes	Drug may require PA

Product Name:Brand Venlafaxine besylate ER	
Diagnosis	Non-Preferred Drugs
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e. other medications or behavioral modification attempted)

AND

2 - The physician attests that the requested medication is medically necessary. (Document rationale for use)

AND

3 - Patient has history of failure or intolerance to preferred generic venlafaxine or venlafaxine ER

AND

4 - Patient has a history of failure, contraindication or intolerance to at least 2 preferred alternatives*

- Bupropion (Generic Wellbutrin)
- Bupropion SR (Generic Wellbutrin SR)
- Bupropion XL (Generic Wellbutrin XL)
- Citalopram (Generic Celexa)
- Generic desvenlafaxine ER (Generic Pristiq)
- Duloxetine 20mg, 30mg, or 60 mg capsules
- Escitalopram tablets (Generic Lexapro)
- Esketamine (Spravato)
- Fluoxetine capsules (Generic Prozac)
- Fluoxetine solution (Generic Prozac)
- Fluvoxamine tablets (Generic Luvox)
- Mirtazapine (Generic Remeron)
- Paroxetine tablets (Generic Paxil)
- Sertraline tablets (Generic Zoloft)
- Trazodone 50mg/100mg/150mg/300mg tablets

Notes	*Drug may require PA

Product Name:Raldesy	
Diagnosis	Non-Preferred Drugs
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Trial and failure, or intolerance to trazodone oral tablet

OR

2 - Patient is unable to swallow the oral tablet formulation of trazodone

Product Name:Auvelity tablets	
Diagnosis	Non-Preferred Drugs: Major Depressive Disorder (MDD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of major depressive disorder (MDD)

AND

2 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e. other medications or behavioral modification attempted)

AND

3 - The physician attests that the requested medication is medically necessary. (Document rationale for use)

AND

4 - Patient has a history of failure, contraindication or intolerance to at least 3 preferred alternatives*

- Bupropion (Generic Wellbutrin)
- Bupropion SR (Generic Wellbutrin SR)
- Bupropion XL (Generic Wellbutrin XL)
- Citalopram (Generic Celexa)
- Generic desvenlafaxine ER (Generic Pristiq)
- Duloxetine 20mg, 30mg, or 60 mg capsules

• Escitalopram tablets (Generic Lexapro) • Esketamine (Spravato) • Fluoxetine capsules (Generic Prozac) • Fluoxetine solution (Generic Prozac) • Fluvoxamine tablets (Generic Luvox) • Mirtazapine (Generic Remeron) • Paroxetine tablets (Generic Paxil) • Sertraline tablets (Generic Zoloft) • Trazodone 50mg/100mg/150mg/300mg tablets • Venlafaxine (Generic Effexor) • Venlafaxine ER capsules (Generic Effexor ER)	
Notes	*Drug may require PA

Product Name:Auvelity tablets, Auvelity titration pack	
Diagnosis	Non-Preferred Drugs: Agitation Associated With Dementia Due To Alzheimer's Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The requested medication is being used for treatment of agitation associated with dementia due to Alzheimer's disease	

Product Name:Brand Anafranil, Brand Celexa, generic citalopram capsules, Brand Cymbalta, generic duloxetine 40mg/80mg/90mg/120mg caps, Drizalma, Brand Effexor XR, generic venlafaxine ER tabs, Emsam, escitalopram capsules, escitalopram oral solution, Exxua, Fetzima, fluvoxamine ER, Brand Lexapro, maprotiline, Marplan, Brand Nardil, generic phenelzine, nefazodone, Brand Norpramin, Brand Pamelor caps/oral soln, Brand Parnate, generic tranylcypromine, Brand Paxil, generic paroxetine capsules, Brand Paxil susp, generic paroxetine suspension, Brand Paxil CR, generic paroxetine ER, Pexeva, Brand Pristiq, Brand Desvenlafaxine ER, Brand Prozac, generic fluoxetine tablets, Brand Remeron SLTB, Brand Remeron, trazodone 25mg/75mg tabs,Trintellix, Viibryd, Brand Wellbutrin SR, Brand Wellbutrin XL/Forfivo, generic bupropion ER (XL) 450mg tabs, Brand Zoloft, generic sertraline capsules	
Diagnosis	Non-Preferred Drugs
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e. other medications or behavioral modification attempted)

AND

2 - The physician attests that the requested medication is medically necessary. (Document rationale for use)

AND

3 - Patient has a history of failure, contraindication or intolerance to at least 3 preferred alternatives*

- Bupropion (Generic Wellbutrin)
- Bupropion SR (Generic Wellbutrin SR)
- Bupropion XL (Generic Wellbutrin XL)
- Citalopram (Generic Celexa)
- Generic desvenlafaxine ER (Generic Pristiq)
- Duloxetine 20mg, 30mg, or 60 mg capsules
- Escitalopram tablets (Generic Lexapro)
- Esketamine (Spravato)
- Fluoxetine capsules (Generic Prozac)
- Fluoxetine solution (Generic Prozac)
- Fluvoxamine tablets (Generic Luvox)
- Mirtazapine (Generic Remeron)
- Paroxetine tablets (Generic Paxil)
- Sertraline tablets (Generic Zoloft)
- Trazodone 50mg/100mg/150mg/300mg tablets
- Venlafaxine (Generic Effexor)
- Venlafaxine ER capsules (Generic Effexor ER)

Notes	*Drug may require PA

2 . Revision History

Date	Notes

9/23/2026	Added GPIs for trazodone 25mg and 75mg as NPD, updated preferr ed trazodone strengths.

Prior Authorization Guideline

Guideline ID	GL-620204
Guideline Name	Antiemetics - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Anzemet, granisetron tablet, granisetron injection, Granisol solution	
Diagnosis	Nausea and vomiting associated with cancer chemotherapy
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Prevention or treatment of nausea and vomiting associated with cancer chemotherapy

AND

2 - For Granisol requests ONLY, BOTH of the following:

2.1 Patient is unable to swallow a solid dosage form (e.g., oral tablet, capsule) due to one of the following:

- Age
- Physical impairment (e.g., difficulties with motor or oral coordination)
- Dysphagia
- Patient is using a feeding tube or nasal gastric tube

AND

2.2 History of failure, contraindication, or intolerance to ondansetron ODT

Product Name:Anzemet, granisetron tablet, granisetron injection, Granisol solution	
Diagnosis	Nausea and vomiting associated with radiotherapy
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Prevention or treatment of nausea and vomiting associated with radiotherapy (total body irradiation, single high-dose fraction to the abdomen, or daily fractions to the abdomen)

AND

2 - For Granisol requests ONLY, BOTH of the following:

2.1 Patient is unable to swallow a solid dosage form (e.g., oral tablet, capsule) due to one of the following:

- Age
- Physical impairment (e.g., difficulties with motor or oral coordination)
- Dysphagia
- Patient is using a feeding tube or nasal gastric tube

AND

2.2 History of failure, contraindication, or intolerance to ondansetron ODT

Product Name:Anzemet, granisetron tablet, granisetron injection, Granisol solution	
Diagnosis	Postoperative nausea and/or vomiting
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Prevention of postoperative nausea and/or vomiting (administration prior to induction of anesthesia)

AND

2 - For Granisol requests ONLY, BOTH of the following:

2.1 Patient is unable to swallow a solid dosage form (e.g., oral tablet, capsule) due to one of the following:

- Age
- Physical impairment (e.g., difficulties with motor or oral coordination)
- Dysphagia
- Patient is using a feeding tube or nasal gastric tube

AND

2.2 History of failure, contraindication, or intolerance to ondansetron ODT

2 . Revision History

Date	Notes

5/27/2026	Added Granisol solution as target, updated criteria.

Prior Authorization Guideline

Guideline ID	GL-624204
Guideline Name	Antiglaucoma Agents - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:generic brinzolamide ophth susp, generic tafluprost ophth soln	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of elevated intraocular pressure due to ocular hypertension or open angle glaucoma	

Product Name:Omlonti, Zolymbus	
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of elevated intraocular pressure due to ocular hypertension or open angle glaucoma

AND

2 - Trial and failure, contraindication, or intolerance to all of the following:

- dorzolamide
- bimatoprost
- latanoprost
- travoprost

2 . Revision History

Date	Notes
5/27/2026	Added Zolymbus as target

Prior Authorization Guideline

Guideline ID	GL-99551
Guideline Name	Antipsoriatic Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021
P&T Approval Date:	
P&T Revision Date:	

1 . Criteria

Product Name:Brand Dovonex cream, generic calcipotriene cream, Brand Calcitrene ointment, generic calcipotriene ointment, Brand Vectical, generic calcitriol ointment	
Diagnosis	Psoriasis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of psoriasis	

AND

2 - History of failure, contraindication, or intolerance to TWO medium to Very high potency corticosteroid topical treatments (see Table 1 in Background section)

2 . Background

Benefit/Coverage/Program Information

Table 1. Relative Potency of Selected Topical Corticosteroid Products

Drug	Dosage Form	Strength
Super High Potency		
Augmented betamethasone dipropionate (Diprolene)	Gel, Ointment	0.05%
Clobetasol propionate (Temovate, Temovate E)	Cream, Solution	0.05%
Halobetasol propionate (Ultravate)	Cream	0.05%
High Potency		
Augmented betamethasone dipropionate (Diprolene, Diprolene AF)	Cream, Lotion	0.05%
Betamethasone dipropionate	Lotion, Ointment	0.05%
Fluocinonide (Lidex, Lidex E)	Cream, Solution	0.05%
Triamcinolone acetonide (Kenalog)	Cream, Ointment	0.5%
Medium Potency		

Betamethasone valerate (Beta-Val)	Cream	0.1%
Fluocinolone acetonide (Synalar)	Cream, Ointment	0.025%
Fluticasone propionate (Cutivate)	Cream, Lotion	0.05%
	Ointment	0.005%
Hydrocortisone butyrate (Locoid)	Ointment, Solution	0.1%
Mometasone furoate (Elocon)	Cream, Ointment, Solution	0.1%
Prednicarbate (Dermatop)	Cream	0.1%
Triamcinolone acetonide (Kenalog)	Cream, Lotion, Ointment	0.1%
	Ointment	0.025%

Prior Authorization Guideline

Guideline ID	GL-715195
Guideline Name	Antipsychotics - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Brand Abilify tablets, generic aripiprazole tablets and oral solution, Brand Geodon capsules, generic ziprasidone capsules, Brand Latuda, generic lurasidone, lithium carbonate (capsules, tablets, ER tablets, oral solution), Brand Lithobid, Brand Risperdal (tablets, solution) generic risperidone (tablets, ODT, solution), Brand Seroquel (IR), generic quetiapine (IR/ER), Brand Zyprexa, Brand Zyprexa Zydis, generic olanzapine (tablets, ODT)	
Diagnosis	PA Required for Patients < 6 years of age
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - The patient has been diagnosed per current DSM (Diagnostic and Statistical Manual of Mental Disorders) criteria with one of the following disorders:

- Bipolar Spectrum Disorder
- Schizophrenic Spectrum Disorder
- Tourette's or other tic disorder
- Autism Spectrum Disorder

AND

2 - The requesting clinician has documented that psychosocial issues have been evaluated before request for antipsychotic medications

AND

3 - The requesting clinician has documented non-medication alternatives that have been attempted before request for antipsychotic medications

AND

4 - The above documentation includes information on the expected outcomes and an evaluation of potential adverse events

AND

5 - The patient does not have a known hypersensitivity to the requested agent

Product Name:chlorpromazine tablets, fluphenazine (tablets, oral concentrate, elixir), haloperidol tablets and oral concentrate, loxapine, molindone, generic paliperidone ER tablets, perphenazine, pimozide, thioridazine, thiothixene, trifluoperazine	
Diagnosis	PA Required for Patients < 12 years of age
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has been diagnosed per current DSM (Diagnostic and Statistical Manual of Mental Disorders) criteria with one of the following disorders:

- Bipolar Spectrum Disorder
- Schizophrenic Spectrum Disorder
- Tourette's or other tic disorder
- Autism Spectrum Disorder

AND

2 - The requesting clinician has documented that psychosocial issues have been evaluated before request for antipsychotic medications

AND

3 - The requesting clinician has documented non-medication alternatives that have been attempted before request for antipsychotic medications

AND

4 - The above documentation includes information on the expected outcomes and an evaluation of potential adverse events

AND

5 - The patient does not have a known hypersensitivity to the requested agent

Product Name:chlorpromazine injection, Brand Clozaril, generic clozapine (tablets, ODT), fluphenazine decanoate, Brand Haldol decanoate injection, generic haloperidol decanoate, Brand Haldol lactate injection, generic haloperidol lactate injection	
Diagnosis	PA Required for Patients < 18 years of age
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 ONE of the following:

1.1.1.1 The requested medication must be used for an FDA (Food and Drug Administration) approved indication

OR

1.1.1.2 The use of the drug is supported by information in ONE of the following appropriate compendia of literature:

- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia – Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

AND

1.1.2 The patient meets the FDA minimum age limit or the prescriber attests they are aware of FDA labeling regarding the use of the antipsychotic medication and feels the treatment with the requested medication is medically necessary (Document rationale for use)

OR

1.2 The patient is currently on the requested medication

Product Name:Abilify Asimtufii, Abilify Maintena	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Schizophrenia or schizoaffective disorder
- Bipolar disorder

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient is non-adherent with oral atypical antipsychotic dosage forms
- Patient has established tolerability with aripiprazole

OR

2.2 Patient is unable to take oral solid alternatives

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

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

Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Patient is 18 years of age or older

AND

1.1.2 Patient has ONE of the following:

- Schizophrenia or schizoaffective disorder
- Bipolar disorder
- Autism
- Major depressive disorder
- Tourette's

AND

1.1.3 Submission of medical records or claims history documenting the patient is currently prescribed aripiprazole and tolerates the medication

AND

1.1.4 Submission of medical records or claims history documenting the patient's adherence to aripiprazole is less than 80 percent within the past 6 months (medication adherence percentage is defined as the number of pills absent in a given time period divided by the number of pills prescribed during that same time, multiplied by 100)

AND

1.1.5 ALL of the following strategies (if applicable to the patient) to improve patient adherence have been tried without success:

- Utilization of a pill box

- Utilization of a smart phone reminder (ex. alarm, application, or text reminder)
- Involving family members or friends to assist
- Coordinating timing of dose to coincide with dosing of another daily medication

AND

1.1.6 Submission of medical records or claims history documenting patient has experienced life-threatening or potentially life-threatening symptoms, or has experienced a severe worsening of symptoms leading to a hospitalization which was attributed to the lack of adherence to aripiprazole

AND

1.1.7 Prescriber acknowledges that Abilify MyCite has not been shown to improve patient adherence and attests that Abilify MyCite is medically necessary for the patient to maintain compliance, avoid life-threatening worsening of symptoms, and reduce healthcare resources utilized due to lack of adherence

AND

1.1.8 Prescriber agrees to track and document adherence of Abilify MyCite through software provided by the manufacturer

AND

1.1.9 The patient has a history of failure, contraindication, or intolerance or reason or special circumstance they cannot use TWO of the following: (Drug may require PA)

- Abilify Maintena
- Invega Sustenna
- Risperdal Consta or Uzedy
- Aristada

OR

1.2 ONE of the following:

1.2.1 The patient has been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan (enrollment effective date within the past 90 days)

OR

1.2.2 The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge

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

Approval Criteria

1 - Documentation that patient is clinically stable on Abilify MyCite

AND

2 - Submission of medical records or claims history documenting that the use of Abilify MyCite has increased adherence to 80 percent or more

AND

3 - Prescriber attests that the patient requires the continued use of Abilify MyCite to remain adherent

Product Name:Aristada, Aristada Initio	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of schizophrenia or schizoaffective disorder

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient is non-adherent with oral atypical antipsychotic dosage forms
- Patient has established tolerability with oral aripiprazole

OR

2.2 Patient is unable to take oral solid alternatives

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

Product Name:Erzofri, Invega Sustenna	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of schizophrenia or schizoaffective disorder

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient is non-adherent with oral atypical antipsychotic dosage forms

- Patient has established tolerability with oral paliperidone or oral risperidone

OR

2.2 Patient is unable to take oral solid alternatives

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

AND

4 - For Erzofri requests ONLY: History of failure or adverse reaction to Invega Sustenna (Applies to Erzofri requests only)

Product Name:Invega Trinza	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of schizophrenia or schizoaffective disorder

AND

2 - Patient has been treated with Invega Sustenna for at least 4 months

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic

products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

Product Name:Invega Hafyera	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of schizophrenia or schizoaffective disorder

AND

2 - Patient has been treated with Invega Sustenna or Invega Trinza for at least 6 months

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

Product Name:Opipza	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Both of the following:

- Patient is 13 years of age or older

- Diagnosis of schizoprenia

OR

1.2 Both of the following:

- Patient is 18 years of age or older
- Diagnosis of major depressive disorder (MDD)

OR

1.3 Both of the following:

- Patient is 6 years of age or older
- Diagnosis of autistic disorder

OR

1.4 Both of the following:

- Patient is 6 years of age or older
- Diagnosis of Tourette's disorder

AND

2 - BOTH of the following:

2.1 ONE of the following:

- History of failure or intolerance to aripiprazole oral tablets
- History of failure or intolerance to aripiprazole oral solution

AND

2.2 Provider submits clinical rationale documenting why patient is unable to take aripiprazole ODT formulation

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

Product Name:Risperdal Consta, Uzedy	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Schizophrenia or schizoaffective disorder
- Bipolar disorder

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient is non-adherent with oral atypical antipsychotic dosage forms
- Patient has established tolerability with oral risperidone

OR

2.2 Patient is unable to take oral solid alternatives

AND

3 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic

products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

Product Name:Perseris, Rykindo, generic risperidone ER IM	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Schizophrenia or schizoaffective disorder
- Bipolar disorder (Applies to Rykindo and generic risperidone ER IM ONLY)

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient is non-adherent with oral atypical antipsychotic dosage forms
- Patient has established tolerability with oral risperidone

OR

2.2 Patient is unable to take oral solid alternatives

AND

3 - History of failure, contraindication or intolerance to ALL of the following:

- Risperdal Consta
- Uzedy

AND

4 - If the patient is less than 18 years of age, the prescriber attests they are aware of FDA (Food and Drug Administration) labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

Product Name:Brand Abilify tablets, Adasuve, aripiprazole ODT, chlorpromazine tablets, Brand Clozaril, fluphenazine (injection, tablets), Brand Geodon (capsules, injection) generic ziprasidone (capsules, injection), Brand Haldol decanoate injection, generic haloperidol injection, Brand Invega tablets, Brand Latuda, Brand Lithobid, loxapine, perphenazine-amitriptyline, prochlorperazine injection, Brand Risperdal (tablets, solution), generic risperidone solution, Brand Saphris, generic asenapine sublingual tablets, Secuado, Brand Seroquel, Brand Seroquel XR, Brand Symbyax, generic fluoxetine-olanzapine, Versacloz, Brand Zyprexa (tablets, injection), Zyprexa Relprevv, Brand Zyprexa Zydis	
Diagnosis	Non-Preferred Drugs
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 ONE of the following:

1.1.1.1 Patient has a history of failure, contraindication or intolerance to at least FOUR of the following:

- Aripiprazole oral (generic Abilify)
- Aripiprazole injectable formulations (Abilify Maintena, Aristada, Aristada Initio)
- Clozapine/clozapine ODT
- Lurasidone
- Olanzapine/olanzapine ODT
- Paliperidone oral tablet
- Paliperidone injectable formulations (Invega Sustenna, Invega Trinza, Hafyera)
- Quetiapine IR or ER
- Risperidone/risperidone ODT
- Risperidone injectable formulations (Risperdal Consta, Uzedy)

OR

1.1.1.2 There are no preferred formulary alternatives for the requested drug

AND

1.1.2 If the request is for a multi-source brand medication (i.e., MSC O), ONE of the following:

1.1.2.1 BOTH of the following:

- The brand is being requested because of an adverse reaction, allergy or sensitivity to the generic and the prescriber must attest to submitting the FDA MedWatch Form for allergic reactions to the medications
- If there are generic product(s), the member has tried at least three (if available)

OR

1.1.2.2 ONE of the following:

- The brand is being requested due to a therapeutic failure with the generic (please provide reason for therapeutic failure)
- The brand is being requested because transition to the generic could result in destabilization of the patient (rationale must be provided)
- Special clinical circumstances exist that preclude the use of the generic equivalent of the multi-source brand medication for the patient (rationale must be provided)

AND

1.1.3 ONE of the following:

1.1.3.1 The requested drug must be used for an FDA (Food and Drug Administration)-approved indication

OR

1.1.3.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols

- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia – Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

AND

1.1.4 ONE of the following:

1.1.4.1 The drug is being prescribed within the manufacturer's published dosing guidelines

OR

1.1.4.2 The drug falls within dosing guidelines found in ONE of the following compendia of current literature:

- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia – Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

AND

1.1.5 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program*

OR **1.2** The requested medication is a behavioral health medication and ONE of the following: **1.2.1** The patient has been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan (enrollment effective date within the past 90 days) **OR** **1.2.2** The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge

Notes	*Note: Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes
9/11/2026	10/1 changes: Generic paliperidone oral tablet and generic quetiapine ER to PDL, Perseris to NPD. Updated preferred prerequisites accordingly.

Prior Authorization Guideline

Guideline ID	GL-126970
Guideline Name	Anxiolytics - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/23/2023

1 . Criteria

Product Name:buspirone, Brand Xanax tabs, generic alprazolam tabs, alprazolam ODT, alprazolam conc, Brand Xanax XR, generic alprazolam ER, chlordiazepoxide, Brand Tranxene T, generic clorazepate dipotassium, Brand Valium tabs, generic diazepam tabs, diazepam conc, diazepam oral soln, Brand Ativan, Loreev XR, generic lorazepam, lorazepam conc, generic oxazepam, Brand Klonopin tabs, generic clonazepam tabs, clonazepam ODT	
Diagnosis	Requests for Patients less than 6 years of age
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e. other medications or behavioral modification attempted).

AND

2 - The physician attests that the requested medication is medically necessary (Document rationale for use)

Product Name:Loreev XR	
Diagnosis	Requests for Patients 6 years of age and older
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Trial and failure, or contraindication to generic lorazepam

AND

2 - The physician attests that the requested medication is medically necessary (Document rationale for use)

Product Name:buspirone, Brand Xanax tabs, generic alprazolam tabs, alprazolam ODT, alprazolam conc, Brand Xanax XR, generic alprazolam ER, chlordiazepoxide, Brand Tranxene T, generic clorazepate dipotassium, Brand Valium tabs, generic diazepam tabs, diazepam conc, diazepam oral soln, Brand Ativan, Loreev XR, generic lorazepam, lorazepam conc, generic oxazepam, Brand Klonopin tabs, generic clonazepam tabs, clonazepam ODT	
Diagnosis	Reject 75: Drug Utilization Review: Greater than 1 Anxiolytic in 30 days
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The medication is being used to adjust the dose of the drug

OR

2 - The medication will be used in place of the previously prescribed drug, and not in addition to it

OR

3 - The medication dosage form will be used in place of the previously prescribed medication dosage form, and not in addition to it

OR

4 - The physician attests they are aware of the multiple anxiolytics prescribed to the patient and feels treatment with both medications is medically necessary (Document rationale for use)

2 . Revision History

Date	Notes
6/22/2023	Updated DUR Reject code from 88 to rej 75. No changes to clinical c riteria.

Prior Authorization Guideline

Guideline ID	GL-484224
Guideline Name	Anzupgo (delgocitinib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Anzupgo	
Diagnosis	Severe Chronic Hand Eczema (CHE)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is 18 years of age or older	

AND

2 - Diagnosis of severe chronic hand eczema (CHE)

AND

3 - Patient is experiencing functional impairment due to severe chronic hand eczema, which may include, but is not limited to, activities of daily living (ADLs), skin infections, sleep disturbances, etc.

AND

4 - Provider attests patient has been counseled regarding avoidance of irritants and allergens

AND

5 - Submission of medical records or paid pharmacy claims documenting that patient is using emollients (e.g., Aquaphor, Eucerin) consistently

AND

6 - Submission of medical records or paid pharmacy claims documenting trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to ALL of the following:

- Medium or higher potency topical corticosteroid
- One calcineurin inhibitor (e.g., tacrolimus ointment)
- Eucrisa (crisaborole)
- Opzelura (ruxolitinib)
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.05% or 0.15% cream
- Adbry (tralokinumab-ldrm)

AND

7 - Not used in combination with other Janus kinase (JAK) inhibitors or potent immunosuppressants (e.g., azathioprine or cyclosporine)

AND

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

- Dermatologist
- Allergist/Immunologist

Product Name:Anzupgo	
Diagnosis	Severe Chronic Hand Eczema (CHE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., erythema, scaling, hyperkeratosis, fissures)

AND

2 - Not used in combination with other JAK inhibitors or potent immunosuppressants (e.g., azathioprine or cyclosporine)

2 . Background

Clinical Practice Guidelines
Table 1. Relative potencies of topical corticosteroids [4]

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream	0.1
	Triamcinolone acetonide	Cream, ointment	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1

Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
12/23/2025	Updated clinical criteria.

Prior Authorization Guideline

Guideline ID	GL-221195
Guideline Name	Apomorphine products (Apokyn, Onapgo)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:Brand Apokyn, generic apomorphine injection, Onapgo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting all of the following:

1.1 Diagnosis of Parkinson’s disease

AND

1.2 Medication will be used as intermittent treatment for OFF episodes

AND

1.3 Patient is currently on a stable dose of a carbidopa/levodopa-containing medication and will continue receiving treatment with a carbidopa/levodopa-containing medication while on therapy

AND

1.4 Patient continues to experience greater than or equal to 2 hours of OFF time per day despite optimal management of carbidopa/levodopa therapy including BOTH of the following:

- Taking carbidopa/levodopa on an empty stomach or at least one half-hour or more before or one hour after a meal or avoidance of high protein diet
- Dose and dosing interval optimization

AND

1.5 History of failure, contraindication, or intolerance to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

AND

2 - Prescribed by or in consultation with a neurologist or specialist in the treatment of Parkinson's disease

Product Name:Brand Apokyn, generic apomorphine injection, Onapgo	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

2 . Revision History

Date	Notes
3/26/2025	Added Onapgo, removed Kynmobi, updated guideline name.

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Prior Authorization Guideline

Guideline ID	GL-749239
Guideline Name	Aqneursa (levacetylleucine)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Aqneursa	
Diagnosis	Niemann-Pick disease type C (NPC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Niemann-Pick disease type C (NPC)	

AND

2 - Submission of medical records (e.g., chart notes) documenting the diagnosis has been confirmed by one of the following:

2.1 Genetically confirmed (deoxyribonucleic acid [DNA] sequence analysis) by mutations in both alleles of NPC1 or NPC2

OR

2.2 Mutation in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane triol/oxysterols (>2 x upper limit of normal)

AND

3 - Patient has at least one neurological symptom of the disease (e.g., hearing loss, vertical supranuclear gaze palsy, ataxia, dementia, dystonia, seizures, dysarthria, or dysphagia)

AND

4 - Patient weighs greater than or equal to 15kg

AND

5 - Requested drug will not be used in combination with Miplyffa (arimoclomol). *The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the same time and the lack of a Miplyffa and Aqneursa head-to-head study.

AND

6 - Prescribed by or in consultation with a specialist knowledgeable in the treatment of Niemann-Pick disease type C

Notes	*The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the sam e time and the lack of a Miplyffa and Aqneursa head-to-head study.

Product Name:Aqneursa	
Diagnosis	Niemann-Pick disease type C (NPC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., slowing of disease progression, improvement in neurological symptoms of the disease)

AND

2 - Requested drug will not be used in combination with Miplyffa (arimoclomol). *The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the same time and the lack of a Miplyffa and Aqneursa head-to-head study.

Notes	*The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the sam e time and the lack of a Miplyffa and Aqneursa head-to-head study.

Product Name:Aqneursa	
Diagnosis	Ataxia-telangiectasia (A-T)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Ataxia-telangiectasia (A-T)

AND

2 - Submission of medical records (e.g., chart notes) documenting the diagnosis has been confirmed by one of the following:

- Identification of the pathological mutations in the ATM gene
- Absence or deficiency of the ATM protein or its kinase activity in cultured cell lines

AND

3 - Patient exhibits neurological manifestations of ataxia (e.g., impaired gait, hand incoordination, abnormal eye movements)

AND

4 - Patient weighs greater than or equal to 15kg

AND

5 - Prescribed by or in consultation with a specialist knowledgeable in the treatment of Ataxia-telangiectasia (A-T)

Product Name:Aqneursa	
Diagnosis	Ataxia-telangiectasia (A-T)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in symptoms of gait ataxia, truncal ataxia, oculomotor ataxia, and difficulties with balance, speech, and hand coordination)

2 . Revision History

Date	Notes
10/28/2026	Added criteria for new indication of Ataxia-telangiectasia (A-T).

Prior Authorization Guideline

Guideline ID	GL-99514
Guideline Name	Aquadeks
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Aquadeks	
Diagnosis	Cystic Fibrosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cystic fibrosis	

2 . Revision History

Date	Notes
4/10/2021	7/1 Implementation

Prior Authorization Guideline

Guideline ID	GL-152659
Guideline Name	Arcalyst (rilonacept)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Arcalyst	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting a diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) [including Familial Cold Auto-inflammatory Syndrome (FCAS), Muckle-Wells Syndrome (MWS)]

AND

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

- Immunologist
- Allergist
- Dermatologist
- Rheumatologist
- Neurologist
- Specialist with expertise in the management of CAPS

AND

3 - The medication will not be used in combination with another biologic agent

Product Name:Arcalyst	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting patient has experienced disease stability or improvement in clinical symptoms while on therapy as evidenced by one of the following:

- Improvement in rash, fever, joint pain, headache, or conjunctivitis
- Decreased number of disease flare days
- Normalization of inflammatory markers (C-reactive protein [CRP], erythrocyte sedimentation rate [ESR], serum amyloid A [SAA])
- Corticosteroid dose reduction
- Improvement in MD global score or active joint count

Product Name:Arcalyst

Diagnosis	Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA)

AND

1.2 Patient weighs at least 10 kg

AND

1.3 Patient is currently in remission (e.g., no fever, skin rash, and bone pain; no radiological evidence of active bone lesions; C-reactive protein [CRP] less than 5 mg/L)

Product Name:Arcalyst	
Diagnosis	Recurrent Pericarditis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:

1.1 Diagnosis of recurrent pericarditis as evidenced by at least 2 episodes that occur a minimum of 4 to 6 weeks apart

AND

1.2 History of failure, contraindication, or intolerance to ALL of the following:

- nonsteroidal anti-inflammatory drugs (e.g., ibuprofen, naproxen)
- colchicine
- corticosteroids (e.g., prednisone)

AND

2 - Prescribed by or in consultation with a cardiologist

Product Name:Arcalyst	
Diagnosis	Recurrent Pericarditis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

2 . Revision History

Date	Notes
8/27/2024	Added criteria for DIRA and recurrent pericarditis. Updated CAPS crit eria.

Prior Authorization Guideline

Guideline ID	GL-99710
Guideline Name	Arikayce
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Arikayce	
Diagnosis	Refractory Mycobacterium avium complex (MAC) lung disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) or claims history documenting respiratory cultures positive for MAC within the previous 6 months

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) or claims history documenting the patient has been receiving a multidrug background regimen containing at least TWO of the following agents for a minimum of 6 consecutive months within the past 12 months (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

- Macrolide antibiotic* (e.g., azithromycin, clarithromycin)
- Ethambutol*
- Rifamycin antibiotic* (e.g., rifampin, rifabutin)

AND

4 - Patient will continue to receive a multidrug background regimen

AND

5 - Documentation that the patient has not achieved negative sputum cultures after receipt of a multidrug background regimen for a minimum of 6 consecutive months

AND

6 - In vitro susceptibility testing of recent (within 6 months) positive culture documents that the MAC isolate is susceptible to amikacin with a minimum inhibitory concentration (MIC) of less than or equal to 64 micrograms per milliliter (mcg/mL)

AND

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

- Infectious disease specialist
- Pulmonologist

Notes	*Drug may require PA)

Product Name:Arikayce	
Diagnosis	Refractory Mycobacterium avium complex (MAC) lung disease
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Documentation that the patient has achieved negative respiratory cultures

OR

1.2 ALL of the following:

1.2.1 Patient has not achieved negative respiratory cultures while on Arikayce

AND

1.2.2 Physician attestation that patient has demonstrated clinical benefit while on Arikayce

AND

1.2.3 In vitro susceptibility testing of most recent (within 6 months) positive culture with available susceptibility testing documents that the Mycobacterium avium complex (MAC) isolate is susceptible to amikacin with an minimum inhibitory concentration (MIC) of less than 64 micrograms per milliliter (mcg/mL)

AND

1.2.4 Patient has NOT received greater than 12 months of Arikayce therapy with continued positive respiratory cultures

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) or claims history documenting that the patient continues to receive a multidrug background regimen containing at least TWO of the following agents (prescription claims history may be used in conjunction as documentation of medication use, dose, and duration):

- Macrolide antibiotic* (e.g., azithromycin, clarithromycin)
- Ethambutol*
- Rifamycin antibiotic* (e.g., rifampin, rifabutin)

AND

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

- Infectious disease specialist
- Pulmonologist

Notes	*Drug may require PA

2 . Revision History

Date	Notes
5/12/2021	Arizona Medicaid 7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-193195
Guideline Name	Attruby (acoramidis)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM)

AND

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

2.1 Presence of a transthyretin (TTR) mutation (e.g., V122I) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

OR

2.2 Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of TTR amyloid deposits

OR

2.3 Both of the following:

- Cardiac magnetic resonance imaging or scintigraphy scan suggestive of amyloidosis
- Absence of light-chain amyloidosis

AND

3 - Submission of medical records (e.g., chart notes) documenting patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

4 - Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Diflunisal)

AND

5 - Prescribed by or in consultation with a cardiologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

2 - Requested drug is not used in combination with a TTR silencer (e.g., Amvuttra) or a TTR stabilizer (e.g., Diflunisal)

AND

3 - Prescribed by or in consultation with a cardiologist

2 . Revision History

Date	Notes
2/25/2025	New program

Prior Authorization Guideline

Guideline ID	GL-155386
Guideline Name	Austedo (deutetrabenazine)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Austedo, Austedo XR	
Diagnosis	Moderate to Severe Tardive dyskinesia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderate to severe tardive dyskinesia (TD) secondary to treatment with a centrally acting dopamine receptor blocking agent (DRBA)	

AND

2 - Prescribed by or in consultation with a psychiatrist or neurologist

AND

3 - Patient is 18 years of age or older

AND

4 - Patient has an Abnormal Involuntary Movement Scale (AIMS) score of 3 or 4 on any one of the AIMS items 1 through 9

AND

5 - Austedo is not prescribed concurrently with tetrabenazine or Ingrezza

AND

6 - Dose does not exceed 48 mg per day

Notes	*NOTE: Patients will be approved for ONE strength of Austedo/Austedo XR ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Austedo products. End-date/Retire all other active PA's for Austedo products.

Product Name:Austedo, Austedo XR	
Diagnosis	Moderate to Severe Tardive dyskinesia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is responding positively to therapy as evidenced by a reduction in the baseline score of any one of the AIMS items 1 through 9

AND

2 - Austedo is not prescribed concurrently with tetrabenazine or Ingrezza

AND

3 - Dose does not exceed 48 mg per day

Notes	*NOTE: Patients will be approved for ONE strength of Austedo/Austedo XR ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Austedo products. End-date/Retire all other active PA's for Austedo products.

Product Name:Austedo, Austedo XR	
Diagnosis	Chorea Associated with Huntington Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chorea associated with Huntington's Disease

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Patient is 18 years of age or older

AND

4 - Targeted mutation analysis demonstrates a cytosine-adenine-guanine (CAG) trinucleotide expansion of ≥ 36 repeats in the huntingtin (HTT) gene

AND

5 - Patient has a Unified Huntington Disease Rating Scale (UHDRS) score ranging from 1 to 4 on any one of UHDRS chorea items 1 through 7

AND

6 - Austedo is not prescribed concurrently with tetrabenazine or Ingrezza

AND

7 - Dose does not exceed 48 mg per day

Notes	*NOTE: Patients will be approved for ONE strength of Austedo/Austedo XR ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Austedo products. End-date/Retire all other active PA's for Austedo products.

Product Name:Austedo, Austedo XR	
Diagnosis	Chorea Associated with Huntington Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is responding positively to therapy as evidenced by a reduction in the baseline score of any one of the UHDRS chorea items 1 through 7

AND **2** - Austedo is not prescribed concurrently with tetrabenazine or Ingrezza **AND** **3** - Dose does not exceed 48 mg per day	
Notes	*NOTE: Patients will be approved for ONE strength of Austedo/Austedo XR ONLY: Approve ALL requests at GPI-14. Confirm there is only 1 active PA on file for ALL Austedo products. End-date/Retire all other active PA's for Austedo products.

2 . Revision History

Date	Notes
9/24/2024	Added note for PA Team, only 1 strength of Austedo can be approved .

Prior Authorization Guideline

Guideline ID	GL-620189
Guideline Name	Avlayah (tividenofusp alfa-eknm)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of Hunter syndrome (Mucopolysaccharidosis type II, MPS II)

AND

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

- Enzyme assay demonstrating deficient iduronate 2 sulfatase (I2S) activity
- Presence of iduronate-2-sulfatase (IDS) gene mutation as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

3 - Disease is one of the following:

- Presymptomatic
- Symptomatic

AND

4 - Requested medication is initiated prior to advanced neurologic impairment (e.g., progressive cognitive decline, status epilepticus)

AND

5 - Patient's weight is greater than or equal to 5 kg

AND

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

- Geneticist
- Metabolic disease specialist
- Physician who specializes in the treatment of lysosomal storage disorders

AND

7 - Requested medication is not used in combination with other enzyme replacement therapies for the treatment of Hunter syndrome (e.g., Elaprase)

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reductions from baseline in cerebrospinal fluid heparan sulfate [CSF HS)])

AND

2 - Requested medication is not used in combination with other enzyme replacement therapies for the treatment of Hunter syndrome (e.g., Elaprase)

2 . Revision History

Date	Notes
5/27/2026	New Program

Prior Authorization Guideline

Guideline ID	GL-669273
Guideline Name	Awiqli (insulin icodec-abae)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of Type 2 Diabetes Mellitus

AND

2 - Patient is 18 years of age or older

AND

3 - Inadequate glycemic control on non-insulin antidiabetic therapy (i.e., HbA1c greater than or equal to 7%)

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming one of the following:

4.1 Trial and inadequate response (minimum 90-day supply) or contraindication to TWO of the following basal insulin:

- Lantus (insulin glargine)
- Rezvoglar Kwikpen (insulin glargine)
- Tresiba (insulin degludec)

OR

4.2 Documentation is submitted demonstrating that patient has a barrier that prevents safe self-administration of daily insulin (e.g., non-adherence to daily basal insulin, visual impairment, need for caregiver assistance, physical or cognitive limitations, etc)

AND

5 - Patient or caregiver has been counseled on all of the following:

- Once weekly administration
- Risk, recognition, and management of hypoglycemia
- Not to be used in combination with any other basal insulin

Product Name:Awiqli	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient demonstrates positive clinical response to therapy (e.g., decrease in HbA1c from baseline)	

2 . Revision History

Date	Notes
7/28/2026	New Program

Prior Authorization Guideline

Guideline ID	GL-731211
Guideline Name	Azole Antifungals
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Systemic Fungal Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following

1.1 Diagnosis of ONE of the following:

- Blastomycosis

- Histoplasmosis
- Aspergillosis

OR

1.2 Both of the following:

1.2.1 Diagnosis of coccidioidomycosis

AND

1.2.2 Patient has a history of failure, contraindication, intolerance, or resistance to fluconazole (generic Diflucan) as evidenced by submission of medical records or claims history

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Fingernails
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of fingernail onychomycosis confirmed by ONE of the following:

- KOH (potassium hydroxide) test
- Fungal culture
- Nail biopsy

AND

1.2 Patient has a history of at least a 6-week trial resulting in therapeutic failure, contraindication, intolerance, or resistance to Terbinafine as evidenced by submission of medical records or claims history

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Fingernails
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Three months have elapsed since completion of initial therapy for fingernail onychomycosis

AND

1.2 Documentation of positive clinical response to therapy

Product Name:Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Toenails
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of toenail onychomycosis confirmed by ONE of the following:

- KOH (potassium hydroxide) test
- Fungal culture
- Nail biopsy

AND

1.2 Patient has a history of at least a 12-week trial resulting in therapeutic failure, contraindication, intolerance, or resistance to Terbinafine as evidenced by submission of medical records or claims history.

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Brand Sporanox capsules, generic itraconazole capsules	
Diagnosis	Onychomycosis Toenails
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Nine months have elapsed since completion of initial therapy for toenail onychomycosis

AND

1.2 Documentation of positive clinical response to therapy

Product Name:Brand Sporanox Oral Solution, generic itraconazole oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnoses:

- Oropharyngeal candidiasis
- Esophageal candidiasis

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Brand Vfend tablets*	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of invasive aspergillosis including Aspergillus fumigatus

OR

1.2 ALL of the following:

- Diagnosis of Candidemia
- Patient is non-neutropenic
- Patient has a history of failure, contraindication, intolerance, or resistance to fluconazole (generic Diflucan) as evidenced by submission of medical records or claims history

OR

1.3 Both of the following:

1.3.1 ONE of the following diagnoses:

- Candida infection in the abdomen
- Candida infection in the kidney
- Candida infection in the bladder wall
- Candida infection in wounds
- Disseminated Candida infections in skin
- Esophageal candidiasis

AND

1.3.2 Patient has a history of failure, contraindication, intolerance, or resistance to fluconazole (generic Diflucan) as evidenced by submission of medical records or claims history

OR

1.4 Diagnosis of Scedosporium apiospermum infection (asexual form of Pseudallescheria boydii)

OR

1.5 Diagnosis of Fusarium spp. infection including Fusarium solani

OR

1.6 Diagnosis of Exserohilum species infection

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Notes	*Note: generic voriconazole tablets are preferred without PA required

Product Name:Brand Vfend Powder for Oral Suspension, generic voriconazole powder for oral suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 One of the following:

1.1.1 Diagnosis of invasive aspergillosis including Aspergillus fumigatus

OR

1.1.2 ALL of the following:

- Diagnosis of Candidemia
- Patient is non-neutropenic
- Patient has a history of failure, contraindication, intolerance, or resistance to fluconazole (generic Diflucan) as evidenced by submission of medical records or claims history

OR

1.1.3 ONE of the following diagnoses:

- Candida infection in the abdomen

- Candida infection in the kidney
- Candida infection in the bladder wall
- Candida infection in wounds
- Disseminated Candida infections in skin
- Esophageal candidiasis

OR

1.1.4 Diagnosis of Scedosporium apiospermum infection (asexual form of Pseudallescheria boydii)

OR

1.1.5 Diagnosis of Fusarium spp. infection including Fusarium solani

OR

1.1.6 Diagnosis of Exserohilum species infection

AND

1.2 Physician has provided rationale for the patient needing to use voriconazole oral suspension instead of voriconazole tablets (generic voriconazole tablets are preferred without PA required)

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Brand Noxafil tablets, generic posaconazole tablets	
Diagnosis	Prophylaxis of Systemic Fungal Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Both of the following:

- Patient is 2 years of age or older
- Patient weighs at least 40 kg

AND

1.2 Used as prophylaxis of invasive fungal infections caused by ONE of the following:

- Aspergillus
- Candida

AND

1.3 One of the following conditions:

1.3.1 Patient is at high risk of infections due to severe immunosuppression from ONE of the following conditions:

- Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)
- Hematologic malignancies with prolonged neutropenia from chemotherapy [eg, acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

1.3.2 Patient has a prior fungal infection requiring secondary prophylaxis

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Brand Noxafil Suspension, generic posaconazole suspension, Noxafil suspension packets (PowderMix)	
Diagnosis	Prophylaxis of Systemic Fungal Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 One of the following:

1.1.1 For Noxafil or posaconazole oral suspension requests ONLY, patient is 13 years of age or older

OR

1.1.2 For Noxafil suspension packets (Noxafil PowderMix), BOTH of the following:

- Patient is 2 years of age or older
- Patient weighs between 10 kg to 40 kg

AND

1.2 Used as prophylaxis of invasive fungal infections caused by ONE of the following:

- Aspergillus
- Candida

AND

1.3 One of the following conditions:

1.3.1 Patient is at high risk of infections due to severe immunosuppression from ONE of the following conditions:

- Hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD)

- Hematologic malignancies with prolonged neutropenia from chemotherapy [eg, acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

1.3.2 Patient has a prior fungal infection requiring secondary prophylaxis

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Brand Noxafil tablets, generic posaconazole tablets, Noxafil suspension packets (PowderMix)	
Diagnosis	Treatment of Systemic Fungal Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Patient is 2 years of age or older

AND

1.2 One of the following:

- For Noxafil or posaconazole oral tablets, patient weighs greater than 40 kg
- For Noxafil suspension packets (PowderMix), patient weighs between 10 kg to 40 kg

AND

1.3 Diagnosis of invasive aspergillosis

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Brand Noxafil Suspension, generic posaconazole suspension	
Diagnosis	Oropharyngeal Candidiasis (OPC)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Patient is 13 years of age or older

AND

1.2 Diagnosis of oropharyngeal candidiasis (OPC)

AND

1.3 The patient has a history of failure, contraindication, intolerance, or resistance to TWO of the following as evidenced by submission of medical records or claims history:

- Fluconazole* (generic Diflucan)
- Itraconazole* (generic Sporanox)
- Clotrimazole Lozenges*

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Notes	*Drug may require PA

Product Name:Cresemba	
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Both of the following:

- Patient is 6 months of age or older
- Patient weighs 16 kg or greater

AND

1.2 One of the following:

1.2.1 Both of the following:

- Diagnosis of invasive aspergillosis
- Patient has a history of failure, contraindication, intolerance, or resistance to voriconazole* (generic Vfend) as evidenced by submission of medical records or claims history

OR

1.2.2 Diagnosis of invasive mucormycosis

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Notes	*Drug may require PA

Product Name:Tolsura

Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of ONE of the following fungal infections:

- Blastomycosis
- Histoplasmosis
- Aspergillosis

AND

1.2 Patient has a history of failure, contraindication, intolerance, or resistance to itraconazole* capsules (generic Sporanox) as evidenced by submission of medical records or claims history

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Notes	*Drug may require PA

Product Name:Brand Sporanox capsules, generic itraconazole capsules, Brand Sporanox oral solution, generic itraconazole oral solution, Brand Vfend tablets, Brand Vfend powder for oral suspension, generic voriconazole powder for oral suspension, Brand Noxafil tablets, generic posaconazole tablets, Brand Noxafil oral suspension, generic posaconazole oral suspension, Noxafil suspension packets (PowderMix), Cresemba, Tolsura	
Diagnosis	All Other Diagnoses
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia – Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

AND

1.2 The medication is being prescribed by or in consultation with an infectious disease specialist

OR

2 - The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Notes	*Authorization duration based on provider recommended treatment du rations, not to exceed 12 months

2 . Revision History

Date	Notes
9/23/2026	Removed generic voriconazole tablets as targets, no longer requires PA.

Prior Authorization Guideline

Guideline ID	GL-211208
Guideline Name	Baclofen products (Fleqsuvy, Lyvispah, Ozobax/Ozobax DS)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:Brand Fleqsuvy, generic baclofen suspension, Lyvispah, Ozobax/DS, Brand Baclofen oral solution, generic baclofen oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Trial and failure, or intolerance to baclofen tablets **OR**	

2 - Patient is unable to swallow oral tablets

2 . Revision History

Date	Notes
3/26/2025	Added Brand/generic Fleqsuvy as targets.

Prior Authorization Guideline

Guideline ID	GL-99516
Guideline Name	Baxdela
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Baxdela	
Diagnosis	Community-Acquired Bacterial Pneumonia
Approval Length	10 Days*
Guideline Type	Prior Authorization

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - All of the following:

3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Baxdela

AND

3.3 History of failure, contraindication, or intolerance to THREE of the following antibiotics or antibiotic regimens:

- Amoxicillin**
- A macrolide**
- Doxycycline**
- A fluoroquinolone**
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

Notes	*Note: Authorization will be issued for up to 10 days. **Drug may require PA

Product Name:Baxdela	
Diagnosis	Acute Bacterial Skin and Skin Structure Infections
Approval Length	14 Days*
Guideline Type	Prior Authorization

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - All of the following:

3.1 One of the following diagnoses:

3.1.1 Both of the following

3.1.1.1 Acute bacterial skin and skin structure infections

AND

3.1.1.2 Infection caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report

OR

3.1.2 Both of the following:

3.1.2.1 Empirical treatment of patients with acute bacterial skin and skin structure infections

AND

3.1.2.2 Presence of MRSA infection is likely

AND

3.2 History of failure, contraindication, or intolerance to linezolid (generic Zyvox)

AND

3.3 History of failure, contraindication, or intolerance to ONE of the following antibiotics:

- Sulfamethoxazole-trimethoprim (SMZ-TMP)**
- A tetracycline**
- Clindamycin**

OR

4 - All of the following:

4.1 Diagnosis of acute bacterial skin and skin structure infections

AND

4.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Baxdela

AND

4.3 History of failure, contraindication, or intolerance to THREE of the following antibiotics:

- A penicillin**
- A cephalosporin**
- A tetracycline**
- Sulfamethoxazole-trimethoprim (SMZ-TMP)**
- Clindamycin**

Notes	*Note: Authorization will be issued for up to 14 days. **Drug may require PA

Product Name:Baxdela	
Diagnosis	Off-Label Uses*
Guideline Type	Prior Authorization

Approval Criteria **1** - For continuation of therapy upon hospital discharge **OR** **2** - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

Notes	*Note: Authorization duration based on provider recommended treatment durations, up to 6 months.

2 . Revision History

Date	Notes
5/12/2021	Arizona Medicaid 7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-669270
Guideline Name	Baxfendy (baxdrostat)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Baxfendy	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of one of the following:

- Uncontrolled hypertension

- Resistant hypertension

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming Baxfendy will be used as part of combination therapy with other antihypertensive medication(s) (e.g., lisinopril, indapamide)

AND

3 - Submission of medical records (e.g., chart notes) confirming patient has not achieved adequate blood pressure control (e.g., systolic blood pressure [SBP] less than 130 mmHg) after treatment with at least two non-mineralocorticoid receptor antagonist (non-MRA) antihypertensive medications from different classes at target doses

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial of all of the following antihypertensive medications from different classes, unless there is a contraindication or intolerance to these medications, for an adequate duration (minimum 4 weeks each) at a maximally tolerated dose:

- Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril) or angiotensin II receptor blocker (ARB) (e.g., candesartan)
- Thiazide-type or thiazide-like diuretic (e.g., hydrochlorothiazide, chlorthalidone)
- Calcium channel blocker (e.g., nifedipine)
- Mineralocorticoid receptor antagonist (MRA) (e.g., eplerenone, spironolactone)

AND

5 - Submission of medical records (e.g., chart notes) or absence of paid claims confirming Baxfendy will not be used in combination with an MRA (e.g., eplerenone, spironolactone) or potassium-sparing diuretic (e.g., triamterene, amiloride)

AND

6 - Provider attests to both of the following:

- Patient’s serum potassium and risk of hyperkalemia have been assessed

- Any serum potassium abnormalities have been corrected prior to initiation of Baxfendy therapy

AND

7 - Provider attests other causes of hypertension have been addressed (e.g., secondary causes ruled out, medication nonadherence)

AND

8 - Prescribed by or in consultation with a specialist experienced in the treatment of uncontrolled or resistant hypertension (e.g., cardiologist, nephrologist)

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., systolic blood pressure [SBP] less than 130 mmHg)

AND

2 - Patient continues to use Baxfendy as part of combination therapy with other antihypertensive medications from different classes (e.g., lisinopril, indapamide)

AND

3 - Trial and inadequate response, contraindication, or intolerance to a mineralocorticoid receptor antagonist (MRA) (e.g., eplerenone, spironolactone)

AND **4** - Requested drug is not being used in combination with an MRA (e.g., eplerenone, spironolactone) or potassium-sparing diuretic (e.g., triamterene, amiloride)

2 . Revision History

Date	Notes
7/28/2026	New program

Prior Authorization Guideline

Guideline ID	GL-754195
Guideline Name	Belbuca, Butrans - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/12/2026

1 . Criteria

Product Name:Brand Belbuca, Brand Butrans, generic buprenorphine patches *	
Diagnosis	Cancer/Hospice/End of Life related pain
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - The patient is being treated for cancer, hospice, or end of life related pain	

AND

2 - If the request is for Belbuca or Brand Butrans, history of failure, contraindication or intolerance to generic buprenorphine patches

Notes	* If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the member is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried generic buprenorphine patches a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 12 month authorization should be entered for generic buprenorphine patches.

Product Name:Brand Belbuca, Brand Butrans, generic buprenorphine patches	
Diagnosis	Cancer/Hospice/End of Life related pain
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is being treated for cancer, hospice, or end of life related pain (Document diagnosis and date of diagnosis)

AND

2 - If the request is for Belbuca or Brand Butrans, history of failure, contraindication or intolerance to generic buprenorphine patches

Product Name:Brand Belbuca, Brand Butrans, generic buprenorphine patches *

Diagnosis	Non-cancer pain/Non-hospice/Non-end of life care pain
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber attests to ALL of the following:

1.1 The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed; and medical information necessary to verify the accuracy of the information provided may be requested

AND

1.2 Treatment goals are defined, including estimated duration of treatment

AND

1.3 Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention

AND

1.4 Patient has been screened for substance abuse/opioid dependence

AND

1.5 If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression

AND

1.6 Pain is moderate to severe and expected to persist for an extended period of time

AND

1.7 Pain is chronic

AND

1.8 Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)

AND

1.9 Pain management is required around the clock with a long-acting opioid

AND

2 - The patient has a history of failure, contraindication, or intolerance to a trial of tramadol IR (immediate release), unless the patient is already receiving chronic opioid therapy prior to surgery for postoperative pain, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time (Drug may require PA)

AND

3 - If the request is for neuropathic pain (examples of neuropathic pain include neuralgias, neuropathies, fibromyalgia), BOTH of the following must be met:

3.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin or pregabalin (Lyrica) titrated to a therapeutic dose (document date of trial)

AND

3.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at

least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose (document drug and date of trial) **AND** **4** - If the request is for Belbuca or Brand Butrans, history of failure, contraindication or intolerance to generic buprenorphine patches

Notes	* If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the member is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried generic buprenorphine patches a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for generic buprenorphine patches.

Product Name:Brand Belbuca, Brand Butrans, generic buprenorphine patches *	
Diagnosis	Non-cancer pain/Non-hospice/Non-end of life care pain
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates meaningful improvement in pain and function (document improvement in function or pain score improvement)

AND

2 - Identify rationale for not tapering and discontinuing opioid (document rationale)

AND

3 - Prescriber attests to ALL of the following:

3.1 The information provided is true and accurate to the best of their knowledge and they understand that a routine audit may be performed; and medical information necessary to verify the accuracy of the information provided may be requested

AND

3.2 Treatment goals are defined, including estimated duration of treatment

AND

3.3 Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention

AND

3.4 Patient has been screened for substance abuse/opioid dependence

AND

3.5 If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression

AND

3.6 Pain is moderate to severe and expected to persist for an extended period of time

AND

3.7 Pain is chronic

AND

3.8 Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)

AND

3.9 Pain management is required around the clock with a long-acting opioid

AND

4 - If the request is for Belbuca or Brand Butrans, history of failure, contraindication or intolerance to generic buprenorphine patches

Notes	* If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. If the member is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried generic buprenorphine patches a denial should be issued and a maximum 60-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. Additionally, a 6 month authorization should be entered for generic buprenorphine patches.

Product Name:Brand Belbuca, Brand Butrans, generic buprenorphine patches *	
Guideline Type	Quantity Limit

Approval Criteria

1 - The requested dose cannot be achieved by moving to a higher strength of the product

AND **2** - The requested dose is within the FDA (Food and Drug Administration) maximum dose per day, where an FDA maximum dose per day exists	
Notes	*Approval durations: 12 months for cancer pain/hospice/end of life rel ated pain; 6 months for non-cancer pain/non-hospice/non-end of life r elated pain

2 . Revision History

Date	Notes
10/12/2026	Updated notes section for non-cancer pain initial and reauth, 6 month auth should be entered for generic patches (not 12 months). No cha nge to clinical intent

Prior Authorization Guideline

Guideline ID	GL-114489
Guideline Name	Benlysta (belimumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Benlysta IV, Benlysta SQ	
Diagnosis	Systemic Lupus Erythematosus
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of systemic lupus erythematosus	

AND

2 - Patient is 5 years of age or older

AND

3 - Laboratory testing has documented the presence of autoantibodies [e.g., ANA, Anti-dsDNA, Anti-Sm, Anti-Ro/SSA, Anti-La/SSB]

AND

4 - Patient is currently receiving standard immunosuppressive therapy [e.g., hydroxychloroquine, chloroquine, prednisone, azathioprine, methotrexate]

AND

5 - Patient does NOT have severe active central nervous system lupus

AND

6 - Patient is not receiving Benlysta in combination with a biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]

Product Name:Benlysta IV, Benlysta SQ	
Diagnosis	Active Lupus Nephritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active lupus nephritis

AND

2 - Patient is 5 years of age or older

AND

3 - Patient is currently receiving standard immunosuppressive therapy for systemic lupus erythematosus [e.g., hydroxychloroquine, chloroquine, prednisone, azathioprine, methotrexate]

AND

4 - Patient does NOT have severe active central nervous system lupus

AND

5 - Patient is not receiving Benlysta in combination with a biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]

Product Name:Benlysta IV, Benlysta SQ	
Diagnosis	Systemic Lupus Erythematosus, Active Lupus Nephritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Benlysta therapy

AND **2** - Patient is not receiving Benlysta in combination with a biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Kineret (anakinra)]

2 . Revision History

Date	Notes
9/26/2022	Updated age requirement. Added IV formulation as target.

Prior Authorization Guideline

Guideline ID	GL-99434
Guideline Name	Benznidazole
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Benznidazole	
Diagnosis	Chagas disease (American trypanosomiasis)
Approval Length	60 Day(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Chagas disease (American trypanosomiasis) due to Trypanosoma cruzi	

2 . Revision History

Date	Notes
3/10/2021	Bulk Copy guidelines starting with B and C from C&S Arizona to Ariz ona Medicaid

Prior Authorization Guideline

Guideline ID	GL-749238
Guideline Name	Besremi (ropeginterferon alfa-2b-njft)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Besremi	
Diagnosis	Polycythemia Vera
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of polycythemia vera

AND

1.2 Patient has absolute erythrocytosis (i.e., hemoglobin > 16.5 g/dL for men or hemoglobin > 16.0 g/dL for women, or hematocrit > 49% for men or hematocrit > 48% for women)

AND

1.3 One of the following:

- Presence of JAK2 V617F or JAK2 exon 12 mutation
- Patient has subnormal serum erythropoietin level

AND

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

- Hematologist
- Oncologist

Product Name:Besremi	
Diagnosis	Essential Thrombocythemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of essential thrombocythemia

AND

1.2 Patient has thrombocytosis (i.e., platelets greater than or equal to 450 x 10^9/L)

AND

1.3 One of the following:

1.3.1 Presence of a JAK2, calreticulin (CALR), or myeloproliferative leukemia virus oncogene (MPL) mutation

OR

1.3.2 Presence of other clonal markers (e.g., presence of a TET2, ASXL1, DNMT3A, SF3B1, EZH2, IDH1, IDH2, DNMT3A, SRSF2, U2AF1, SF3B1, TP53, IKZF1, NF-E2, or CUX1 mutation)

AND

1.4 No evidence of reactive (secondary) thrombocytosis (e.g., thrombocytosis due to infection, inflammation, or iron deficiency anemia)

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming trial and inadequate response, contraindication, or intolerance to hydroxyurea

AND

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

- Hematologist
- Oncologist

Product Name:Besremi	
Diagnosis	All indications listed above

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

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

2 . Revision History

Date	Notes
10/28/2026	Added criteria for new indication of Essential Thrombocythemia, upd ated submission of records requirement throughout.

Prior Authorization Guideline

Guideline ID	GL-396211
Guideline Name	Bevacizumab Products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Preferred: Mvasi, Zirabev	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The drug is being used as indicated by National Comprehensive Cancer Network (NCCN) guidelines with a Category of Evidence and Consensus of 1, 2A, or 2B	

Product Name:Non-Preferred*: Alymsys, Avastin, Avzivi, Jobevne, Vegzelma, and newly launched bevacizumab products

Approval Length	Requests for Non-Preferred biosimilars are not approved at this time
Guideline Type	Prior Authorization
Approval Criteria **1** - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred products are Mvasi and Zirabev. **Please note: The drug(s) listed above may require additional review.	
Notes	*Patients must use preferred bevacizumab biosimilar(s).

2 . Revision History

Date	Notes
9/25/2025	Added Jobevne as NP target

Prior Authorization Guideline

Guideline ID	GL-589217
Guideline Name	Bimzelx (bimekizumab-bkzx)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Bimzelx	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of moderate to severe plaque psoriasis (PsO)

AND

1.2 One of the following:

- At least 3% body surface area (BSA) involvement
- Severe scalp psoriasis
- Palmoplantar (i.e., palms, soles), facial, or genital involvement

AND

1.3 Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies:

- corticosteroids (e.g., betamethasone, clobetasol)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to one of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Infliximab
- Otezla (apremilast)

- A preferred ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a dermatologist

Product Name:Bimzelx	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by ONE of the following:

- Reduction the body surface area (BSA) involvement from baseline
- Improvement in symptoms (e.g., pruritus, inflammation) from baseline

AND

2 - Prescribed by or in consultation with a dermatologist

Product Name:Bimzelx	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- Enbrel (etanercept) or a preferred adalimumab biosimilar
- infliximab
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

AND

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

- Dermatologist
- Rheumatologist

Product Name:Bimzelx	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by ONE of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline
- Reduction in the body surface area (BSA) involvement from baseline

AND

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

- Dermatologist
- Rheumatologist

Product Name:Bimzelx	
Diagnosis	Non-radiographic Axial Spondyloarthritis (nr-AxSpA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of active non-radiographic axial spondyloarthritis

AND

1.2 Patient has objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints)

AND

1.3 History of a minimum duration of one month trial, contraindication, or intolerance to two different nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen) at maximally tolerated doses

AND

1.4 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Bimzelx	
Diagnosis	Non-radiographic Axial Spondyloarthritis (nr-AxSpA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following:

- Disease activity (e.g., pain, fatigue, inflammation, stiffness)
- Function
- Lab values (erythrocyte sedimentation rate, C-reactive protein level)
- Axial status (e.g., lumbar spine motion, chest expansion)
- Total active (swollen and tender) joint count

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Bimzelx	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of active ankylosing spondylitis

AND

1.2 History of a minimum duration of one month trial, contraindication, or intolerance to two different nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen) at maximally tolerated doses

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Bimzelx	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following:

- Disease activity (e.g., pain, fatigue, inflammation, stiffness)
- Function
- Lab values (erythrocyte sedimentation rate, C-reactive protein level)
- Axial status (e.g., lumbar spine motion, chest expansion)
- Total active (swollen and tender) joint count

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Bimzelx	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to a preferred adalimumab biosimilar

AND

3 - Prescribed by or in consultation with a dermatologist

Product Name:Bimzelx	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by at least one of the following:

- Reduction in the abscess and inflammatory nodule count from baseline
- Reduced formation of new sinus tracts and scarring
- Improvement in symptoms (e.g., pain, suppuration) from baseline

AND

2 - Prescribed by or in consultation with a dermatologist

2 . Revision History

Date	Notes
4/30/2026	nr-AxSpA indication: updated embedded step to mirror AS step.

Prior Authorization Guideline

Guideline ID	GL-99566
Guideline Name	Blood Glucose Monitors
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Non-preferred Blood Glucose Monitors*	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is visually impaired	
Notes	*Please reference background table for list of Non-preferred Blood Glucose Monitors **Approve Glucose Monitor at NDC Level

2 . Background

Benefit/Coverage/Program Information

Non-preferred Blood Glucose Monitors*

CONTOUR KIT NEXT LNK	EASY TOUCH KIT MONITOR	EASYMAX V KIT SYSTEM
CONTOUR NXT KIT LINK 2.4	KROGER BGM KIT SYSTEM	EASYMAX NG KIT SYSTEM
CONTOUR KIT NEXT EZ	ELEMENT AUTO KIT SYSTEM	MEIJER BGM KIT ESSENTIA
CONTOUR KIT NEXT	SMARTEST KIT EJECT	MEIJER GLUCO KIT MONITOR
CONTOUR KIT MONITOR	SMARTEST KIT PROTEGE	MEIJER BGM KIT PREMIUM
RELION MICRO KIT	SMARTEST KIT PRONTO	FORA V30A KIT
RELION KIT MONITOR	SMARTEST KIT PERSONA	FORA TN'G KIT VOICE
BD LOGIC KIT MONITOR	GLUCOCOM KIT MONITOR	REFUAH PLUS KIT SYSTEM
BD LATITUDE KIT	RIGHTEST SYS KIT GM300	KROGER BGM KIT
BD LATITUDE KIT SYSTEM	RIGHTEST SYS KIT GM100	KROGER BGM KIT PREMIUM
QUICKTEK KIT	RIGHTEST SYS KIT GM550	CONTOUR KIT LINK 2.4
ADVANCE KIT INTUITIO	IGLUCOSE KIT	EASYMAX V KIT SYSTEM
GLUCOCARD KIT SHNE CON	NOVA MAX KIT SYSTEM	EASYMAX NG KIT SYSTEM
GLUCOCARD KIT SHNE EXP	WAVESENSE KIT KEYNOTE	MYGLUCOHEALT KIT SYSTEM

GLUCOCARD KIT EXPRESSI	AGAMA JAZZ KIT WRLSS 2	MICRODOT KIT SYSTEM
POCKETCHEM KIT EZ	AGAMATRIX KIT PRESTO	ONE TOUCH KIT VERIO FL
GLUCOCARD 01 KIT SYSTEM	WAVESENSE KIT AMP	RELION TRUE KIT MET AIR
GLUCOCARD 01 KIT MINI	SOLUS V2 KIT SYSTEM	VERASENS KIT
GLUCOCARD KIT X-METER	COOL MONITOR KIT	INFINITY KIT VOICE
GLUCOCARD KIT VITAL	TRUERESULT KIT MONITOR	OPTIUM KIT BL GLUC
RELION PREMI KIT COMP SYS	TRUERESULT KIT SYSTEM	PRECISION KIT XTRA
SMART SENSE KIT GLUC SYS	MEIJER BGM KIT ESSENTIA	PRECISION KIT LINK
CVS GLUCOSE KIT METER	MEIJER GLUCO KIT MONITOR	BIOTEL CARE KIT SYSTEM
INFINITY KIT SYSTEM	MEIJER BGM KIT PREMIUM	BIOTEL CARE KIT
EASYPRO KIT MONITOR	FORA V30A KIT	FREESTYLE KIT SIDEKICK
EASYPRO PLUS KIT	FORA TN'G KIT VOICE	FREESTYLE KIT FREEDOM
PRODIGY PCKT KIT METER	REFUAH PLUS KIT SYSTEM	KROGER BGM KIT PREMIUM
PRODIGY AUTO KIT MONITOR	KROGER BGM KIT	CONTOUR KIT LINK 2.4
PRODIGY VOIC KIT METER		
PRODIGY KIT NO CODIN		

3 . Revision History

Date	Notes
7/12/2021	New Program

Prior Authorization Guideline

Guideline ID	GL-669269
Guideline Name	Blujepa (gepotidacin)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Blujepa	
Diagnosis	Uncomplicated Urinary Tract Infection (uUTI)
Approval Length	5 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of an uncomplicated urinary tract infection (uUTI)

AND

2 - Patient is 12 years of age or older

AND

3 - Patient weighs at least 40kg

AND

4 - Trial and inadequate response, contraindication or resistance to BOTH of the following alternative oral antibacterial treatment options:

- ciprofloxacin
- nitrofurantoin

AND

5 - Infection is caused by one of the following:

- Escherichia coli
- Klebsiella pneumoniae
- Citrobacter freundii complex
- Staphylococcus saprophyticus
- Enterococcus faecalis

Product Name:Blujepa	
Diagnosis	Uncomplicated Urogenital Gonorrhea
Approval Length	3 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of uncomplicated urogenital gonorrhea susceptible to gepotidacin

AND

2 - Patient is 12 years of age or older

AND

3 - Patient weighs at least 45kg

AND

4 - Trial and inadequate response, contraindication or resistance to one of the following alternative antibacterial treatment options:

- ceftriaxone
- ceftriaxone plus azithromycin

2 . Revision History

Date	Notes
7/28/2026	Updated step requirements

Prior Authorization Guideline

Guideline ID	GL-99436
Guideline Name	Bonjesta and Diclegis
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Bonjesta, Brand Diclegis, generic doxylamine/pyridoxine	
Diagnosis	Nausea and vomiting associated with pregnancy
Approval Length	9 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of nausea and vomiting associated with pregnancy

AND

2 - Documented failure or contraindication to lifestyle modifications (e.g., diet, avoidance of triggers)

AND

3 - Documented trial and failure or contraindication to a five day trial of over-the-counter doxylamine taken together with pyridoxine (i.e., not a combined dosage form, but separate formulations taken concomitantly)

2 . Revision History

Date	Notes
3/10/2021	Bulk Copy guidelines starting with B and C from C&S Arizona to Ariz ona Medicaid

Prior Authorization Guideline

Guideline ID	GL-99590
Guideline Name	Brand Over Generic Not Covered
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Generic products on a brand* over generic program	
Guideline Type	Administrative
Approval Criteria **1** - Requests for a generic product on a brand over generic program (presence of Brand over generic-Not Covered clinical program in formulary lookup) shall be denied. The plan's preferred product is the brand medication.	
Notes	* Brand product may require prior authorization.

2 . Revision History

Date	Notes
10/29/2021	Changed effective date to 12/1/21

Prior Authorization Guideline

Guideline ID	GL-99541
Guideline Name	Breast Cancer - Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Arimidex, generic anastrozole	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Adjuvant treatment of postmenopausal patients with hormone receptor-positive early breast cancer

OR

1.2 First-line treatment of postmenopausal patients with hormone receptor-positive or hormone receptor status unknown locally advanced or metastatic breast cancer

OR

1.3 Postmenopausal patients with disease progression following tamoxifen therapy

Product Name:Brand Aromasin, generic exemestane	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Adjuvant treatment of postmenopausal patients with estrogen receptor-positive early breast cancer who have received 2 to 3 years of tamoxifen and are switched to exemestane for completion of a total of 5 consecutive years of adjuvant hormonal therapy

OR

1.2 Treatment of advanced breast cancer in postmenopausal patients whose disease has progressed following tamoxifen therapy

Product Name:Brand Fareston, generic toremifene	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Treatment of metastatic breast cancer in postmenopausal patients with estrogen receptor positive tumors or with tumors of unknown estrogen receptor status

Product Name:Brand Arimidex, generic anastrozole, Brand Aromasin, generic exemestane, Brand Fareston, generic toremifene	
Diagnosis	National Comprehensive Cancer Network (NCCN) Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Brand Arimidex, generic anastrozole, Brand Aromasin, generic exemestane, Brand Fareston, generic toremifene	
Diagnosis	National Comprehensive Cancer Network (NCCN) Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
6/3/2021	Arizona Medicaid 7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-120435
Guideline Name	Brexafemme (ibrexafungerp)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2023

1 . Criteria

Product Name:Brexafemme	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Requested drug is being used for a Food and Drug Administration (FDA)-approved indication

AND

2 - Trial and failure, contraindication, or intolerance to both of the following:

- One intravaginal product (e.g., clotrimazole, miconazole, tioconazole, terconazole, boric acid)
- Oral fluconazole for a minimum of 3 days duration

2 . Revision History

Date	Notes
1/24/2023	New program

Prior Authorization Guideline

Guideline ID	GL-642189
Guideline Name	Breztri, Trelegy Ellipta - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Breztri, Trelegy Ellipta	
Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of asthma	

AND

2 - One of the following:

- For Breztri requests: Patient is 12 years of age or older
- For Trelegy requests: Patient is 18 years of age or older

AND

3 - History of failure, contraindication, or intolerance to treatment with ALL of the following preferred products:

- Wixela Inhub, generic fluticasone-salmeterol diskus, or Advair HFA
- Dulera
- generic budesonide-formoterol (generic for Symbicort)

Product Name:Breztri, Trelegy Ellipta	
Diagnosis	COPD
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD), including chronic bronchitis and/or emphysema

AND

2 - History of failure, contraindication, or intolerance to treatment with at least a 30 day trial of both of the following used in combination:

- Stiolto Respimat (tiotropium-olodaterol)

- Brand Flovent HFA or generic fluticasone propionate

Product Name:Breztri, Trelegy Ellipta	
Diagnosis	Asthma, COPD
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
6/25/2026	Added new Breztri GPI, added Breztri to Asthma criteria box with age criterion added.

Prior Authorization Guideline

Guideline ID	GL-427214
Guideline Name	Brinsupri (brensocatib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

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

Approval Criteria

1 - Both of the following:

1.1 Diagnosis of non-cystic fibrosis bronchiectasis (NCFB)

AND

1.2 Diagnosis has been confirmed by computed tomographic (CT) scan

AND

2 - Diagnostic testing confirms patient does not have cystic fibrosis

AND

3 - Submission of medical records (e.g., chart notes) confirming patient has a clinical history consistent with non-cystic fibrosis bronchiectasis (e.g., chronic cough or sputum production or recurrent respiratory tract infections)

AND

4 - One of the following:

4.1 If patient is 12 to 17 years of age, patient has had at least one (1) documented pulmonary exacerbation requiring treatment with systemic antibiotics in the previous 12 months

OR

4.2 If patient is 18 years of age or older, patient has had at least two (2) documented pulmonary exacerbations requiring treatment with systemic antibiotics in the previous 12 months

AND

5 - Patient is 12 years of age and older

AND

6 - One of the following:

6.1 For patients with co-existing COPD, submission of medical records (e.g., chart notes) or paid claims documenting that the patient is receiving one of the following therapies:

- Triple therapy (i.e., an inhaled corticosteroid (ICS) [e.g., budenoside], a long-acting muscarinic antagonist (LAMA) [e.g., tiotropium, umeclidinium] and a long-acting beta agonist (LABA) [e.g., salmeterol, arformoterol, formoterol]
- If ICS are contraindicated, a LAMA and a LABA

OR

6.2 For patients with co-existing asthma, submission of medical records (e.g., chart notes) or paid claims documenting that patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications:

6.2.1 Both of the following:

- Inhaled corticosteroid (ICS) (e.g., fluticasone propionate)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium])

OR

6.2.2 One combination ICS/LABA product (e.g., Advair, Breo Ellipta)

AND

7 - Prescribed by or in consultation with a pulmonologist

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., stabilization or reduction in number of pulmonary exacerbations)

2 . Revision History

Date	Notes
10/29/2025	New program

Prior Authorization Guideline

Guideline ID	GL-481227
Guideline Name	Buprenorphine Sublingual Tablet
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Buprenorphine Sublingual Tablet	
Approval Length	6 Months*
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of opioid abuse/dependence

AND

2 - One of the following:

2.1 Patient is pregnant or breastfeeding;*

OR

2.2 Both of the following:

2.2.1 Patient had an intolerance or side effect to generic buprenorphine-naloxone sublingual tablet or Brand Suboxone film

AND

2.2.2 Side effects or intolerances to generic buprenorphine-naloxone sublingual tablet or Brand Suboxone film were not resolved with a trial of anti-emetics (e.g., ondansetron) or non-opioid analgesics

OR

2.3 Patient has a contraindication to naloxone

OR

2.4 Both of the following:

2.4.1 Patient has a severe allergy to naloxone [e.g., Stevens-Johnson syndrome, DRESS (Drug Rash with Eosinophilia and Systemic Symptoms)];

AND

2.4.2 Provider has submitted a copy of the MedWatch Form 3500 to the Food and Drug Administration documenting the adverse reaction

AND

3 - Patient is not currently on ANY of the following:

- Benzodiazepines (e.g., Alprazolam, Diazepam, Lorazepam)

• Hypnotics (e.g., Temazepam, Rozerem, Zolpidem) • Opioids (e.g., Oxycodone, Tramadol, Hydrocodone) **AND** **4** - Prescriber attests that the Arizona State Board of Pharmacy Controlled Substance Prescription Drug Monitoring Program database has been reviewed and that patient has been warned about the dangers of ingesting concurrent sedating medications	
Notes	*Approve for 1 year if pregnant or breastfeeding

2 . Revision History

Date	Notes
12/17/2025	Specified Brand Suboxone film and generic buprenorphine-naloxone SL tablets are the preferred prerequisites

Prior Authorization Guideline

Guideline ID	GL-417196
Guideline Name	Bylvay (odevixibat)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Bylvay	
Diagnosis	Progressive Familial Intrahepatic Cholestasis (PFIC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a molecular diagnosis of progressive familial intrahepatic cholestasis (PFIC)

AND

2 - Patient does not have a ABCB11 variant resulting in non-functional or complete absence of bile salt export pump protein (BSEP-3)

AND

3 - Patient is experiencing both of the following:

- Moderate to severe pruritus
- Patient has a serum bile acid concentration above the upper limit of the normal reference for the reporting laboratory

AND

4 - Patient is 3 months of age or older

AND

5 - Patient has had an inadequate response to at least two of the following treatments used for the relief of pruritus:

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

AND

6 - Prescribed dose is consistent with FDA-approved package labeling and does not exceed a total daily dose of 6 mg

AND

7 - Prescribed by or in consultation with a hepatologist or gastroenterologist

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

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduced serum bile acids, improved pruritus)

AND

2 - Prescribed dose is consistent with FDA-approved package labeling and does not exceed a total daily dose of 6 mg

Product Name:Bylvay	
Diagnosis	Alagille Syndrome (ALGS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of Alagille Syndrome (ALGS)

AND

1.2 Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene

AND

2 - Patient is experiencing both of the following:

- Moderate to severe pruritus
- Patient has a serum bile acid concentration above the upper limit of the normal reference for the reporting laboratory

AND

3 - Patient is 12 months of age or older

AND

4 - Patient has had an inadequate response to at least two of the following treatments used for the relief of pruritus:

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

AND

5 - Prescribed by or in consultation with a hepatologist or gastroenterologist

Product Name:Bylvay	
Diagnosis	Alagille Syndrome (ALGS)
Approval Length	12 Months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduced bile acids, reduced pruritus severity score)

2 . Revision History

Date	Notes
10/29/2025	Updated diagnostic criteria for PFIC

Prior Authorization Guideline

Guideline ID	GL-502258
Guideline Name	Cablivi
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Cablivi	
Diagnosis	Acquired thrombotic thrombocytopenic purpura (aTTP)
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 12 years of age or older

AND

2 - Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP)

AND

3 - Cablivi was initiated in the inpatient setting in combination with plasma exchange therapy

AND

4 - Cablivi will be used in combination with immunosuppressive therapy (e.g., corticosteroids)

AND

5 - Total treatment duration will be limited to 58 days beyond the last therapeutic plasma exchange

Product Name:Cablivi	
Diagnosis	Acquired thrombotic thrombocytopenic purpura (aTTP)
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Request is for a new (different) episode requiring the re-initiation of plasma exchange for the treatment of acquired thrombotic thrombocytopenic purpura (aTTP) (Documentation of date of prior episode and documentation date of new episode required)

AND

2 - Patient is 12 years of age or older

2 . Revision History

Date	Notes
1/28/2026	Added age criterion due to expanded approval.

Prior Authorization Guideline

Guideline ID	GL-553402
Guideline Name	Cabotegravir Containing Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Vocabria*, Cabenuva*	
Diagnosis	Treatment of HIV-1 Infection
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 Diagnosis of HIV-1 infection

AND

1.2 Patient is 12 years of age or older

AND

1.3 Patient's weight is greater than or equal to 35 kg

AND

1.4 Patient is currently virologically suppressed (HIV-1 RNA less than 50 copies/mL) on a stable, uninterrupted antiretroviral regimen for at least 6 months

AND

1.5 Patient has no history of treatment failure or known/suspected resistance to either cabotegravir or rilpivirine

AND

1.6 Provider attests that patient would benefit from long-acting injectable therapy over standard oral regimens

AND

1.7 Prescribed by or in consultation with a clinician with HIV expertise

OR

2 - For continuation of prior therapy

Notes	*If patient meets criteria above, please approve both Vocabria and Cabenuva at GPI list “CABOTEGRPA”.

Product Name:Vocabria**, Apretude**	
Diagnosis	HIV-1 Pre-Exposure Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Requested drug is being used for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 infection

AND

2 - Patient's weight is greater than or equal to 35 kg

AND

3 - Both of the following:

3.1 Patient has a negative HIV-1 test

AND

3.2 Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection

AND

4 - One of the following:

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

- emtricitabine-tenofovir (generic Truvada)
- Descovy

OR

4.2 Submission of medical records (e.g., chart notes) from provider documenting BOTH of the following:

- Patient would benefit from long-acting injectable therapy over standard oral regimens
- Patient would be adherent to testing and dosing schedule

Notes	**If patient meets criteria above, please approve both Vocabria and A pretude at GPI list “APRETUDEPA”

Product Name:Vocabria**, Apretude**	
Diagnosis	HIV-1 Pre-Exposure Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Provider attests that patient is adherent to the testing appointments and scheduled injections of Apretude

AND

2 - Both of the following:

2.1 Patient has a negative HIV-1 test

AND

2.2 Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection

Notes	**If patient meets criteria above, please approve both Vocabria and A pretude at GPI list “APRETUDEPA”

2 . Revision History

Date	Notes
3/24/2026	Update HIV testing requirement for PrEP indication in both initial and reauth.

Prior Authorization Guideline

Guideline ID	GL-547234
Guideline Name	Calcium/Vitamin D
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Calcium/Vitamin D	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) including lab values documenting a Vitamin D deficiency	
Notes	Calcium carbonate and calcium lactate are covered without the need f or prior authorization.

Product Name:Calcium/Vitamin D	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) including lab values documenting improvement in Vitamin D deficiency (e.g., Vitamin D levels within normal range)	
Notes	Calcium carbonate and calcium lactate are covered without the need f or prior authorization.

2 . Revision History

Date	Notes
3/24/2026	Updated submission of records verbiage, added reauth criteria

Prior Authorization Guideline

Guideline ID	GL-749241
Guideline Name	Camzyos (mavacamten)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Camzyos	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of obstructive hypertrophic cardiomyopathy (HCM)

AND

2 - Patient has New York Heart Association (NYHA) Class II or III symptoms (e.g., shortness of breath, chest pain)

AND

3 - Submission of medical records (e.g., chart notes) confirming both of the following were measured prior to Camzyos therapy:

3.1 Patient had a left ventricular ejection fraction of greater than or equal to 55%

AND

3.2 Patient had a valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation

AND

4 - Patient weighs greater than or equal to 30kg

AND

5 - Trial and failure, contraindication, or intolerance to both of the following at a maximally tolerated dose:

- non-vasodilating beta blocker (e.g., bisoprolol, propranolol)
- calcium channel blocker (e.g., verapamil, diltiazem)

AND

6 - Requested drug will not be used in combination with another cardiac myosin inhibitor (e.g., Myqorzo)

AND

7 - Prescribed by or in consultation with a cardiologist

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

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., improved symptom relief)

AND

2 - Patient has a left ventricular ejection fraction of greater than or equal to 50%

AND

3 - Requested drug will not be used in combination with another cardiac myosin inhibitor (e.g., Myqorzo)

AND

4 - Prescribed by or in consultation with a cardiologist

2 . Revision History

Date	Notes
10/28/2026	Updated LVEF and LVOT requirements to specify that these should b e measured prior to Camzyos therapy, added weight criterion due to expanded indication, added concomitant use criterion

Prior Authorization Guideline

Guideline ID	GL-104872
Guideline Name	Carbaglu (carglumic acid)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2022

1 . Criteria

Product Name:Brand Carbaglu, Generic carglumic acid	
Diagnosis	Acute Hyperammonemia due to N-acetylglutamate Synthase (NAGS) Deficiency
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of acute hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency

AND

2 - Medication will be used as adjunctive therapy to other ammonia lowering therapies (e.g., protein restriction, ammonia scavengers, dialysis)

AND

3 - Prescribed by or in consultation with a specialist focused in the treatment of metabolic disorders

Product Name:Brand Carbaglu, Generic carglumic acid	
Diagnosis	Acute Hyperammonemia due to Propionic Acidemia (PA) or Methylmalonic Acidemia (MMA)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA)

AND

2 - Medication will be used as adjunctive therapy to other ammonia lowering therapies (e.g. intravenous glucose, insulin, protein restriction, dialysis)

AND

3 - Patient’s plasma ammonia level is greater than or equal to 50 micromol/L

AND

4 - Medication will be used for a maximum duration of 7 days

AND

5 - Prescribed by or in consultation with a specialist focused in the treatment of metabolic disorders

Product Name:Brand Carbaglu, Generic carglumic acid	
Diagnosis	Chronic Hyperammonemia due to N-acetylglutamate Synthase (NAGS) Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of chronic hyperammonemia due to N-acetylglutamate synthase (NAGS) deficiency

AND

2 - NAGS deficiency has been confirmed by genetic/mutational analysis

AND

3 - Medication will be used as maintenance therapy

AND

4 - Prescribed by or in consultation with a specialist focused in the treatment of metabolic disorders

Product Name:Brand Carbaglu, Generic carglumic acid	
Diagnosis	Chronic Hyperammonemia due to N-acetylglutamate Synthase (NAGS) Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting a positive clinical response to therapy (e.g., plasma ammonia level within the normal range)

2 . Revision History

Date	Notes
3/31/2022	New program for Carbaglu, mirrors ORx LOB. Added submission of MR to each section.

Prior Authorization Guideline

Guideline ID	GL-669258
Guideline Name	Casgevy (exagamglogene autotemcel injection)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Casgevy	
Diagnosis	Sickle Cell Disease
Approval Length	1 Time Authorization in Lifetime*
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records including but not limited to laboratory and genetic testing to confirm sickle cell disease (SCD)

AND

2 - Patient is 2 years of age or older

AND

3 - Provider attests that patient is clinically stable and eligible to undergo hematopoietic stem cell transplant (HSCT)

AND

4 - Provider attests the patient has experienced recurrent VOCs defined as two or more documented VOCs per year in the previous 24 months:

- Acute pain event requiring a visit to a medical facility and administration of pain medications (opioids or intravenous [IV] non-steroidal anti-inflammatory drugs [NSAIDs]) or RBC transfusions
- Acute chest syndrome
- Priapism lasting > 2 hours and requiring a visit to a medical facility
- Splenic or Hepatic sequestration

AND

5 - Submission of medical records (e.g., chart notes) confirming patient has obtained a negative test result for all of the following prior to cell collection:

- Hepatitis B virus (HBV)
- Hepatitis C virus (HCV)
- Human immunodeficiency virus (HIV)

AND

6 - Provider attests the patient is clinically stable and fit for transplantation

AND

7 - Both of the following:

- Patient has never received any previous sickle cell gene therapy treatment in their lifetime (i.e., Casgevy, Lyfgenia)
- Patient has never received prior allogeneic transplant

AND

8 - Prescribed by a provider at a SCD Treatment center with expertise in gene therapy

AND

9 - Prescribed by one of the following:

- Hematologist/Oncologist
- Specialist with expertise in the diagnosis and management of sickle cell disease

Notes	*Per prescribing information, Casgevy is for one-time, single dose intr avenous use only

Product Name:Casgevy	
Diagnosis	Transfusion-dependent β-thalassemia (TDT)
Approval Length	1 Time Authorization in Lifetime*
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of transfusion-dependent β-thalassemia (TDT)

AND

2 - Submission of medical records (e.g., chart notes) confirming presence of a mutation at both alleles of the β-globin gene (i.e., β0/β0, β0/β+, β+/β+, β0/βE)

AND

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

- Patient has a history of requiring at least 100 mL/kg/year of RBC transfusions in the prior 2 years
- Patient requires 10 units/year of RBC transfusions in the prior 2 years

AND

4 - Patient is 2 years of age or older

AND

5 - Provider attests that patient is clinically stable and eligible to undergo hematopoietic stem cell transplant (HSCT)

AND

6 - Submission of medical records (e.g., chart notes) confirming patient has obtained a negative test result for all of the following prior to cell collection:

- Hepatitis B virus (HBV)
- Hepatitis C virus (HCV)
- Human immunodeficiency virus (HIV)

AND

7 - Patient is anticipated to provide an adequate number of cells to meet the minimum recommended dose of 3 x 10^6 CD34+ cells/kg

AND

8 - Patient does not have any of the following:

- Severely elevated iron in the heart (e.g., patients with cardiac T2* less than 10 msec by MRI)
- Advanced liver disease
- MRI results of the liver demonstrating liver iron content greater than or equal to 15 mg/g (unless biopsy confirms absence of advanced disease)

AND

9 - Both of the following:

- Iron chelation therapy (e.g., deferoxamine, deferasirox) will be discontinued for at least 7 days prior to initiating myeloablative conditioning therapy
- Hydroxyurea, Oxbryta (voxelotor), and Adakveo (crizanlizumab) will be discontinued at least 8 weeks prior to start of mobilization and conditioning

AND

10 - Patient will receive both of the following:

10.1 Full myeloablative conditioning with busulfan prior to treatment with Casgevy

AND

10.2 Anti-seizure prophylaxis with agents other than phenytoin prior to initiating busulfan conditioning

AND

11 - Both of the following:

- Patient has never received any previous transfusion dependent beta-thalassemia gene therapy treatment in their lifetime (i.e., Casgevy, Zynteglo)
- Patient has never received prior allogeneic transplant

AND

12 - Prescribed by a provider at a treatment center with expertise in gene therapy

AND **13** - Prescribed by one of the following: • Hematologist/Oncologist • Stem transplant specialist	
Notes	*Per prescribing information, Casgevy is for one-time, single dose intr avenous use only

2 . Revision History

Date	Notes
7/28/2026	Updated age criteria due to expanded indications.

Prior Authorization Guideline

Guideline ID	GL-99603
Guideline Name	Cayston
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Cayston	
Diagnosis	Cystic Fibrosis (CF)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cystic fibrosis (CF)	

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona SP to Medicaid Arizona SP for 7/1 eff

Prior Authorization Guideline

Guideline ID	GL-734190
Guideline Name	CGRP Inhibitors - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Aimovig, Ajovy, Emgality 120 mg/ml	
Diagnosis	Preventive Treatment of Migraine
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Diagnosis of episodic migraines

AND

1.1.2 Patient has 4 to 14 migraine days per month, but no more than 14 headache days per month

OR

1.2 All of the following:

1.2.1 Diagnosis of chronic migraines

AND

1.2.2 Patient has greater than or equal to 15 headache days per month, of which at least 8 must be migraine days for at least 3 months

AND

1.2.3 Medication overuse headache has been considered and potentially offending medication(s) have been discontinued

AND

2 - One of the following:

2.1 Patient is 18 years of age or older

OR

2.2 Both of the following (applies to Ajovy for episodic migraines ONLY):

- Patient is between 6-17 years of age
- Patient weight at least 45 kg or greater

AND

3 - Two of the following:

3.1 One of the following:

- History of failure (after at least a two month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine)
- Patient has a contraindication to both Elavil (amitriptyline) and Effexor (venlafaxine)

OR

3.2 One of the following:

- History of failure (after at least a two month trial) or intolerance to Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)
- Patient has a contraindication to both Depakote/Depakote ER (divalproex sodium) and Topamax (topiramate)

OR

3.3 One of the following:

- History of failure (after at least a two month trial) or intolerance to one of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol
- Patient has a contraindication to all of the following beta blockers: atenolol, propranolol, nadolol, timolol, metoprolol

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

5 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Aimovig, Ajovy, Emgality 120 mg/ml	
Diagnosis	Preventive Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

2 - Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

4 - For Chronic Migraine only: Patient continues to be monitored for medication overuse headache (MOH)

AND

5 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Emgality 100 mg/mL	
Diagnosis	Episodic Cluster Headaches
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of episodic cluster headache

AND

2 - Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months

AND

3 - Patient is 18 years of age or older

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

5 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Emgality 100 mg/mL	
Diagnosis	Episodic Cluster Headaches
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

3 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Qulipta, Vyepti	
Diagnosis	Preventive Treatment of Migraine
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Diagnosis of episodic migraines

AND

1.1.2 Patient has 4 to 14 migraine days per month, but no more than 14 headache days per month

OR

1.2 All of the following:

1.2.1 Diagnosis of chronic migraines

AND

1.2.2 Patient has greater than or equal to 15 headache days per month, of which at least 8 must be migraine days for at least 3 months

AND

1.2.3 Medication overuse headache has been considered and potentially offending medication(s) have been discontinued

AND

2 - Patient is 18 years of age or older

AND

3 - Two of the following:

3.1 One of the following:

- History of failure (after at least a two month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine)
- Patient has a contraindication to both Elavil (amitriptyline) and Effexor (venlafaxine)

OR

3.2 One of the following:

- History of failure (after at least a two month trial) or intolerance to Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)

- Patient has a contraindication to both Depakote/Depakote ER (divalproex sodium) and Topamax (topiramate)

OR

3.3 One of the following:

- History of failure (after at least a two month trial) or intolerance to one of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol
- Patient has a contraindication to all of the following beta blockers: atenolol, propranolol, nadolol, timolol, metoprolol

AND

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

- Aimovig
- Ajovy
- Emgality

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

6 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Qulipta, Vyepti	
Diagnosis	Preventive Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

2 - Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy

AND

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

- Aimovig
- Ajovy
- Emgality

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

5 - For Chronic Migraine only: Patient continues to be monitored for medication overuse headache (MOH)

AND

6 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Nurtec ODT	
Diagnosis	Preventive Treatment of Episodic Migraine
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Diagnosis of episodic migraines

AND

1.2 Patient has 4 to 18 migraine days per month, but no more than 18 headache days per month

AND

2 - Patient is 18 years of age or older

AND

3 - Two of the following:

3.1 One of the following:

- History of failure (after at least a two month trial) or intolerance to Elavil (amitriptyline) or Effexor (venlafaxine)
- Patient has a contraindication to both Elavil (amitriptyline) and Effexor (venlafaxine)

OR

3.2 One of the following:

- History of failure (after at least a two month trial) or intolerance to Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)
- Patient has a contraindication to both Depakote/Depakote ER (divalproex sodium) and Topamax (topiramate)

OR

3.3 One of the following:

- History of failure (after at least a two month trial) or intolerance to one of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol
- Patient has a contraindication to all of the following beta blockers: atenolol, propranolol, nadolol, timolol, metoprolol

AND

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

- Aimovig
- Ajovy
- Emgality

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

6 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Nurtec ODT	
Diagnosis	Preventive Treatment of Episodic Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

2 - Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

4 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the PREVENTIVE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Nurtec ODT, Zavzpret	
Diagnosis	Acute Treatment of Migraine
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of migraine with or without aura

AND

2 - Will be used for the acute treatment of migraine

AND

3 - Patient has fewer than 15 headache days per month

AND

4 - Patient is 18 years of age or older

AND

5 - Patient has a history of a one-month trial resulting in therapeutic failure, contraindication, or intolerance to FOUR of the following as evidenced by submission of medical records or claims history:

- naratriptan tablets
- rizatriptan tablets/ODT (Oral Disintegrating Tablets)
- sumatriptan tablets/auto injection/cartridge
- sumatriptan nasal spray
- zolmitriptan tablets/ODT
- Zomig nasal spray (Brand only)

AND

6 - Patient has a history of a one-month trial resulting in therapeutic failure, contraindication, or intolerance to Ubrelvy as evidenced by submission of medical records or claims history**

AND

7 - If patient has 4 or more headache days per month, patient must meet one of the following:

7.1 Currently being treated with Elavil (amitriptyline) or Effexor (venlafaxine) unless there is a contraindication or intolerance to these medications

OR

7.2 Currently being treated with Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate) unless there is a contraindication or intolerance to these medications

OR

7.3 Currently being treated with a beta blocker (i.e., atenolol, propranolol, nadolol, timolol, or metoprolol) unless there is a contraindication or intolerance to these medications

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

9 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the ACUTE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS). **Patients requesting initial aut horization who were established on therapy via the receipt of a manuf acturer supplied sample at no cost in the prescriber's office or any for m of assistance from the manufacturer sponsored programs shall be r equired to meet initial authorization criteria as if patient were new to th erapy.

Product Name:Nurtec ODT, Zavzpret	
Diagnosis	Acute Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea)

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

3 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the ACUTE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Ubrelvy	
Diagnosis	Acute Treatment of Migraine
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of migraine with or without aura

AND

2 - Will be used for the acute treatment of migraine

AND

3 - Will not be used for preventive treatment of migraine

AND

4 - Patient has fewer than 15 headache days per month

AND

5 - Patient is 18 years of age or older

AND

6 - Patient has a history of a one-month trial resulting in therapeutic failure, contraindication, or intolerance to TWO of the following as evidenced by submission of medical records or claims history:

- naratriptan tablets
- rizatriptan tablets/ODT (Oral Disintegrating Tablets)
- sumatriptan tablets/auto injection/cartridge
- zolmitriptan tablets/ODT
- Zomig nasal spray (Brand only)
- sumatriptan nasal spray

AND

7 - If patient has 4 or more headache days per month, patient must meet one of the following:

7.1 Currently being treated with Elavil (amitriptyline) or Effexor (venlafaxine) unless there is a contraindication or intolerance to these medications

OR

7.2 Currently being treated with Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate) unless there is a contraindication or intolerance to these medications

OR

7.3 Currently being treated with a beta blocker (i.e., atenolol, propranolol, nadolol, timolol, or metoprolol) unless there is a contraindication or intolerance to these medications

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

9 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the ACUTE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

Product Name:Ubrelvy	
Diagnosis	Acute Treatment of Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea)

AND

2 - Will not be used for preventive treatment of migraine

AND

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

- Neurologist
- Pain specialist
- Headache specialist*

AND

4 - Both of the following:

- Medication will not be used in combination with another CGRP inhibitor for the ACUTE treatment of migraines
- Patient will use only ONE CGRP for the PREVENTIVE treatment of migraines and ONE CGRP for the ACUTE treatment of migraines

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS).

2 . Revision History

Date	Notes
9/17/2026	Updated age criteria for Ajovy (removed criterion from NPD section, added to preferred section)

Prior Authorization Guideline

Guideline ID	GL-300310
Guideline Name	Chenodiol Products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of radiolucent gallstones

AND

1.2 Patient has a well-opacifying gallbladder visualized by oral cholecystography

AND

1.3 Trial and failure, contraindication or intolerance to ursodiol

AND

1.4 Patient is not a candidate for surgery

AND

1.5 Stones are not calcified (radiopaque) or radiolucent bile pigment stones

AND

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

- Gastroenterologist
- A provider who has specialized expertise in the management of gallstones

Notes	If patient meets criteria above, please approve at NDC level.

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

Approval Criteria

1 - Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment as evidenced by oral cholecystograms or ultrasonograms

AND

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

- Gastroenterologist
- A provider who has specialized expertise in the management of gallstones

Notes	If patient meets criteria above, please approve at NDC level.

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

Approval Criteria

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

1.1 Diagnosis of cerebrotendinous xanthomatosis (cholestanol storage disease)

AND

1.2 Disease is confirmed by the presence of pathogenic variant(s) in the CYP27A1 gene, as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

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

- Neurologist
- Geneticist

• Metabolic disease specialist	
Notes	If patient meets criteria above, please approve at NDC level.

Product Name:Ctexli	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient demonstrates positive clinical response to therapy (e.g. stabilization or improvement in symptoms, reduction in biochemical markers [e.g., serum cholestanol, urine 23S-pentol])	
Notes	If patient meets criteria above, please approve at NDC level.

2 . Revision History

Date	Notes
7/16/2025	New program

Prior Authorization Guideline

Guideline ID	GL-99700
Guideline Name	Cholbam
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Cholbam	
Diagnosis	Bile Acid Synthesis Disorder
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of a bile acid synthesis disorder

AND

2 - It is due to single enzyme defects

Product Name:Cholbam	
Diagnosis	Peroxisomal Disorders Including Zellweger Spectrum Disorders
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of peroxisomal disorders including Zellweger spectrum disorders

AND

2 - Patient exhibits manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption

AND

3 - It is being used as adjunctive treatment

Product Name:Cholbam	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria
1 - Documentation of positive clinical response to Cholbam therapy

2 . Revision History

Date	Notes
4/10/2021	7/1 Implementation

Prior Authorization Guideline

Guideline ID	GL-105174
Guideline Name	Cialis for BPH - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2022

1 . Criteria

Product Name:Brand Cialis 5mg, generic tadalafil 5mg	
Diagnosis	Benign Prostatic Hyperplasia (BPH)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 The patient has a diagnosis of benign prostatic hyperplasia (BPH)

AND

1.2 History of failure, intolerance, or contraindication to BOTH of the following:

- Alpha Blockers (e.g., tamsulosin, alfuzosin ER, doxazosin, or terazosin)
- 5-alpha reductase inhibitors (e.g., finasteride)

AND

1.3 Dose does not exceed 5 milligrams once daily

AND

2 - Provider attests that patient is not using any form of organic nitrate (for example, nitroglycerin, isosorbide dinitrate, isosorbide mononitrate or amyl nitrate) or Adempas

2 . Revision History

Date	Notes
3/24/2022	Added physician attestation re: patient not using nitrates

Prior Authorization Guideline

Guideline ID	GL-141167
Guideline Name	Cibinqo (abrocitinib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/7/2024

1 . Criteria

Product Name:Cibinqo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of moderate to severe atopic dermatitis

AND

2 - Submission of medical records documenting one of the following:

- Involvement of at least 10% body surface area (BSA)
- SCORing Atopic Dermatitis (SCORAD) index value of at least 25 [A]

AND

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

- Dermatologist
- Allergist/Immunologist

AND

4 - Submission of medical records (e.g., chart notes, lab work, imaging) or paid claims history documenting ALL of the following**:

4.1 History of failure, contraindication, or intolerance to the following topical therapies: (document drug, date of trial, and/or contraindication to medication)*

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)

AND

4.2 Submission of medical records (e.g., chart notes, lab work, imaging) or paid claims history documenting trial and failure of a minimum 12-week supply of Dupixent (dupilumab) **

AND

4.3 Submission of medical records (e.g., chart notes, lab work, imaging) or paid claims history documenting trial and failure of a minimum 12-week supply of Adbry (tralokinumab-ldrm) **

AND

5 - Not used in combination with biologic immunomodulators (e.g., Dupixent, Adbry) or other immunosuppressants (e.g., azathioprine, cyclosporine)

AND

6 - Patient is 12 years of age or older

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication **PA may be required

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting a positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in body surface area involvement from baseline
- Reduction in SCORing Atopic Dermatitis (SCORAD) index value from baseline [A]

AND

2 - Not used in combination with biologic immunomodulators (e.g., Dupixent, Adbry) or other immunosuppressants (e.g., azathioprine, cyclosporine)

2 . Background

Clinical Practice Guidelines

Table 1. Relative potencies of topical corticosteroids [2]

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05

	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
2/6/2024	Updated criteria to include submission of records where applicable, a dded step through Adbry.

Prior Authorization Guideline

Guideline ID	GL-300282
Guideline Name	Cimzia (certolizumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Cimzia	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 History of failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred tocilizumab biosimilar

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Cimzia	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:

2.1 Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:

- methotrexate
- leflunomide

AND

2.2 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet
- A preferred tocilizumab biosimilar

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name:Cimzia	
Diagnosis	Ankylosing Spondylitis (AS) or Non-Radiographic Axial (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 One of the following diagnoses:

- Active ankylosing spondylitis (AS)
- Active non-radiographic axial spondyloarthritis (nr-axSpA)

AND

1.2 History of failure to two NSAIDs (non-steroidal anti-inflammatory drugs; e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Cimzia	
Diagnosis	Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Ankylosing Spondylitis (AS) or Non-Radiographic Axial (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Cimzia	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of moderately to severely active Crohn's disease (CD)

AND

1.2 History of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Methotrexate (Rheumatrex, Trexall)

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- A preferred ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a gastroenterologist

Product Name:Cimzia

Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a gastroenterologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Otezla (apremilast)
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

AND

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

- Rheumatologist
- Dermatologist

Product Name:Cimzia	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

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

- Rheumatologist

- Dermatologist

Product Name:Cimzia	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of moderate to severe plaque psoriasis (PsO)

AND

1.2 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.3 History of failure to one of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure of a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to one of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Infliximab
- Otezla (apremilast)
- A preferred ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a dermatologist

Product Name:Cimzia	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a dermatologist

2 . Revision History

Date	Notes
7/3/2025	Updated preferred agents/embedded steps, updated criteria through out.

Prior Authorization Guideline

Guideline ID	GL-731210
Guideline Name	Clotic (clotrimazole otic solution)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Clotic	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of fungal otitis externa (otomycosis) due to Aspergillus species or Candida species

AND

2 - Patient has an intact tympanic membrane, with no known or suspected tympanic membrane perforation

AND

3 - One of the following:

3.1 Trial and failure (minimum 14-day supply) contraindication, or intolerance to generic clotrimazole 1% topical solution (Rx or OTC)

OR

3.2 Provider has provided a reason or special circumstance explaining why the patient is unable to use generic clotrimazole 1% topical solution (Rx or OTC) (please document reason/special circumstance)

2 . Revision History

Date	Notes
9/23/2026	New program

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-356254
Guideline Name	CMV and Herpes Virus Agents - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Brand Valcyte tabs/oral soln, generic valganciclovir tabs/oral soln, Brand Cytovene inj, generic ganciclovir inj, Foscavir inj	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Medication is being used for ONE of the following: **1.1** Cytomegalovirus (CMV) disease prophylaxis	

OR

1.2 Cytomegalovirus (CMV) retinitis

OR

1.3 Cytomegalovirus (CMV) retinitis prophylaxis

OR

1.4 BOTH of the following:

1.4.1 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology

AND

1.4.2 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*

Notes	*Note: Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

Product Name:cidofovir inj	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Medication is being used for ONE of the following:

1.1 Cytomegalovirus (CMV) retinitis

OR

1.2 Cytomegalovirus (CMV) retinitis prophylaxis

OR

1.3 BOTH of the following:

1.3.1 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology

AND

1.3.2 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*

Notes	*Note: Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

Product Name:famciclovir tabs	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Medication is being used for ONE of the following:

1.1 Herpes genitalis

OR

1.2 Herpes genitalis prophylaxis

OR

1.3 Herpes labialis

OR

1.4 Herpes simplex virus infection

OR

1.5 Herpes zoster (shingles) infection

OR

1.6 BOTH of the following:

1.6.1 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology

AND

1.6.2 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*

Notes	*Note: Medications used for anti-obesity/weight loss, cosmetic (e.g., al opecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysf unction purposes are NOT medically accepted indications and are NO T recognized as a covered benefit. Erectile dysfunction drugs (Cialis/T adalafil) are covered for clinical diagnoses other than ED.

Product Name:Brand Valtrex tabs, generic valacyclovir tabs	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Medication is being used for ONE of the following:

1.1 Herpes genitalis

OR

1.2 Herpes genitalis prophylaxis

OR

1.3 Herpes labialis

OR

1.4 Herpes simplex virus infection

OR

1.5 Herpes zoster (shingles) infection

OR

1.6 Varicella (chicken pox) infection

OR

1.7 BOTH of the following

1.7.1 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology

AND

1.7.2 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*

Notes	*Note: Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes
8/28/2025	Removed the word "solely" from notes section, no change to clinical intent.

Prior Authorization Guideline

Guideline ID	GL-642203
Guideline Name	Colony Stimulating Factors - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Preferred: Fulphila, Fylnetra, Nivestym, Releuko	
Diagnosis	Bone Marrow/Stem Cell Transplant
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient has non-myeloid malignancies and is undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant (BMT)

OR

1.2 Used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis

OR

1.3 Patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy

AND

2 - Prescribed by, or in consultation with, a hematologist or oncologist

Product Name:Preferred: Fulphila, Fylnetra, Nivestym, Releuko	
Diagnosis	AML Induction or Consolidation Therapy
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute myeloid leukemia (AML)

AND

2 - Patient has completed either induction or consolidation chemotherapy

AND

3 - Prescribed by, or in consultation with, a hematologist or oncologist

Product Name:Preferred: Fulphila, Fylnetra, Nivestym, Releuko	
Diagnosis	Neutropenia Associated with Cancer Chemotherapy –Dose Dense Chemotherapy
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer

OR

1.2 Patient is receiving a dose-dense chemotherapy regimen for which the incidence of febrile neutropenia (FN) is unknown

AND

2 - Prescribed by, or in consultation with, a hematologist or oncologist

Product Name:Preferred: Fulphila, Fylnetra, Nivestym, Releuko	
Diagnosis	Primary Prophylaxis of Chemotherapy-Induced Febrile Neutropenia (FN)
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is receiving chemotherapy regimen(s) associated with greater than 20 percent incidence of febrile neutropenia (FN)

OR

1.2 BOTH of the following:

- Patient is receiving chemotherapy regimen(s) associated with 10-20 percent incidence of FN
- Patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia

AND

2 - Prescribed by, or in consultation with, a hematologist or oncologist

Product Name:Preferred: Fulphila, Fylnetra, Nivestym, Releuko	
Diagnosis	Secondary Prophylaxis of Febrile Neutropenia (FN)
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is receiving myelosuppressive anti-cancer drugs associated with neutropenia (absolute neutrophil count [ANC] less than or equal to 500 cells per mm3)

AND

2 - Patient has a history of febrile neutropenia (FN) during a previous course of chemotherapy

AND

3 - Prescribed by, or in consultation with, a hematologist or oncologist

Product Name:Preferred: Fulphila, Fylnetra, Nivestym, Releuko

Diagnosis	Treatment of Febrile Neutropenia (FN) (off-label)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is receiving myelosuppressive anti-cancer drugs associated with neutropenia (absolute neutrophil count [ANC] less than or equal to 500 cells per mm3)

AND

2 - Diagnosis of febrile neutropenia (FN) and patient is considered high risk for infection-associated complications

AND

3 - Prescribed by, or in consultation with, a hematologist or oncologist

Product Name:Preferred: Fulphila, Fylnetra, Nivestym, Releuko	
Diagnosis	Severe Chronic Neutropenia (SCN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe chronic neutropenia (SCN) (i.e., congenital, cyclic, and idiopathic neutropenias with chronic absolute neutrophil count [ANC] less than or equal to 500 cells per mm3)

AND

2 - Prescribed by, or in consultation with, a hematologist or oncologist

Product Name:Preferred: Fulphila, Fylnetra, Nivestym, Releuko	
Diagnosis	HIV-Related Neutropenia (off-label)
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV) infection

AND

2 - Patient has an absolute neutrophil count (ANC) less than or equal to 1,000 cells per mm3

AND

3 - Prescribed by, or in consultation with, ONE of the following:

- Hematologist
- Oncologist
- Infectious disease specialist

Product Name:Preferred: Fulphila, Fylnetra, Nivestym, Releuko	
Diagnosis	Hepatitis C Treatment Related Neutropenia (off-label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

- Diagnosis of hepatitis C virus

- Patient is undergoing treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a)
- Documentation of neutropenia (absolute neutrophil count [ANC] less than or equal to 500 cells per mm3) after dose reduction of Peg-Intron or Pegasys

OR

1.2 BOTH of the following:

1.2.1 Documentation of interferon-induced neutropenia (ANC less than or equal to 500 cells per mm3) due to treatment with Peg-Intron (peginterferon alfa-2b) or Pegasys (peginterferon alfa-2a)

AND

1.2.2 ONE of the following:

- Diagnosis of human immunodeficiency virus (HIV) co-infection
- Status post liver transplant
- Diagnosis of established cirrhosis

AND

2 - Prescribed by, or in consultation with, a hematologist, oncologist, gastroenterologist, hepatologist, or infectious disease specialist

Product Name:Preferred: Fulphila, Fylnetra, Nivestym, Releuko	
Diagnosis	Hematopoietic Syndrome of Acute Radiation Syndrome
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has been acutely exposed to myelosuppressive doses of radiation

AND **2** - Prescribed by, or in consultation with, a hematologist or oncologist

Product Name:Non-Preferred*: Armlupeg, Filkri, Granix, Neulasta, Neulasta Onpro, Neupogen, Nypozi, Nyvepria, Rolvedon, Ryzneuta, Stimufend, Udenyca, Zarxio, Ziextenzo, and newly launched CSF/biosimilar products	
Approval Length	Requests for Non-Preferred biosimilars are not approved at this time
Guideline Type	Prior Authorization
Approval Criteria **1** - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred products are Fulphila, Fylnetra, Nivestym, and Releuko. **Please note: The drug(s) listed above may require additional review.	
Notes	*Patients must use preferred colony stimulating factors.

2 . Revision History

Date	Notes
6/25/2026	Added GPIs for Armlupeg and Filkri as NPD

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-398215
Guideline Name	Combination Basal Insulin/GLP-1 Receptor Agonist
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

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

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus

AND

2 - Inadequately controlled on BOTH of the following

- GLP-1 (glucagon-like peptide-1) receptor agonist [e.g. Adlyxin (lixisenatide), Trulicity (dulaglutide), Victoza (liraglutide), Bydureon (exenatide extended-release), Byetta (exenatide)]
- Basal insulin (e.g. insulin glargine, insulin degludec, insulin detemir)

AND

3 - Provider attests that the requested medication will not be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use

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

Approval Criteria

1 - Diagnosis of type 2 diabetes mellitus

AND

2 - Inadequately controlled on BOTH of the following

- GLP-1 (glucagon-like peptide-1) receptor agonist [e.g. Adlyxin (lixisenatide), Trulicity (dulaglutide), Victoza (liraglutide), Bydureon (exenatide extended-release), Byetta (exenatide)]
- Basal insulin (e.g. insulin glargine, insulin degludec, insulin detemir)

AND

3 - History of failure, intolerance, or contraindication to Soliqua

AND

4 - Provider attests that the requested medication will not be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Provider attests that the requested medication will not be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use

2 . Revision History

Date	Notes
9/25/2025	Soliqua: changed guideline type from ST to PA, added dx criterion, a dded reauth criteria

Prior Authorization Guideline

Guideline ID	GL-139359
Guideline Name	Compounds and Bulk Powders
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2024

1 . Criteria

Product Name:Requests for Compounds or Bulk Powders	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Administrative

Approval Criteria

1 - One of the following:

1.1 The compound is an antibiotic.

OR

1.2 Each active ingredient in the compounded drug is a covered medication

AND

2 - ONE of the following:

2.1 Each active ingredient in the compounded drug is to be administered for an FDA (Food and Drug Administration)-approved indication

OR

2.2 The use of each active ingredient in the compounded drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

3 - If a drug included in the compound requires prior authorization and/or step therapy, all drug specific clinical criteria must also be met

AND

4 - The compounded drug must not include any ingredient that has been withdrawn or removed from the market due to safety reasons.

AND

5 - ONE of the following:

5.1 A unique vehicle is required for topically administered compounds

OR

5.2 A unique dosage form is required for a commercially available product due to patient's age, weight, or inability to take a solid dosage form

OR

5.3 A unique formulation is required for a commercially available product due to an allergy or intolerance to an inactive ingredient in the commercially available product

OR

5.4 There is a shortage of the commercially available product per the FDA Drug Shortage database or the ASHP Current Drug Shortages tracking log

AND

6 - Coverage for compounds and bulk powders will NOT be approved for any of the following:

6.1 For topical compound preparations (e.g. creams, ointments, lotions, or gels to be applied to the skin for transdermal, transcutaneous, or any other topical route), requested compound contains any FDA approved ingredient that is not FDA approved for TOPICAL use (see Table 1 in Background section)

OR

6.2 If the requested compound contains topical fluticasone, topical fluticasone will NOT be approved unless both of the following are met:

6.2.1 Topical fluticasone is intended to treat a dermatologic condition (scar treatments are considered cosmetic and will not be covered)

AND

6.2.2 Patient has a contraindication to all commercially available topical fluticasone formulations

OR

6.3 Requested compound contains any ingredients when used for cosmetic purposes (see Table 2 in Background section)

OR

6.4 Requested compound contains any ingredient(s) which are on the FDA's Do Not Compound List (see Table 3 in Background section)

Product Name:Requests for Compounds or Bulk Powders	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Administrative

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

2 . Background

Benefit/Coverage/Program Information
Table 1: Example topical compound preparations that contain any FDA approved ingredient that are not FDA approved for TOPICAL use, including but NOT LIMITED TO the following: (1) Ketamine

(2) Gabapentin

(3) Flurbiprofen (topical ophthalmic use not included)

(4) Ketoprofen

(5) Morphine

(6) Nabumetone

(7) Oxycodone

(8) Cyclobenzaprine

(9) Baclofen

(10) Tramadol

(11) Hydrocodone

(12) Meloxicam

(13) Amitriptyline

(14) Pentoxifylline

(15) Orphenadrine

(16) Piroxicam

(17) Levocetirizine

(18) Amantadine

(19) Oxytocin

(20) Sumatriptan

(21) Chorionic gonadotropin (human)

(22) Clomipramine

(23) Dexamethasone

(24) Hydromorphone

(25) Methadone

(26) Papaverine

(27) Mefenamic acid

(28) Promethazine

(29) Succimer DMSA

(30) Tizanidine

(31) Apomorphine

(32) Carbamazepine

(33) Ketorolac

(34) Dimercaptopropane-sulfonate

(35) Dimercaptosuccinic acid

(36) Duloxetine

(37) Fluoxetine

(38) Bromfenac (topical ophthalmic use not included)

(39) Nepafenac (topical ophthalmic use not included)

Table 2: Example compounds that contain ingredients for cosmetic purposes:

(1) Hydroquinone

(2) Acetyl hexapeptide-8

(3) Tocopheryl Acid Succinate

(4) PracaSil TM-Plus

(5) Chrysaderm Day Cream

(6) Chrysaderm Night Cream

(7) PCCA Spira-Wash

(8) Lipopen Ultra

(9) Versapro

(10) Fluticasone

(11) Mometasone

(12) Halobetasol

(13) Betamethasone

(14) Clobetasol

(15) Triamcinolone

(16) Minoxidil

(17) Tretinoin

(18) Dexamethasone

(19) Spironolactone

(20) Cycloserine

(21) Tamoxifen

(22) Sermorelin

(23) Mederma Cream

(24) PCCA Cosmetic HRT Base

(25) Sanare Scar Therapy Cream

(26) Scarcin Cream

(27) Apothederm

(28) Stera Cream

(29) Copasil

(30) Collagenase

(31) Arbutin Alpha

(32) Nourisil

(33) Freedom Cepapro

(34) Freedom Silomac Andydrous

(35) Retinaldehyde

(36) Apothederm

Table 3: Example ingredients on the FDA's Do Not Compound List:

(1) 3,3′,4′,5-tetrachlorosalicylanilide

(2) Adenosine phosphate

(3) Adrenal cortex

(4) Alatrofloxacin mesylate

(5) Aminopyrine

(6) Astemizole

(7) Azaribine

(8) Benoxaprofen

(9) Bithionol

(10) Camphorated oil

(11) Carbetapentane citrate

(12) Casein, iodinated

(13) Cerivastatin sodium

(14) Chlormadinone acetate

(15) Chloroform

(16) Cisapride

(17) Defenfluramine hydrochloride

(18) Diamthazole dihydrochloride

(19) Dibromsalan

(20) Dihydrostreptomycin sulfate

(21) Dipyrone

(22) Encainide hydrochloride

(23) Etretinate

(24) Fenfluramine hydrochloride

(25) Flosequinan

(26) Glycerol, iodinated

(27) Grepafloxacin

(28) Mepazine

(29) Metabromsalan

(30) Methapyrilene

(31) Methopholine

(32) Methoxyflurane

(33) Mibefradil dihydrochloride

(34) Nomifensine maleate

(35) Novobiocin sodium

(36) Oxyphenisatin acetate

(37) Oxyphenisatin

(38) Pemoline

(39) Pergolide mesylate

(40) Phenacetin

(41) Phenformin hydrochloride

(42) Phenylpropanolamine

(43) Pipamazine

(44) Potassium arsenite

(45) Propoxyphene

(46) Rapacuronium bromide

(47) Rofecoxib

(48) Sibutramine hydrochloride

(49) Sparteine sulfate

(50) Sulfadimethoxine

(51) Sweet spirits of nitre

(52) Tegaserod maleate

(53) Temafloxacin hydrochloride

(54) Terfenadine

(55) Ticrynafen

(56) Tribromsalan

(57) Trichloroethane

(58) Troglitazone

(59) Trovafloxacin mesylate:

(60) Urethane

(61) Valdecoxib

(62) Zomepirac sodium

3 . Revision History

Date	Notes
1/23/2024	Changed initial approval duration to 6 months and added reauth with 12 month approval duration.

Prior Authorization Guideline

Guideline ID	GL-715189
Guideline Name	Constipation Agents - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

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

Approval Criteria

1 - One of the following:

1.1 ONE of the following diagnoses:

- Opioid-induced constipation in an adult with chronic, non-cancer pain

- Opioid-induced constipation in patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation
- Chronic idiopathic constipation

OR

1.2 Both of the following:

- Diagnosis of irritable bowel syndrome with constipation
- Patient was female at birth

AND

2 - ALL of the following:

2.1 Trial and failure, contraindication, or intolerance to an osmotic laxative e.g., (lactulose, polyethylene glycol, sorbitol)

AND

2.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Bulk Forming Laxatives (e.g., psyllium, fiber)
- Stimulant Laxatives (e.g., bisacodyl, senna)

AND

2.3 History of failure to generic lubiprostone

Notes	Note: generic lubiprostone is preferred without PA required

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

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with constipation

AND

2 - History of failure, contraindication or intolerance to BOTH of the following:

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - History of failure, contraindication or intolerance to ONE of the following:

- generic lubiprostone
- Linzess

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

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- Diagnosis of irritable bowel syndrome with constipation (IBS-C)
- Patient is 7 years of age or older

OR

1.2 Both of the following:

- Diagnosis of chronic idiopathic constipation (CIC)
- Patient is 18 years of age or older

OR

1.3 Both of the following (Applies to Linzess 72mcg requests ONLY)

- Diagnosis of functional constipation (FC)
- Patient is 2-17 years of age

AND

2 - Both of the following:

2.1 Trial and failure, contraindication, or intolerance to an osmotic laxative e.g., (lactulose, polyethylene glycol, sorbitol)

AND

2.2 Trial and failure, contraindication, or intolerance to ONE of the following:

- Bulk Forming Laxatives (e.g., psyllium, fiber)
- Stimulant Laxatives (e.g., bisacodyl, senna)

AND

3 - Trial and failure, contraindication, or intolerance to BOTH of the following (applies to patients new to Linzess therapy ONLY):

- generic lubiprostone
- generic prucalopride

Product Name:Brand Motegrity	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic idiopathic constipation

AND

2 - Both of the following

2.1 History of failure, contraindication or intolerance to BOTH of the following:

- Lactulose
- Polyethylene glycol (Miralax)

AND

2.2 History of failure to generic prucalopride

Notes	Note: generic prucalopride is preferred without PA required

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

Approval Criteria

1 - ONE of the following diagnoses:

- Opioid-induced constipation in patients being treated for chronic, non-cancer pain
- Opioid-induced constipation in patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation

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

Approval Criteria

1 - ONE of the following diagnoses:

- Opioid-induced constipation in patients being treated for chronic, non-cancer pain
- Opioid-induced constipation in patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation

AND

2 - History of failure, contraindication or intolerance to BOTH of the following:

- Lactulose
- Polyethylene glycol (Miralax)

AND

3 - History of failure, contraindication or intolerance to Movantik

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

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with constipation

AND

2 - Patient was female at birth

AND

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

- Lactulose
- Polyethylene glycol (Miralax)

AND

4 - History of failure, contraindication or intolerance to ONE of the following:

- Generic lubiprostone
- Linzess

Product Name:Brand Amitiza, Ibsrela, Linzess, Brand Motegrity, Movantik, Symproic, Zelnorm	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes

9/11/2026	10/1 Changes: Generic lubiprostone and prucalopride to preferred wi thout PA req, Linzess added step through generic lubiprostone and p rucalopride for new starts only.

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-553392
Guideline Name	Continuous Blood Glucose Monitoring Devices (CGM)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/20/2026

1 . Criteria

Product Name:PREFERRED Continuous Glucose Monitors, Sensors, and Transmitters: Freestyle Libre receiver, Freestyle Libre 14 receiver/sensor, Freestyle Libre 2 receiver/sensor, Freestyle Libre 2 Plus/2+ sensor/system, Freestyle Libre 3 sensor, Freestyle Libre 3 Plus/3+ sensor/system	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following:	

1.1 Member is already established on an integrated closed loop insulin pump system. The current CGM product will be approved* (NOTE: Members starting on a closed loop insulin pump system will be required to obtain a new PA if they are changing CGM devices)

OR

1.2 Member is insulin dependent as confirmed by paid claims for insulin within the past 60 days and the request is for a Freestyle Libre product (Freestyle Libre products will adjudicate without a prior authorization submission when the member is insulin dependent as confirmed by insulin paid claims in the members PBM profile)

OR

1.3 All of the following:

1.3.1 One of the following:

1.3.1.1 Both of the following:

- Diagnosis of Type I or II Diabetes Mellitus
- Frequent insulin adjustments are required based on the results of blood glucose monitoring or CGM testing results

OR

1.3.1.2 One of the following diagnoses:

- Gestational Diabetes
- Hypoglycemia Unawareness (HU) (defined as the onset of neuroglycopenia, low blood glucose in the brain, before the appearance of autonomic warning symptoms, or the failure to sense a significant fall in blood glucose below normal levels)
- Documented Postprandial Hyperglycemia
- Documented Recurrent Diabetic Ketoacidosis

OR

1.3.1.3 Member requires short term use (72 hours) to determine baseline insulin levels prior to insulin pump initiation

AND

1.3.2 One of the following:

- Hemoglobin A1c > 7.0%
- Frequent hypoglycemic episodes as evidenced by submitted chart documentation
- Member has a diagnosis that is not defined by elevated hemoglobin A1c or frequent hypoglycemia (e.g., Gestational Diabetes)

AND

1.3.3 Provider attests member is enrolled or has completed a comprehensive diabetes education program

AND

1.3.4 Member must meet the FDA approved age for the requested product (new products entering the market shall not be approved below the FDA approved age)

Notes	*NOTE: Members starting on a closed loop insulin pump system will b e required to obtain a new PA if they are changing CGM devices. **Third Party Exception Flag and Medicaid Product Flag must be flipp ed to = Y for the claim to pay with the PA in place. Please run a trial cl aim to make sure claim pays with PA ***Approve Freestyle Libre products at NDC Level – With NDC List AZ MFR3 (see background section for details)

Product Name:NONPREFERRED Continuous Glucose Monitors, Sensors, and Transmitters: Dexcom G6 receiver/sensor/transmitter, Dexcom G7 receiver/sensor, Guardian receiver/sensor/transmitter, Enlite sensor, Eversense sensor/transmitter, Minilink transmitter, Minimed 630G Guardian transmitter, Paradigm transmitter, Simplera sensor/system	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Submission of medical records (e.g., chart notes) documenting member is already established on an integrated closed loop insulin pump system. The current CGM product will be approved* (NOTE: Members starting on a closed loop insulin pump system will be required to obtain a new PA if they are changing CGM devices)

OR

1.2 Requests for a CGM product other than Freestyle Libre requires submission of medical records (e.g., chart notes, lab results) documenting ALL of the following:

1.2.1 Member has tried and failed the Freestyle Libre system (For other AHCCCS Contractors required steps, please refer to Preferred CGM Products table)

AND

1.2.2 One of the following:

1.2.2.1 All of the following:

- Diagnosis of Type I or II Diabetes Mellitus
- Member is insulin dependent as demonstrated by paid claims within the past 60 days
- Frequent insulin adjustments are required based on the results of blood glucose monitoring or CGM testing results and supporting documentation has been submitted by the provider

OR

1.2.2.2 One of the following diagnoses:

- Gestational Diabetes
- Hypoglycemia Unawareness (HU) (defined as the onset of neuroglycopenia, low blood glucose in the brain, before the appearance of autonomic warning symptoms, or the failure to sense a significant fall in blood glucose below normal levels) (submission of medical records/supporting documentation is required)
- Documented Postprandial Hyperglycemia (submission of medical records/supporting documentation is required)
- Documented Recurrent Diabetic Ketoacidosis (submission of medical records/supporting documentation is required)

OR

1.2.2.3 Member requires short term use (72 hours) to determine baseline insulin levels prior to insulin pump initiation

AND

1.2.3 Member must meet the FDA approved age for the requested product (new products entering the market shall not be approved below the FDA approved age)

AND

1.2.4 One of the following:

- Hemoglobin A1c > 7.0%
- Frequent hypoglycemic episodes as evidenced by submitted chart documentation
- Member has a diagnosis that is not defined by elevated hemoglobin A1c or frequent hypoglycemia (e.g., Gestational Diabetes)

AND

1.2.5 Provider attests member is enrolled or has completed a comprehensive diabetes education program

Notes	*NOTE: Members starting on a closed loop insulin pump system will b e required to obtain a new PA if they are changing CGM devices **Third Party Exception Flag and Medicaid Product Flag must be flipp ed to = Y for the claim to pay with the PA in place. Please run a trial cl aim to make sure claim pays with PA ***Approve all NonPreferred CGM products at GPI Level – With GPI L ist AZMCGMNP (see background section for details)

Product Name:ALL Continuous Glucose Monitors, Sensors, and Transmitters: Freestyle Libre receiver, Freestyle Libre 14 receiver/sensor, Freestyle Libre 2 receiver/sensor, Freestyle Libre 2 Plus/2+ sensor/system, Freestyle Libre 3 sensor, Freestyle Libre 3 Plus/3+ sensor/system, Dexcom G6 receiver/sensor/transmitter, Dexcom G7 receiver/sensor, Guardian receiver/sensor/transmitter, Enlite sensor, Eversense sensor/transmitter, Minilink transmitter, Minimed 630G Guardian transmitter, Paradigm transmitter, Simplera sensor/system

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

Approval Criteria

1 - Member is using the same continuous glucose monitoring device on a regular basis as evidenced through the Member's claims history and the providers chart notes

AND

2 - Member is adherent to using the device

AND

3 - Member has shared the device readings with physician or healthcare professional for review as part of overall diabetes management

Notes	Third Party Exception Flag and Medicaid Product Flag must be flipped to = Y for the claim to pay with the PA in place. Please run a trial clai m to make sure claim pays with PA Approve all Preferred Freestyle Libre products at NDC Level - With N DC List AZMFR3 Approve all NonPreferred CGM products at GPI Level – With GPI List AZMCGMNP (see background section for details)

Product Name:ALL Continuous Glucose Monitors, Sensors, and Transmitters: Freestyle Libre receiver, Freestyle Libre 14 receiver/sensor, Freestyle Libre 2 receiver/sensor, Freestyle Libre 2 Plus/2+ sensor/system, Freestyle Libre 3 sensor, Freestyle Libre 3 Plus/3+ sensor/system, Dexcom G6 receiver/sensor/transmitter, Dexcom G7 receiver/sensor, Guardian receiver/sensor/transmitter, Enlite sensor, Eversense sensor/transmitter, Minilink transmitter, Minimed 630G Guardian transmitter, Paradigm transmitter, Simplera sensor/system	
Diagnosis	Requests Exceeding Quantity Limit
Approval Length	1 Time(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - Request is for a vacation override

OR

2 - If not for a vacation override, requests for additional transmitter/sensor quantities should be denied

- Dexcom 6 or 7 sensors: The plan covers a maximum of 3 sensors for a 30 day supply. For defective products, please contact Dexcom CARE at 1-888-738-3646 for a replacement.
- For FreeStyle Libre 2, 3, or 3 plus/3+ sensors – The plan covers a maximum of 2 sensors for a 28-day supply. For defective products, please contact FreeStyle Libre Customer Support at 1-844-330-5535 for a replacement.
- Guardian Sensor 3 or 4 products – The plan covers a maximum of 5 sensors (1box) for a 35-day supply. For defective products, please contact Guardian Customer Service Center at 1-800-646-4633 for a replacement.
- Simplera Sensors - The plan covers a maximum of 5 sensors (1 box) for a 24-day supply. For defective products, please contact Medtronic Customer Support at 1-800-646-4633 for a replacement.

Notes	*Requests for additional quantities for purposes other than a vacation override are to be denied, utilize the product specific denial verbiage b elow. Third Party Exception Flag and Medicaid Product Flag must be f lipped to = Y for the claim to pay with the PA in place. Please run a tri al claim to ensure the claim adjudicates with PA Approve at NDC/GPI Level. Denial language: ● Dexcom 6 or 7 transmitters - The prior authorization request for mor e than 1 transmitter in 90 days are to be denied. The plan covers a m aximum of 1 transmitter for a 90-day supply. If the member has a defe ctive transmitter, please contact Dexcom CARE at 1- 888-738-3646 fo r a replacement. ● Dexcom 6 or 7 sensors - The prior authorization request for more th an 3 sensors in 30 days are to be denied. The plan covers a maximu m of 3 sensors for a 30-day supply. If the member has a defective sen sor, please contact Dexcom CARE at 1-888-738-3646 for a replacem ent. ● Dexcom G6 Receiver - The prior authorization request for more tha n 1 receiver in 365 days are to be denied. The plan covers a maximu m of 1 transmitter for a 365-day supply. If the member has a defective receiver, please contact Dexcom CARE at 1- 888-738-3646 for a repl acement.

	FreeStyle Libre & FreeStyle Libre 2, 3, or 3 plus/3+ sensors- The prior authorization request for more than 2 sensors, for a 28-day supply, are to be denied. ● The plan covers a maximum of 2 sensors for a 28-Day supply. If yo u have a defective a sensor, please contact Abbott's FreeStyle Libre Customer Support at 1-844-330-5535 for a replacement. Guardian Sensor 3 or 4 Sensors – The prior authorization request for more than 5 sensors, for a 35-day supply, are to be denied. The plan covers a maximum of 5 sensors (1 box) for a 35-day supply. For defective products, please contact Guar dian Customer Service Center at 1-800-646-4633 for a replacement. Simplera sensors - The prior authorization request for more than 5 se nsors, for a 24-day supply, are to be denied. The plan covers a maxim um of 5 sensors (1 box) for a 24-day supply. For defective products, pl ease contact Medtronic Customer Support at 1-800-646-4633 for a re placement.

2 . Background

Benefit/Coverage/Program Information
Preferred CGM Products

Health Plan	CGM Step Therapy Requirements
Arizona Complete Health	**Freestyle Libre 2 & 3**
Banner University Family Care	**Freestyle Libre 2 & 3**
Care 1st Health Plan	**Freestyle Libre 2 & 3**
DCS Comprehensive Health Plan	**Dexcom G6 & G7** **Freestyle Libre 2 & 3**
Division of Developmental Disabilities	**Freestyle Libre 2 & 3**
AHCCCS Fee-For-Service American Indian Health Plan	**Freestyle Libre 2 & 3**

Health Choice Arizona	**Freestyle Libre 2 & 3**
Mercy Care	**Dexcom G6 & G7** **Freestyle Libre 2 & 3**
Molina Healthcare	**Freestyle Libre 2 & 3**
United Community Plan	**Dexcom G6 & G7** **Freestyle Libre 2 & 3**

NDC List for Preferred CGM Products

NDC List	NDC	Product Label	GPI	GPI-14 Description
AZMFR3	57599080300	FREESTY LIBR MIS 2 READER	97202012026200	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***
AZMFR3	57599000021	FREESTYLE MI S READER	97202012026200	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***
AZMFR3	57599000200	FREESTYLE MI S READER	97202012026200	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***
AZMFR3	57599082000	FREESTY LIBR MIS 3 READER	97202012046300	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***
AZMFR3	57599082001	FREESTY LIBR MIS 3 READER	97202012046300	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***
AZMFR3	57599081800	FREESTY LIBR KIT 3 SENSOR	97202012046300	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***

AZMFR3	57599084400	FREE LIBRE3 KIT PLUS/SEN	97202012046300	*CONTINUOUS GLUCOSE SYSTEM SENSOR***
AZMFR3	57599084401	FREE LIBRE3 KIT PLUS/SEN	97202012046300	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***
AZMFR3	57599083500	FREE LIBRE2 KIT PLUS/SEN	97202012046300	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***
AZMFR3	57599083501	FREE LIBRE2 KIT PLUS/SEN	97202012046300	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***
AZMFR3	57599080000	FREESTY LIBR KIT 2 SENSOR	97202012046300	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***
AZMFR3	57599000101	FREESTYLE KIT SENSOR	97202012046300	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***

GPI Lists for NonPreferred CGM Products

GPI List	GPI	GPI-14 Description
AZMCGMNP	97202012026200	*CONTINUOUS BLOOD GLUCOSE SYSTEM RECEIVER***
AZMCGMNP	97202012046300	*CONTINUOUS BLOOD GLUCOSE SYSTEM SENSOR***

AZMCGMNP	97202012066300	*CONTINUOUS BLOOD GLUCOSE SYSTEM TRANSMITTER***

Third Party Exception Flag and Medicaid Product Flag must be flipped to = Y for the claim to pay with the PA in place. Please run a trial claim to make sure claim pays with PA

Notes

Third Party Exception Flag and Medicaid Product Flag must be flipped to = Y for the claim to pay with the PA in place. Please run a trial claim to make sure claim pays with PA

Coverage Notes:

AHCCCS Rule R9-22-202 requires that services be cost effective. The corresponding federal regulations are found in 42 CFR Part 447

R9-22-202. General Requirements

B. In addition to other requirements and limitations specified in this Chapter, the following general requirements apply: Only medically necessary, cost effective, and federally reimbursable and state-reimbursable services are covered.

3 . Revision History

Date	Notes
3/20/2026	Updated internal note for PA reviewer for processing, no change to cl inical intent

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Prior Authorization Guideline

Guideline ID	GL-135313
Guideline Name	Copper Chelating Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2023

1 . Criteria

Product Name:Brand Depen Titratab, generic penicillamine tablets	
Diagnosis	Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of severe active rheumatoid arthritis	

Product Name:Brand Depen Titratab, generic penicillamine tablets	
Diagnosis	Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Depen Titratabs therapy

Product Name:Brand Depen Titratab, generic penicillamine tablets	
Diagnosis	Wilson’s disease (i.e., hepatolenticular degeneration), Cystinuria
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Diagnosis of Wilson’s disease (i.e., hepatolenticular degeneration)
- Diagnosis of Cystinuria

Product Name:Brand Cuprimine, generic penicillamine capsules	
Diagnosis	Wilson’s disease (i.e., hepatolenticular degeneration), Cystinuria, Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has ONE of the following diagnoses:

- Wilson's disease (i.e., hepatolenticular degeneration)
- Cystinuria
- Severe active rheumatoid arthritis

AND

2 - History of failure or intolerance to Depen (penicillamine)

Product Name:Brand Cuprimine, generic penicillamine capsules	
Diagnosis	Wilson's disease (i.e., hepatolenticular degeneration), Cystinuria, Severe active rheumatoid arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Cuprimine (penicillamine) therapy

Product Name:Brand Syprine, generic trientine, generic Clovique	
Diagnosis	Wilson's disease (i.e., hepatolenticular degeneration)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration)

AND

2 - History of failure, contraindication, or intolerance to Depen (penicillamine) or Cuprimine (penicillamine)

Product Name:Brand Syprine, generic trientine, generic Clovique	
Diagnosis	Wilson's disease (i.e., hepatolenticular degeneration)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Syprine (trientine) therapy

2 . Revision History

Date	Notes
10/23/2023	Added new GPI for trientine

Prior Authorization Guideline

Guideline ID	GL-99441
Guideline Name	Corlanor
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Corlanor	
Diagnosis	Chronic Heart Failure
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Worsening heart failure in a diagnosis of stable, symptomatic chronic (e.g. New York Heart Association (NYHA) class II, III or IV) heart failure

AND

2 - Patient has a left ventricular ejection fraction (EF) less than or equal to 35%

AND

3 - The patient is in sinus rhythm

AND

4 - Patient has a resting heart rate greater than or equal to 70 beats per minute

AND

5 - ONE of the following:

5.1 Patient is on maximum tolerated doses of beta blockers (e.g., carvedilol, metoprolol succinate, bisoprolol)

OR

5.2 Patient has a contraindication or intolerance to beta-blocker therapy

Product Name:Corlanor	
Diagnosis	Heart Failure due to Dilated Cardiomyopathy (DCM)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of stable symptomatic heart failure due to dilated cardiomyopathy (DCM)

AND

2 - Patient is in sinus rhythm

AND

3 - Patient has an elevated heart rate

Product Name:Corlanor	
Diagnosis	Chronic Heart Failure, Heart Failure due to Dilated Cardiomyopathy (DCM)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Corlanor therapy

2 . Revision History

Date	Notes
3/10/2021	Bulk Copy guidelines starting with B and C from C&S Arizona to Ariz ona Medicaid

Prior Authorization Guideline

Guideline ID	GL-620200
Guideline Name	Cosentyx (secukinumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Cosentyx SC	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of moderate to severe plaque psoriasis (PsO)

AND

1.2 Greater than or equal to 3 percent body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.3 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to one of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Infliximab (Janssen manufacturer)
- Otezla (apremilast)
- A preferred ustekinumab biosimilar

AND

2 - Patient is 6 years of age or older

AND

3 - Prescribed by or in consultation with a dermatologist

Product Name:Cosentyx SC	
Diagnosis	Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Submission of medical records (e.g., chart notes) confirming a diagnosis of moderate to severe hidradenitis suppurativa (HS)

AND

1.2 Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to a preferred adalimumab biosimilar

AND

1.3 Patient is 12 years of age or older

AND

2 - Prescribed by or in consultation with a dermatologist

Product Name:Cosentyx SC	
Diagnosis	Plaque Psoriasis (PsO), Hidradenitis Suppurativa (HS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a dermatologist

Product Name:Cosentyx SC	
Diagnosis	Enthesitis-Related Arthritis (ERA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting BOTH of the following:

1.1 Diagnosis of active enthesitis-related arthritis (ERA)

AND

1.2 Trial and failure, contraindication, or intolerance to TWO preferred non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen)

AND

2 - Patient is 4 years of age or older

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name:Cosentyx SC	
Diagnosis	Enthesitis-Related Arthritis (ERA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy as evidenced by at least one of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Cosentyx SC, Cosentyx IV	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Infliximab (Janssen manufacturer)
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

AND

2 - Patient is 2 years of age or older

AND

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

- Rheumatologist
- Dermatologist

AND

4 - Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to self-administered Cosentyx SC (APPLIES TO REQUESTS FOR COSENTYX IV ONLY):

Product Name:Cosentyx SC, Cosentyx IV	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

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

- Rheumatologist
- Dermatologist

Product Name:Cosentyx SC, Cosentyx IV	
Diagnosis	Ankylosing Spondylitis (AS), Non-radiographic axial spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 One of the following diagnoses:

- Active ankylosing spondylitis (AS)
- Active non-radiographic axial spondyloarthritis (nr-axSpA)

AND

1.2 History of failure to two NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Infliximab (Janssen manufacturer)
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

2 - One of the following:

- For diagnoses of ankylosing spondylitis (AS): patient is 12 years of age or older
- For diagnoses of non-radiographic axial spondyloarthritis (nr-axSpA): patient is 18 years of age or older

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to self-administered Cosentyx SC (APPLIES TO REQUESTS FOR COSENTYX IV ONLY)

Product Name:Cosentyx SC, Cosentyx IV	
Diagnosis	Ankylosing Spondylitis (AS), Non-radiographic axial spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

2 . Revision History

Date	Notes
5/27/2026	Added age criterion for AS/nr-axSpA due to expanded indication for A S.

Prior Authorization Guideline

Guideline ID	GL-104889
Guideline Name	Cough and Cold Products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/28/2022

1 . Criteria

Product Name:Hydromet, generic Tussigon, Z-Tuss AC, Tuzistra XR, Tussicaps, generic Tussionex, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss, generic promethazine w/codeine, generic promethazine-phenylephrine-codeine, Rydex, Mar-Cof BP/Mar-Cof GG, Ninjacof-XG, Coditussin AC/Coditussin DAC, generic guaifenesin-codeine, generic pseudoephedrine w/codeine-guaifenesin, Tuxarin ER	
Diagnosis	Under the Age of 18 Years for Cough and Cold Products
Approval Length	30 Day(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Prescriber attests they are aware of Food and Drug Administration (FDA) labeled	

contraindications regarding use of opioid containing cough and cold products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary (Document rationale for use)

AND

2 - Patient does not have a comorbid condition that may impact respiratory depression (e.g., asthma or other chronic lung disease, sleep apnea, body mass index greater than 30)

AND

3 - Patient has tried and failed at least one non-opioid containing cough and cold remedy

Product Name:Hydromet, generic Tussigon, Z-Tuss AC, Tuzistra XR, Tussicaps, generic Tussionex, M-END PE, Poly-Tussin AC, Capcof, Pro-Red AC, Histex-AC, Maxi-Tuss, generic promethazine w/codeine, generic promethazine-phenylephrine-codeine, Rydex, Mar-Cof BP/Mar-Cof GG, Ninjacof-XG, Coditussin AC/Coditussin DAC, generic guaifenesin-codeine, generic pseudoephedrine w/codeine-guaifenesin, Tuxarin ER	
Diagnosis	Quantity Limit
Approval Length	30 Day(s)
Guideline Type	Quantity Limit*

Approval Criteria

1 - Prescriber attests that a larger quantity is medically necessary

AND

2 - The requested dose is within the Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists (See table in background section)

Notes	*Authorization will be issued for up to 30 days. The authorization should be entered for the quantity requested.

2 . Background

Benefit/Coverage/Program Information

CDC Recommended Opioid Maximum Morphine Milligram Equivalents per Day*

Active Ingredient	FDA Label Max Daily Doses
Morphine	None
Hydromorphone	None
Hydrocodone	None
Tapentadol	600mg IR products
Oxymorphone	None
Oxycodone	None
Codeine	360mg
Pentazocine	None
Tramadol	400mg IR products
Meperidine	600mg
Butorphanol nasal	None
Opium	4 suppositories/day Deodorized tincture: 24mg/day Camphorated tincture: 16mg/day
Acetaminophen	4g/day
Aspirin	2080mg/day
Ibuprofen	3200mg/day
Benzhydrocodone**	None

3 . Revision History

Date	Notes

3/28/2022	Updated product list, no changes to criteria.

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Prior Authorization Guideline

Guideline ID	GL-164857
Guideline Name	Coverage of Off-Label Non-FDA Approved Indications
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2025

1 . Criteria

Product Name:A drug (non-anti-cancer chemotherapeutic regimen) used for an off-label indication or non-FDA approved indication	
Diagnosis	Off-label non-cancer indication
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- Published practice guidelines and treatment protocols

- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia – Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

AND

2 - Per the AHCCCS Medical Policy Manual- Policy 310-V - Prescription Medications / Pharmacy Services, Section III 1, The Contractor and FFS Programs shall approve the Preferred Drugs listed for the therapeutic classes contained on the AHCCCS Drug List, as appropriate, before approving a Non-Preferred Drug unless ONE of the following applies:

2.1 Submission of medical records (e.g., chart notes) or paid claims confirming history of trial resulting in a therapeutic failure, contraindication, or intolerance to at least THREE preferred alternatives (if available) (Prior trials of formulary/preferred drug list (PDL) alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request)

OR

2.2 Submission of medical records (e.g., chart notes) from prescribing clinician supporting the medical necessity of the Non-Preferred Drug over the Preferred Drug for the patient

Notes	Off-label use may be reviewed for medical necessity and denied as su ch if the off-label criteria are not met. Please refer to drug specific PA guideline for off-label criteria if available.

Product Name:A drug or biological in an anti-cancer chemotherapeutic regimen	
Diagnosis	Off-label cancer indication
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - One of the following:

1.1 Diagnosis is supported as a use in AHFS DI

OR

1.2 Diagnosis is supported as a use in the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B (see NCCN Categories of Evidence and Consensus table in Background section)

OR

1.3 Diagnosis is supported in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of Class I, Class IIa, or Class IIb (see DRUGDEX Strength of Recommendation table in Background section)

OR

1.4 Diagnosis is supported as an indication in Clinical Pharmacology

OR

1.5 Off-label use is supported in one of the published, peer-reviewed medical literature listed below:

- American Journal of Medicine
- Annals of Internal Medicine
- Annals of Oncology
- Annals of Surgical Oncology
- Biology of Blood and Marrow Transplantation
- Blood
- Bone Marrow Transplantation
- British Journal of Cancer
- British Journal of Hematology
- British Medical Journal
- Cancer
- Clinical Cancer Research
- Drugs

- European Journal of Cancer (formerly the European Journal of Cancer and Clinical Oncology)
- Gynecologic Oncology
- International Journal of Radiation, Oncology, Biology, and Physics
- The Journal of the American Medical Association
- Journal of Clinical Oncology
- Journal of the National Cancer Institute
- Journal of the National Comprehensive Cancer Network (NCCN)
- Journal of Urology
- Lancet
- Lancet Oncology
- Leukemia
- The New England Journal of Medicine
- Radiation Oncology

OR

1.6 Diagnosis is supported as a use in Wolters Kluwer Lexi-Drugs rated as "Evidence Level A" with a "Strong" recommendation. (see Lexi-Drugs Strength of Recommendation table in Background section)

AND

2 - Per the AHCCCS Medical Policy Manual- Policy 310-V - Prescription Medications / Pharmacy Services, Section III 1, The Contractor and FFS Programs shall approve the Preferred Drugs listed for the therapeutic classes contained on the AHCCCS Drug List, as appropriate, before approving a Non-Preferred Drug unless ONE of the following applies:

2.1 Submission of medical records (e.g., chart notes) or paid claims confirming history of trial resulting in a therapeutic failure, contraindication, or intolerance to at least THREE preferred alternatives (if available) (Prior trials of formulary/preferred drug list (PDL) alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request)

OR

2.2 Submission of medical records (e.g., chart notes) from prescribing clinician supporting the medical necessity of the Non-Preferred Drug over the Preferred Drug for the patient

Notes	Off-label use may be reviewed for medical necessity and denied as su ch if the off-label criteria are not met. Please refer to drug specific PA guideline for off-label criteria if available.

2 . Background

Clinical Practice Guidelines

DRUGDEX Strength of Recommendation

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

NCCN Categories of Evidence and Consensus [A]

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

2B	Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
3	Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.

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

Strength of Recommendation for Inclusion

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

Against proposed off-label use	The evidence either advocates against the off-label use or suggests a lack of support for the off-label use (independent of Level of Evidence). Additional studies are necessary to define the role of this medication for the off-label use.

Level of Evidence Scale for Oncology Off-Label Use

A	**Consistent evidence from well-performed randomized, controlled trials or overwhelming evidence of some other form (eg, results of the introduction of penicillin treatment) to support off-label use. Further research is unlikely to change confidence in the estimate of benefit.**
B	**Evidence from randomized, controlled trials with important limitations (eg, inconsistent results, methodologic flaws, indirect, imprecise); or very strong evidence of some other research design. Further research (if performed) is likely to have an impact on confidence in the estimate of benefit and risk and may change the estimate.**

C	**Evidence from observational studies (eg, retrospective case series/reports providing significant impact on patient care); unsystematic clinical experience; or potentially flawed randomized, controlled trials (eg, when limited options exist for condition). Any estimate of effect is uncertain.**
G	**Use has been substantiated by inclusion in at least one evidence-based or consensus-based clinical practice guideline.**

3 . Endnotes

A. NCCN Categories of Evidence and Consensus. Category 1: The recommendation is based on high-level evidence (i.e., high-powered randomized clinical trials or meta-analyses), and the NCCN Guideline Panel has reached uniform consensus that the recommendation is indicated. In this context, uniform means near unanimous positive support with some possible neutral positions. Category 2A: The recommendation is based on lower level evidence, but despite the absence of higher level studies, there is uniform consensus that the recommendation is appropriate. Lower level evidence is interpreted broadly, and runs the gamut from phase II to large cohort studies to case series to individual practitioner experience. Importantly, in many instances, the retrospective studies are derived from clinical experience of treating large numbers of patients at a member institution, so NCCN Guideline Panel Members have first-hand knowledge of the data. Inevitably, some recommendations must address clinical situations for which limited or no data exist. In these instances the congruence of experience-based judgments provides an informed if not confirmed direction for optimizing patient care. These recommendations carry the implicit recognition that they may be superseded as higher level evidence becomes available or as outcomes-based information becomes more prevalent. Category 2B: The recommendation is based on lower level evidence, and there is nonuniform consensus that the recommendation should be made. In these instances, because the evidence is not conclusive, institutions take different approaches to the management of a particular clinical scenario. This nonuniform consensus does not represent a major disagreement, rather it recognizes that given imperfect information, institutions may adopt different approaches. A Category 2B designation should signal to the user that more than one approach can be inferred from the existing data. Category 3: Including the recommendation has engendered a major disagreement among the NCCN Guideline Panel Members. The level of evidence is not pertinent in this category, because experts can disagree about the significance of high level trials. Several circumstances can cause major disagreements. For example, if substantial data exist about two interventions but they have never been directly compared in a randomized trial, adherents to one set of data may not accept the

interpretation of the other side's results. Another situation resulting in a Category 3 designation is when experts disagree about how trial data can be generalized. An example of this is the recommendation for internal mammary node radiation in postmastectomy radiation therapy. One side believed that because the randomized studies included this modality, it must be included in the recommendation. The other side believed, based on the documented additional morbidity and the role of internal mammary radiation therapy in other studies, that this was not necessary. A Category 3 designation alerts users to a major interpretation issue in the data and directs them to the manuscript for an explanation of the controversy.

B. Abstracts (including meeting abstracts) are excluded from consideration. When evaluating peer-reviewed medical literature, the following (among other things) should be considered: 1) Whether the clinical characteristics of the beneficiary and the cancer are adequately represented in the published evidence 2) Whether the administered chemotherapy regimen is adequately represented in the published evidence. 3) Whether the reported study outcomes represent clinically meaningful outcomes experienced by patients. 4) Whether the study is appropriate to address the clinical question. The following should be considered: a) Whether the experimental design, in light of the drugs and conditions under investigation, is appropriate to address the investigative question. (For example, in some clinical studies, it may be unnecessary or not feasible to use randomization, double blind trials, placebos, or crossover.); b) That non-randomized clinical trials with a significant number of subjects may be a basis for supportive clinical evidence for determining accepted uses of drugs; and c) That case reports are generally considered uncontrolled and anecdotal information and do not provide adequate supportive clinical evidence for determining accepted uses of drugs.

4 . Revision History

Date	Notes
2/25/2025	Added criteria directing patients to preferred drugs or clinical rationale from provider. Non-cancer section: removed option allowing for FDA approved indication compendia support

Prior Authorization Guideline

Guideline ID	GL-321192
Guideline Name	Crenessity (crinecerfont)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Crenessity	
Diagnosis	Congenital Adrenal Hyperplasia (CAH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of classic 21-hydroxylase deficiency congenital adrenal hyperplasia

AND

2 - Patient is 4 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting patient is receiving chronic treatment with glucocorticoid (GC) replacement therapy (e.g., dexamethasone, hydrocortisone, methylprednisolone) for adrenal insufficiency as one of the following:

3.1 Both of the following:

- Patient is 4 to 17 years old
- Daily GC dose is greater than 12 mg/m2/day in hydrocortisone dose equivalents

OR

3.2 Both of the following:

- Patient is 18 years of age or older
- Daily GC dose is greater than 13 mg/m2/day in hydrocortisone dose equivalents

AND

4 - Prescribed by an endocrinologist

Product Name:Crenessity	
Diagnosis	Congenital Adrenal Hyperplasia (CAH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates positive clinical response to therapy (e.g., lowered androgen levels, reduced daily dose of steroids)

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting patient continues to receive chronic treatment with glucocorticoid (GC) replacement therapy (e.g., dexamethasone, hydrocortisone, methylprednisolone)

AND

3 - Prescribed by or in consultation with an endocrinologist

2 . Revision History

Date	Notes
7/16/2025	Added GPI for new 25mg caps.

Prior Authorization Guideline

Guideline ID	GL-127083
Guideline Name	Cuvrior (trientine hydrochloride)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name:Cuvrior	
Diagnosis	Wilson's disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration)

AND

2 - Documentation of one of the following:

- Presence of Kayser-Fleisher rings
- Serum ceruloplasmin (CPN) less than 20 mg/dL
- 24-hour urinary copper excretion greater than 100 mcg
- Liver biopsy with copper dry weight greater than 250 mcg/g
- ATP7B mutation via genetic testing

AND

3 - Trial and failure, contraindication, or intolerance to generic penicillamine capsules

AND

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

- Gastroenterologist
- Hepatologist

Product Name:Cuvrior	
Diagnosis	Wilson's disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy

2 . Revision History

Date	Notes
6/26/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-99663
Guideline Name	Cystaran, Cystadrops
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Cystaran, Cystadrops	
Diagnosis	Cystinosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cystinosis	

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona Medicaid SP to Medicaid Arizona SP for eff 7 /1

Prior Authorization Guideline

Guideline ID	GL-117633
Guideline Name	Daliresp (roflumilast)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name:Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe to very severe chronic obstructive pulmonary disease (COPD) (i.e., FEV1 less than or equal to 50% of predicted)

AND

2 - COPD is associated with chronic bronchitis

AND

3 - History of COPD exacerbation(s)

Product Name:Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Daliresp therapy

2 . Revision History

Date	Notes
12/4/2022	Added generic roflumilast as target

Prior Authorization Guideline

Guideline ID	GL-99605
Guideline Name	Daraprim
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Daraprim, generic pyrimethamine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Medical record documentation (e.g. chart notes) of one of the following:

1.1 Treatment of severe acquired toxoplasmosis, including toxoplasmic encephalitis

OR

1.2 Treatment of congenital toxoplasmosis

OR

1.3 Secondary prophylaxis of toxoplasmic encephalitis

OR

1.4 ALL of the following:

1.4.1 Primary Pneumocystis pneumonia (PCP) prophylaxis in human immunodeficiency virus (HIV)-infected patients or as secondary prophylaxis in HIV-infected patients who have been treated for an acute episode of Pneumocystis pneumonia

AND

1.4.2 Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

AND

1.4.3 ONE of the following:

1.4.3.1 Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate

OR

1.4.3.2 Evidence of moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past (e.g. toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome)

OR

1.5 ALL of the following:

1.5.1 Primary prophylaxis of toxoplasmic encephalitis

AND

1.5.2 Toxoplasma immunoglobulin G (IgG) positive

AND

1.5.3 CD4 (cluster of differentiation 4) less than or equal to 100 cells per mm3 if initiating prophylaxis or CD4 100-200 cells per mm3 if reinstituting prophylaxis

AND

1.5.4 Will be used in combination with dapsone or atovaquone

AND

1.5.5 Patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX)

AND

1.5.6 ONE of the following:

1.5.6.1 Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate

OR

1.5.6.2 Evidence of moderately severe or life threatening-reaction to trimethoprim-sulfamethoxazole (TMP-SMX) in the past (e.g. toxic epidermal necrolysis (TEN), Stevens-Johnson syndrome)

Notes	*Consider discontinuation of primary prophylaxis if CD4 greater than 200 cells/mm3 for greater than 3 months after institution of combination antiretroviral therapy.

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona SP to Medicaid Arizona SP for 7/1 eff

Prior Authorization Guideline

Guideline ID	GL-135325
Guideline Name	Daxxify (botulinum toxin type a injection)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2023

1 . Criteria

Product Name:Daxxify	
Diagnosis	Cervical Dystonia
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of cervical dystonia

Product Name:Daxxify	
Diagnosis	Cervical Dystonia
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

2 - At least 3 months have or will have elapsed since the last treatment

Product Name:Daxxify	
Diagnosis	Cosmetic Use
Approval Length	N/A - requests for cosmetic use are excluded and will not be approved
Guideline Type	Prior Authorization

Approval Criteria

1 - Requests for coverage of any Daxxify product for treating the appearance of facial lines are not authorized and will not be approved. These uses are considered cosmetic only and are excluded from coverage.

Notes	Requests for coverage of any Daxxify product for treating the appearance of facial lines are not authorized and will not be approved. These uses are considered cosmetic only and are excluded from coverage.

2 . Revision History

Date	Notes

10/23/2023	New program

Prior Authorization Guideline

Guideline ID	GL-508202
Guideline Name	Daybue (trofinetide)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Daybue, Daybue Stix	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Rett syndrome

AND

2 - One of the following:

2.1 Submission of medical records (e.g., chart notes) confirming presence of ALL of the following clinical signs and symptoms:

- A pattern of development, regression, then recovery or stabilization
- Partial or complete loss of purposeful hand skills such as grasping with fingers, reaching for things, or touching things on purpose
- Partial or complete loss of spoken language
- Repetitive hand movements, such as wringing the hands, washing, squeezing, clapping, or rubbing
- Gait abnormalities, including walking on toes or with an unsteady, wide-based, stiff-legged gait

OR

2.2 Submission of medical records (e.g., chart notes) documenting molecular genetic testing confirms mutations in the MECP2 gene

AND

3 - Patient is 2 years of age or older

AND

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

- Geneticist
- Neurologist

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

Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

2 . Revision History

Date	Notes
1/28/2026	Added new GPIs for Daybue Stix

Prior Authorization Guideline

Guideline ID	GL-553396
Guideline Name	DDAVP, Desmoda (desmopressin)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Brand DDAVP tablets, generic desmopressin acetate tablets, generic desmopressin nasal spray, Desmoda oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - ONE of the following: **1.1** Diagnosis of central diabetes insipidus	

OR

1.2 Diagnosis of polyuria and/or polydipsia following head trauma or surgery in the pituitary region

OR

1.3 Diagnosis of primary nocturnal enuresis

AND

2 - For Brand DDAVP ONLY: Trial and failure to generic desmopressin tablets (verified via paid pharmacy claims or submission of medical records)

AND

3 - For Desmoda requests ONLY: Trial and failure to BOTH of the following (verified via paid pharmacy claims or submission of medical records):

- generic desmopressin tablets
- generic desmopressin nasal spray

Notes	NOTE: Plan setup requires use of generic desmopressin tablets before Brand DDAVP. Not all preferred products require Prior Authorization for FFS patients.

2 . Revision History

Date	Notes
3/24/2026	Added Desmoda oral soln (NP) and generic nasal spray, updated guideline name.

Prior Authorization Guideline

Guideline ID	GL-99559
Guideline Name	Declomycin - Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:demeclocycline*	
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of ONE of the following:

- Rocky Mountain spotted fever, typhus fever and the typhus group, Q fever, rickettsialpox and tick fevers caused by rickettsiae
- Respiratory tract infections caused by Mycoplasma pneumoniae
- Lymphogranuloma venereum due to Chlamydia trachomatis

- Psittacosis (Ornithosis) due to Chlamydia psittaci
- Trachoma due to Chlamydia trachomatis
- Inclusion conjunctivitis caused by Chlamydia trachomatis
- Nongonococcal urethritis in adults caused by Ureaplasma urealyticum or Chlamydia trachomatis
- Relapsing fever due to Borrelia recurrentis
- Chancroid caused by Haemophilus ducreyi
- Plague due to Yersinia pestis
- Tularemia due to Francisella tularensis
- Cholera caused by Vibrio cholerae
- Campylobacter fetus infections cause by Campylobacter fetus
- Brucellosis due to Brucella species (in conjunction with streptomycin)
- Bartonellosis due to Bartonella bacilliformis
- Granuloma inguinale caused by Calymmatobacterium granulomatis
- Infection due to Escherichia coli
- Infection due to Enterobacter aerogenes
- Infection due to Shigella species
- Infection due to Acinetobacter species
- Respiratory tract infections caused by Haemophilus influenza
- Respiratory tract and urinary tract infections caused by Klebsiella species
- Upper respiratory infections caused by Streptococcus pneumoniae
- Skin and skin structure infections caused by Staphylococcus aureus.
- Uncomplicated urethritis in men due to Neisseria gonorrhoeae, and for the treatment of other uncomplicated gonococcal infections
- Infections in women caused by Neisseria gonorrhoeae
- Syphilis caused by Treponema pallidum subspecies pallidum
- Yaws caused by Treponema pallidum subspecies pertenue
- Listeriosis due to Listeria monocytogenes
- Anthrax due to Bacillus anthracis
- Vincent's infection caused by Fusobacterium fusiforme
- Actinomycosis caused by Actinomyces israelii
- Clostridial diseases caused by Clostridium species
- Acute intestinal amebiasis, as adjunctive therapy
- Severe acne, as adjunctive therapy

OR

1.2 The medication is being prescribed by or in consultation with an Infectious Disease specialist

Notes	*Approval duration: 6 months

2 . Revision History

Date	Notes

6/23/2021	update program

Prior Authorization Guideline

Guideline ID	GL-749235
Guideline Name	Deflazacort products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:PREFERRED: generic deflazacort, Jaythari, Kymbee, Pyquvi; NON-PREFERRED: Brand Emflaza	
Diagnosis	Duchenne Muscular Dystrophy
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Duchenne muscular dystrophy	

AND

2 - Patient is 2 years of age or older

AND

3 - History of failure, contraindication, or intolerance to ONE of the following for the treatment of Duchenne muscular dystrophy:

- Prednisone
- Prednisolone

AND

4 - Prescribed by or in consultation with a neurologist

AND

5 - If the request is for Brand Emflaza or another non-preferred product; patient must have tried and failed a preferred deflazacort product

AND

6 - Requested medication will not be used in combination with Agamree (vamorolone) (approval will not be granted for both agents)

Product Name:PREFERRED: generic deflazacort, Jaythari, Kymbee, Pyquvi; NON-PREFERRED: Brand Emflaza	
Diagnosis	Duchenne Muscular Dystrophy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Physician attestation that the patient has had a positive clinical response to therapy

AND

2 - If the request is for Brand Emflaza or another non-preferred product; patient must have tried and failed a preferred deflazacort product

AND

3 - Requested medication will not be used in combination with Agamree (vamorolone) (approval will not be granted for both agents)

2 . Revision History

Date	Notes
10/28/2026	Added Agamree concomitant use criteria to initial and reauth (approval will not be granted for both agents)

Prior Authorization Guideline

Guideline ID	GL-357232
Guideline Name	Dificid (fidaxomicin)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Preferred: Brand Dificid tablets; Non-Preferred: generic fidaxomicin tablets, Brand Dificid oral suspension	
Approval Length	10 Day(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Clostridioides difficile-associated diarrhea (CDAD) [previously known as Clostridium difficile- associated diarrhea] **AND**	

2 - BOTH of the following: **2.1** One of the following: • History of failure, contraindication, or intolerance to generic vancomycin oral solution • For continuation of prior Dificid therapy **AND** **2.2** Trial and failure, or intolerance to Brand Dificid tablets (applies to requests for generic fidaxomicin and Brand Dificid suspension only)	
Notes	PA Team Note: To approve, flip Brand/Generic Flag to "Y", approve at MSC "O"

2 . Revision History

Date	Notes
8/28/2025	Added generic fidaxomicin and Brand Dificid susp, updated step requirements

Prior Authorization Guideline

Guideline ID	GL-99445
Guideline Name	Dofetilide - Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:: Brand Tikosyn, generic dofetilide	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Atrial fibrillation
- Atrial flutter

AND

2 - Patient requires ONE of the following:

- Conversion to normal sinus rhythm
- Maintenance of normal sinus rhythm

AND

3 - Verification that the patient has already started on dofetilide while in the hospital for a minimum of 3 days

AND

4 - Patient does NOT have severe renal impairment [Creatinine Clearance (CrCl) less than 20 milliliters per minute]

AND

5 - Patient does NOT have congenital or acquired long QT syndromes

AND

6 - Patient is NOT concurrently using cimetidine, hydrochlorothiazide, ketoconazole, megestrol, prochlorperazine, trimethoprim, dolutegravir or verapamil

2 . Revision History

Date	Notes
3/10/2021	Bulk Copied C&S Arizona standard to Arizona Medicaid for 7/1 effecti ve

Prior Authorization Guideline

Guideline ID	GL-116190
Guideline Name	Dojolvi (triheptanoin)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2022

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of a long-chain fatty acid oxidation disorder (LC-FAOD) has been confirmed by at least two of the following:

- Disease specific elevation of acyl-carnitines on a newborn blood spot or in plasma
- Low enzyme activity in cultured fibroblasts

- One or more known pathogenic mutations in CPT2, ACADVL, HADHA, or HADHB

AND

2 - Not used with any other medium-chain triglyceride (MCT) product

AND

3 - Prescribed by or in consultation with a clinical specialist knowledgeable in appropriate disease-related dietary management (e.g., geneticist, cardiologist, gastroenterologist, etc.)

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

Approval Criteria

1 - Prescriber attests to continued need of therapy

AND

2 - Not used with any other medium-chain triglyceride (MCT) product

AND

3 - Prescribed by or in consultation with a clinical specialist knowledgeable in appropriate disease-related dietary management (e.g., geneticist, cardiologist, gastroenterologist, etc.)

2 . Revision History

Date	Notes

10/28/2022	New Program

Prior Authorization Guideline

Guideline ID	GL-700351
Guideline Name	DPP-4 Inhibitors - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:PREFERRED: generic alogliptin, generic alogliptin-metformin, generic alogliptin-pioglitazone, Brand Janumet, Janumet XR, Brand Januvia, Jentadueto, Tradjenta	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The patient has a diagnosis of type 2 diabetes mellitus **AND**	

2 - ONE of the following:

2.1 History of failure to metformin at a minimum dose of 1500 milligrams daily for 90 days

OR

2.2 Contraindication or intolerance to metformin

AND

3 - Provider attests that the requested medication will not be used concurrently with a GLP-1 RA or combination agent [e.g., Victoza (liraglutide), Byetta (exenatide), Xultophy (insulin degludec-liraglutide)], or a plan has been developed to address concomitant use

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:NON-PREFERRED: Brynovin, Jentadueto XR, Kombiglyze XR, generic saxagliptin-metformin ER, Brand Onglyza, generic saxagliptin, Brand Zituvimet, Brand Sitagliptin-metformin, Zituvimet XR, Brand Sitagliptin-metformin XR, Brand Zituvio, Brand Sitagliptin, generic sitagliptin phosphate, generic sitagliptin phosphate-metformin, generic sitagliptin phosphate-metformin ER	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of type 2 diabetes mellitus

AND

2 - ONE of the following:

2.1 History of failure to metformin at a minimum dose of 1500 milligrams daily for 90 days

OR

2.2 Contraindication or intolerance to metformin

AND

3 - ONE of the following:

3.1 History of failure for 90 days to three of the following:

- generic alogliptin, generic alogliptin-metformin, or generic alogliptin-pioglitazone
- Brand Januvia
- Brand Janumet/Janumet XR
- Jentadueto
- Tradjenta

OR

3.2 Intolerance or contraindication to THREE of the following:

- generic alogliptin, generic alogliptin-metformin, or generic alogliptin-pioglitazone
- Brand Januvia
- Brand Janumet/Janumet XR
- Jentadueto
- Tradjenta

AND

4 - Provider attests that the requested medication will not be used concurrently with a GLP-1 RA or combination agent [e.g., Victoza (liraglutide), Byetta (exenatide), Xultophy (insulin degludec-liraglutide)], or a plan has been developed to address concomitant use

2 . Revision History

Date	Notes
8/26/2026	Added new generic for Janumet XR as NPD.

Prior Authorization Guideline

Guideline ID	GL-154534
Guideline Name	Drugs for Compassionate Use
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD) • Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Eulexin, Humatin, Leukeran, Myleran, Tabloid	
Approval Length	N/A- drugs not covered by Medicaid must be obtained through Waylis Therapeutics for Compassionate Use
Guideline Type	Prior Authorization
Approval Criteria **1** - Provider attests that the requested medication will be obtained under compassionate use through Wayliss Pharmaceuticals	
Notes	Approval Length: N/A- Requests for drugs not covered by Medicaid m ust be obtained through Waylis Therapeutics for Compassionate Use

2 . Revision History

Date	Notes
9/26/2024	New program

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-357222
Guideline Name	Dry Eye Disease - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

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

Approval Criteria

1 - Tear deficiency associated with ocular inflammation due to one of the following:

- Moderate to severe keratoconjuctivitis sicca
- Moderate to severe dry eye disease

AND

2 - Submission of medical records (e.g., chart notes) confirming diagnosis by ONE of the following diagnostic tests:

- Schirmer test
- Ocular surface dye staining (e.g., rose bengal, fluorescein, lissamine green)
- Tear function index/fluorescein clearance test
- Tear break up time
- Tear film osmolarity
- Slit lamp lid evaluation
- Lacrimal gland function

AND

3 - Medication is not being prescribed to manage dry eyes peri-operative elective eye surgery (e.g., LASIK)

AND

4 - Submission of medical records (e.g., chart notes) or paid claims confirming trial and failure, contraindication, or intolerance to at least one OTC ocular lubricant (e.g., artificial tears, lubricating gels/ointments) in the past 60 days

AND

5 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist
- Rheumatologist

AND

6 - Submission of medical records (e.g., chart notes) or paid claims confirming a minimum trial of 60 days of Brand Restasis single dose vials, unless contraindicated

Product Name:Non-Preferred: Cequa, generic cyclosporine emulsion, Miebo, Restasis MultiDose, Tryptyr, Tyrvaya, Vevye	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Tear deficiency associated with ocular inflammation due to one of the following:

- Moderate to severe keratoconjuctivitis sicca
- Moderate to severe dry eye disease

AND

2 - Submission of medical records (e.g., chart notes) confirming diagnosis by ONE of the following diagnostic tests:

- Schirmer test
- Ocular surface dye staining (e.g., rose bengal, fluorescein, lissamine green)
- Tear function index/fluorescein clearance test
- Tear break up time
- Tear film osmolarity
- Slit lamp lid evaluation
- Lacrimal gland function

AND

3 - Medication is not being prescribed to manage dry eyes peri-operative elective eye surgery (e.g., LASIK)

AND

4 - Submission of medical records (e.g., chart notes) or paid claims confirming trial and failure, contraindication, or intolerance to at least one OTC ocular lubricant (e.g., artificial tears, lubricating gels/ointments) in the past 60 days

AND

5 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist
- Rheumatologist

AND

6 - Submission of medical records (e.g., chart notes) or paid claims confirming a minimum trial of 60 days of BOTH of the following, unless contraindicated:

- Brand Restasis single dose vials
- Xiidra (PA may be required)

Product Name:Preferred: Xiidra; Non-Preferred: Cequa, generic cyclosporine emulsion, Miebo, Restasis MultiDose, Tryptyr, Tyrvaya, Vevye	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., increased tear production or improvement in dry eye symptoms)

2 . Revision History

Date	Notes
8/28/2025	Added Tryptyr as NP

Prior Authorization Guideline

Guideline ID	GL-99563
Guideline Name	Duexis and Vimovo - Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Duexis	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following risk factors for NSAID (non-steroidal anti-inflammatory drug) induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI bleeding

- Untreated or active H. Pylori gastritis
- Concurrent use of oral corticosteroids (eg, prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (eg, warfarin, heparin)
- Concurrent use of antiplatelets (eg, aspirin including low-dose, clopidogrel)

AND

2 - Documentation of history of failure, contraindication, or intolerance to THREE combinations of preferred NSAIDS taken with preferred H2 (histamine 2)-receptor antagonists. (Provide name and date preferred products were tried)*

AND

3 - Physician has provided rationale for needing to use fixed-dose combination therapy with Duexis instead of taking individual products in combination.

Notes	*Please reference background section for preferred products table

Product Name:Brand Vimovo, generic naproxen-esomeprazole	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following risk factors for NSAID (non-steroidal anti-inflammatory drug) induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI bleeding
- Untreated or active H. Pylori gastritis
- Concurrent use of oral corticosteroids (eg, prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (eg, warfarin, heparin)
- Concurrent use of antiplatelets (eg, aspirin including low-dose, clopidogrel)

AND

2 - Documentation of history of failure, contraindication, or intolerance to THREE combinations of preferred NSAIDS taken with preferred proton pump inhibitors (PPIs). (Provide name and date preferred products were tried)* **AND** **3** - Physician has provided rationale for needing to use fixed-dose combination therapy with Vimovo instead of taking individual products in combination.	
Notes	*Please reference background section for preferred products table

2 . Background

Benefit/Coverage/Program Information

Preferred Table

NSAIDS	Proton Pump Inhibitors (PPIs)	H2 (histamine 2)-receptor antagonists
Diclofenac DR (Generic Voltaren)	esomeprazole (Generic Nexium)	Famotidine (Generic Pepcid)
Diclofenac ER (Generic Voltaren ER)	lansoprazole (Generic Prevacid)	Nizatidine (Generic Axid)
Etodolac (Generic Lodine)	omeprazole (Generic Prilosec)	Ranitidine (Generic Zantac)
Etodolac ER (Generic Lodine ER)	pantoprazole sodium (Generic Protonix)	
Fenoprofen (Generic Nalfon)		
Flurbiprofen (Generic Ansaid)		

Ibuprofen		
Indomethacin (Generic Indocin)		
Ketorolac (Generic Toradol)		
Mefenamic (Generic Ponstel)		
Meloxicam (Generic Mobic)		
Nabumetone (Generic Relafen)		
Nabumetone DS (Generic Relafen DS)		
Naproxen (Generic Anaprox)		
Naproxen DR (Generic Anaprox DR)		
Naproxen EC (Generic Anaprox EC)		
Oxaprozin (Generic Daypro)		

Piroxicam (Generic Feldene)		
Sulindac (Generic Clinoril)		

Prior Authorization Guideline

Guideline ID	GL-734243
Guideline Name	Dupixent (dupilumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Dupixent	
Diagnosis	Atopic Dermatitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of moderate to severe chronic atopic dermatitis

AND

1.2 History of failure, contraindication, or intolerance to TWO of the following: (document drug, date of trial, and/or contraindication to medication)*

- Opzelura (ruxolitinib)
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.15% cream

AND

2 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Remicade/Inflectra (infliximab)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication

Product Name:Dupixent	
Diagnosis	Atopic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Positive clinical response to therapy

AND

1.2 History of failure, contraindication, or intolerance to TWO of the following: (document drug, date of trial, and/or contraindication to medication)*

- Opzelura (ruxolitinib)
- Vtama (tapinarof)
- Zoryve (roflumilast) 0.15% cream

AND

2 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Rituxan (rituximab), Enbrel (etanercept), Remicade/Inflectra (infliximab)]

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication

Product Name:Dupixent	
Diagnosis	Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 6 years of age or older

AND

2 - Submission of documentation (e.g., chart notes) confirming diagnosis of moderate to severe asthma

AND

3 - Classification of asthma as uncontrolled or inadequately controlled as defined by at least ONE of the following

- Poor symptom control (e.g., Asthma Control Questionnaire [ACQ] score consistently greater than 1.5 or Asthma Control Test [ACT] score consistently less than 20)
- Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months
- Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment)
- Airflow limitation (e.g., after appropriate bronchodilator withhold forced expiratory volume in 1 second [FEV1] less than 80% predicted [in the face of reduced FEV1/forced vital capacity [FVC] defined as less than the lower limit of normal])
- Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

4 - Dupixent will be used in combination with one of the following:

4.1 ONE high-dose (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta2 agonist (LABA) [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)] (see Table 2 in Background section)

OR

4.2 Combination therapy including BOTH of the following:

4.2.1 ONE high-dose (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco), mometasone furoate (Asmanex), beclomethasone dipropionate (QVAR)] (see Table 2 in Background section)

AND

4.2.2 ONE additional asthma controller medication [e.g., LABA - olodaterol (Striverdi) or indacaterol (Arcapta); leukotriene receptor antagonist – montelukast (Singulair); theophylline]

AND

5 - ONE of the following:

5.1 Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting that asthma is an eosinophilic phenotype as defined by a baseline (pre-dupilumab treatment) peripheral blood eosinophil level greater than or equal to 150 cells/microliter within the past 6 weeks

OR

5.2 Patient is currently dependent on oral corticosteroids for the treatment of asthma

AND

6 - Patient is NOT receiving Dupixent in combination with ONE of the following:

- Anti-interleukin-5 therapy [e.g. Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g. Xolair (omalizumab)]

AND

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

- Pulmonologist
- Allergist
- Immunologist

Product Name:Dupixent

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

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to Dupixent therapy as demonstrated by at least ONE of the following:

- Reduction in the frequency of exacerbations
- Decreased utilization of rescue medications
- Increase in percent predicted forced expiratory volume in 1 second (FEV1) from pretreatment baseline
- Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.)
- Reduction in oral corticosteroid requirements

AND

2 - Dupixent is being used in combination with an inhaled corticosteroid (ICS)-containing controller medication (see Table 2 in Background section)

AND

3 - Patient is NOT receiving Dupixent in combination with ONE of the following:

- Anti-interleukin-5 therapy [e.g. Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]
- Anti-IgE (immunoglobulin E) therapy [e.g. Xolair (omalizumab)]

AND

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

- Pulmonologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyposis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 12 years of age or older

AND

2 - Submission of documentation (e.g., chart notes) confirming ALL of the following:

2.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by ALL of the following:

2.1.1 TWO or more of the following symptoms for greater than or equal to 12 weeks duration:

- Mucopurulent discharge
- Nasal obstruction and congestion
- Decreased or absent sense of smell
- Facial pressure or pain

AND

2.1.2 ONE of the following:

- Evidence of inflammation on paranasal sinus examination or computed tomography (CT)
- Evidence of purulence coming from paranasal sinuses or ostiomeatal complex

AND

2.1.3 The presence of nasal polyps

AND

2.2 ONE of the following:

- Patient has required prior sino-nasal surgery
- Patient has required systemic corticosteroids in the previous 2 years

AND

2.3 Patient has been unable to obtain symptom relief after trial of BOTH of the following agents/classes of agents:

- Intranasal corticosteroids (e.g. fluticasone, mometasone, triamcinolone, etc.)
- Antileukotriene agents (e.g. montelukast, zafirlukast, zileuton)

AND

3 - Patient will receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids

AND

4 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

AND

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

- Otolaryngologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyposis

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

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to Dupixent therapy

AND

2 - Patient will continue to receive Dupixent as add-on maintenance therapy in combination with intranasal corticosteroids

AND

3 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

AND

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

- Otolaryngologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Eosinophilic Esophagitis (EoE)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

- Patient is at least 1 year of age
- Patient weighs at least 15 kg

AND

2 - Submission of documentation (e.g., chart notes) confirming diagnosis of eosinophilic esophagitis (EoE)

AND

3 - Patient has symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, gastroesophageal reflux disease [GERD]/heartburn symptoms, chest pain, abdominal pain)

AND

4 - Submission of documentation (e.g., chart notes, lab values) confirming patient has at least 15 intraepithelial eosinophils per high power field (HPF)

AND

5 - Other causes of esophageal eosinophilia have been excluded

AND

6 - Paid claims or submission of documentation (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to at least an 8-week trial of one of the following:

- Proton pump inhibitors (e.g., pantoprazole, omeprazole)
- Topical (esophageal) corticosteroids (e.g., budesonide, fluticasone)

AND

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

- Gastroenterologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Eosinophilic Esophagitis (EoE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to therapy as evidenced by improvement of at least one of the following from baseline:

- Symptoms (e.g., dysphagia, food impaction, heartburn, chest pain)
- Histologic measures (e.g., esophageal intraepithelial eosinophil count)
- Endoscopic measures (e.g., edema, furrows, exudates, rings, strictures)

AND

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

- Gastroenterologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Prurigo Nodularis (PN)
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Submission of documentation (e.g., chart notes) confirming diagnosis of prurigo nodularis (PN)

AND

3 - Patient has at least 20 nodular lesions

AND

4 - Trial and failure, contraindication, or intolerance to one previous PN treatment (e.g., topical corticosteroids, topical calcineurin inhibitors [pimecrolimus, tacrolimus], topical capsaicin)

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Prurigo Nodularis (PN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to therapy as evidenced by improvement of at least one of the following:

- Reduction in the number of nodular lesions from baseline
- Improvement in symptoms (e.g., pruritus, inflammation) from baseline

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Chronic obstructive pulmonary disease (COPD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Submission of medical records (e.g., chart notes) confirming diagnosis of chronic obstructive pulmonary disease (COPD)

AND

3 - Submission of medical records (e.g., chart notes) confirming the presence of Type 2 inflammation evidenced by blood eosinophils greater than or equal to 300 cells per microliter at baseline

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming the patient is receiving one of the following therapies at maximally tolerated doses:

- Triple therapy (i.e., an inhaled corticosteroid (ICS), a long-acting muscarinic antagonist (LAMA) and a long-acting beta agonist (LABA)
- If ICS are contraindicated, a LAMA and a LABA

AND

5 - Patient must have post-bronchodilator forced expiratory volume [FEV1] / forced vital capacity [FVC] ratio less than 0.70

AND

6 - Patient has had ONE of the following within the past 12 months:

- At least two exacerbations where systemic corticosteroids [intramuscular, intravenous, or oral (e.g., prednisone)] were required at least once
- A COPD-related hospitalization

AND

7 - Submission of medical records (e.g., chart notes) confirming the patient experiences dyspnea during everyday activities (e.g., needs to stop for breath when walking on level ground)

Product Name:Dupixent	
Diagnosis	Chronic obstructive pulmonary disease (COPD)

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a positive clinical response to therapy (e.g., improved lung function, a reduction in COPD exacerbations)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming the patient continues to receive one of the following therapies:

- Triple therapy (i.e., an inhaled corticosteroid (ICS), a long-acting muscarinic antagonist (LAMA) and a long-acting beta agonist (LABA)
- If ICS are contraindicated, a LAMA and a LABA

Product Name:Dupixent	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 2 years of age or older

AND

2 - Submission of documentation (e.g., chart notes) confirming diagnosis of chronic spontaneous urticaria

AND

3 - Persistent symptoms (itching and hives) for at least 4 consecutive weeks despite titrating to an optimal dose with a second generation H1 antihistamine (e.g., cetirizine, fexofenadine), unless there is a contraindication or intolerance to H1 antihistamines

AND

4 - Paid claims or submission of documentation (e.g., chart notes) confirming concurrent use with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines

AND

5 - Paid claims or submission of documentation (e.g., chart notes) confirming patient has tried and had an inadequate response or intolerance to at least TWO of the following additional therapies:

- Doxepin
- H1 antihistamine
- H2 antagonist (e.g., famotidine, cimetidine)
- Hydroxyzine
- Leukotriene receptor antagonist (e.g., montelukast)

AND

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

- Allergist/immunologist
- Dermatologist

Product Name:Dupixent	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment

AND

2 - Submission of documentation (e.g., chart notes) confirming patient has experienced at least one of the following:

- Reduction in itching severity from baseline
- Reduction in the number of hives from baseline

Product Name:Dupixent	
Diagnosis	Bullous Pemphigoid (BP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of bullous pemphigoid (BP) as confirmed by skin biopsy or serology

AND

2 - Will be used in combination with a tapering course of oral corticosteroids (e.g., prednisone) until disease control has occurred

AND

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

- Allergist/Immunologist
- Dermatologist

Product Name:Dupixent	
Diagnosis	Bullous Pemphigoid (BP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., decreased pruritus severity from baseline, no new lesions or worsening of old lesions)

Product Name:Dupixent	
Diagnosis	Allergic Fungal Rhinosinusitis (AFRS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of allergic fungal rhinosinusitis (AFRS)

AND

2 - Patient is 6 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) confirming patient has a history of sino-nasal surgery

AND

4 - Submission of medical records (e.g., chart notes) confirming that unless contraindicated, the patient has had an inadequate response to a trial (of a minimum 30-day supply) of appropriate post-operative management for AFRS [e.g., systemic glucocorticoids (e.g., prednisone), intranasal glucocorticoids (e.g., budesonide)]

AND

5 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

AND

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

- Allergist/Immunologist
- Otolaryngologist
- Pulmonologist

Product Name:Dupixent	
Diagnosis	Allergic Fungal Rhinosinusitis (AFRS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to Dupixent therapy (e.g., reduction in sinus opacification)

AND

2 - Patient is NOT receiving Dupixent in combination with another biologic medication [e.g., Xolair (omalizumab), Nucala (mepolizumab), Cinqair (reslizumab), Fasenra (benralizumab)]

AND

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

- Allergist/Immunologist
- Otolaryngologist
- Pulmonologist

2 . Revision History

Date	Notes
9/23/2026	Dupixent preferred 10/1/26: 1) Removed step through other preferred agents for AD (Adbry/Eucrisa/TCS/TCI), Asthma/CRSwNP (Fasenra/ Xolair), CSU (Xolair). 2) Updated specialist requirement verbiage 3) updated initial/reauth durations 4)CRSwNP removed saline as prereq uisite therapy 5) COPD updated criterion requiring exacerbations/hos pitalization.

Prior Authorization Guideline

Guideline ID	GL-99567
Guideline Name	Durezol
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Durezol	
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - History of failure, contraindication, or intolerance to BOTH of the following:

- prednisolone 1%
- dexamethasone ophthalmic drops and/or ointment.

2 . Revision History

Date	Notes
7/8/2021	Changed approval length to 2 months

Prior Authorization Guideline

Guideline ID	GL-703319
Guideline Name	Duvyzat (givinostat)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Duvyzat	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of Duchenne muscular dystrophy (DMD)

AND

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

2.1 Patient has a confirmed mutation of the dystrophin gene

OR

2.2 Muscle biopsy confirmed an absence of dystrophin protein

AND

3 - Patient is 6 years of age or older

AND

4 - Submission of medical records including results of baseline North Star Ambulatory Assessment (NSAA) confirming patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) as evidenced by NSAA scoring prior to initiating Duvyzat

AND

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

- Baseline platelet count ≥ 150 x 10^9/L
- Triglyceride level drawn prior to therapy initiation (document baseline TG level)

AND

6 - Submission of medical records (e.g., chart notes) or paid claims confirming requested drug will be used concomitantly with a corticosteroid regimen (e.g., prednisone/prednisolone, Emflaza [deflazacort], Agamree)

AND

7 - Patient will not receive Duvyzat in combination with or following Elevidys (delandistrogene moxeparvovec-rokl) treatment or exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

AND

8 - Prescribed by or in consultation with a pediatric neurologist with expertise in treating DMD

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming patient has experienced a benefit from therapy (e.g., improvement in preservation of muscle strength)

AND

2 - Submission of medical records including results of recent North Star Ambulatory Assessment (NSAA) confirming patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) as evidenced by NSAA scoring

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming patient continues to receive concomitant corticosteroid regimen (e.g., prednisone/prednisolone, Emflaza [deflazacort], Agamree)

AND

4 - Patient will not receive Duvyzat in combination with or following Elevidys (delandistrogene moxeparvovec-rokl) treatment or exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

2 . Revision History

Date	Notes
8/26/2026	Updated verbiage in concomitant use criterion

Prior Authorization Guideline

Guideline ID	GL-161671
Guideline Name	Ebglyss (lebrikizumab-lbkz)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name:Ebglyss	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of moderate to severe atopic dermatitis

AND

1.2 One of the following:

- Involvement of at least 10% body surface area (BSA)
- SCORing Atopic Dermatitis (SCORAD) index value of at least 25

AND

1.3 Both of the following:

- Patient is 12 years of age or older
- Patient weighs at least 40 kg

AND

1.4 History of failure, contraindication, or intolerance to ALL of the following: (document drug, date of trial, and/or contraindication to medication)*

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole) ointment
- Adbry (tralokizumab-ldrm)
- Dupixent (dupilumab)

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication

Product Name:Ebglyss	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) demonstrating positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in body surface area involvement from baseline
- Reduction in SCORing Atopic Dermatitis (SCORAD) index value from baseline

AND

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

- Dermatologist
- Allergist
- Immunologist

2 . Background

Benefit/Coverage/Program Information

Table 1. Relative potencies of topical corticosteroids [2]

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
	Amcinonide	Cream, lotion, ointment	0.1

High Potency	Augmented betamethasone dipropionate	Cream	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream	0.1
	Triamcinolone acetonide	Cream, ointment	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05

	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
12/6/2024	New program

Prior Authorization Guideline

Guideline ID	GL-99550
Guideline Name	Ecoza (econazole)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021
P&T Approval Date:	
P&T Revision Date:	

1 . Criteria

Product Name:Ecoza, Generic econazole	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - History of failure, contraindication, or intolerance to ALL of the following:

- butenafine
- ciclopirox

- clotrimazole
- clotrimazole w/ betamethasone
- ketoconazole
- miconazole
- nystatin
- terbinafine
- tolnaftate

2 . Revision History

Date	Notes
6/10/2021	Update guideline

Prior Authorization Guideline

Guideline ID	GL-636309
Guideline Name	Eculizumab (Soliris, Bkemv, Epysqli)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Epysqli	
Diagnosis	Paroxysmal nocturnal hemoglobinuria (PNH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)

AND

2 - BOTH of the following:

- Flow cytometry analysis confirming presence of PNH clones
- Laboratory results, signs, and/or symptoms attributed to PNH (e.g., abdominal pain, anemia, dyspnea, extreme fatigue, smooth muscle dystonia, unexplained/unusual thrombosis, hemolysis/hemoglobinuria, kidney disease, pulmonary hypertension, etc.)

AND

3 - Patient is treatment naïve with eculizumab therapy

AND

4 - Requested medication is dosed according to the United States Food and Drug Administration (FDA) labeled dosing for PNH

AND

5 - Prescribed by, or in consultation with, ONE of the following:

- Hematologist
- Oncologist

Product Name:Epysqli	
Diagnosis	Paroxysmal nocturnal hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical response from baseline (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in lactate dehydrogenase [LDH], increased reticulocyte count, etc.)

AND

2 - Requested medication is dosed according to the United States Food and Drug Administration (FDA) labeled dosing for paroxysmal nocturnal hemoglobinuria (PNH)

AND

3 - Prescribed by, or in consultation with, ONE of the following:

- Hematologist
- Oncologist

Product Name:Epysqli	
Diagnosis	Atypical hemolytic uremic syndrome (aHUS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) supporting a diagnosis of atypical hemolytic uremic syndrome (aHUS) by ruling out BOTH of the following:

- Shiga toxin E. coli-related hemolytic uremic syndrome (STEC-HUS)*
- Thrombotic thrombocytopenia purpura (TTP) (e.g., rule out ADAMTS13 deficiency)

AND

2 - Laboratory results, signs, and/or symptoms attributed to aHUS (e.g., thrombocytopenia, microangiopathic hemolysis, thrombotic microangiopathy, acute renal failure, etc.)

AND

3 - Patient is treatment naïve with eculizumab therapy

AND

4 - Requested medication is dosed according to the Food and Drug Administration (FDA) labeled dosing for aHUS

AND

5 - Prescribed by, or in consultation with, a hematologist or nephrologist

Product Name:Epysqli	
Diagnosis	Atypical hemolytic uremic syndrome (aHUS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical response from baseline (e.g., reduction of plasma exchanges, reduction of dialysis, increased platelet count, reduction of hemolysis)

AND

2 - Requested medication is dosed according to the United States Food and Drug Administration (FDA) labeled dosing for atypical hemolytic uremic syndrome (aHUS)

AND

3 - Prescribed by, or in consultation with, a hematologist or nephrologist

Product Name:Epysqli	
Diagnosis	Generalized myasthenia gravis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of generalized myasthenia gravis (gMG)

AND

1.2 Patient has not failed a previous course of eculizumab therapy

AND

1.3 Positive serologic test for anti-acetylcholine receptor (AChR) antibodies

AND

1.4 ONE of the following:

- History of abnormal neuromuscular transmission test demonstrated by single-fiber electromyography (SFEMG) or repetitive nerve stimulation
- History of positive anticholinesterase test, e.g., edrophonium chloride test
- Patient has demonstrated improvement in myasthenia gravis (MG) signs on oral cholinesterase inhibitors, as assessed by the treating neurologist

AND

1.5 Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy

AND

1.6 Patient has a Myasthenia Gravis-specific Activities of Daily Living scale (MG-ADL) total score greater than or equal to 6 at initiation of therapy

AND

2 - Patient is 6 years of age or older

AND

3 - ONE of the following:

3.1 For patients between 6 and 17 years of age, trial and failure, contraindication, or intolerance to one of the following:

- Immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)
- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)

AND

3.2 For patients 18 years of age or older, BOTH of the following:

- History of failure of at least TWO immunosuppressive agents over the course of at least 12 months [e.g., azathioprine, methotrexate, cyclosporine, mycophenolate, etc.]
- Patient has required TWO or more courses of plasmapheresis/plasma exchanges and/or intravenous immune globulin for at least the previous 12 months without symptom control

AND

4 - Patient is currently on a stable therapeutic dose (at least 3 to 6 months) of immunosuppressive therapy

AND

5 - Requested medication is initiated and titrated according to the United States Food and Drug Administration (FDA) labeled dosing for gMG: up to a maximum of 1200 milligrams every 2 weeks

AND

6 - Prescribed by, or in consultation, with a neurologist

AND

7 - Requested medication is not being used in combination with any one of the following:

- Neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo, Vyvgart, Vyvgart Hytrulo)
- Another complement inhibitor (e.g., Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)
- B-cell depletion therapy (e.g., Uplizna)

Product Name:Epysqli	
Diagnosis	Generalized myasthenia gravis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical response from baseline as evidenced by ALL of the following:

- Improvement and/or maintenance of at least a 3 point improvement (reduction in score) in the Myasthenia Gravis Activities of Daily Living (MG-ADL) score from pre-treatment baseline
- Reduction in signs and symptoms of myasthenia gravis

- Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting eculizumab therapy (Note: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on eculizumab therapy will be considered as treatment failure)

AND

2 - Requested medication is dosed according to the United States Food and Drug Administration (FDA) labeled dosing for generalized myasthenia gravis (gMG): up to a maximum of 1200 milligrams every 2 weeks

AND

3 - Prescribed by, or in consultation, with a neurologist

AND

4 - Requested medication is not being used in combination with any one of the following:

- Neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo, Vyvgart, Vyvgart Hytrulo)
- Another complement inhibitor (e.g., Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)
- B-cell depletion therapy (e.g., Uplizna)

Product Name:Epysqli	
Diagnosis	Neuromyelitis optica spectrum disorder (NMOSD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of neuromyelitis optica spectrum disorder (NMOSD)

AND

1.2 Past medical history of ONE of the following:

- Optic neuritis
- Acute myelitis
- Area postrema syndrome: Episode of otherwise unexplained hiccups or nausea and vomiting
- Acute brainstem syndrome
- Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
- Symptomatic cerebral syndrome with NMOSD-typical brain lesions

AND

1.3 Positive serologic test for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMO-IgG antibodies

AND

1.4 Diagnosis of multiple sclerosis or other diagnoses have been ruled out

AND

2 - Patient has not failed a previous course of eculizumab therapy

AND

3 - History of failure of, contraindication, or intolerance to rituximab (Ruxience, Truxima) therapy

AND

4 - One of the following:

4.1 History of at least two relapses during the previous 12 months prior to initiating eculizumab therapy

OR

4.2 History of at least three relapses during the previous 24 months, at least one relapse occurring within the past 12 months prior to initiating eculizumab therapy

AND

5 - Requested medication is initiated and titrated according to the U.S. FDA labeled dosing for NMOSD, up to a maximum of 1200 mg every 2 weeks

AND

6 - Prescribed by, or in consultation with, a neurologist

Product Name:Epysqli	
Diagnosis	Neuromyelitis optica spectrum disorder (NMOSD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical response from baseline as evidenced by BOTH of the following:

1.1 Reduction in the number and/or severity of relapses or signs and symptoms of neuromyelitis optica spectrum disorder (NMOSD)

AND

1.2 Maintenance, reduction, or discontinuation of dose(s) of any baseline

immunosuppressive therapy (IST) prior to starting eculizumab therapy. (Note: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat NMOSD or exacerbation of symptoms while on eculizumab therapy will be considered as treatment failure) **AND** **2** - Requested medication is dosed according to the U.S. FDA (Food and Drug Administration) labeled dosing for NMOSD: up to a maximum of 1200 mg every 2 weeks **AND** **3** - Prescribed by, or in consultation with, a neurologist

Product Name:Non-Preferred*: Soliris, Bkemv, and newly launched eculizumab products	
Approval Length	Requests for Non-Preferred biosimilars are not approved at this time
Guideline Type	Prior Authorization
Approval Criteria **1** - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred product is Epysqli (eculizumab-aagh). **Please note: The drug(s) listed above may require additional review.	
Notes	*Patients must use preferred eculizumab biosimilar.

2 . Revision History

Date	Notes
6/25/2026	gMG: Added combination therapy criteria to initial and reauth.

Prior Authorization Guideline

Guideline ID	GL-490254
Guideline Name	Effient (prasurgel)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Brand Effient, Generic prasurgrel	
Diagnosis	Acute coronary syndrome (ACS)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute coronary syndrome (ACS) [e.g., unstable angina (UA), non-ST elevation myocardial infarction (NSTEMI) or ST-segment elevation myocardial infarction (STEMI)]

AND **2** - The patient must be managed with percutaneous coronary intervention (PCI)

2 . Revision History

Date	Notes
1/28/2026	Removed Brilinta as target, PA not required.

Prior Authorization Guideline

Guideline ID	GL-99606
Guideline Name	Egrifta
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Egrifta SV	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of human immunodeficiency virus (HIV)-associated lipodystrophy	

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona SP to Medicaid Arizona SP for 7/1 eff

Prior Authorization Guideline

Guideline ID	GL-99607
Guideline Name	Elaprase - Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Elaprase	
Diagnosis	Hunter syndrome
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Hunter syndrome (Mucopolysaccharidosis II, MPS II)	

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona SP to Medicaid Arizona SP for 7/1 eff

Prior Authorization Guideline

Guideline ID	GL-641224
Guideline Name	Elevidys (delandistrogene moxeparvovec-rokl)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Elevidys	
Diagnosis	Duchenne Muscular Dystrophy (DMD)
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of Duchenne Muscular Dystrophy (DMD)

AND

1.2 Mutation in the DMD gene has been confirmed

AND

1.3 No deletion in exon 8 or exon 9 in the DMD gene is present

AND

1.4 Patient is 4 through 5 years of age (at least 4 years 0 days and less than 6 years old)

AND

1.5 Submission of medical records including results of baseline North Star Ambulatory Assessment (NSAA) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) as evidenced by NSAA scoring

AND

1.6 Anti-AAVrh74 total binding antibody titers are less than 1:400

AND

1.7 Patient has been on a stable dose of a corticosteroid, unless contraindicated or intolerance, prior to start of therapy and will be used concomitantly with a corticosteroid regimen pre- and post- infusion

AND

1.8 Submission of medical records (e.g., chart notes) documenting results of all of the following laboratory values in the 30 days prior to therapy:

- Liver function (i.e., clinical exam, GGT, total bilirubin)
- Platelet counts
- Troponin-I

AND

1.9 Patient has a left ventricular ejection fraction of greater than or equal to 40 percent (%)

AND

1.10 Patient does not have clinical signs or symptoms of infection

AND

1.11 A one-time gene therapy for ambulatory children ages 4 through 5 years of age for the treatment of Duchenne Muscular Dystrophy. Patient will not receive Duvyzat (givinostat) or exon-skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)] concomitantly or following Elevidys treatment

AND

1.12 Patient has never received Elevidys treatment in their lifetime

AND

2 - Provider attests that patient does not have preexisting liver impairment, chronic hepatic condition or acute liver disease

AND

3 - Provider attests that liver function (clinical exam, GGT, and total bilirubin) will be monitored weekly for the first 3 months following Elevidys infusion and monitoring will be continued thereafter if clinically indicated as per FDA-approved recommendations in the labeling

AND

4 - Provider attests that these laboratory values will be monitored after administration according to the FDA-approved recommendations in the labeling:

- Platelet counts
- Troponin-I

AND

5 - Prescribed by a neurologist with expertise in the treatment of DMD at an authorized treatment center with expertise in gene therapy

2 . Revision History

Date	Notes
6/25/2026	Updated concomitant use criterion verbiage

Prior Authorization Guideline

Guideline ID	GL-479199
Guideline Name	Elidel (pimecrolimus) cream, tacrolimus ointment
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Elidel, generic pimecrolimus, generic tacrolimus 0.03%, generic tacrolimus 0.1%	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*

AND

2 - One of the following:

- For Brand Elidel, generic pimecrolimus, or tacrolimus 0.03% ointment: Patient is at least 2 years of age
- For tacrolimus 0.1% ointment: Patient is at least 16 years of age (for patients under age 16 yo, refer to off-label PA criteria)

AND

3 - ONE of the following:

3.1 History of failure, contraindication, or intolerance to ONE topical corticosteroid in the past 90 days

OR

3.2 Drug is being prescribed for the facial or groin area

Notes	*Note: Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

Product Name:Brand Elidel, generic pimecrolimus, generic tacrolimus 0.03%, generic tacrolimus 0.1%	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*

AND **2** - Patient demonstrates positive clinical response to therapy	
Notes	*Note: Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunction purposes are NOT medically accepted indications and are NOT recognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadalafil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes
12/17/2025	Added criterion/note regarding approved/excluded use (cosmetic, vitiligo).

Prior Authorization Guideline

Guideline ID	GL-99448
Guideline Name	Elmiron
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Elmiron	
Diagnosis	Bladder pain or discomfort associated with interstitial cystitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a documented diagnosis of bladder pain or discomfort associated with interstitial cystitis

2 . Revision History

Date	Notes
3/10/2021	Bulk Copied C&S Arizona standard to Arizona Medicaid for 7/1 effecti ve

Prior Authorization Guideline

Guideline ID	GL-749233
Guideline Name	Empaveli (pegcetacoplan)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Empaveli	
Diagnosis	Paroxysmal nocturnal hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)	

AND

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

- Hematologist
- Oncologist

Product Name:Empaveli	
Diagnosis	Paroxysmal nocturnal hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in hemoglobin level, hemoglobin stabilization, decrease in the number of red blood cell transfusions)

Product Name:Empaveli	
Diagnosis	Complement 3 Glomerulopathy or Primary Immune-Complex Membranoproliferative Glomerulonephritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Complement 3 glomerulopathy (C3G)

- Primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN)

AND

2 - For primary immune-complex membranoproliferative glomerulonephritis, patient has not had a kidney transplant

AND

3 - Used to reduce proteinuria and/or reduce the loss of kidney function

AND

4 - Patient is 12 years of age or older

AND

5 - Patient is currently being treated with a maximally tolerated dose of one of the following for at least 12 weeks prior to initiating treatment:

- Angiotensin-converting enzyme inhibitors (e.g., benazepril, lisinopril)
- Angiotensin receptor blockers (e.g., losartan, valsartan)
- Sodium-glucose cotransporter-2 (SGLT2) inhibitors (e.g., Farxiga [dapagliflozin] Jardiance [empagliflozin])

AND

6 - Prescribed by or in consultation with nephrologist

Product Name:Empaveli	
Diagnosis	Complement 3 Glomerulopathy or Primary Immune-Complex Membranoproliferative Glomerulonephritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., reduction in UPCR, stable or improved eGFR compared to baseline)

AND

2 - For primary immune-complex membranoproliferative glomerulonephritis, patient has not had a kidney transplant

AND

3 - Patient continues to be treated with a maximally tolerated dose of one of the following:

- Angiotensin-converting enzyme inhibitors (e.g., benazepril, lisinopril)
- Angiotensin receptor blockers (e.g., losartan, valsartan)
- Sodium-glucose cotransporter-2 (SGLT2) inhibitors (e.g., Farxiga [dapagliflozin] Jardiance [empagliflozin])

2 . Revision History

Date	Notes
10/28/2026	Added "used to reduce loss of kidney function" to criterion 3 under C3G/IC-MPGN indication

Prior Authorization Guideline

Guideline ID	GL-164415
Guideline Name	Emrosi (minocycline)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2025

1 . Criteria

Product Name:Emrosi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Medication will be used for treatment of inflammatory lesions (papules and pustules) of rosacea

AND

2 - History of failure to generic minocycline 50mg capsules

2 . Revision History

Date	Notes
1/30/2025	New program

Prior Authorization Guideline

Guideline ID	GL-139348
Guideline Name	Enbrel (etanercept)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2024

1 . Criteria

Product Name:Enbrel	
Diagnosis	Moderately to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderately to severely active Rheumatoid Arthritis (RA)	

AND

2 - History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)*

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial

Product Name:Enbrel	
Diagnosis	Moderately to Severely Active Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Enbrel therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Enbrel	
Diagnosis	Moderately to Severely Active Polyarticular Juvenile Idiopathic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

AND

2 - Patient is 2 years of age or older

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name:Enbrel	
Diagnosis	Moderately to Severely Active Polyarticular Juvenile Idiopathic Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Enbrel therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Enbrel	
Diagnosis	Active Psoriatic Arthritis

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

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)*

AND

3 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial

Product Name:Enbrel	
Diagnosis	Active Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Enbrel therapy

AND

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

- Rheumatologist
- Dermatologist

Product Name:Enbrel	
Diagnosis	Moderate to Severe Chronic Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe chronic plaque psoriasis

AND

2 - Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

3 - Both of the following:

3.1 History of failure to one of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):*

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin

- Coal tar

AND

3.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)*

AND

4 - Prescribed by or in consultation with a dermatologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial

Product Name:Enbrel	
Diagnosis	Moderate to Severe Chronic Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Enbrel therapy

AND

2 - Prescribed by or in consultation with a dermatologist

Product Name:Enbrel	
Diagnosis	Ankylosing spondylitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - History of failure to two non-steroidal anti-inflammatory drugs (NSAIDs: e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trials)*

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial

Product Name:Enbrel	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Enbrel therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

2 . Revision History

Date	Notes
1/26/2024	Added age criteria for PJIA indication, removed concomitant use safe ty criterion from all sections

Prior Authorization Guideline

Guideline ID	GL-274200
Guideline Name	Encelto (revakinagene taroretcel-lwey)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Encelto	
Approval Length	1 Time Authorization per Eye in Lifetime
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of macular telangiectasia type 2 (MacTel)

AND

2 - Provider attests patient has not received prior treatment with Encelto in the affected eye in their lifetime

AND

3 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

2 . Revision History

Date	Notes
5/29/2025	New program

Prior Authorization Guideline

Guideline ID	GL-99450
Guideline Name	Endari
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Endari	
Diagnosis	Sickle cell disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

- Diagnosis of sickle cell disease

- Used to reduce acute complications of sickle cell disease

AND

2 - ONE of the following:

- Patient is using Endari with concurrent hydroxyurea therapy
- Patient is unable to take hydroxyurea due to a contraindication or intolerance

AND

3 - Patient has had 2 or more painful sickle cell crises within the past 12 months

Product Name:Endari	
Diagnosis	Sickle cell disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Endari therapy

2 . Revision History

Date	Notes
3/10/2021	Bulk Copied C&S Arizona standard to Arizona Medicaid for 7/1 effecti ve

Prior Authorization Guideline

Guideline ID	GL-123730
Guideline Name	Enjaymo (sutimlimab-jome)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2023

1 . Criteria

Product Name:Enjaymo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of cold agglutinin disease (CAD) based on ALL of the following:

- Presence of chronic hemolysis (e.g., bilirubin level above the normal reference range, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count)
- Positive polyspecific direct antiglobulin test (DAT)
- Monospecific DAT strongly positive for C3d
- Cold agglutinin titer greater than or equal to 64 measured at 4 degree celsius
- Direct antiglobulin test (DAT) result for Immunoglobulin G (IgG) of 1 plus or less

AND

2 - Patient does not have cold agglutinin syndrome secondary to other factors (e.g., overt hematologic malignancy, primary immunodeficiency, infection, rheumatologic disease, systemic lupus erythematosus or other autoimmune disorders)

AND

3 - Baseline hemoglobin level less than or equal to 10.0 gram per deciliter (g/dL)

AND

4 - One of the following:

- Prescribed dose will not exceed 6,500 mg on day 0, 7, and every 14 days thereafter for patients weighing between 39 kg to less than 75 kg
- Prescribed dose will not exceed 7,500 mg on day 0, 7, and every 14 days thereafter for patients for patients weighing 75 kg or greater

AND

5 - Prescribed by or in consultation with a hematologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating positive clinical response to therapy as evidenced by ALL of the following:

- The patient has not required any blood transfusions after the first 5 weeks of therapy with Enjaymo
- Hemoglobin level greater than or equal to 12 gram per deciliter (g/dL) or increased greater than or equal to 2 g/dL from baseline

AND

2 - One of the following:

- Prescribed dose will not exceed 6,500 mg on day 0, 7, and every 14 days thereafter for patients weighing between 39 kg to less than 75 kg
- Prescribed dose will not exceed 7,500 mg on day 0, 7, and every 14 days thereafter for patients for patients weighing 75 kg or greater

AND

3 - Prescribed by or in consultation with a hematologist

2 . Background

Clinical Practice Guidelines

Weight-Based Dosing

The dosing is 6,500mg or 7,500mg Enjaymo (based on body weight) intravenously over approximately 60 minutes on Day 0, Day 7, and every 14 days thereafter	
Body Weight Range	Dose
39kg to less than 75kg	6,500 mg

75kg or greater	7,500 mg

3 . Revision History

Date	Notes
3/23/2023	New program

Prior Authorization Guideline

Guideline ID	GL-99451
Guideline Name	Entocort EC
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Entocort EC, generic budesonide	
Diagnosis	Chrohn's Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Entocort EC is being used for the treatment of Crohn's disease	

2 . Revision History

Date	Notes
3/10/2021	Bulk Copied C&S Arizona standard to Arizona Medicaid for 7/1 effecti ve

Prior Authorization Guideline

Guideline ID	GL-300286
Guideline Name	Entyvio (vedolizumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Entyvio IV	
Diagnosis	Crohn's Disease (CD)
Approval Length	14 Weeks
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active Crohn's disease

AND

2 - One of the following:

- Frequent diarrhea and abdominal pain
- At least 10% weight loss
- Complications such as obstruction, fever, abdominal mass
- Abnormal lab values (e.g., C-reactive protein [CRP])
- CD Activity Index (CDAI) greater than 220

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- azathioprine
- corticosteroids (e.g., prednisone)
- methotrexate

AND

4 - One of the following:

4.1 Paid claims or submission of medical records (e.g., chart notes) confirming history of failure, contraindication, or intolerance to ALL of the following :

- A preferred adalimumab biosimilar
- infliximab
- A preferred ustekinumab biosimilar

OR

4.2 Paid claims or submission of medical records (e.g., chart notes) confirming continuation of prior Entyvio therapy, defined as no more than a 45-day gap in therapy

AND

5 - Prescribed by or in consultation with a gastroenterologist

Product Name:Entyvio IV	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

AND

2 - Prescribed by or in consultation with a gastroenterologist

Product Name:Entyvio IV	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	4 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis

AND

2 - One of the following:

- Greater than 6 stools per day
- Frequent blood in the stools
- Frequent urgency
- Presence of ulcers
- Abnormal lab values (e.g., hemoglobin, ESR, CRP)
- Dependent on, or refractory to, corticosteroids

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
- Azathioprine
- Corticosteroids (e.g., prednisone)

AND

4 - One of the following:

4.1 Paid claims or submission of medical records (e.g., chart notes) confirming history of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

OR

4.2 Paid claims or submission of medical records (e.g., chart notes) confirming continuation of prior Entyvio therapy, defined as no more than a 45-day gap in therapy

AND

5 - Prescribed by or in consultation with a gastroenterologist

AND

6 - Entyvio IV formulation will be used for induction purposes only and patient will be switched to the Entyvio SC (subcutaneous) formulation for week 6 dose

Product Name:Entyvio IV	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	N/A - Requests for Entyvio IV should be denied
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Requests for continuing Entyvio IV therapy should be denied. The plan's preferred product is Entyvio SC (SC will require PA)	
Notes	Requests for continuing Entyvio IV therapy should be denied. The pla n's preferred product for UC indication is Entyvio SC (SC will require PA)

Product Name:Entyvio SC	
Diagnosis	Crohn's Disease (CD), Ulcerative Colitis (UC)
Approval Length	14 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - One of the following:

1.1 All of the following:

1.1.1 Submission of medical records (e.g., chart notes) confirming a diagnosis of one of the following:

- Moderately to severely active Crohn's disease
- Moderately to severely active ulcerative colitis

AND

1.1.2 Paid claims or submission of medical records (e.g., chart notes) confirming ONE of the following:

1.1.2.1 Will be used as a maintenance dose following two doses of Entyvio IV* for induction

OR

1.1.2.2 Patient is currently established on Entyvio IV*

AND

1.1.3 Prescribed by or in consultation with a gastroenterologist

OR

1.2 Patient has received 2 doses of Entyvio IV* for induction

Notes	* This product will require prior authorization

Product Name:Entyvio SC	
Diagnosis	Crohn's Disease (CD), Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

2 . Revision History

Date	Notes
7/3/2025	Updated preferred agents/embedded steps, updated criteria through out.

Prior Authorization Guideline

Guideline ID	GL-146018
Guideline Name	Eohilia (budesonide)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2024

1 . Criteria

Product Name:Eohilia	
Diagnosis	Eosinophilic Esophagitis (EoE)
Approval Length	12 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of eosinophilic esophagitis (EoE)

AND

2 - Patient has symptoms of esophageal dysfunction (e.g., dysphagia, food impaction, heartburn, abdominal pain)

AND

3 - Patient has at least 15 intraepithelial eosinophils per high power field (HPF)

AND

4 - Other causes of esophageal eosinophilia have been excluded

AND

5 - Patient is 11 years of age or older

AND

6 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure (of a minimum 8-week duration), contraindication, or intolerance to a proton pump inhibitor (e.g., pantoprazole, omeprazole)

AND

7 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure (of a minimum 8-week duration), or intolerance to a topical (esophageal) corticosteroid (e.g., budesonide, fluticasone)

AND

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

- Allergist/Immunologist
- Gastroenterologist

2 . Revision History

Date	Notes
4/23/2024	New program

Prior Authorization Guideline

Guideline ID	GL-99453
Guideline Name	Epaned
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Epaned	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is less than 8 years of age

OR

1.2 BOTH of the following:

1.2.1 ONE of the following diagnoses:

- Hypertension
- Heart failure
- Asymptomatic left ventricular dysfunction, defined as left ventricular ejection fraction less than or equal to 35%

AND

1.2.2 ONE of the following:

1.2.2.1 History of failure, contraindication, or intolerance to TWO formulary oral anti-hypertensives (e.g., angiotensin-converting enzyme (ACE) inhibitor, ACE inhibitor combination, angiotensin-receptor blockers (ARB), ARB combination, thiazide diuretic)

OR

1.2.2.2 Patient is unable to ingest a solid dosage form (e.g. an oral tablet or capsule) due to ONE of the following:

- Oral/motor difficulties
- Dysphagia

2 . Revision History

Date	Notes
3/10/2021	Bulk Copied C&S Arizona standard to Arizona Medicaid for 7/1 effecti ve

Prior Authorization Guideline

Guideline ID	GL-269193
Guideline Name	Epinephrine Products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Epinephrine Pens (Non-Mylan Manufacturer)*, Neffy	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - There is a shortage on Epinephrine Pens manufactured by Mylan.	
Notes	*Only approve other rebatable epinephrine autoinjectors if both the br anded EpiPen and authorized generic are on the FDA shortage list.

Product Name:Epinephrine Pens (Mylan Manufacturer)

Approval Length	6 month(s)
Guideline Type	Quantity Limit
Approval Criteria **1** - Medication has been used or lost or the member is going on vacation.*	
Notes	*Only approve other rebatable epinephrine autoinjectors if both the br anded EpiPen and authorized generic are on the FDA shortage list

2 . Revision History

Date	Notes
5/29/2025	Added new Neffy GPI

Prior Authorization Guideline

Guideline ID	GL-99454
Guideline Name	Eplerenone- Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Inspra, generic eplerenone	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

1.1 Symptomatic heart failure with reduced ejection fraction (HFrEF) after an acute myocardial infarction

OR **1.2** Hypertension

2 . Revision History

Date	Notes
3/10/2021	Bulk Copied C&S Arizona standard to Arizona Medicaid for 7/1 effecti ve

Prior Authorization Guideline

Guideline ID	GL-108675
Guideline Name	Epsolay (benzoyl peroxide) cream
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2022

1 . Criteria

Product Name:Epsolay	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of rosacea

AND

2 - Patient has inflammatory lesions

AND

3 - Trial and failure (of a minimum 30-day supply), contraindication or intolerance to one preferred topical product for rosacea (e.g., metronidazole cream/gel/lotion) (verified via paid pharmacy claims)

2 . Revision History

Date	Notes
6/24/2022	New Program

Prior Authorization Guideline

Guideline ID	GL-554249
Guideline Name	Ergot Alkaloids
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Brekiya injection, Brand Migranal nasal spray, Generic dihydroergotamine mesylate nasal spray, Trudhesa nasal spray	
Diagnosis	Migraines
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of migraine headaches with or without aura	

AND

2 - Will be used for the acute treatment of migraine

AND

3 - Patient is 18 years of age or older

AND

4 - History of failure, contraindication, or intolerance to TWO preferred 5-HT1 (5-hydroxytryptamine-1) receptor agonist (triptan) alternatives [eg, Imitrex (sumatriptan), Maxalt or Maxalt-MLT (rizatriptan)]

Product Name:Brekiya injection, Brand Migranal nasal spray, Generic dihydroergotamine mesylate nasal spray, Trudhesa nasal spray	
Diagnosis	Migraines
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea)

Product Name:Brekiya injection	
Diagnosis	Cluster Headaches
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cluster headache

AND

2 - Patient is 18 years of age or older

AND

3 - Trial and failure, contraindication, or intolerance to sumatriptan injection

Product Name:Brekiya injection	
Diagnosis	Cluster Headaches
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

2 . Revision History

Date	Notes
3/24/2026	Added Brekiya and Trudhesa as targets, added criteria for cluster he adaches, updated guideline name.

Prior Authorization Guideline

Guideline ID	GL-325192
Guideline Name	Erythropoietic Agents - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Preferred: Retacrit	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic kidney disease (CKD)	

AND

2 - Hematocrit is less than 30% at initiation of therapy

AND

3 - ONE of the following:

3.1 Patient is on dialysis

OR

3.2 ALL of the following:

3.2.1 Patient is NOT on dialysis

AND

3.2.2 The rate of hematocrit decline indicates the likelihood of requiring a red blood cell (RBC) transfusion

AND

3.2.3 Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal

Product Name:Preferred: Retacrit	
Diagnosis	Anemia Due to Chronic Kidney Disease (CKD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD)

AND

2 - ONE of the following:

2.1 Both of the following:

- Patient is on dialysis
- Most recent or average Hct over 3 months is 33% or less (Hgb 11 g/dL or less)

OR

2.2 All of the following:

- Patient is NOT on dialysis
- Most recent or average (avg) Hct over 3 mo is 30% or less (Hgb 10 g/dL or less)
- Reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal

OR

2.3 Both of the following:

- Request is for a pediatric patient
- Most recent or average Hct over 3 mo is 36% or less (Hgb 12 g/dL or less)

AND

3 - One of the following:

- Decrease in the need for blood transfusion
- Hemoglobin (Hgb) increased greater than or equal to 1g/dL from pre-treatment level

Product Name:Preferred: Retacrit	
Diagnosis	Anemia Associated with Zidovudine Treatment in HIV-Infected Patients
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is receiving zidovudine administered at less than or equal to 4200 milligrams per week

AND

2 - Endogenous serum erythropoietin level is less than or equal to 500 milliunits per milliliter

AND

3 - Hematocrit is less than 30% at initiation of therapy

Product Name:Preferred: Retacrit	
Diagnosis	Anemia Due to Cancer Chemotherapy
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Hematocrit less than 30% at initiation of therapy

AND

2 - There is a minimum of two additional months of planned chemotherapy

Product Name:Preferred: Retacrit	
Diagnosis	Preoperative Use for Reduction of Allogeneic Blood Transfusions in Surgery Patients
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Perioperative hematocrit is greater than 30% and less than or equal to 39%

AND

2 - Patient is at high risk for blood loss during surgery

AND

3 - Patient is unable or unwilling to donate autologous blood

AND

4 - Surgery procedure is elective, non-cardiac, and non-vascular

Product Name:Preferred: Retacrit	
Diagnosis	Anemia Associated with Myelodysplastic Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of myelodysplastic disease (MDS)

AND

2 - ONE of the following:

- Serum erythropoietin level less than or equal to 500 milliunits per milliliter
- Hematocrit is less than or equal to 30% at the initiation of therapy

Product Name:Preferred: Retacrit	
Diagnosis	Anemia Associated with Myelodysplastic Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Hematocrit remains less than 36%

OR

1.2 Patient has demonstrated a response to therapy

Product Name:Preferred: Retacrit	
Diagnosis	Anemia in Patients with Hepatitis C with Ribavirin and Interferon Therapy
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hepatitis C virus (HCV) infection

AND

2 - Patient is receiving ribavirin and interferon therapy

AND

3 - Hematocrit is less than or equal to 30% at initiation of therapy

Product Name:Preferred: Retacrit*	
Diagnosis	Anemia in Patients with Hepatitis C with Ribavirin and Interferon Therapy
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Hematocrit remains less than 36%

OR

1.2 Patient has demonstrated a response to therapy

Notes	*NOTE: Authorization will be issued for 12 months or if patient has de monstrated response to therapy, authorization will be issued for the ful l course of ribavirin therapy.

Product Name:Preferred: Retacrit*	
Diagnosis	Erythropoietin Stimulating Agents –Off-Label Uses
Guideline Type	Prior Authorization

Approval Criteria

1 - Off-label requests will be evaluated on a case-by-case basis by a clinical pharmacist

AND

2 - Requests for coverage in patients with hemoglobin (Hgb) greater than 10 grams per deciliter or hematocrit (Hct) greater than 30% will not be approved

Notes	*If the request is deemed medically necessary, the authorization will b e issued for requested length of therapy.

Product Name:Non-Preferred*: Aranesp, Epogen, Mircera, Procrit, and newly launched erythropoietin stimulating agents	
Approval Length	Requests for Non-Preferred biosimilars are not approved at this time
Guideline Type	Prior Authorization

Approval Criteria

1 - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred product is Retacrit. **Please note: The drug(s) listed above may require additional review.

Notes	*Patients must use preferred erythropoietin stimulating agent (Retacrit).

2 . Revision History

Date	Notes
7/16/2025	Updated preferred/NPD agents, updated criteria throughout. Updated NP section verbiage.

Prior Authorization Guideline

Guideline ID	GL-620196
Guideline Name	Esbriet, Jascayd, Ofev
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/20/2026

1 . Criteria

Product Name:Preferred: generic pirfenidone 267mg capsules, generic nintedanib 100mg and 150mg capsules (Sandoz mfg); Non-Preferred: Brand Esbriet, generic pirfenidone tablets, Brand Pirfenidone 534 mg tablets, Jascayd, Brand Ofev, generic nintedanib capsules (not mfg by Sandoz)	
Diagnosis	Idiopathic Pulmonary Fibrosis (IPF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of idiopathic pulmonary fibrosis (IPF) as documented by ALL of the following criteria:

1.1 Exclusion of other known causes of interstitial lung disease (e.g. domestic and occupational environmental exposures, connective tissue disease, and drug toxicity), as documented by the following:

- ICD-10 Code J84.112 (Idiopathic pulmonary fibrosis)

AND

1.2 ONE of the following:

1.2.1 In patients NOT subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF

OR

1.2.2 In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern reveal IPF or probable IPF

AND

2 - Requested agent is not being used in combination with another agent for IPF [e.g., Esbriet (pirfenidone), Jascayd, or Ofev (nintedanib)]

AND

3 - Prescribed by or in consultation with a pulmonologist

AND

4 - For Non-Preferred requests: patient has tried and failed, or has intolerance to BOTH of the following:

- generic pirfenidone 267mg capsules

• generic nintedanib (Sandoz mfg)	
Notes	PA Team: Please approve preferred generic nintedanib at NDC level

Product Name:Preferred: generic pirfenidone 267mg capsules, generic nintedanib 100mg and 150mg capsules (Sandoz mfg); Non-Preferred: Brand Esbriet, generic pirfenidone tablets, Brand Pirfenidone 534 mg tablets, Jascayd, Brand Ofev, generic nintedanib capsules (not mfg by Sandoz)	
Diagnosis	Idiopathic Pulmonary Fibrosis (IPF)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Requested agent is not being used in combination with another agent for IPF [e.g., Esbriet (pirfenidone), Jascayd, or Ofev (nintedanib)]

AND

3 - Prescribed by or in consultation with a pulmonologist

AND

4 - For Non-Preferred requests: patient has tried and failed, or has intolerance to BOTH of the following:

- generic pirfenidone 267mg capsules
- generic nintedanib (Sandoz mfg)

Notes	PA Team: Please approve preferred generic nintedanib at NDC level

Product Name:Preferred: generic nintedanib 100mg and 150mg capsules (Sandoz mfg); Non-Preferred: Brand Ofev, generic nintedanib capsules (not mfg by Sandoz)	
Diagnosis	Systemic Sclerosis-associated Interstitial Lung Disease (SSc-ILD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of systemic sclerosis (SSc) - associated interstitial lung disease as documented by ALL of the following:

1.1 ONE of the following:

1.1.1 Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints

OR

1.1.2 TWO of the following:

- Skin thickening of the fingers (e.g., puffy fingers, sclerodactyly of the fingers)
- Fingertip lesions (e.g., digital tip ulcers, fingertip pitting scars)
- Telangiectasia
- Abnormal nailfold capillaries
- Pulmonary arterial hypertension
- Raynaud's phenomenon
- SSc-related autoantibodies (e.g., anticentromere, anti-topoisomerase I, anti-RNA polymerase III)

AND

1.2 Presence of interstitial lung disease as determined by finding evidence of pulmonary fibrosis on high-resolution computed tomography (HRCT), involving at least 10 percent of the lungs

AND

2 - Prescribed by or in consultation with a pulmonologist

AND

3 - For Non-Preferred requests: patient has tried and failed, or has intolerance to generic nintedanib (Sandoz mfg)

Notes	PA Team: Please approve preferred generic nintedanib at NDC level

Product Name:Preferred: generic nintedanib 100mg and 150mg capsules (Sandoz mfg); Non-Preferred: Brand Ofev, generic nintedanib capsules (not mfg by Sandoz)	
Diagnosis	Systemic Sclerosis-associated Interstitial Lung Disease (SSc-ILD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a pulmonologist

AND

3 - For Non-Preferred requests: patient has tried and failed, or has intolerance to generic nintedanib (Sandoz mfg)

Notes	PA Team: Please approve preferred generic nintedanib at NDC level

Product Name:Preferred: generic nintedanib 100mg and 150mg capsules (Sandoz mfg); Non-Preferred: Brand Ofev, generic nintedanib capsules (not mfg by Sandoz), Jascayd	
Diagnosis	Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a Progressive Phenotype, Progressive Pulmonary Fibrosis (PPF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Chronic fibrosing interstitial lung disease
- Progressive pulmonary fibrosis (PPF)

AND

2 - Patient does not have idiopathic pulmonary fibrosis

AND

3 - BOTH of the following:

3.1 Presence of fibrotic ILD as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10 percent of the lungs

AND

3.2 Patient is presenting with clinical signs of progression as defined by ONE of the following in the previous 24 months:

3.2.1 Forced vital capacity (FVC) decline of greater than 10 percent

OR

3.2.2 TWO of the following:

- FVC decline of greater than or equal to 5 percent, but less than 10 percent
- Patient is experiencing worsening respiratory symptoms
- Patient is exhibiting increasing extent of fibrotic changes on chest imaging

AND

4 - Prescribed by or in consultation with a pulmonologist

AND

5 - For Non-Preferred requests: patient has tried and failed, or has intolerance to generic nintedanib (Sandoz mfg)

Notes	PA Team: Please approve preferred generic nintedanib at NDC level

Product Name:Preferred: generic nintedanib 100mg and 150mg capsules (Sandoz mfg); Non-Preferred: Brand Ofev, generic nintedanib capsules (not mfg by Sandoz), Jascayd	
Diagnosis	Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a Progressive Phenotype, Progressive Pulmonary Fibrosis (PPF)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a pulmonologist

AND

3 - For Non-Preferred requests: patient has tried and failed, or has intolerance to generic nintedanib (Sandoz mfg)	
Notes	PA Team: Please approve preferred generic nintedanib at NDC level

2 . Revision History

Date	Notes
5/20/2026	Updated PA Team note for clarification

Prior Authorization Guideline

Guideline ID	GL-99455
Guideline Name	Estrogens- Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Femring	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe vasomotor symptoms due to menopause

OR

2 - Diagnosis of moderate to severe vulvar and vaginal atrophy due to menopause

Product Name:Premarin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of atrophic vaginitis and kraurosis vulvae	

2 . Revision History

Date	Notes
3/10/2021	Bulk Copied C&S Arizona standard to Arizona Medicaid for 7/1 effecti ve

Prior Authorization Guideline

Guideline ID	GL-117636
Guideline Name	Eucrisa
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name:Eucrisa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 History of failure, contraindication, or intolerance to ONE topical corticosteroid [e.g., mometasone furoate, fluocinolone acetonide (generic Synalar), fluocinonide]

AND

1.2 ONE of the following:

1.2.1 Patient is less than 2 years of age

OR

1.2.2 Patient is greater than or equal to 2 years of age and has history of failure, contraindication, or intolerance to ONE topical calcineurin inhibitor [e.g., pimecrolimus (generic Elidel), tacrolimus (generic Protopic)]

2 . Revision History

Date	Notes
12/4/2022	Changed from ST to PA

Prior Authorization Guideline

Guideline ID	GL-642233
Guideline Name	Everolimus Products (Afinitor, Torpenz, Yulithira)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Neuroendocrine tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Neuroendocrine tumors of pancreatic origin

- Neuroendocrine tumors of gastrointestinal origin
- Neuroendocrine tumors of lung origin
- Neuroendocrine tumors of thymic origin

AND

2 - Disease is progressive

AND

3 - One of the following:

- Disease is unresectable
- Disease is locally advanced
- Disease is metastatic

AND

4 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz orTorpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC leve l

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Renal cell cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of renal cell cancer

AND

2 - One of the following:

2.1 Disease has relapsed

OR

2.2 BOTH of the following

- Medically or surgically unresectable tumor
- Diagnosis of Stage IV disease

AND

3 - One of the following:

3.1 Patient with non-clear cell histology

OR

3.2 Both of the following:

3.2.1 Patient with predominantly clear cell histology

AND

3.2.2 History of failure, contraindication, or intolerance to at least one prior systemic therapy [e.g., Nexavar (sorafenib), Sutent (sunitinib), Opdivo (nivolumab), Cabometyx (cabozantinib)]

AND

4 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC leve l

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Renal Angiomyolipoma with Tuberous Sclerosis Complex
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of renal angiomyolipoma and tuberous sclerosis complex (TSC), not requiring immediate surgery **AND** **2** - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)	
Notes	PA Team: Please approve preferred everolimus products at NDC leve l

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Subependymal Giant Cell Astrocytoma Associated with Tuberous Sclerosis Complex
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of subependymal giant cell astrocytoma (SEGA) associated with tuberous sclerosis (TS)

AND

2 - Patient is not a candidate for curative surgical resection

AND

3 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC leve l

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Waldenströms Macroglobulinemia or Lymphoplasmacytic Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Waldenströms macroglobulinemia
- Lymphoplasmacytic lymphoma

AND

2 - One of the following:

- Disease is non-responsive to primary treatment
- Disease is progressive

- Disease has relapsed

AND

3 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC leve l

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Breast Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of breast cancer

AND

2 - One of the following:

2.1 Disease is recurrent

OR

2.2 Disease is metastatic

AND

3 - One of the following:

3.1 Disease is hormone receptor positive (HR+) [i.e., estrogen-receptor-positive (ER+) or progesterone-receptor-positive (PR+)]

OR

3.2 BOTH of the following:

- Disease is hormone receptor negative (HR-)
- Disease has clinical characteristics that predict a HR+ tumor

AND

4 - Disease is human epidermal growth factor receptor 2 (HER2)-negative

AND

5 - One of the following:

5.1 Patient is a postmenopausal woman

OR

5.2 BOTH of the following:

- Patient is a premenopausal woman
- Patient is being treated with ovarian ablation/suppression

OR

5.3 Patient is male

AND

6 - One of the following:

6.1 Both of the following:

6.1.1 Used in combination with Aromasin (exemestane)

AND

6.1.2 One of the following:

6.1.2.1 Disease progressed while on or within 12 months of non-steroidal aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole)] therapy

OR

6.1.2.2 Patient was treated with tamoxifen at any time

OR

6.2 Used in combination with ONE of the following:

- Fulvestrant
- Tamoxifen

AND

7 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC level

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Hodgkin Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of classical Hodgkin lymphoma

AND

2 - ONE of the following:

- Disease is refractory
- Disease has relapsed

AND

3 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC leve l

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	PEComa (perivascular epitheliod cell tumor), recurrent angiomyolipoma, lymphangioleiomyomatosis, or gastrointestinal stromal tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following

1.1 One of the following diagnoses:

- PEComa (perivascular epitheliod cell tumor)

- Recurrent angiomyolipoma
- Lymphangioleiomyomatosis

OR

1.2 All of the following:

1.2.1 Diagnosis of Gastrointestinal Stromal Tumor (GIST)

AND

1.2.2 Disease has progressed after single agent therapy with ONE of the following:

- Gleevec (imatinib)
- Sutent (sunitinib)
- Stivarga (regorafenib)

AND

1.2.3 Used in combination with ONE of the following:

- Gleevec (imatinib)
- Sutent (sunitinib)
- Stivarga (regorafenib)

AND

2 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC leve l

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Thymic Carcinoma or Thymoma
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

- Diagnosis of thymic carcinoma
- Diagnosis of thymoma

AND

2 - ONE of the following:

2.1 History of failure, contraindication, or intolerance to at least one prior first-line chemotherapy regimen

OR

2.2 Patient has extrathoracic metastatic disease

AND

3 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC leve l

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Follicular carcinoma, Hürthle cell carcinoma, or papillary carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Follicular carcinoma
- Hürthle cell carcinoma
- Papillary carcinoma

AND

2 - ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

3 - ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

4 - Disease is refractory to radioactive iodine treatment

AND

5 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC leve l

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Meningioma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of meningioma

AND

2 - Disease is recurrent or progressive

AND

3 - Surgery and/or radiation is not possible

AND

4 - Used in combination with bevacizumab (e.g., Avastin, Mvasi, Zirabev)

AND

5 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC leve l

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Endometrial Carcinoma

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

Approval Criteria

1 - Diagnosis of endometrial carcinoma

AND

2 - Used in combination with letrozole

AND

3 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC level

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	Tuberous Sclerosis Complex associated Partial-Onset Seizures
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of tuberous sclerosis complex associated partial-onset seizures

AND

2 - Used as adjunctive therapy

AND

3 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC level

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Use supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

AND

2 - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)

Notes	PA Team: Please approve preferred everolimus products at NDC level

Product Name:PREFERRED: generic everolimus tablet, generic everolimus tablet for oral suspension, Yulithira; NON-PREFERRED: Brand Afinitor, Brand Afinitor Disperz, Torpenz	
Diagnosis	All indications listed above
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy **AND** **2** - For Brand Afinitor/Afinitor Disperz or Torpenz requests only: History of failure, intolerance, or contraindication to generic everolimus tablet/tablet for oral suspension or Yulithira (Applies to requests for Brand Afinitor/Afinitor Disperz or Torpenz ONLY)	
Notes	PA Team: Please approve preferred everolimus products at NDC leve l

2 . Revision History

Date	Notes
6/25/2026	Yulithira to PDL (generic everolimus also preferred). Added note to approve preferred generic everolimus at NDC level, a dded step through preferred drugs to reauth.

Prior Authorization Guideline

Guideline ID	GL-427207
Guideline Name	Evkeeza (evinacumab-dgnb)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Evkeeza	
Diagnosis	Homozygous Familial Hypercholesterolemia [HoFH]
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is 1 year of age or older	

AND

2 - Submission of medical records (e.g. chart notes) documenting diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by one of the following:

2.1 Genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus

OR

2.2 Both of the following:

2.2.1 One of the following:

- Untreated/pre-treatment LDL-C greater than 500 mg/dL
- Treated LDL-C greater than 300 mg/dL

AND

2.2.2 One of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia in both parents

AND

3 - Submission of medical records (e.g., chart notes) demonstrating that patient has failed to achieve a low-density lipoprotein-cholesterol (LDL-C) goal of less than 100 mg/dL despite use of both of the following: *Paid pharmacy claims may be used to confirm trial requirements

3.1 One of the following:

3.1.1 Patient is currently treated with maximally tolerated statin therapy plus ezetimibe

OR

3.1.2 Patient is unable to tolerate statin therapy as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

OR

3.1.3 Patient has a labeled contraindication to all statins

OR

3.1.4 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

3.2 One of the following:

- Patient has been treated with PCSK9 therapy or did not respond to PCSK9 therapy
- Physician attests that the patient is known to have two LDL-receptor negative alleles (little to no residual function) and therefore would not respond to PCSK9 therapy
- Patient has a history of intolerance or contraindication to PCSK9 therapy
- Patient has previously been treated with Juxtapid (lomitapide)
- Patient has previously been treated with lipoprotein apheresis

AND

4 - Patient will continue other traditional lipid-lowering therapies (e.g., maximally tolerated statins, ezetimibe) in combination with Evkeeza

AND

5 - Dose will not exceed 15 milligrams per kilogram of bodyweight infused once every 4 weeks

AND

6 - Prescribed by one of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

Product Name:Evkeeza	
Diagnosis	Homozygous Familial Hypercholesterolemia [HoFH]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting LDL-C reduction from baseline while on Evkeeza therapy

AND

2 - Patient will continue other traditional lipid-lowering therapies (e.g., maximally tolerated statins, ezetimibe) in combination with Evkeeza

AND

3 - Dose will not exceed 15 milligrams per kilogram of bodyweight infused once every 4 weeks

AND

4 - Prescribed by one of the following:

- Cardiologist
- Endocrinologist

• Lipid specialist

2 . Revision History

Date	Notes
10/29/2025	Updated age criterion due to expanded approval.

Prior Authorization Guideline

Guideline ID	GL-224200
Guideline Name	Evrysdi (risdiplam)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:Evrysdi	
Diagnosis	Spinal Muscular Atrophy (SMA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of spinal muscular atrophy (SMA)	

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in ONE of the following:

2.1 Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)

OR

2.2 Compound heterozygous mutation of SMN1 gene [e.g., deletion of SMN1 exon 7 (allele 1) and mutation of SMN1 (allele 2)]

AND

3 - Patient is not dependent on invasive ventilation or tracheostomy

AND

4 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

5 - Patient is not receiving concomitant chronic survival motor neuron (SMN)-modifying therapy [e.g., Spinraza (nusinersen)]

AND

6 - Patient has not previously received gene replacement therapy for the treatment of SMA [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

AND

7 - Submission of medical records (e.g., chart notes, laboratory values) documenting the baseline assessment of at least ONE of the following exams (based on patient age and motor ability) to establish baseline motor ability (baseline motor function analysis could include assessments evaluated prior to receipt of previous chronic SMN-modifying therapy if transitioning therapy)*:

- Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)
- Hammersmith Infant Neurological Exam Part 2 (HINE-2)
- Hammersmith Functional Motor Scale Expanded (HFMSE)
- Upper Limb Module (ULM) Test
- Motor Function Measure 32 (MFM-32) Scale

AND

8 - Prescribed by a neurologist with expertise in the treatment of SMA

Notes	*Baseline assessments for patients less than 2 months of age request ing Evrysdi are not necessary in order not to delay access to initial the rapy in recently diagnosed infants. Initial assessments shortly post-the rapy can serve as baseline with respect to efficacy reauthorization ass essment.

Product Name:Evrysdi	
Diagnosis	Spinal Muscular Atrophy (SMA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) with the most recent results documenting a positive clinical response to Evrysdi compared to pretreatment baseline status [inclusive of baseline assessments prior to receipt of previous chronic survival motor neuron (SMN)-modifying therapy] as demonstrated by at least ONE of the following exams:

1.1 Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) with ONE of the following:

1.1.1 Improvement or maintenance of previous improvement of at least a 4-point increase in score from pretreatment baseline

OR

1.1.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.2 Hammersmith Infant Neurological Exam Part 2 (HINE-2) with ONE of the following:

1.2.1 Improvement or maintenance of previous improvement of at least a 2-point (or maximal score) increase in ability to kick

OR

1.2.2 Improvement or maintenance of previous improvement of at least a 1-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp

OR

1.2.3 The patient exhibited improvement, or maintenance of previous improvement, in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)

OR

1.2.4 Patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so

OR

1.3 Hammersmith Functional Motor Scale Expanded (HFMSE) with ONE of the following:

1.3.1 Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

OR

1.3.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.4 Upper Limb Module (ULM) with ONE of the following:

1.4.1 Improvement or maintenance of previous improvement of at least a 2-point increase in score from pretreatment baseline

OR

1.4.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

1.5 Motor Function Measure 32 (MFM-32) with ONE of the following:

1.5.1 Improvement or maintenance of previous improvement of at least a 3-point increase in score from pretreatment baseline

OR

1.5.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

AND

2 - Patient is not dependent on invasive ventilation or tracheostomy

AND

3 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

4 - Patient is not receiving concomitant chronic SMN-modifying therapy [e.g., Spinraza (nusinersen)]

AND

5 - Patient has not previously received gene replacement therapy for the treatment of spinal muscular atrophy (SMA) [e.g., Zolgensma (onasemnogene abeparvovec-xioi)]

AND

6 - Prescribed by a neurologist with expertise in the treatment of SMA

2 . Revision History

Date	Notes
3/26/2025	Added new GPI for Evrysdi tablet

Prior Authorization Guideline

Guideline ID	GL-642272
Guideline Name	Exdensur (depemokimab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Exdensur	
Diagnosis	Severe Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming diagnosis of severe asthma

AND

2 - Submission of documentation (e.g., chart notes, lab values) confirming asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter

AND

3 - One of the following:

3.1 Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months

OR

3.2 Prior asthma-related hospitalization within the past 12 months

AND

4 - Patient is 12 years of age or older

AND

5 - Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications (verified via paid pharmacy claims):

5.1 Both of the following:

- High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta• Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium])

AND

5.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate 500mcg/ salmeterol 50mcg], Symbicort [budesonide 160mcg/ formoterol 4.5mcg], Breo Ellipta [fluticasone 200mcg/ vilanterol 25mcg])

AND

6 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to ALL of the following:

- Dupixent (dupilumab)
- Fasenra (benralizumab)
- Xolair (omalizumab)

AND

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

- Pulmonologist
- Allergist/Immunologist

Product Name:Exdensur	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a positive clinical response to therapy (e.g., reduction in clinically significant exacerbations requiring systemic corticosteroids)

AND

2 - Paid claims or submission of documentation (e.g., chart notes) confirming patient

continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to ALL of the following:

- Dupixent (dupilumab)
- Fasenra (benralizumab)
- Xolair (omalizumab)

AND

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

- Pulmonologist
- Allergist/Immunologist

2 . Background

Clinical Practice Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 1. Low, medium and high daily doses of inhaled corticosteroids in adolescents and adults 12 years and older

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	200-500	> 500-1000	> 1000
Beclometasone dipropionate (DPI or pMDI, extrafine particle*, HFA)	100-200	> 200-400	> 400

Budesonide (DPI, or pMDI, standard particle, HFA)	200-400	> 400-800	> 800
Ciclesonide (pMDI, extrafine particle*, HFA)	80-160	> 160-320	> 320
Fluticasone furoate (DPI)	100		200
Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (pMDI, standard particle, HFA)	100-250	> 250-500	> 500
Mometasone furoate (DPI)	Depends on DPI device – see product information		
Mometasone furoate (pMDI, standard particle, HFA)	200-400		> 400

DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information.

***This is not a table of equivalence**,* but instead, suggested total daily doses for the 'low', 'medium' and 'high' dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country -specific depending on local availability, regulatory labelling and clinical guidelines.

For new preparations, including generic ICS, the manufacturer's information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.

3 . Revision History

Date	Notes
6/24/2026	Dupixent Preferred 10/1/26: updated step for asthma

Prior Authorization Guideline

Guideline ID	GL-530191
Guideline Name	Exondys 51 (eteplirsen)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Exondys 51	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of Duchenne muscular dystrophy (DMD)

AND

1.2 Disease is confirmed by the presence of a mutation of the dystrophin gene amenable to exon 51 skipping

AND

2 - Patient is 7 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Dose will not exceed 30 milligrams per kilogram of body weight once weekly

AND

5 - Submission of medical records including results of baseline North Star Ambulatory Assessment (NSAA) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) as evidenced by NSAA scoring

AND

6 - Patient will not receive Exondys 51 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

Product Name:Exondys 51	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is tolerating therapy

AND

2 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

3 - Dose will not exceed 30 milligrams per kilogram of body weight once weekly

AND

4 - Submission of medical records including results of recent North Star Ambulatory Assessment (NSAA) confirming patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) as evidenced by NSAA scoring

AND

5 - Patient will not receive Exondys 51 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]

2 . Revision History

Date	Notes
2/26/2026	Added submission of NSAA testing for confirmation of ambulatory sta tus.

Prior Authorization Guideline

Guideline ID	GL-131964
Guideline Name	Ezallor Sprinkle (rosuvastatin)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2023

1 . Criteria

Product Name:Ezallor	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Patient is less than 10 years of age

AND

1.1.2 Prescribed by or in consultation with a cardiologist

OR

1.2 Both of the following:

1.2.1 Medication is being used for one of the following:

1.2.1.1 To reduce the risk of one of the following:

- Myocardial infarction (MI), stroke, revascularization procedures, and angina in adults with multiple risk factors for coronary heart disease (CHD) but without clinically evident CHD
- MI and stroke in adults with type 2 diabetes mellitus with multiple risk factors for CHD but without clinically evident CHD
- Non-fatal MI, fatal and non-fatal stroke, revascularization procedures, hospitalization for congestive heart failure, and angina in adults with clinically evident CHD

OR

1.2.1.2 As an adjunct to diet to reduce low-density lipoprotein cholesterol (LDL-C) in one of the following:

- Adults with primary hyperlipidemia
- Adults and pediatric patients aged 10 years and older with heterozygous familial hypercholesterolemia (HeFH)

OR

1.2.1.3 As an adjunct to other LDL-C-lowering therapies, or alone if such treatments are unavailable, to reduce LDL-C in adults and pediatric patients aged 7 years and older with homozygous familial hypercholesterolemia (HoFH)

OR

1.2.1.4 As an adjunct to diet for the treatment of adults with one of the following:

- Primary dysbetalipoproteinemia
- Hypertriglyceridemia

AND

1.2.2 One of the following:

1.2.2.1 Trial and failure, contraindication, or intolerance to generic rosuvastatin tablets (verified via paid pharmacy claims or submitted chart notes)

OR

1.2.2.2 Patient is unable to swallow oral tablets

2 . Revision History

Date	Notes
8/29/2023	New program

Prior Authorization Guideline

Guideline ID	GL-707207
Guideline Name	Fabhalta (iptacopan)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Fabhalta	
Diagnosis	Paroxysmal nocturnal hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)	

AND

2 - Hemoglobin level of less than 10 g/dL

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

Product Name:Fabhalta	
Diagnosis	paroxysmal nocturnal hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions)

Product Name:Fabhalta	
Diagnosis	Immunoglobulin A nephropathy (IgAN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN)

AND

2 - Patient is at risk for disease progression (e.g., proteinuria of at least 0.5 g/day, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool)

AND

3 - Used to slow kidney function decline

AND

4 - One of the following:

4.1 Patient has been on a minimum 90-day trial of a maximally tolerated dose of one of the following:

- An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

OR

4.2 Patient has a contraindication or intolerance to both ACE inhibitors and ARBs

AND

5 - Prescribed by or in consultation with a nephrologist

Product Name:Fabhalta	
Diagnosis	Immunoglobulin A nephropathy (IgAN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates a positive clinical response to therapy as demonstrated by a decrease in urine protein-to-creatinine ratio (UPCR) from baseline

Product Name:Fabhalta	
Diagnosis	Complement 3 Glomerulopathy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of kidney complement 3 glomerulopathy (C3G)

AND

2 - Used to reduce proteinuria

AND

3 - Patient is on a maximally tolerated renin-angiotensin system (RAS) inhibitor (e.g., benazepril, lisinopril, losartan, valsartan)

AND

4 - Patient has not had a kidney transplant

AND

5 - Prescribed by or in consultation with a nephrologist

Product Name:Fabhalta	
Diagnosis	Complement 3 Glomerulopathy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates a positive clinical response to therapy (e.g., reduction in 24-hour UPCR, stable or improved eGFR compared to baseline)

AND

2 - Patient is on a maximally tolerated renin-angiotensin system (RAS) inhibitor (e.g., benazepril, lisinopril, losartan, valsartan)

AND

3 - Patient has not had a kidney transplant

2 . Revision History

Date	Notes
8/26/2026	IgAN: Updated criteria due to revised indication and updated KDIGO guidelines

Prior Authorization Guideline

Guideline ID	GL-150054
Guideline Name	Fabry Disease Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

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

Approval Criteria

1 - Diagnosis of Fabry disease

AND

2 - Patient is 2 years of age or older

AND

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

- Detection of pathogenic mutations in the GLA gene by molecular genetic testing
- Deficiency in α-galactosidase A (α-Gal A) enzyme activity in plasma, isolated leukocytes, or dried blood spots (DBS)
- Significant clinical manifestations (e.g., neuropathic pain, cardiomyopathy, renal insufficiency, angiokeratomas, cornea verticillata)

AND

4 - Will not be used in combination with Galafold (migalastat)

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

Approval Criteria

1 - Diagnosis of Fabry disease

AND

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

- Detection of pathogenic mutations in the GLA gene by molecular genetic testing
- Deficiency in α-galactosidase A (α-Gal A) enzyme activity in plasma, isolated leukocytes, or dried blood spots (DBS)
- Significant clinical manifestations (e.g., neuropathic pain, cardiomyopathy, renal insufficiency, angiokeratomas, cornea verticillata)

AND **3** - Will not be used in combination with Galafold (migalastat)

Product Name:Fabrazyme, Elfabrio	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
7/20/2024	Added new GPI for Elfabrio

Prior Authorization Guideline

Guideline ID	GL-642200
Guideline Name	Fasenra (benralizumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Fasenra	
Diagnosis	Severe Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming diagnosis of severe asthma

AND

2 - Submission of documentation (e.g., chart notes, lab values) confirming asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter

AND

3 - One of the following:

3.1 Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months

OR

3.2 Prior asthma-related hospitalization within the past 12 months

AND

4 - One of the following:

4.1 Both of the following:

4.1.1 Patient is 6 years of age or older but less than 12 years of age

AND

4.1.2 Paid claims or submission of medical records (e.g., chart notes) confirming patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications:

4.1.2.1 Both of the following:

- Medium-dose inhaled corticosteroid (e.g., greater than 100 – 200 mcg fluticasone propionate equivalent/day)

- Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium])

OR

4.1.2.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

OR

4.2 Both of the following:

4.2.1 Patient is 12 years of age or older

AND

4.2.2 Paid claims or submission of medical records (e.g., chart notes) confirming patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications:

4.2.2.1 Both of the following:

- High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium])

OR

4.2.2.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

AND

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

- Pulmonologist

- Allergist/Immunologist

Product Name:Fasenra	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a positive clinical response to therapy as evidenced by one of the following:

- A reduction in asthma exacerbations
- Improvement in forced expiratory volume in 1 second [FEV1] from baseline

AND

2 - Paid claims or submission of documentation (e.g., chart notes) confirming patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications

AND

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

- Pulmonologist
- Allergist/Immunologist

Product Name:Fasenra	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)

AND

2 - Submission of medical records (e.g., chart notes) confirming patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy)

AND

3 - Submission of medical records (e.g., chart notes) confirming patient is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone) unless there is a contraindication or intolerance to corticosteroid therapy

AND

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

- Pulmonologist
- Rheumatologist
- Allergist/Immunologist

Product Name:Fasenra	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy (e.g., increase in remission time)

AND

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

- Pulmonologist
- Rheumatologist
- Allergist/Immunologist

Product Name:Fasenra	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of hypereosinophilic syndrome (HES)

AND

2 - Patient is 12 years of age or older

AND

3 - Provider attests that other non-hematologic secondary causes of HES have been ruled out

(e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy)

AND

4 - Patient is Fip1-like1-platelet-derived growth factor receptor alpha (FIP1L1-PDGFRA)-negative

AND

5 - Patient has uncontrolled HES defined as both of the following:

5.1 Pre-treatment blood eosinophil count greater than or equal to 1000 cells

AND

5.2 One of the following:

5.2.1 History of 2 or more flares within the past 12 months

OR

5.2.2 Signs or symptoms of active HES flare (e.g., dyspnea)

AND

6 - Trial and failure, contraindication, or intolerance to one of the following:

- Corticosteroid therapy (e.g., prednisone)
- Cytotoxic/immunosuppressive therapy (e.g., hydroxyurea, cyclosporine, imatinib)

AND

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

- Allergist/Immunologist

- Hematologist

Product Name:Fasenra	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy (e.g., reduction in flares, decreased blood eosinophil count, reduction in corticosteroid dose)

2 . Background

Clinical Practice Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 1. Low, medium and high daily doses of inhaled corticosteroids in adolescents and adults 12 years and older [4]

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	200-500	> 500-1000	> 1000
Beclometasone dipropionate (DPI or pMDI, extrafine particle*, HFA)	100-200	> 200-400	> 400
Budesonide (DPI, or pMDI, standard particle, HFA)	200-400	> 400-800	> 800
Ciclesonide (pMDI, extrafine particle*, HFA)	80-160	> 160-320	> 320

Fluticasone furoate (DPI)	100		200
Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (pMDI, standard particle, HFA)	100-250	> 250-500	> 500
Mometasone furoate (DPI)	Depends on DPI device – see product information		
Mometasone furoate (pMDI, standard particle, HFA)	200-400		> 400

DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information.

***This is not a table of equivalence**,* but instead, suggested total daily doses for the 'low', 'medium' and 'high' dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country -specific depending on local availability, regulatory labelling and clinical guidelines.

For new preparations, including generic ICS, the manufacturer's information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 2. Low, medium and high daily doses of inhaled corticosteroids in children 6 – 11 years [4]

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	100-200	> 200-400	> 400
Beclometasone dipropionate (pMDI, extrafine particle, HFA)	50-100	> 100-200	> 200
Budesonide (DPI, or pMDI, standard particle, HFA)	100-200	> 200-400	> 400
Budesonide (nebules)	250-500	>500-1000	>1000

Ciclesonide (pMDI, extrafine particle*, HFA)	80	>80-160	>160
Fluticasone furoate (DPI)	50		n.a.
Fluticasone propionate (DPI)	50-100	> 100-200	> 200
Fluticasone propionate (pMDI, standard particle, HFA)	50-100	> 100-200	> 200
Mometasone furoate (pMDI, standard particle, HFA)	100		200

DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information.

***This is not a table of equivalence**,* but instead, suggested total daily doses for the 'low', 'medium' and 'high' dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country -specific depending on local availability, regulatory labelling and clinical guidelines.

For new preparations, including generic ICS, the manufacturer's information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.

3 . Revision History

Date	Notes
6/25/2026	Added criteria for new HES indication

Prior Authorization Guideline

Guideline ID	GL-128980
Guideline Name	Fecal Microbiota Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name:Rebyota	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming diagnosis of recurrent clostridioides difficile infection (CDI) as defined by both of the following:

- Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive days
- A positive stool test for C.difficile toxin or toxigenic C.difficile

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has a history of one or more recurrent episodes of CDI

AND

4 - Submission of medical records (e.g., chart notes) confirming BOTH of the following:

4.1 Patient has completed at least 10 consecutive days of one of the following antibiotic therapies between 24 to 72 hours prior to initiating Rebyota*:

- oral vancomycin
- Dificid (fidaxomicin)

AND

4.2 Previous episode of CDI is under control (e.g., less than 3 unformed/loose [i.e., Bristol Stool Scale type 6-7] stools/day for 2 consecutive days)

AND

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

- Gastroenterologist
- Infectious disease specialist

Notes	*Trial requirements may be verified via paid pharmacy claims or submission of medical records/chart notes

Product Name:Vowst	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming diagnosis of recurrent clostridioides difficile infection (CDI) as defined by both of the following:

- Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive days
- A positive stool test for C.difficile toxin or toxigenic C.difficile

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has a history of two or more recurrent episodes of CDI within 12 months

AND

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

4.1 Patient has completed at least 10 consecutive days of one of the following antibiotic therapies 2-4 days prior to initiating Vowst*:

- oral vancomycin
- Dificid (fidaxomicin)

AND

4.2 Patient has completed the recommended course of magnesium citrate the day before and at least 8 hours prior to initiating Vowst [A]

AND

4.3 Previous episode of CDI is under control (e.g., less than 3 unformed/loose [i.e., Bristol Stool Scale type 6-7] stools/day for 2 consecutive days)

AND **5** - Prescribed by or in consultation with one of the following: • Gastroenterologist • Infectious disease specialist

Notes	*Trial requirements may be verified via paid pharmacy claims or submission of medical records/chart notes

2 . Endnotes

A. Patients are required to take magnesium citrate 24 hours prior to the first dose of Vowst per the prescribing information. There is currently no efficacy data regarding the use of Vowst without magnesium citrate and the thought is that it helps to clear the antibiotics prior to administration of Vowst. [2,3]

3 . Revision History

Date	Notes
7/26/2023	New program

Prior Authorization Guideline

Guideline ID	GL-99519
Guideline Name	Fentanyl IR
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Fentanyl citrate lozenges (generic Actiq)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records demonstrating use is for the management of breakthrough pain associated with a cancer diagnosis (cancer diagnosis must be documented)

AND

2 - Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids (Document drug and date of trial):

- Morphine sulfate at a doses of greater than or equal to 60 milligrams per day
- Fentanyl transdermal patch at a dose of greater than or equal to 25 micrograms per hour
- Oxycodone at a dose of greater than or equal to 30 milligrams per day
- Oral hydromorphone at a dose of greater than or equal to 8 milligrams per day
- Oral oxymorphone at a dose of greater than or equal to 25 milligrams per day
- An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 milligrams per day)

AND

3 - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug)

AND

4 - ONE of the following:

4.1 The patient is not concurrently receiving an alternative fentanyl transmucosal product

OR

4.2 BOTH of the following:

4.2.1 The patient is currently receiving an alternative transmucosal fentanyl product

AND

4.2.2 The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

Product Name:Abstral, Brand Actiq, Brand Fentora, generic fentanyl citrate buccal tablet, Lazanda, Subsys

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records demonstrating use is for the management of breakthrough pain associated with a cancer diagnosis (cancer diagnosis must be documented)

AND

2 - Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids (Document drug and date of trial):

- Morphine sulfate at a doses of greater than or equal to 60 milligrams per day
- Fentanyl transdermal patch at a dose of greater than or equal to 25 micrograms per hour
- Oxycodone at a dose of greater than or equal to 30 milligrams per day
- Oral hydromorphone at a dose of greater than or equal to 8 milligrams per day
- Oral oxymorphone at a dose of greater than or equal to 25 milligrams per day
- An alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 milligrams per day)

AND

3 - The patient is currently taking a long-acting opioid around the clock for cancer pain (Document drug)

AND

4 - ONE of the following:

4.1 The patient is not concurrently receiving an alternative fentanyl transmucosal product

OR

4.2 BOTH of the following:

4.2.1 The patient is currently receiving an alternative transmucosal fentanyl product

AND

4.2.2 The prescriber is requesting the termination of all current authorizations for alternative transmucosal fentanyl products in order to begin treatment with the requested medication (Only one transmucosal fentanyl product will be approved at a time. If previous authorizations cannot be terminated, the PA request will be denied)

AND

5 - History of failure, contraindication, or intolerance to Fentanyl citrate lozenges (generic Actiq) [Document date of trial]

2 . Revision History

Date	Notes
6/8/2021	Arizona Medicaid 7.1 Implementation

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-99458
Guideline Name	Fexmid (cyclobenzaprine 7.5mg)- Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Fexmid 7.5mg, generic cyclobenzaprine 7.5mg	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of muscle spasm associated with acute, painful musculoskeletal conditions

AND

2 - Reason or special circumstance the patient cannot use cyclobenzaprine 5 milligram (mg) or 10mg tablet

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona standard to Medicaid Arizona

Prior Authorization Guideline

Guideline ID	GL-620202
Guideline Name	Filspari (sparsentan)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Filspari	
Diagnosis	Primary immunoglobulin A nephropathy (IgAN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting diagnosis of primary immunoglobulin A nephropathy (IgAN) as confirmed by a kidney biopsy

AND

2 - Patient is at risk for disease progression (e.g., proteinuria of at least 0.5 g/day, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool

AND

3 - Used to slow kidney function decline

AND

4 - Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 30 mL/min/1.73 m2

AND

5 - Submission of medical records (e.g., chart notes) demonstrating patient has been on a minimum 90-day trial of a maximally tolerated dose of one of the following (paid pharmacy claims may be used to confirm appropriate trial):

- An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

AND

6 - Medication will not be used in combination with any of the following:

- Angiotensin receptor blockers or angiotensin receptor-neprilysin inhibitor (ARNI) [e.g., Entresto (sacubitril/valsartan)]
- Endothelin receptor antagonists (ERAs) [e.g., Letairis (ambrisentan), Tracleer (bosentan), Opsumit (macitentan)]
- Tekturna (aliskiren)

AND

7 - Prescribed by or in consultation with a nephrologist

AND

8 - Prescriber is certified/enrolled in the Filspari REMS (Risk Evaluation and Mitigation Strategy) Program

Product Name:Filspari	
Diagnosis	Primary immunoglobulin A nephropathy (IgAN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy as demonstrated by a decrease in urine protein-to-creatinine ratio (UPCR) from baseline

AND

2 - Medication is not taken in combination with any of the following:

- Angiotensin receptor blockers or angiotensin receptor-neprilysin inhibitor (ARNI) [e.g., Entresto (sacubitril/valsartan)]
- Endothelin receptor antagonists (ERAs) [e.g., Letairis (ambrisentan), Tracleer (bosentan), Opsumit (macitentan)]
- Tekturna (aliskiren)

AND

3 - Prescriber is certified/enrolled in the Filspari REMS (Risk Evaluation and Mitigation Strategy) Program

Product Name:Filspari	
Diagnosis	Focal Segmental Glomerulosclerosis

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of focal segmental glomerulosclerosis

AND

2 - Used to reduce proteinuria

AND

3 - Patient is 8 years of age or older

AND

4 - Patient does not have nephrotic syndrome

AND

5 - Medication is not taken in combination with any of the following:

- Angiotensin receptor blockers or angiotensin receptor-neprilysin inhibitor (ARNI) [e.g., Entresto (sacubitril/valsartan)]
- Endothelin receptor antagonists (ERAs) [e.g., Letairis (ambrisentan), Tracleer (bosentan), Opsumit (macitentan)]
- Tekturna (aliskiren)

AND

6 - Prescribed by or in consultation with a nephrologist

AND

7 - Prescriber is certified/enrolled in the Filspari REMS (Risk Evaluation and Mitigation Strategy) Program

Product Name:Filspari	
Diagnosis	Focal Segmental Glomerulosclerosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy (e.g., UPCR reduction from baseline)

AND

2 - Medication is not taken in combination with any of the following:

- Angiotensin receptor blockers or angiotensin receptor-neprilysin inhibitor (ARNI) [e.g., Entresto (sacubitril/valsartan)]
- Endothelin receptor antagonists (ERAs) [e.g., Letairis (ambrisentan), Tracleer (bosentan), Opsumit (macitentan)]
- Tekturna (aliskiren)

AND

3 - Prescriber is certified/enrolled in the Filspari REMS (Risk Evaluation and Mitigation Strategy) Program

2 . Revision History

Date	Notes
6/25/2026	Added criteria for new indication of FSGS

Prior Authorization Guideline

Guideline ID	GL-641219
Guideline Name	Filsuvez (birch triterpenes)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Filsuvez	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Dystrophic epidermolysis bullosa (DEB)
- Junctional epidermolysis bullosa (JEB)

AND

2 - Disease is confirmed by one of the following:

2.1 Genetic testing confirms mutation in one of the following genes:

2.1.1 For Dystrophic epidermolysis bullosa (DEB), collagen type VII (COL7A1)

OR

2.1.2 For Junctional epidermolysis bullosa (JEB), one of the following:

- ITGA6
- ITGB4
- collagen type XVII (COL17A1)
- LAMA3
- LAMB3
- LAMC2
- ITGA3
- LAMA3A

OR

2.2 Skin biopsy

AND

3 - Patient is 6 months of age or older

AND

4 - Medication is being used for the treatment of wounds

AND

5 - DEB or JEB associated wounds are present for at least 21 days

AND

6 - Patient does not have signs of infection for wound being treated

AND

7 - Patient has no evidence or history of basal or squamous cell carcinoma for wound being treated

AND

8 - Patient does not have history of stem cell transplant

AND

9 - Medication is not being used concurrently with other FDA approved therapies (e.g.,Vyjuvek) for the treatment of epidermolysis bullosa

AND

10 - Standard wound care management not adequate in healing wounds (e.g., daily wound dressings, pain management, controlling infections)

AND

11 - Prescribed by or in consultation with a specialist with expertise in wound care

Product Name:Filsuvez	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by wound is healing but not completely closed

AND

2 - Patient does not have signs of infection for wound being treated

AND

3 - Patient has no evidence or history of basal or squamous cell carcinoma for wound being treated

AND

4 - Prescribed by or in consultation with a specialist with expertise in wound care

AND

5 - Medication is not being used concurrently with other FDA approved therapies (e.g.,Vyjuvek) for the treatment of epidermolysis bullosa

2 . Revision History

Date	Notes
6/25/2026	Updated concurrent use criterion verbiage, also added to reauth.

Prior Authorization Guideline

Guideline ID	GL-116131
Guideline Name	Firdapse
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2022

1 . Criteria

Product Name:Firdapse	
Diagnosis	Lambert-Eaton myasthenic syndrome (LEMS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient has a diagnosis of Lambert-Eaton myasthenic syndrome (LEMS)	

AND

2 - Patient is not receiving Firdapse in combination with similar potassium channel blockers [e.g., Ampyra (dalfampridine), Ruzurgi (amiframpridine)]

AND

3 - Patient is 6 years of age or older

Product Name:Firdapse	
Diagnosis	Lambert-Eaton myasthenic syndrome (LEMS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Firdapse therapy

AND

2 - Patient is not receiving Firdapse in combination with similar potassium channel blockers [e.g., Ampyra (dalfampridine), Ruzurgi (amifampridine)]

2 . Revision History

Date	Notes
10/27/2022	Added age requirement

Prior Authorization Guideline

Guideline ID	GL-99520
Guideline Name	Flucytosine- Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Ancobon, generic flucytosine	
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Diagnosis of septicemia, endocarditis or a urinary system infection caused by Candida species

OR

1.2 Diagnosis of meningitis or a pulmonary infection caused by Cryptococcus species

AND

2 - If the patient is being treated for a systemic infection, flucytosine is being used in combination with amphotericin B

Product Name:Brand Ancobon, generic flucytosine*	
Diagnosis	Infectious Diseases Society of America (IDSA) Recommended Regimens
Guideline Type	Prior Authorization
Approval Criteria **1** - The medication is being prescribed by or in consultation with an infectious disease specialist.	
Notes	*Approval duration based on provider recommended treatment duratio ns, up to 12 months.

2 . Revision History

Date	Notes
5/13/2021	Arizona Medicaid 7.1 Implementation

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-747200
Guideline Name	Forteo and Teriparatide Products, Prolia and Denosumab 60mg Products, Tymlos
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Preferred Drugs: Brand Forteo, Bildyos	
Diagnosis	Patients with osteoporosis at high risk for fracture
Approval Length	12 Months**
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of osteoporosis	

AND

2 - ONE of the following:

2.1 Bone Mineral Density (BMD) T-score less than or equal to -3.5 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [NOTE: Provider must submit patient specific BMD T-score]

OR

2.2 BOTH of the following:

2.2.1 BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [NOTE: Provider must submit patient specific BMD T-score]

AND

2.2.2 ONE of the following:

2.2.2.1 History of ONE of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.2.2.2 History of failure, contraindication, or intolerance to ONE conventional osteoporosis therapy [e.g., bisphosphonate or selective estrogen receptor modulator (SERM)] (Document drug, date, and duration of trial)**

OR

2.3 ALL of the following:

2.3.1 BMD T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [NOTE: Provider must submit patient specific BMD T-score]

AND

2.3.2 ONE of the following:

2.3.2.1 History of ONE of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.3.2.2 ONE of the following Fracture Risk Assessment Tool (FRAX) 10-year fracture probabilities:

- Major osteoporotic fracture at 20 percent or more
- Hip fracture at 3 percent or more

AND

2.3.3 History of failure, contraindication, or intolerance to ONE conventional osteoporosis therapy [e.g., bisphosphonate or selective estrogen receptor modulator (SERM)] (Document drug, date, and duration of trial)*

AND

3 - For Brand Forteo Requests ONLY: Treatment duration has not exceeded a total of 24 months** of cumulative use of parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos) during the patient's lifetime (APPLIES TO BRAND FORTEO ONLY)

Notes	*Claims history may be used in conjunction as documentation of drug, date, and duration of trial **Duration of coverage will be limited to 24 months of cumulative parat

	hyroid hormone analog therapy (e.g., Forteo, Tymlos) in the patient's l ifetime

Product Name:Non-Preferred Drugs: Bonsity, Bosaya, Conexxence, Enoby, Jubbonti, Ospomyv, Osvyrti, Prolia, Stoboclo, Brand Teriparatide, generic teriparatide, Tymlos	
Diagnosis	Patients with osteoporosis at high risk for fracture
Approval Length	12 Months**
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of osteoporosis

AND

2 - ONE of the following:

2.1 Bone Mineral Density (BMD) T-score less than or equal to -3.5 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [NOTE: Provider must submit patient specific BMD T-score]

OR

2.2 BOTH of the following:

2.2.1 BMD T-score between -2.5 and -3.5 (BMD T-score greater than -3.5 and less than or equal to -2.5) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [NOTE: Provider must submit patient specific BMD T-score]

AND

2.2.2 ONE of the following:

2.2.2.1 History of ONE of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.2.2.2 History of failure, contraindication, or intolerance to BOTH of the following (Document drug, date, and duration of trial):

- bisphosphonate (e.g. ALENDRONATE, IBANDRONATE)
- selective estrogen receptor modulator (SERM) (e.g RALOXIFENE)

OR

2.3 ALL of the following:

2.3.1 BMD T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) [NOTE: Provider must submit patient specific BMD T-score]

AND

2.3.2 ONE of the following:

2.3.2.1 History of ONE of the following resulting from minimal trauma:

- Vertebral compression fracture
- Fracture of the hip
- Fracture of the distal radius
- Fracture of the pelvis
- Fracture of the proximal humerus

OR

2.3.2.2 ONE of the following Fracture Risk Assessment Tool (FRAX) 10-year fracture probabilities:

- Major osteoporotic fracture at 20 percent or more
- Hip fracture at 3 percent or more

AND

2.3.3 History of failure, contraindication, or intolerance to BOTH of the following (Document drug, date, and duration of trial)

- bisphosphonate (e.g. ALENDRONATE, IBANDRONATE)
- selective estrogen receptor modulator (SERM) (e.g RALOXIFENE)

AND

3 - Treatment duration has not exceeded a total of 24 months** of cumulative use of parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos) during the patient's lifetime

AND

4 - History of failure, contraindication, or intolerance to BOTH of the following preferred drugs:

- Bildyos (denosumab-nxxp)
- Brand Forteo (teriparatide)

Notes	*Claims history may be used in conjunction as documentation of drug, date, and duration of trial **Duration of coverage will be limited to 24 months of cumulative parat hyroid hormone analog therapy (e.g., Forteo, Tymlos) in the patient's l ifetime

Product Name:Preferred Drugs: Brand Forteo, Bildyos; Non-Preferred Drugs: Bonsity, Bosaya, Conexxence, Enoby, Jubbonti, Ospomyv, Osvyrti, Prolia, Stoboclo, Brand Teriparatide, generic teriparatide, Tymlos	
Diagnosis	Patients with osteoporosis at high risk for fracture
Approval Length	12 Months*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - Treatment duration has not exceeded a total of 24 months* of cumulative use of parathyroid hormone analogs (e.g., Teriparatide Injection, Forteo, Tymlos) during the patient's lifetime)

AND

3 - For Non-Preferred Drug requests ONLY, one of the following:

3.1 Requests for Non-Preferred denosumab products (e.g., Brand Prolia, Enoby, Jubbonti): History of failure, contraindication, or intolerance to the preferred denosumab product Bildyos (denosumab-nxxp)

OR

3.2 Requests for Non-Preferred teriparatide products (e.g., Brand Teriparatide, Bonsity) or Tymlos: History of failure, contraindication, or intolerance to the preferred teriparatide product Brand Forteo (teriparatide)

Notes	*Duration of coverage will be limited to 24 months of cumulative parat hyroid hormone analog therapy (e.g., Forteo, Tymlos) in the patient's l ifetime

2 . Revision History

Date	Notes
10/28/2026	Updated step for NPD drugs in initial and reauth criteria.

Prior Authorization Guideline

Guideline ID	GL-481198
Guideline Name	Forzinity (elamipretide)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of Barth syndrome

AND

2 - Disease is confirmed by the presence of a mutation in the Tafazzin gene

AND

3 - Patient weight is greater than or equal to 30kg

AND

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

- geneticist
- cardiologist
- neurologist
- specialist focused on the treatment of metabolic disorders

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in knee extensor muscle strength or 6 minute walking test, quality of life)

2 . Revision History

Date	Notes
12/17/2025	New program

Prior Authorization Guideline

Guideline ID	GL-700352
Guideline Name	Furosemide injection products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Furoscix, Furoscix ReadyFlow	
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

- chronic heart failure
- chronic kidney disease

AND

2 - Drug will be used for the treatment of edema

AND

3 - Patient weighs at least 43 kg

AND

4 - Patient is currently on maintenance oral diuretic therapy (e.g., bumetanide, furosemide, torsemide)

AND

5 - Provider attests that patient will be closely monitored for fluid, electrolyte, and metabolic abnormalities throughout therapy (e.g., hypokalemia, hypovolemia, hyponatremia)

AND

6 - Submission of medical records (e.g., chart notes) or paid claims documenting one of the following:

6.1 History of failure to intravenous furosemide (Lasix IV)

OR

6.2 Provider has submitted clinical rationale for why intravenous furosemide is inappropriate

Product Name:Lasix Onyu	
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting diagnosis of chronic heart failure

AND

2 - Drug will be used for the treatment of edema

AND

3 - Patient is currently on maintenance oral diuretic therapy (e.g., bumetanide, furosemide, torsemide)

AND

4 - Provider attests that patient will be closely monitored for fluid, electrolyte, and metabolic abnormalities throughout therapy (e.g., hypokalemia, hypovolemia, hyponatremia)

AND

5 - Submission of medical records (e.g., chart notes) or paid claims documenting one of the following:

5.1 History of failure to intravenous furosemide (Lasix IV)

OR

5.2 Provider has submitted clinical rationale for why intravenous furosemide is inappropriate

2 . Revision History

Date	Notes
8/26/2026	Added new GPI for Furoscix ReadyFlow, added tx of edema to Furoscix criteria.

Prior Authorization Guideline

Guideline ID	GL-99613
Guideline Name	Galafold
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Galafold	
Diagnosis	Fabry disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Fabry disease

AND

2 - Patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data

AND

3 - Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta)

Product Name:Galafold	
Diagnosis	Fabry disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Galafold therapy

AND

2 - Patient is not receiving Galafold in combination with Fabrazyme (agalsidase beta)

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona SP to Medicaid Arizona SP for 7/1 eff

Prior Authorization Guideline

Guideline ID	GL-396204
Guideline Name	Gamifant (emapalumab-lzsg)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Gamifant	
Diagnosis	Primary Hemophagocytic Lymphohistiocytosis (HLH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of primary hemophagocytic lymphohistiocytosis (HLH)

AND

2 - Submission of medical records (e.g., chart notes) or paid claims confirming one of the following:

2.1 Disease is one of the following:

- Refractory
- Recurrent
- Progressive

OR

2.2 Trial and failure, contraindication, or intolerance to conventional HLH therapy (e.g., etoposide, dexamethasone, cyclosporine A, intrathecal methotrexate)

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

AND

4 - Patient has not received hematopoietic stem cell transplantation (HSCT)

Product Name:Gamifant	
Diagnosis	Primary Hemophagocytic Lymphohistiocytosis (HLH)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical

response to therapy (e.g., improvement in hemoglobin/lymphocyte/platelet counts, afebrile, normalization of inflammatory factors/markers)

AND

2 - Patient has not received HSCT

Product Name:Gamifant	
Diagnosis	Hemophagocytic Lymphohistiocytosis (HLH)/Macrophage Activation Syndrome (MAS) in Still's disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

- Diagnosis of active hemophagocytic lymphohistiocytosis (HLH)/macrophage activation syndrome (MAS)
- Disease occurs in known or suspected Still's disease [e.g., systemic Juvenile Idiopathic Arthritis (sJIA), adult onset Still's disease (AOSD)]

AND

2 - Submission of medical records (e.g., chart notes) or paid claims confirming one of the following:

- Trial and failure, contraindication, or intolerance to high-dose corticosteroids (e.g., methylprednisolone, prednisone)
- Patient experiences recurrent MAS

AND

3 - Prescribed by or in consultation with a rheumatologist/hematologist

Product Name:Gamifant	
Diagnosis	Hemophagocytic Lymphohistiocytosis (HLH)/Macrophage Activation Syndrome (MAS) in Still’s disease
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating a positive clinical response to therapy (e.g., improvement in leukocyte/platelet counts, afebrile, normalization of inflammatory factors/markers)

2 . Revision History

Date	Notes
9/25/2025	Added criteria for new indication

Prior Authorization Guideline

Guideline ID	GL-135438
Guideline Name	Gattex (teduglutide)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2023

1 . Criteria

Product Name:Gattex	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of short bowel syndrome

AND

1.2 Patient is 1 year of age and older

AND

1.3 Documentation that the patient is dependent on parenteral nutrition/intravenous (PN/IV) support for at least 12 consecutive months

AND

2 - Prescribed by or in consultation with a gastroenterologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that the patient has had a reduction in weekly parenteral nutrition/intravenous (PN/IV) support from baseline while on Gattex therapy

AND

2 - Prescribed by or in consultation with a gastroenterologist [C]

2 . Revision History

Date	Notes

10/27/2023	New program

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Prior Authorization Guideline

Guideline ID	GL-525287
Guideline Name	Gaucher's Disease Agents - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:NON-PREFERRED: Cerdelga	
Diagnosis	Type 1 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Type 1 Gaucher disease	

AND

2 - Patient is one of the following as detected by a Food and Drug Administration (FDA)-cleared test:

- CYP2D6 extensive metabolizer
- CYP2D6 intermediate metabolizer
- CYP2D6 poor metabolizer

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic miglustat (AG is preferred)

Product Name:NON-PREFERRED: Cerezyme	
Diagnosis	Type 1 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Type 1 Gaucher disease that results in one or more of the following conditions:

- Anemia
- Thrombocytopenia
- Bone disease
- Hepatomegaly or splenomegaly

AND

2 - Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to BOTH of the following:

- generic miglustat (AG preferred)

- Elelyso

Product Name:NON-PREFERRED: Cerezyme	
Diagnosis	Type 3 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Type 3 Gaucher disease

AND

2 - Presence of a non-central nervous system (CNS) manifestation (e.g., moderate to severe anemia, thrombocytopenia, bone disease, hepatomegaly, or splenomegaly)

Product Name:PREFERRED: Elelyso; NON-PREFERRED: Vpriv	
Diagnosis	Type 1 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Type 1 Gaucher disease

AND

2 - For VPRIV requests ONLY: Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to BOTH of the following:

- generic miglustat (AG preferred)
- Elelyso

Product Name:PREFERRED: generic miglustat (AG/Authorized Generic); NON-PREFERRED: Brand Zavesca, Yargesa, generic miglusat	
Diagnosis	Type 1 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of mild to moderate Type 1 Gaucher disease

AND

2 - For Non-Preferred Requests ONLY: Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic miglustat (AG is preferred)

Product Name:PREFERRED: generic miglustat (AG/Authorized Generic), Eleyso; NON-PREFERRED: Cerdelga, Cerezyme, Vpriv, Brand Zavesca, Yargesa, generic miglusat	
Diagnosis	Type 1 Gaucher Disease, Type 3 Gaucher Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
3/5/2026	Added criteria for Gaucher Type 3 for Cerezyme; updated preferred a gents/steps with Jan P&T changes (Miglustat AG preferred, Yargesa NPD).

Prior Authorization Guideline

Guideline ID	GL-99460
Guideline Name	Global Quantity Limits
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Quantity limit review (General)
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - ONE of the following:

1.1 The requested drug must be used for an FDA-approved indication

OR

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - The drug is being prescribed within the manufacturer's published dosing guidelines or falls within dosing guidelines found in ONE of the following compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

3 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation.

AND

4 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program.

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Quantity limit review for the treatment of gender dysphoria*
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - The drug is being prescribed for an indication that is recognized as a covered benefit by the applicable health plans' program.

Notes	* If the above criteria are not met, then refer for clinical review by an a ppropriate trained professional (physician or pharmacist) based on the applicable regulatory requirement.

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Monthly prescription limit review for migraine therapy, benzodiazepines, or muscle relaxants
Approval Length	1 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Medical necessity rationale provided for why the member requires 5 or more fills of the same drug or drug class within a month.

Notes	*If deemed medically necessary, longer authorization duration is perm itted

Product Name:Quantity Limit, Prescription Limit	
Diagnosis	Topical products exceeding the allowable package size per fill OR the allowable quantity per month

Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - The physician attests that a larger quantity is needed for treatment of a larger surface area.

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona standard to Medicaid Arizona

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Prior Authorization Guideline

Guideline ID	GL-749236
Guideline Name	GLP-1 Agonists - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Preferred Drugs: Mounjaro, Trulicity, Brand Victoza, generic liraglutide	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Submission of medical records (e.g. chart notes, lab values) confirming both of the following:

- Diagnosis of type 2 diabetes mellitus

- Baseline A1C greater than or equal to 6.5% (lab report MUST be submitted)

AND

1.2 Submission of medical records (e.g., chart notes) or verification of paid claims documenting one of the following:

- Verification of paid claims documenting history of failure to metformin at a minimum dose of 1500 milligrams (mg) daily for 90 days (Note: MUST be verified via paid claims)
- Patient has contraindication or intolerance to metformin

AND

2 - Patient is 10 years of age or older

AND

3 - Drug is not being used for weight loss

AND

4 - Provider attests that the requested medication will not be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use

AND

5 - Medication is not being co-administered with another GLP-1 receptor agonist [e.g., Mounjaro (tirzepatide), semaglutide, Trulicity (dulaglutide), Victoza (liraglutide)]

Notes	If requested medication is being used to treat appetite suppression/weight loss or improve conditions caused by obesity (i.e., Zepbound for OSA) – deny the case for Plan Exclusion. For all other indications deny the case for medical necessity and do not review for off-label use.

Product Name:Non-Preferred Drugs: Ozempic injection, Exenatide

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Submission of medical records (e.g. chart notes, lab values) confirming both of the following:

- Diagnosis of type 2 diabetes mellitus
- Baseline A1C greater than or equal to 6.5% (lab report MUST be submitted)

AND

1.2 Submission of medical records (e.g., chart notes) or verification of paid claims documenting one of the following:

- Verification of paid claims documenting history of failure to metformin at a minimum dose of 1500 milligrams (mg) daily for 90 days (Note: MUST be verified via paid claims)
- Patient has contraindication or intolerance to metformin

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting a history of a 90 day trial resulting in a therapeutic failure, contraindication, or intolerance to ALL of the following:

- Trulicity
- Brand Victoza or generic liraglutide
- Mounjaro

AND

3 - Patient is 18 years of age or older

AND

4 - Drug is not being used for weight loss

AND

5 - Provider attests that the requested medication will not be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use

AND

6 - Medication is not being co-administered with another GLP-1 receptor agonist [e.g., Mounjaro (tirzepatide), semaglutide, Trulicity (dulaglutide), Victoza (liraglutide)]

Notes	If requested medication is being used to treat appetite suppression/weight loss or improve conditions caused by obesity (i.e., Zepbound for OSA) – deny the case for Plan Exclusion. For all other indications deny the case for medical necessity and do not review for off-label use.

Product Name:Non-Preferred: Ozempic tablets, Rybelsus	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Submission of medical records (e.g. chart notes, lab values) confirming both of the following:

- Diagnosis of type 2 diabetes mellitus
- Baseline A1C greater than or equal to 6.5% (lab report MUST be submitted)

AND

1.2 Submission of medical records (e.g., chart notes) or verification of paid claims documenting one of the following:

- Verification of paid claims documenting history of failure to metformin at a minimum dose of 1500 milligrams (mg) daily for 90 days (Note: MUST be verified via paid claims)
- Patient has contraindication or intolerance to metformin

AND

2 - ONE of the following:

2.1 Submission of medical records (e.g., chart notes) or paid claims documenting a history of a 90 day trial resulting in a therapeutic failure, contraindication, or intolerance to ALL of the following:

- Trulicity
- Brand Victoza or generic liraglutide
- Mounjaro

OR

2.2 BOTH of the following:

2.2.1 Submission of medical records (e.g., chart notes) confirming that the patient is unable to self-inject due to ONE of the following:

- Physical impairment
- Visual impairment
- Lipohypertrophy
- Documented needle-phobia to the degree that the patient has previously refused any injectable therapy or medical procedure (refer to DSM-5 for specific phobia diagnostic criteria)

AND

2.2.2 Submission of medical records (e.g., chart notes) or paid claims documenting a history of a 90 day trial resulting in a therapeutic failure, contraindication, or intolerance to ALL of the following:

- Farxiga
- Jardiance
- Synjardy
- Xigduo XR

AND **3** - Patient is 18 years of age or older **AND** **4** - Drug is not being used for weight loss **AND** **5** - Provider attests that the requested medication will not be used concurrently with a DPP-4 inhibitor-containing agent [e.g., Januvia (sitagliptin), Jentadueto (linagliptin-metformin), Tradjenta (linagliptin)] or a plan has been developed to address concomitant use **AND** **6** - Medication is not being co-administered with another GLP-1 receptor agonist [e.g., Mounjaro (tirzepatide), semaglutide, Trulicity (dulaglutide), Victoza (liraglutide)]

Notes	If requested medication is being used to treat appetite suppression/weight loss or improve conditions caused by obesity (i.e., Zepbound for OSA) – deny the case for Plan Exclusion. For all other indications deny the case for medical necessity and do not review for off-label use.

2 . Revision History

Date	Notes
10/28/2026	Updated criteria to require lab values for A1C, claim verification of 90-day metformin trial, and added GLP-1 concomitant use criterion.

Prior Authorization Guideline

Guideline ID	GL-108674
Guideline Name	Glycopyrrolate Products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2022

1 . Criteria

Product Name:Brand Cuvposa oral solution, Dartisla ODT, Brand Robinul, Brand Robinul Forte	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes, lab work, imaging) documenting requested drug is being used for a Food and Drug Administration (FDA)-approved indication **AND**	

2 - Trial and failure or intolerance to generic glycopyrrolate tablets or oral solution (verified via pharmacy paid claims or submission of medical records/chart notes)

Product Name:Glycopyrrolate injection 0.6mg/3ml	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting requested drug is being used for a Food and Drug Administration (FDA)-approved indication

AND

2 - Trial and failure or intolerance to preferred glycopyrrolate injection strengths (e.g., 0.2 mg/ml, 0.4mg/2ml, 1 mg/5ml, 4mg/20ml) (verified via pharmacy paid claims or submission of medical records/chart notes)

2 . Revision History

Date	Notes
6/24/2022	Added NP glycopyrrolate inj as target. Changed guideline name to Glycopyrrolate Products.

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Prior Authorization Guideline

Guideline ID	GL-734191
Guideline Name	Gonadotropin-Releasing Hormone Agonists
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/14/2026

1 . Criteria

Product Name:Preferred: Fensolvi, Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg; Non-Preferred: Lupron Depot-Ped 3-Month (11.25mg and 30mg) and 6 month, Triptodur	
Diagnosis	Central Precocious Puberty (CPP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of central precocious puberty (idiopathic or neurogenic)	

AND

2 - Onset of secondary sexual characteristics in one of the following:

2.1 Females less than or equal to 8 years of age

OR

2.2 Males less than or equal to 9 years of age

AND

3 - Confirmation of diagnosis as defined by one of the following:

3.1 Pubertal basal level of luteinizing hormone (based on laboratory reference ranges)

OR

3.2 A pubertal luteinizing hormone response to a gonadotropin releasing hormone (GnRH) stimulation test

OR

3.3 Bone age advanced one year beyond the chronological age

AND

4 - For Non-Preferred requests: History of failure, contraindication, or intolerance to one of the following:

- Fensolvi
- Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg

Product Name:Preferred: Fensolvi, Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg; Non-Preferred: Lupron Depot-Ped 3-Month (11.25mg and 30mg) and 6 month, Triptodur	
Diagnosis	Central Precocious Puberty (CPP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is currently receiving therapy for central precocious puberty

AND

2 - Documentation of positive clinical response to therapy

AND

3 - Patient is ONE of the following (younger than the appropriate time point for the onset of puberty):

3.1 Female younger than 11 years of age

OR

3.2 Male younger than 12 years of age

AND

4 - For Non-Preferred requests, One of the following:

4.1 For Lupron Depot-Ped (3-Month and 6-Month) requests: Continuation of prior therapy (Applies to requests for Lupron Depot-Ped (3-Month and 6-Month) ONLY)

OR

4.2 History of failure, contraindication, or intolerance to one of the following:

- Fensolvi
- Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg

Product Name:Preferred: Lupron Depot 3.75 mg; Non-Preferred: Lupron Depot 3-month 11.25mg	
Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of endometriosis or endometriosis is suspected

AND

2 - One of the following:

2.1 History of failure, contraindication, or intolerance to both of the following:

2.1.1 Oral contraceptives or depot medroxyprogesterone (e.g., Depo- Provera)

AND

2.1.2 Non-steroidal anti-inflammatory drugs (NSAIDs)

OR

2.2 Patient has had surgical ablation to prevent recurrence

AND

3 - For Non-Preferred Requests, history of failure, contraindication, or intolerance to Lupron Depot 3.75 mg

Product Name:Preferred: Lupron Depot 3.75 mg; Non-Preferred: Lupron Depot 3-month 11.25mg	
Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of endometriosis or endometriosis is suspected

AND

2 - Recurrence of symptoms following an initial course of therapy

AND

3 - Concurrently to be used with add-back therapy (e.g., progestin, estrogen, or bone sparing agents)

AND

4 - For Non-Preferred Requests, history of failure, contraindication, or intolerance to Lupron Depot 3.75 mg

Product Name:Preferred: Lupron Depot 3.75 mg; Non-Preferred: Lupron Depot 3-month 11.25mg

Diagnosis	Uterine Leiomyomata (Fibroids)
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 For the treatment of uterine leiomyomata-related anemia

AND

1.1.2 Patient did not respond to iron therapy of 1 month duration

AND

1.1.3 For use prior to surgery

OR

1.2 For use prior to surgery to reduce the size of fibroids to facilitate a surgical procedure (e.g., myomectomy, hysterectomy)

AND

2 - For Non-Preferred Requests, history of failure, contraindication, or intolerance to Lupron Depot 3.75 mg

Product Name:Preferred: Fensolvi, Lupron Depot 3.75 mg, Lupron Depot 7.5mg, Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg; Non-Preferred: Leuprolide acetate inj kit 5mg/ml, Lupron Depot 3-Month (11.25mg and 22.5mg), 4-Month 30mg, 6-Month 45mg, Lutrate Depot, Lupron Depot-Ped 3-Month (11.25mg and 30mg) and 6 month, Triptodur	
Diagnosis	Gender dysphoria in adolescents less than 19 years old

Guideline Type	Prior Authorization

Approval Criteria

1 - Gonadotropin-Releasing Hormone Agonists used for gender dysphoria in adolescents less than 19 years of age are no longer covered under Medicaid and will be denied as benefit exclusion. If requested Gonadotropin-Releasing Hormone Agonist was started ON or BEFORE October 13, 2026, patient will be grandfathered for 6 months.

Notes	Note: Gonadotropin-Releasing Hormone Agonists (e.g., Fensolvi, Lupron) used for gender dysphoria in adolescents less than 19 years of age are no longer covered under Medicaid and will be denied as a benefit exclusion. If requested Gonadotropin-Releasing Hormone Agonist was started ON or BEFORE October 13, 2026, patients will be grandfathered for 6 months.

Product Name:Preferred: Fensolvi, Lupron Depot 3.75 mg, Lupron Depot 7.5mg, Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg; Non-Preferred: Leuprolide acetate inj kit 5mg/ml, Lupron Depot 3-Month (11.25mg and 22.5mg), 4-Month 30mg, 6-Month 45mg, Lutrate Depot, Lupron Depot-Ped 3-Month (11.25mg and 30mg) and 6 month, Triptodur	
Diagnosis	Adjunct for Gender-Affirming Hormonal Therapy for Transgender Adults age 19 and older
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 19 years of age or older

AND

2 - Diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional

AND

3 - Medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in transgender hormone therapy

AND

4 - Gonads (i.e., testes, ovaries) have not been removed and are functional (e.g., hormone producing)

AND

5 - Patient is currently receiving hormonal therapy (e.g., testosterone, estrogens, progesterones) to achieve the desired (e.g., non-natal) gender

AND

6 - Inability of cross sex hormone therapy to inhibit natal secondary sex characteristics, luteinizing hormone (LH), or gonadotropins (e.g., menses, testosterone)

AND

7 - A letter from the prescriber and/or formal documentation stating all of the following:

7.1 Transgender patient has identified goals of gender-affirming hormone therapy

AND

7.2 Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment have been addressed or removed

AND

7.3 Both of the following:

7.3.1 Current enrollment, attendance, and active participation in psychological and social support treatment program

AND

7.3.2 Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment

AND

7.4 Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

AND

8 - For Non-Preferred requests: History of failure, contraindication, or intolerance to one of the following:

- Fensolvi
- Lupron Depot 3.75 mg or 7.5mg
- Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg

Product Name:Preferred: Fensolvi, Lupron Depot 3.75 mg, Lupron Depot 7.5mg, Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg; Non-Preferred: Leuprolide acetate inj kit 5mg/ml, Lupron Depot 3-Month (11.25mg and 22.5mg), 4-Month 30mg, 6-Month 45mg, Lutrate Depot, Lupron Depot-Ped 3-Month (11.25mg and 30mg) and 6 month, Triptodur	
Diagnosis	Adjunct for Gender-Affirming Hormonal Therapy for Transgender Adults age 19 and older
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 19 years of age or older

AND

2 - One of the following:

- Documentation (within the last 6 months) of appropriate luteinizing hormone (LH) suppression
- Change in dosing

AND

3 - Documented diagnosis of gender dysphoria, according to the current Diagnostic and Statistical Manual of Mental Disorders (i.e., DSM-5) criteria, by a mental health professional

AND

4 - Medication is prescribed by or in consultation with an endocrinologist or a medical provider experienced in transgender hormone therapy

AND

5 - Gonads (i.e., testes, ovaries) are intact

AND

6 - Patient is currently receiving hormonal therapy (e.g., testosterone, estrogens, progesterones) to achieve the desired (e.g., non-natal) gender

AND

7 - Inability of cross sex hormone therapy to inhibit natal secondary sex characteristics, luteinizing hormone (LH), or gonadotropins (e.g., menses, testosterone)

AND

8 - A letter from the prescriber and/or formal documentation stating all of the following:

8.1 Transgender patient continues to meet goals of gender-affirming hormone therapy

AND

8.2 Coexisting psychiatric and medical comorbidities or social problems that may interfere with the diagnostic procedures or treatment continue to be addressed or removed

AND

8.3 Both of the following:

8.3.1 Current enrollment, attendance, and active participation in psychological and social support treatment program

AND

8.3.2 Patient will continue enrollment, attendance and active participation in psychological and social support throughout the course of treatment

AND

8.4 Patient demonstrates knowledge and understanding of the expected outcomes of treatment and related transgender therapies

AND

9 - For Non-Preferred requests, One of the following:

9.1 For Lupron Depot 6-Month and Lupron Depot-Ped (3-Month and 6-Month) requests: Continuation of prior therapy [Applies to requests for Lupron Depot 6-Month and Lupron Depot-Ped (3-Month and 6-Month) ONLY]

OR

9.2 History of failure, contraindication, or intolerance to one of the following:

- Fensolvi
- Lupron Depot 3.75 mg or 7.5mg
- Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg

Product Name:Preferred: Fensolvi, Lupron Depot 3.75 mg, Lupron Depot 7.5mg, Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg; Non-Preferred: Leuprolide acetate inj kit 5mg/ml, Lupron Depot 3-Month (11.25mg and 22.5mg), 4-Month 30mg, 6-Month 45mg, Lutrate Depot, Lupron Depot-Ped 3-Month (11.25mg and 30mg) and 6 month, Triptodur	
Diagnosis	Fertility Preservation
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - For use in pre-menopausal women

AND

2 - Patient is receiving a cytotoxic agent that is associated with causing primary ovarian insufficiency (premature ovarian failure) [e.g., Cytoxan (cyclophosphamide), procarbazine, vinblastine, cisplatin]

AND

3 - For Non-Preferred requests: History of failure, contraindication, or intolerance to one of the following:

- Fensolvi
- Lupron Depot 3.75 mg or 7.5mg
- Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg

Product Name:Preferred: Fensolvi, Lupron Depot 3.75 mg, Lupron Depot 7.5mg, Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg; Non-Preferred: Leuprolide acetate inj kit 5mg/ml, Lupron Depot 3-Month (11.25mg and 22.5mg), 4-Month 30mg, 6-Month 45mg, Lutrate Depot, Lupron Depot-Ped 3-Month (11.25mg and 30mg) and 6 month, Triptodur	
Diagnosis	Fertility Preservation
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is currently receiving gonadotropin-releasing hormone (GnRH) analog therapy for the purpose of fertility preservation

AND

2 - Patient continues to receive a cytotoxic agent that is associated with causing primary ovarian insufficiency (premature ovarian failure) [e.g., Cytoxan (cyclophosphamide), procarbazine, vinblastine, cisplatin]

AND

3 - For Non-Preferred requests, One of the following:

3.1 For Lupron Depot 6-Month and Lupron Depot-Ped (3-Month and 6-Month) requests: Continuation of prior therapy [Applies to requests for Lupron Depot 6-Month and Lupron Depot-Ped (3-Month and 6-Month) ONLY]

OR

3.2 History of failure, contraindication, or intolerance to one of the following:

- Fensolvi
- Lupron Depot 3.75 mg or 7.5mg
- Lupron Depot-Ped (1-month): 7.5 mg, 11.25 mg, or 15 mg

Product Name:Preferred: Eligard, Leuprolide inj 3-month 22.5mg, Lupron Depot 7.5mg; Non-Preferred: Leuprolide acetate inj kit 5mg/ml, Lupron Depot 3-Month 22.5mg, 4-Month 30mg, 6-Month 45mg, Lutrate Depot, Vabrinty, Camcevi	
Diagnosis	Advanced or Metastatic Prostate Cancer
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of advanced or metastatic prostate cancer

AND

2 - For Non-Preferred Requests, One of the following:

2.1 For Lupron Depot 6-Month requests: Continuation of prior therapy (Applies to requests for Lupron Depot 6-Month ONLY)

OR

2.2 History of failure, contraindication, or intolerance to one of the following:

- Eligard
- Leuprolide Inj 3-month 22.5mg
- Lupron Depot 7.5mg

2 . Revision History

Date	Notes
9/23/2026	Gender dysphoria and gender-affirming hormonal therapy criteria up dated; indications no longer covered for patients less than 19 yo und er Medicaid.

Prior Authorization Guideline

Guideline ID	GL-450258
Guideline Name	Gralise, Horizant - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Gralise, generic gabapentin (once-daily)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of postherpetic neuralgia (PHN)

AND

2 - Trial and failure or intolerance to generic immediate-release gabapentin (generic for Neurontin)

AND

3 - For generic gabapentin (once-daily) requests ONLY: Trial and failure or intolerance to Brand Gralise

Product Name:Horizant	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- Diagnosis of postherpetic neuralgia (PHN)
- Trial and failure or intolerance to generic immediate-release gabapentin (generic for Neurontin)

OR

1.2 Diagnosis of restless legs syndrome

2 . Revision History

Date	Notes
12/17/2025	Added new GPIs for generic Gralise (NP)

Prior Authorization Guideline

Guideline ID	GL-730187
Guideline Name	Growth Hormone, Growth Stimulating Agents - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:All products	
Diagnosis	Idiopathic Short Stature (ISS)
Approval Length	N/A - Requests for non-approvable diagnoses should not be approved
Guideline Type	Prior Authorization
Approval Criteria **1** - Requests for coverage for diagnosis of Idiopathic Short Stature (ISS) are not authorized and will not be approved	
Notes	Approval Length: N/A - Requests for Idiopathic Short Stature (ISS) sh ould not be approved. Deny as a benefit exclusion.

Product Name:Non Preferred: Humatrope, Ngenla, Nutropin AQ NuSpin, Omnitrope, Saizen, Saizen Click Easy, Serostim, Skytrofa, Zomacton	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to ALL preferred products listed below:

- Genotropin Miniquick or Genotropin cartridge
- Norditropin
- Sogroya

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following:

1.1.1 All of the following:

- Infant is less than 4 months of age
- Infant has growth deficiency
- Prescribed by an endocrinologist

OR

1.1.2 BOTH of the following:

- History of neonatal hypoglycemia associated with pituitary disease
- Prescribed by an endocrinologist

OR

1.1.3 BOTH of the following:

- Diagnosis of panhypopituitarism
- Prescribed by an endocrinologist

OR

1.2 ALL of the following:

1.2.1 Diagnosis of pediatric growth hormone (GH) deficiency as confirmed by ONE of the following:

1.2.1.1 Projected height (as determined by extrapolating pre-treatment growth trajectory along current channel to 18-20 year mark) is greater than 2.0 standard deviations [SD] below midparental height utilizing age and gender growth charts related to height

OR

1.2.1.2 Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) utilizing age and gender growth charts related to height

OR

1.2.1.3 Growth velocity is greater than 2 SD below mean for age and gender

OR

1.2.1.4 Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age)

AND

1.2.2 ONE of the following:

1.2.2.1 BOTH of the following:

- Patient is male
- Bone age less than 16 years

OR

1.2.2.2 BOTH of the following:

- Patient is female
- Bone age less than 14 years

AND

1.2.3 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following:

1.2.3.1 BOTH of the following:

1.2.3.1.1 Patient has undergone TWO of the following provocative GH stimulation tests:

- Arginine
- Clonidine
- Glucagon
- Insulin
- Levodopa
- Growth hormone releasing hormone

AND

1.2.3.1.2 BOTH GH response values are less than 10 micrograms per liter

OR

1.2.3.2 BOTH of the following:

1.2.3.2.1 Patient is less than 1 year of age

AND

1.2.3.2.2 ONE of the following is below the age and gender adjusted normal range as provided by the physician's lab:

- Insulin-like Growth Factor 1 (IGF-1/Somatomedin-C)
- Insulin Growth Factor Binding Protein-3 (IGFBP-3)

AND

1.2.4 ONE of the following:

1.2.4.1 Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

OR

1.2.4.2 BOTH of the following:

- Tanner Stage 3 or greater
- Request does not exceed a maximum supply limit of 0.7 milligrams per kilogram per week

AND

1.2.5 Prescribed by an endocrinologist

Notes	*Includes children who have undergone brain radiation. If patient is a Transition Phase Adolescent or Adult who had childhood onset GH de ficiency, utilize criteria for Transition Phase Adolescent or Adult GH de ficiency.

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Pediatric Growth Hormone Deficiency (GHD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:**

- Previous height and date obtained
- Current height and date obtained

AND

2 - BOTH of the following:**

- Expected adult height not attained
- Documentation of expected adult height goal (e.g. genetic potential)

AND

3 - Calculated height (growth) velocity over the past 12 months

AND

4 - ONE of the following:

4.1 BOTH of the following:

- Patient is male
- Bone age less than 16 years

OR

4.2 BOTH of the following:

- Patient is female
- Bone age less than 14 years

AND

5 - ONE of the following:

5.1 Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

OR

5.2 BOTH of the following:

- Tanner Stage 3 or greater
- Request does not exceed a maximum supply limit of 0.7 milligrams per kilogram per week

AND

6 - Prescribed by an endocrinologist

Notes	*Includes children who have undergone brain radiation. If patient is a Transition Phase Adolescent or Adult who had childhood onset GH de ficiency, utilize criteria for Transition Phase Adolescent or Adult GH de ficiency. ** Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin	
Diagnosis	Prader-Willi Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Prader-Willi Syndrome

AND

2 - Prescribed by an endocrinologist

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin	
Diagnosis	Prader-Willi Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following criteria:

1.1 BOTH of the following:

1.1.1 Evidence of positive response to therapy (e.g., increase in total lean body mass, decrease in fat mass)

AND

1.1.2 Prescribed by an endocrinologist

OR

1.2 ALL of the following:

1.2.1 Height increase of at least 2 centimeters per year over the previous year of treatment as documented by BOTH of the following:

- Previous height and date obtained
- Current height and date obtained

AND

1.2.2 BOTH of the following:

- Expected adult height not attained
- Documentation of expected adult height goal

AND

1.2.3 Prescribed by an endocrinologist

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Growth Failure in Children Small for Gestational Age (SGA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of small for gestational age (SGA) based on demonstration of catch up growth failure in the first 24 months of life using a 0-36 month growth chart as confirmed by documentation that ONE of the following is below the third percentile for gestational age (more than 2 standard deviations [SD] below population mean):

- Birth weight
- Birth length

AND

2 - Documentation that height remains less than or equal to the third percentile (more than 2 SD below population mean)

AND

3 - Prescribed by an endocrinologist

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Growth Failure in Children Small for Gestational Age (SGA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Turner Syndrome or Noonan Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pediatric growth failure associated with ONE of the following:

1.1 BOTH of the following:

1.1.1 Turner Syndrome (Gonadal Dysgenesis)

AND

1.1.2 BOTH of the following:

- Patient is female
- Bone age less than 14 years

OR

1.2 BOTH of the following:

1.2.1 Noonan Syndrome

AND

1.2.2 ONE of the following:

1.2.2.1 BOTH of the following:

- Patient is male
- Bone age less than 16 years

OR

1.2.2.2 BOTH of the following:

- Patient is female
- Bone age less than 14 years

AND

2 - Height is below the fifth percentile on growth charts for age and gender

AND

3 - Prescribed by an endocrinologist

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Turner Syndrome or Noonan Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya

Diagnosis	Short-Stature Homeobox (SHOX) Gene Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pediatric growth failure with short-stature homeobox (SHOX) gene deficiency as confirmed by genetic testing

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient is male
- Bone age less than 16 years

OR

2.2 BOTH of the following:

- Patient is female
- Bone age less than 14 years

AND

3 - Prescribed by an endocrinologist

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Short-Stature Homeobox (SHOX) Gene Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Growth Failure associated with Chronic Renal Insufficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pediatric growth failure associated with chronic renal insufficiency

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient is male
- Bone age less than 16 years

OR

2.2 BOTH of the following:

- Patient is female
- Bone age less than 14 years

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Growth Failure associated with Chronic Renal Insufficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not attained
- Expected adult height goal

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Adult Growth Hormone Deficiency
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of adult growth hormone deficiency (GHD) as a result of ONE of the following:

1.1 Clinical records supporting a diagnosis of childhood-onset GHD

OR

1.2 BOTH of the following:

1.2.1 Adult-onset GHD

AND

1.2.2 Clinical records documenting that hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (e.g., damage from surgery, cranial irradiation, head trauma, or subarachnoid hemorrhage)

AND

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

2.1 BOTH of the following:

2.1.1 Patient has undergone ONE of the following GH (growth hormone) stimulation tests to confirm adult GH deficiency:

- Insulin tolerance test (ITT)
- ARG (Arginine) and GHRH (growth hormone releasing hormone)
- Glucagon
- ARG

AND

2.1.2 ONE of the following peak GH values:

2.1.2.1 ITT less than or equal to 5 micrograms per liter

OR

2.1.2.2 GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter if body mass index [BMI] is less than 25 kilograms per meter squared
- Less than or equal to 8 micrograms per liter if BMI is greater than or equal to 25 and less than 30 kilograms per meter squared
- Less than or equal to 4 micrograms per liter if BMI is greater than or equal to 30 kilograms per meter squared

OR

2.1.2.3 Glucagon less than or equal to 3 micrograms per liter

OR

2.1.2.4 ARG less than or equal to 0.4 micrograms per liter

OR

2.2 BOTH of the following:

2.2.1 Submission of medical records (e.g., chart notes, laboratory values) documenting deficiency of THREE of the following anterior pituitary hormones:

- Prolactin
- ACTH (adrenocorticotropic hormone)
- TSH (thyroid stimulating hormone)
- FSH/LH (follicle-stimulating hormone/luteinizing hormone)

AND

2.2.2 Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

AND

3 - ONE of the following:

3.1 Diagnosis of panhypopituitarism

OR

3.2 Other diagnosis and not used in combination with BOTH of the following:

- Aromatase inhibitors [e.g., Arimidex (anastrazole),Femara (letrazole)]

- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

4 - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

AND

5 - Prescribed by an endocrinologist

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Adult Growth Hormone Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of Insulin-like Growth Factor 1 (IGF-1)/Somatomedin C level within the past 12 months

AND

2 - ONE of the following:

2.1 Diagnosis of panhypopituitarism

OR

2.2 Other diagnosis and not used in combination with BOTH of the following:

- Aromatase inhibitors [e.g., Arimidex (anastrazole), Femara (letrazole)]

- Androgens [e.g., Delatestryl (testosterone enanthate), Depo-Testosterone (testosterone cypionate)]

AND

3 - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

AND

4 - Prescribed by an endocrinologist

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Transition Phase Adolescent Patients
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

AND

2 - Documentation of ONE of the following:

- Attained expected adult height
- Closed epiphyses on bone radiograph

AND

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

3.1 BOTH of the following:

3.1.1 Documentation of high risk of growth hormone (GH) deficiency due to GH deficiency in childhood from ONE of the following:

3.1.1.1 Embryopathic/congenital defects

OR

3.1.1.2 Genetic mutations

OR

3.1.1.3 Irreversible structural hypothalamic-pituitary disease

OR

3.1.1.4 Panhypopituitarism

OR

3.1.1.5 Deficiency of THREE of the following anterior pituitary hormones:

- ACTH (adrenocorticotropic hormone)
- TSH (thyroid stimulating hormone)
- Prolactin
- FSH/LH (follicle-stimulating hormone/luteinizing hormone)

AND

3.1.2 ONE of the following:

3.1.2.1 Insulin-like Growth Factor 1 (IGF-1)/Somatomedin-C level is below the age and gender adjusted normal range as provided by the physician's lab

OR

3.1.2.2 ALL of the following:

3.1.2.2.1 Patient does not have a low IGF-1/Somatomedin C level

AND

3.1.2.2.2 Discontinued GH therapy for at least 1 month

AND

3.1.2.2.3 Patient has undergone ONE of the following GH stimulation tests after discontinuation of therapy for at least 1 month:

- Insulin tolerance test (ITT)
- ARG (Arginine) and GHRH (growth hormone releasing hormone)
- ARG
- Glucagon

AND

3.1.2.2.4 ONE of the following peak GH values:

3.1.2.2.4.1 ITT less than or equal to 5 micrograms per liter

OR

3.1.2.2.4.2 GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter if body mass index [BMI] is less than 25 kilograms per meter squared
- Less than or equal to 8 micrograms per liter if BMI is greater than or equal to 25 and less than 30 kilograms per meter squared
- Less than or equal to 4 micrograms per liter if BMI is greater than or equal to 30 kilograms per meter squared

OR

3.1.2.2.4.3 Glucagon less than or equal to 3 micrograms per liter

OR

3.1.2.2.4.4 ARG less than or equal to 0.4 micrograms per liter

OR

3.2 ALL of the following:

3.2.1 At low risk of severe GH deficiency (e.g., due to isolated and/or idiopathic GH deficiency)

AND

3.2.2 Discontinued GH therapy for at least 1 month

AND

3.2.3 BOTH of the following:

3.2.3.1 Patient has undergone ONE of the following GH stimulation tests after discontinuation of therapy for at least 1 month:

- ITT
- GHRH and ARG
- ARG
- Glucagon

AND

3.2.3.2 ONE of the following peak GH values:

3.2.3.2.1 ITT less than or equal to 5 micrograms per liter

OR

3.2.3.2.2 GHRH and ARG of ONE of the following:

- Less than or equal to 11 micrograms per liter if body mass index [BMI] is less than 25 kilograms per meter squared
- Less than or equal to 8 micrograms per liter if BMI is greater than or equal to 25 and less than 30 kilograms per meter squared
- Less than or equal to 4 micrograms per liter if BMI is greater than or equal to 30 kilograms per meter squared

OR

3.2.3.2.3 Glucagon less than or equal to 3 micrograms per liter

OR

3.2.3.2.4 ARG less than or equal to 0.4 micrograms per liter

AND

4 - Prescribed by an endocrinologist

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Transition Phase Adolescent Patients
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive response to therapy (e.g., increase in total lean body mass, exercise capacity or IGF-1 [Insulin-like Growth Factor 1] and IGFBP-3 [Insulin-like growth factor binding protein 3] levels)

AND

2 - Request does not exceed a maximum supply limit of 0.3 milligrams per kilogram per week

AND

3 - Prescribed by an endocrinologist

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of human immunodeficiency virus (HIV)-associated wasting syndrome or cachexia

AND

2 - Documentation of ONE of the following:

2.1 Unintentional weight loss of greater than 10 percent over the last 12 months

OR

2.2 Unintentional weight loss of greater than 7.5 percent over the last 6 months

OR

2.3 Loss of 5 percent body cell mass (BCM) within 6 months

OR

2.4 Body mass index (BMI) less than 20 kilograms per meter squared

OR

2.5 ONE of the following:

2.5.1 ALL of the following:

- Patient is male
- BCM less than 35 percent of total body weight
- BMI less than 27 kilograms per meter squared

OR

2.5.2 ALL of the following:

- Patient is female
- BCM less than 23 percent of total body weight
- BMI less than 27 kilograms per meter squared

AND

3 - A nutritional evaluation has been completed since onset of wasting first occurred

AND

4 - Patient has not had weight loss as a result of other underlying treatable conditions (e.g., depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes)

AND

5 - Patient's anti-retroviral therapy has been optimized to decrease the viral load

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Human Immunodeficiency Virus (HIV)-associated wasting syndrome or cachexia
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Evidence of positive response to therapy (i.e., greater than or equal to 2 percent increase in body weight and/or body cell mass [BCM])

AND

2 - ONE of the following targets or goals has not been achieved:

- Weight
- BCM
- Body Mass Index (BMI)

Product Name:Preferred: Genotropin Miniquick, Genotropin cartridge, Norditropin, Sogroya	
Diagnosis	Short Bowel Syndrome
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Short Bowel Syndrome

AND

2 - Patient is currently receiving specialized nutritional support (e.g., intravenous parenteral nutrition, fluid, and micronutrient supplements)

AND

3 - Patient has not previously received 4 weeks of treatment for this indication

Notes	*Treatment will not be authorized beyond 4 weeks. Administration for more than 4 weeks has not been adequately studied.

Product Name:Increlex	
Diagnosis	Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following criteria:

1.1 Documentation of ALL of the following:

1.1.1 Diagnosis of severe primary Insulin-like Growth Factor 1 (IGF-1) deficiency

AND

1.1.2 Height standard deviation score less than or equal to -3.0

AND

1.1.3 Basal IGF-1 standard deviation score less than or equal to -3.0

AND

1.1.4 Normal or elevated growth hormone levels

AND

1.1.5 Documentation of open epiphyses on last bone radiograph

AND

1.1.6 The patient will not be treated with concurrent growth hormone therapy

AND

1.1.7 Prescribed by an endocrinologist

OR

1.2 ALL of the following:

1.2.1 Diagnosis of growth hormone gene deletion and has developed neutralizing antibodies to growth hormone

AND

1.2.2 Documentation of open epiphyses on last bone radiograph

AND

1.2.3 The patient will not be treated with concurrent growth hormone therapy

AND

1.2.4 Prescribed by an endocrinologist

Product Name:Increlex	
Diagnosis	Severe Primary IGF-1 Deficiency / Growth Hormone Gene Deletion
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Height increase of at least 2 centimeters per year over the previous year of treatment as documented by BOTH of the following:*

- Previous height and date obtained
- Current height and date obtained

AND

2 - Documentation of BOTH of the following:*

- Expected adult height not obtained
- Expected adult height goal

AND

3 - Patient is not treated with concurrent growth hormone therapy

AND

4 - Prescribed by an endocrinologist

Notes	*Documentation of previous height, current height and goal expected adult height will be required for renewal.

2 . Revision History

Date	Notes

9/16/2026	Updated target GPIs for HIV/SBS indications, no change to clinical in tent

Prior Authorization Guideline

Guideline ID	GL-99463
Guideline Name	HCG
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Novarel, Ovidrel, Brand Pregnyl, generic chorionic gonadotropin	
Diagnosis	Prepubertal Cryptorchidism
Approval Length	6 Week(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction	

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona standard to Medicaid Arizona

Prior Authorization Guideline

Guideline ID	GL-623273
Guideline Name	Hemangeol (propranolol oral solution)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Hemangeol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Patient is 10 years of age or younger

OR

1.2 All of the following:

1.2.1 Patient is greater than 10 years of age

AND

1.2.2 Diagnosis of proliferating infantile hemangioma

AND

1.2.3 Prescriber provides a reason or special circumstance the patient cannot use generic propranolol oral solution

Notes	Note: PA is required for patients greater than 10 years of age

2 . Revision History

Date	Notes
5/27/2026	Removed Preferred/NPD specifics, all NDCs are now preferred.

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-626187
Guideline Name	Hemgenix (etranacogene dezaparvovec-drlb)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Hemgenix	
Approval Length	1 Time Authorization in Lifetime*
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of Hemophilia B (congenital Factor IX deficiency)

AND

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

2.1 Both of the following:

- Diagnosis of severe hemophilia B
- Documentation of endogenous Factor IX levels less than 1% of normal Factor IX (< 0.01 IU/mL)

OR

2.2 All of the following:

- Diagnosis of moderately severe hemophilia B
- Documentation of endogenous Factor IX levels greater than or equal to 1% to less than or equal to 2% (greater than or equal to 0.01 IU/mL to less than or equal to 0.02 IU/mL)
- Patient has current or historical life-threatening hemorrhage or repeated, serious spontaneous bleeding episodes

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming that the patient is currently using Factor IX prophylaxis therapy (e.g., BeneFIX, Ixinity, Rixubis, etc.) and will discontinue treatment after stable on Hemgenix therapy

AND

4 - Patient has greater than 150 previous exposure days of treatment with a Factor IX agent

AND

5 - Patient is 18 years of age or older

AND

6 - Submission of medical records (e.g., chart notes) documenting that the patient does not have any of the following:

- Positive human immunodeficiency virus (HIV) test at screening that is not controlled with anti-viral therapy
- Active infection with hepatitis B or C virus
- Currently on antiviral treatment for hepatitis B or C
- Positive Factor IX inhibitor titer test prior to therapy
- History of Factor IX inhibitor
- Anti-AAV antibody (e.g., AAV-5) titers exceeding 1:678

AND

7 - Both of the following:

7.1 Submission of medical records (e.g., chart notes) documenting that the following laboratory values have been checked prior to therapy and are less than two times the upper limit of normal and provider attests that these laboratory values will be monitored after administration according to the FDA-approved recommendations in the labeling:

- Alanine aminotransferase (ALT)
- Alkaline phosphatase (ALP)
- Aspartate aminotransferase (AST)
- Total bilirubin

AND

7.2 Submission of medical records (e.g., chart notes) documenting results of the following baseline tests and provider attests there will be ongoing monitoring according to the recommendations in the FDA labeling:

7.2.1 Factor IX activity (i.e., Exogenous Factor IX and Human Factor IX inhibitors)

AND

7.2.2 In patients with preexisting risk factors for hepatocellular carcinoma (e.g., in patients with cirrhosis, advanced hepatic fibrosis, hepatitis B or C, non-alcoholic fatty liver disease (NAFLD), chronic alcohol consumption, non-alcoholic steatohepatitis (NASH), and advanced age), both of the following:

- Alpha-fetoprotein (AFP) level
- Abdominal ultrasound

AND **8** - Submission of medical records (e.g., chart notes) documenting that hepatic ultrasound and elastography have been completed prior to therapy **AND** **9** - Prescribed by a hematologist at a Hemophilia Treatment Center (HTC) **AND** **10** - Patient has never received any previous Hemophilia B gene therapy treatment in their lifetime (e.g., Hemgenix, Beqvez)

Notes	*Per prescribing information, Hemgenix can be administered only once.

2 . Revision History

Date	Notes
5/27/2026	New program

Prior Authorization Guideline

Guideline ID	GL-700341
Guideline Name	Hemophilia Clotting Factors
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Corifact	
Diagnosis	Congenital Factor XIII Deficiency
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital factor XIII deficiency

AND

2 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:Tretten	
Diagnosis	Congenital Factor XIII Deficiency
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital factor XIII A-subunit deficiency

AND

2 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:Humate-P	
Diagnosis	Von Willebrand Disease (VWD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 BOTH of the following:

- Diagnosis of Type 1, 2A, 2M, or 2N von Willebrand disease (VWD)
- History of failure, contraindication or intolerance to treatment with desmopressin

OR

1.2 Diagnosis of Type 2B or Type 3 von Willebrand disease (VWD)

OR

1.3 Requested medication is being used for treatment of spontaneous and trauma-induced bleeding episodes

Product Name:Alphanate	
Diagnosis	Von Willebrand Disease (VWD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of Type 1, 2A, 2M, or 2N von Willebrand disease (VWD)

AND

1.2 History of failure, contraindication or intolerance to treatment with desmopressin

OR

2 - Diagnosis of Type 2B or Type 3 von Willebrand disease (VWD)

Product Name:Wilate or Vonvendi	
Diagnosis	Von Willebrand Disease (VWD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- Diagnosis of Type 1, 2A, 2M, or 2N von Willebrand disease (VWD)
- History of failure, contraindication or intolerance to treatment with desmopressin

OR

1.2 Diagnosis of Type 2B or Type 3 von Willebrand disease (VWD)

AND

2 - ONE of the following:

- Treatment of bleeding episodes
- Peri-operative management of surgical bleeding
- Routine prophylactic treatment

Product Name:NovoSeven RT	
Diagnosis	Congenital Factor VII Deficiency
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital factor VII deficiency

AND

2 - ONE of the following:

- Treatment of bleeding episodes
- Routine prophylactic treatment of bleeding

Product Name:Advate, Alphanate, Humate-P, Hemofilm, KoAte, KoAte-DVI, Kogenate FS, Kovaltry, NovoEight, Nuwiq, Recombinate, Xyntha, or Xyntha Solofuse	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:Eloctate	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

AND

3 - Patient is not a suitable candidate for treatment with shorter half-life Factor VIII (recombinant) products [e.g., Advate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, or Recombinate] as attested by the prescribing physician

AND

4 - ONE of the following:

4.1 BOTH of the following:

- Dose does not exceed 50 IU/kg
- Infusing no more frequently than every 4 days

OR

4.2 Requested dosage regimen does not exceed 12.5 IU/kg/day

OR

4.3 BOTH of the following:

4.3.1 Patient is less than 6 years of age

AND

4.3.2 ONE of the following:

- Pharmacokinetic (PK) testing results suggest that dosing more intensive than 50 IU/kg is required
- PK testing results suggest that dosing more frequently than every 3 to 5 days is required
- PK testing results suggest that dosing more intensive than 14.5 IU/kg/day is required

Product Name:Jivi	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - ONE of the following:

- Peri-operative management of surgical bleeding
- Routine prophylactic treatment of bleeding
- Treatment of bleeding episodes

AND

3 - Patient has previously received Factor VIII replacement therapy

AND

4 - Patient is 7 years of age or older

AND

5 - Patient is not a candidate for treatment with shorter acting half-life Factor VIII (recombinant) products [e.g., Advate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, or Recombinate] as attested by the prescribing physician

AND

6 - Patient is not to receive routine infusions more than 2 times per week

Product Name:Afstyla	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

AND

3 - Patient is not a suitable candidate for treatment with shorter acting half-life Factor VIII (recombinant) products [e.g., Advate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, Recombinate] as attested by the prescribing physician

AND

4 - ONE of the following:

4.1 Patient is not to receive routine infusions more frequently than 3 times per week

OR

4.2 BOTH of the following:

- Patient is less than 12 years of age
- Pharmacokinetic (PK) testing results suggest that more frequently than 3 times per week dosing is required

Product Name:Hemlibra	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of severe hemophilia A

AND

1.1.2 Documentation of endogenous factor VIII level less than 1% of normal factor VIII (< 0.01 IU/mL)

AND

1.1.3 Physician attestation that the patient is not to receive extended half-life factor VIII replacement products (e.g., Eloctate, Adynovate, Afstyla, Jivi) for the treatment of breakthrough bleeding episodes

OR

1.2 All of the following:

1.2.1 One of the following:

1.2.1.1 BOTH of the following:

- Diagnosis of moderate hemophilia A
- Documentation of endogenous factor VIII level greater than or equal to 1% to less than 5% (greater than or equal to 0.01 IU/mL to less than 0.05 IU/mL)

OR

1.2.1.2 Both of the following:

- Diagnosis of mild hemophilia A
- Documentation of endogenous factor VIII level greater than or equal to 5% (greater than 0.05 IU/mL)

AND

1.2.2 Submission of medical records (e.g., chart notes, laboratory values) documenting a failure to meet clinical goals (e.g., continuation of spontaneous bleeds, inability to achieve appropriate trough level, previous history of inhibitors) after a trial of prophylactic factor VIII replacement products

AND

1.2.3 Physician attestation that the patient is not to receive extended half-life factor VIII replacement products (e.g., Eloctate, Adynovate, Afstyla, Jivi) for the treatment of breakthrough bleeding episodes

OR

1.3 BOTH of the following:

- Diagnosis of hemophilia A
- Patient has developed high-titer factor VIII inhibitors (greater than or equal to 5 Bethesda units [BU])

AND

2 - Prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis)

Product Name:FEIBA	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - Documentation of inhibitors (e.g., Bethesda inhibitor assay)

AND

3 - One of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:NovoSeven RT, Obizur	
Diagnosis	Acquired factor VIII Hemophilia

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acquired factor VIII hemophilia (e.g., acquired hemophilia A, Factor VIII deficiency)

AND

2 - Treatment or prevention of bleeding episodes

Product Name:Adynovate	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - One of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

AND

3 - Patient is not a suitable candidate for treatment with shorter acting half-life Factor VIII (recombinant) products [Advate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, or Recombinate] as attested by the prescribing physician

AND

4 - One of the following:

4.1 BOTH of the following:

- Patient is not to receive routine infusions more frequently than 2 times per week
- Patient is not to receive a routine dose greater than 50 IU/kg

OR

4.2 ALL of the following:

- Patient is less than 12 years of age
- Patient is not to receive routine infusions more frequently than 2 times per week
- Patient is not to receive a routine dose greater than 70 IU/kg

Product Name:Esperoct	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

AND

3 - ONE of the following:

3.1 Patient is not to receive routine infusions more frequently than 2 times per week

OR

3.2 BOTH of the following:

- Patient is less than 12 years of age
- Pharmacokinetic (PK) testing results suggest that more frequent than 2 times per week dosing is required

Product Name:Wilate	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - ONE of the following:

2.1 Routine prophylactic treatment of bleeding

OR

2.2 Treatment of bleeding episodes

Product Name:NovoSeven RT, Sevenfact	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - Documentation of inhibitors (e.g., Bethesda inhibitor assay)

AND

3 - One of the following:

- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:Altuviiio	
Diagnosis	Hemophilia A
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia A

AND

2 - ONE of the following:

- Treatment of bleeding episodes
- Prevention of bleeding in surgical interventions or invasive procedures (e.g., surgical prophylaxis)
- Prevention of bleeding episodes (i.e., routine prophylaxis)

AND

3 - Patient is not a suitable candidate for treatment with shorter acting half-life Factor VIII (recombinant) products [e.g., Advate, Kogenate FS, Kovaltry, Novoeight, Nuwiq, or Recombinate] as attested by the prescribing physician

AND

4 - Both of the following:

- Dose does not exceed 50 IU/kg
- Patient is infusing no more frequently than every 7 days

Product Name:AlphaNine SD, Mononine, Profilnine, Profilnine SD	
Diagnosis	Hemophilia B
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia B

AND

2 - One of the following:

- Routine prophylactic treatment
- Treatment of bleeding episodes

Product Name:BeneFIX, Rixubis, Alprolix, Idelvion, Ixinity, or Rebinyn	
Diagnosis	Hemophilia B
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia B

AND

2 - ONE of the following:

- Routine prophylactic treatment
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:FEIBA	
Diagnosis	Hemophilia B
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia B

AND

2 - Documentation of inhibitors (e.g., Bethesda inhibitor assay)

AND

3 - ONE of the following:

- Routine prophylactic treatment of bleeding
- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:NovoSeven RT, Sevenfact	
Diagnosis	Hemophilia B
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hemophilia B

AND

2 - Documentation of inhibitors (e.g., Bethesda inhibitor assay)

AND

3 - ONE of the following:

- Peri-operative management of surgical bleeding
- Treatment of bleeding episodes

Product Name:Fesilty, Fibryga, RiaSTAP	
Diagnosis	Fibrinogen Deficiency
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia

AND

2 - Treatment of bleeding episodes

Product Name:NovoSeven RT	
Diagnosis	Glanzmann Thrombasthenia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Glanzmann's thrombasthenia

AND

2 - Refractory to platelet transfusions

AND

3 - ONE of the following:

- Treatment of bleeding episodes
- Peri-operative management of surgical bleeding

Product Name:Coagadex	
Diagnosis	Congenital Factor X Deficiency

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital Factor X deficiency

AND

2 - ONE of the following:

- Treatment of bleeding episodes
- Peri-operative management of surgical bleeding
- Routine prophylactic treatment

Product Name:Hympavzi	
Diagnosis	Hemophilia A, Hemophilia B
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- hemophilia A (congenital factor VIII deficiency) without factor VIII inhibitors
- hemophilia B (congenital factor IX deficiency) without factor IX inhibitors

AND

2 - Patient is 6 years of age or older

AND

3 - Drug will be used for prophylaxis to prevent or reduce the frequency of bleeding episodes

Product Name:Alhemo	
Diagnosis	Hemophilia A, Hemophilia B
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- hemophilia A (congenital factor VIII deficiency) with or without factor VIII inhibitors
- hemophilia B (congenital factor IX deficiency) with or without factor IX inhibitors

AND

2 - Patient is 12 years of age or older

AND

3 - Drug will be used for prophylaxis to prevent or reduce the frequency of bleeding episodes

Product Name:Qfitlia	
Diagnosis	Hemophilia A, Hemophilia B
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- hemophilia A (congenital factor VIII deficiency) with or without factor VIII inhibitors

- hemophilia B (congenital factor IX deficiency) with or without factor IX inhibitors

AND

2 - Patient is 12 years of age or older

AND

3 - Drug will be used for prophylaxis to prevent or reduce the frequency of bleeding episodes

2 . Revision History

Date	Notes
8/26/2026	Updated criteria for VWD drugs, verbiage now specific to type of VW D

Prior Authorization Guideline

Guideline ID	GL-371191
Guideline Name	Hepatitis C - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2025

Note:

Preferred drugs Mavyret and sofosbuvir-velpatasvir (authorized generic of Epclusa) will be approved without requiring prior authorization ONE time per lifetime. Requests for retreatment or non-preferred drugs will require PA

1 . Criteria

Product Name:Preferred: sofosbuvir-velpatasvir (authorized generic of Epclusa)**, Mavyret**	
Diagnosis	Hepatitis C Retreatment
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Hepatitis C infection status which has been confirmed by detectable serum	

hepatitis C virus (HCV) RNA by quantitative assay completed within the past 90 days from the date of the prior authorization request

AND

2 - Age of the patient is Food and Drug Administration (FDA) approved for the specific HCV DAA (Direct Acting Antiviral) product

AND

3 - The prescribing provider assesses the patient's ability to adhere to the HCV DAA treatment plan and attests the assessment has been documented within the clinical record. For patients that would benefit from adherence aids, the treating provider shall refer the patient to a treatment adherence program

AND

4 - Patient agrees to adhere to the proposed course of treatment, including taking medications as prescribed, attending follow-up appointments, and, if applicable, participating in a treatment adherence program

AND

5 - One of the following:

5.1 Patient has been screened for Hepatitis A and B and has received one Hepatitis A and one Hepatitis B vaccine prior to requesting treatment

OR

5.2 Patient demonstrates laboratory evidence of immunity to Hepatitis A and B

AND

6 - The Prescriber must submit the following information with the request for HCV DAA medications to be considered:

6.1 HCV treatment history and responses to treatment

AND

6.2 Current medication list

AND

6.3 Laboratory results for all of the following:

- HCV screen test results
- Genotype and current baseline HCV viral load
- Total bilirubin
- Albumin level
- International Normalized Ratio (INR)
- Creatinine Clearance (CrCl) or Glomerular Filtration Rate (GFR)
- Liver Function Tests (LFTs)
- Complete Blood Count (CBC)
- Viral resistance status (when applicable)
- Hepatic status (Child Pugh Score)

AND

7 - If the HCV DAA product is being used in combination with ribavirin, the prescribing provider attests to monitoring hemoglobin levels periodically

AND

8 - The prescribing provider attests to monitoring HCV RNA levels obtained at 12- and 24-weeks post therapy completion to demonstrate the Sustained Virologic Response (SVR)

AND

9 - DAA HCV treatment coverage is NOT provided for ANY of the following:

9.1 DAA dosages greater than the FDA approved maximum dosage

OR

9.2 Patients currently using a potent P-gp inducer drug (St. John's wart, rifampin, carbamazepine, ritonavir, tipranavir, etc.)

OR

9.3 Lost or stolen medication absent of good cause

OR

9.4 Fraud, waste, or misuse of HCV DAA medications

Notes	*Approval length: Mavyret = 8-16 Week(s), sofosbuvir-velpatasvir (authorized generic of Epclusa) = 12-24 Weeks(s). **Preferred drugs Mavyret and sofosbuvir-velpatasvir (authorized generic of Epclusa) will be approved without requiring prior authorization ONE time per lifetime. Requests for retreatment or non-preferred drugs will require PA. Refer to AASLD for specific approval durations AASLD: https://www.hcvguidelines.org/contents

Product Name:Non-Preferred: Brand Epclusa, Brand Harvoni, ledipasvir-sofosbuvir (authorized generic of Harvoni), Sovaldi, Zepatier	
Diagnosis	Hepatitis C
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Patient was adherent to previous DAA therapy as evidenced by submission of medical records and/or pharmacy prescription claims

OR

1.2 If prior therapy was discontinued due to adverse effects from the DAA, the medical record shall be provided which documents these adverse effects and recommendation of discontinuation by treatment provider

AND

2 - The patient's ability to adhere to the planned course of retreatment has been assessed by the treating provider and documented within the clinical record

AND

3 - Resistance-associated polymorphism testing, when applicable, has been completed and submitted with the prior authorization request when BOTH of the following are true

- Required for regimens whereby the FDA (Food and Drug Administration) requires such testing prior to treatment to ensure clinical appropriateness
- Deemed medically necessary by the clinical reviewer prior to approval of the requested regimen

AND

4 - HCV retreatment with a DAA shall NOT be approved for ANY of the following:

4.1 Is considered an experimental service

OR

4.2 Monotherapy of Sofosbuvir (Sovaldi)

OR

4.3 DAA dosages greater than the FDA approved maximum dosage

OR

4.4 Grazoprevir/elbasvir (Zepatier) if the NS5A polymorphism testing has not been completed and submitted with the prior authorization request

OR

4.5 Patients currently using a potent P-gp inducer drug (St. John's wart, rifampin, carbamazepine, ritonavir, tipranavir, etc.)

OR

4.6 Lost or stolen medication absent of good cause

OR

4.7 Fraudulent use of HCV DAA medications

AND

5 - If the request if for brand Epclusa or brand Harvoni BOTH of the following:

5.1 The patient has a therapeutic failure, contraindication, or intolerance to the generic as evidenced by submission of medical records or claims history

AND

5.2 The prescriber must submit the FDA MedWatch form

Notes	*NOTE: The approval length should be as recommended per AASLD. Refer to AASLD for specific approval durations. AASLD: https://www.hcvguidelines.org/contents

Product Name:Non-Preferred: Brand Harvoni, ledipasvir-sofosbuvir (authorized generic of Harvoni)	
Diagnosis	Hepatitis C Retreatment
Approval Length	24 Week(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C infection

AND

2 - Patient has decompensated cirrhosis (e.g., Child-Pugh Class B or C)

AND

3 - One of the following:

3.1 Patient is ribavirin ineligible

OR

3.2 Both of the following:

- Prior failure (defined as viral relapse, breakthrough while on therapy, or non-responder therapy) to Sovaldi or NS5A-based therapy
- Used in combination with ribavirin

AND

4 - Not used in combination with another HCV direct acting antiviral agent (e.g., Sovaldi [sofosbuvir])

Product Name:Non-Preferred: Vosevi, Viekira Pak	
Diagnosis	Hepatitis C
Approval Length	12 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C infection

AND

2 - One of the following:

2.1 Patient is a previous relapser to an NS5A-based regimen (e.g., Daklinza [daclatasvir]; Epclusa [sofosbuvir/velpatasvir]; Harvoni [ledipasvir/sofosbuvir]; Mavyret [glecaprevir/pibrentasvir]; Technivie [ombitasvir/paritaprevir/ritonavir]; Viekira [ombitasvir/paritaprevir/ritonavir & dasabuvir]; Zepatier [elbasvir/grazoprevir])

OR

2.2 Patient is a previous relapser to a sofosbuvir-based regimen without an NS5A inhibitor

AND

3 - Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

4 - Not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Product Name:Non-Preferred: Vosevi, Viekira Pak	
Diagnosis	Hepatitis C: Prior Failure to Vosevi/Viekira Pak
Approval Length	24 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C infection

AND

2 - Both of the following:

2.1 Patient had a prior treatment failure with Vosevi or Viekira

AND

2.2 Used in combination with ribavirin

AND

3 - Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

4 - Not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

Product Name:Pegasys, PegIntron	
Diagnosis	Hepatitis C
Approval Length	48 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C infection

AND

2 - Patient without decompensated liver disease (defined as Child-Pugh Class B or C)

AND

3 - Will be used as part of a combination antiviral treatment regimen

Product Name:Ribavirin tablets and capsules	
Diagnosis	Hepatitis C
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic hepatitis C infection

AND

2 - Used in combination with a direct-acting agent

2 . Revision History

Date	Notes
8/28/2025	Mavyret and sofosbuvir-velpatasvir: removed chronic from diagnosis criterion due to Mavyret expanded indication.

Prior Authorization Guideline

Guideline ID	GL-700340
Guideline Name	Hepcludex (bulevirtide-gmod)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of chronic hepatitis delta virus (HDV) infection

AND

2 - Submission of medical records (e.g., chart notes, lab results) documenting detectable HDV RNA within the 6 months before initiating therapy

AND

3 - Patient has active liver disease (e.g., ALT above the upper limit of normal [ULN], evidence of hepatic fibrosis by noninvasive testing [e.g., transient elastography])

AND

4 - Patient is without decompensated liver disease (e.g., Child-Pugh Class B or C)

AND

5 - One of the following:

- Patient is receiving concomitant therapy for hepatitis B virus (HBV) (e.g., entecavir, tenofovir disoproxil fumarate)
- Patient is not a candidate for HBV therapy

AND

6 - Prescriber attests that the patient has been counseled on the importance of adherence to therapy with risk of disease reactivation and need for ongoing monitoring if discontinued

AND

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

- Hepatologist
- Gastroenterologist
- Infectious disease specialist

Product Name:Hepcludex	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., ALT normalization, improvement in or stabilization of fibrosis, undetectable HDV RNA level)

AND

2 - Prescriber attests that the patient has been counseled on the importance of adherence to therapy with risk of disease reactivation and need for ongoing monitoring if discontinued

2 . Revision History

Date	Notes
8/26/2026	Added criterion requiring concomitant HBV therapy

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Prior Authorization Guideline

Guideline ID	GL-525295
Guideline Name	Hereditary Angioedema (HAE) Agents - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Preferred: Cinryze, Haegarda; Non-Preferred: Andembry, Dawnzera, Orladeyo, Takhzyro	
Diagnosis	Prophylaxis of HAE attacks
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting diagnosis of hereditary angioedema (HAE) confirmed by ONE of the following:	

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of a FXII, angiopoietin-1 or plasminogen gene mutation
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

AND

2 - For prophylaxis against HAE attacks

AND

3 - One of the following:

- Patient is 2 years of age or older (applies to Orladeyo pellets and Takhzyro only)
- Patient is 6 years of age or older (applies to Cinryze and Haegarda only)
- Patient is 12 years of age or older (applies to Andembry, Dawnzera, and Orladeyo capsules only)

AND

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

- Immunologist
- Allergist

AND

5 - ONE of the following: (APPLIES TO ANDEMBRY, DAWNZERA, ORLADEYO, AND TAKHZYRO ONLY):

5.1 Submission of medical records documenting a history of failure, contraindication, or intolerance to Cinryze or Haegarda

OR

5.2 Submission of medical records documenting patient is currently on Andembry, Dawnzera, Orladeyo, or Takhzyro therapy

Notes	*Please note: Preferred agents are Cinryze and Haegarda

Product Name:Preferred: Berinert, Cinryze [off-label],Generic icatibant, Kalbitor; Non-Preferred: Brand Firazyr, Ekterly, Ruconest, or Sajazir	
Diagnosis	Treatment of acute HAE attacks
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting diagnosis of hereditary angioedema (HAE) confirmed by ONE of the following:

1.1 C1 inhibitor (C1-INH) deficiency or dysfunction (Type I or II HAE) as documented by ONE of the following (per laboratory standard):

- C1-INH antigenic level below the lower limit of normal
- C1-INH functional level below the lower limit of normal

OR

1.2 HAE with normal C1 inhibitor levels and ONE of the following:

- Confirmed presence of a FXII, angiopoietin-1 or plasminogen gene mutation
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema

AND

2 - For the treatment of acute HAE attacks

AND

3 - Not used in combination with other approved treatments for acute HAE attacks

AND

4 - One of the following:

- Patient is 6 years of age or older (applies to Cinryze only)
- Patient is 12 years of age or older (applies to Ekterly and Kalbitor only)
- Patient is 18 years of age or older (applies to Brand Firazyr, generic icatibant, and Sajazir only)

AND

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

- Immunologist
- Allergist

AND

6 - ONE of the following (APPLIES TO BRAND FIRAZYR, EKTERLY, RUCONEST, AND SAJAZIR ONLY):

6.1 Submission of medical records documenting a history of failure, contraindication, or intolerance to ALL of the following preferred HAE agents:

- Berinert
- Cinryze
- generic icatibant
- Kalbitor

OR

6.2 Submission of medical records or paid claims documenting patient is currently on Brand Firazyr, Ekterly, Ruconest, or Sajazir therapy	
Notes	Please note: Preferred HAE agents are Berinert, Cinryze, generic icatibant, and Kalbitor

2 . Revision History

Date	Notes
3/5/2026	January P&T changes: Haegarda to PDL. Added Orladeyo pellet packets, updated age criterion.

Prior Authorization Guideline

Guideline ID	GL-149318
Guideline Name	Hetlioz, Hetlioz LQ (tasimelteon)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/2/2024

1 . Criteria

Product Name:Brand Hetlioz capsule, generic tasimelteon capsule	
Diagnosis	Non-24-Hour Sleep-Wake Disorder (Non-24)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting diagnosis of non-24-hour sleep-wake disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome) confirmed by meeting ONE of the following conditions:

1.1 Assessment of at least one physiologic circadian phase marker [e.g., measurement of urinary melatonin levels, dim light melatonin onset (as measured in blood or saliva), assessment of core body temperature]

OR

1.2 If assessment of at least one physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy performed for at least 1 week plus evaluation of sleep logs recorded for at least 1 month

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting patient is totally blind (has no light perception) *Requests for patients who are sighted (non-blinded) will be reviewed on a case-by-case basis

AND

3 - Patient is 18 years of age or older

AND

4 - Patient has received at least 3 months of continuous therapy (i.e., 3 consecutive months of daily treatment) under the guidance of a physician who specializes in the treatment of sleep disorders of BOTH of the following:

- Melatonin
- Rozerem (ramelteon)

AND

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

- Specialist in sleep disorders
- Neurologist

AND

6 - For Brand Hetlioz capsule requests ONLY: History of failure, intolerance, or contraindication to generic tasimelteon

Product Name:Brand Hetlioz capsule, generic tasimelteon capsule	
Diagnosis	Non-24-Hour Sleep-Wake Disorder (Non-24)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep)

AND

2 - Submission of patient's sleep log demonstrating positive clinical response to therapy

AND

3 - For Brand Hetlioz capsule requests ONLY: History of failure, intolerance, or contraindication to generic tasimelteon

Product Name:Brand Hetlioz capsule, generic tasimelteon capsule	
Diagnosis	Smith-Magenis Syndrome (SMS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of Smith-Magenis Syndrome (SMS)

AND

2 - Submission of test results confirming patient has microdeletion of the chromosome band 17p11.2 by fluorescent in situ hybridization (FISH) analysis

AND

3 - Patient is 16 years of age or older

AND

4 - Patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking)

AND

5 - Patient has received at least 3 months of continuous therapy (i.e., 3 consecutive months of daily treatment) under the guidance of a physician who specializes in the treatment of sleep disorders of BOTH of the following

- Melatonin
- Rozerem (ramelteon) (unless contraindicated due to patient age)

AND

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

- Specialist in sleep disorders
- Neurologist

AND

7 - For Brand Hetlioz capsule requests ONLY: History of failure, intolerance, or contraindication to generic tasimelteon

Product Name:Hetlioz LQ suspension	
Diagnosis	Smith-Magenis Syndrome (SMS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of Smith-Magenis Syndrome (SMS)

AND

2 - Submission of test results confirming patient has microdeletion of the chromosome band 17p11.2 by fluorescent in situ hybridization (FISH) analysis

AND

3 - Patient is 3 through 15 years of age

AND

4 - Patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking)

AND

5 - Patient has received at least 3 months of continuous therapy (i.e., 3 consecutive months of

daily treatment) of melatonin under the guidance of a physician who specializes in the treatment of sleep disorders

AND

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

- Specialist in sleep disorders
- Neurologist

Product Name:Brand Hetlioz capsule, generic tasimelteon capsule, Hetlioz LQ suspension	
Diagnosis	Smith-Magenis Syndrome (SMS)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (i.e., improvement in nighttime total sleep time, improvement in nighttime sleep quality)

AND

2 - Submission of patient's sleep log demonstrating positive clinical response to therapy

AND

3 - For Brand Hetlioz capsule requests ONLY: History of failure, intolerance, or contraindication to generic tasimelteon

2 . Revision History

Date	Notes
7/2/2024	Updated reauth section for SMS indication to include Hetlioz LQ in pr oduct name

Prior Authorization Guideline

Guideline ID	GL-715196
Guideline Name	High Cost Oral Atypical Antipsychotics (Bysanti, Caplyta, Cobenfy, Fanapt, Lybalvi, Rexulti, Vraylar)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Preferred: Vraylar	
Diagnosis	Schizophrenia
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of schizophrenia	

AND

2 - Patient is 13 years of age or older

AND

3 - One of the following:

3.1 Inadequate response (minimum 30 day trial) or adverse reaction to ONE, or contraindication to ALL of the following:

- Aripiprazole
- Clozapine
- Olanzapine
- Quetiapine
- Risperidone
- Ziprasidone

OR

3.2 One of the following:

3.2.1 The patient has been receiving treatment with the requested medication, and is new to the plan (enrollment effective date within the past 90 days)

OR

3.2.2 The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Non-Preferred: Bysanti, Caplyta, Fanapt, Lybalvi, Rexulti	
Diagnosis	Schizophrenia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of schizophrenia

AND

2 - One of the following:

- For Rexulti requests: Patient is 13 years of age or older
- For Bysanti, Caplyta, Fanapt, and Lybalvi requests: Patient is 18 years of age or older

AND

3 - One of the following:

3.1 Inadequate response (minimum 30 day trial) or adverse reaction to TWO, or contraindication to ALL of the following:

- Aripiprazole
- Clozapine
- Olanzapine
- Quetiapine
- Risperidone
- Ziprasidone

OR

3.2 One of the following:

3.2.1 The patient has been receiving treatment with the requested medication, and is new to the plan (enrollment effective date within the past 90 days)

OR

3.2.2 The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

AND

4 - For Lybalvi requests ONLY, One of the following:

- Patient has a BMI of 30 kg/m2 or greater
- Patient has a BMI of 27 kg/m2 or greater with a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea)
- Patient has a documented history of weight gain of greater than or equal to 10% of their baseline weight after initiating antipsychotic medication
- Physician has provided clinical rationale for requiring samidorphan in addition to olanzapine therapy

AND

5 - For Bysanti requests ONLY, history of failure to Fanapt

Product Name:Non-Preferred: Cobenfy	
Diagnosis	Schizophrenia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of schizophrenia

AND

2 - One of the following:

2.1 BOTH of the following:

2.1.1 Inadequate response (minimum 30 day trial), adverse reaction, or contraindication to aripiprazole

AND

2.1.2 Inadequate response (minimum 30 day trial) or adverse reaction to ONE, or contraindication to ALL of the following:

- Clozapine
- Olanzapine
- Quetiapine
- Risperidone
- Ziprasidone

OR

2.2 One of the following:

2.2.1 The patient has been receiving treatment with the requested medication, and is new to the plan (enrollment effective date within the past 90 days)

OR

2.2.2 The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Preferred: Vraylar	
Diagnosis	Bipolar I Disorder
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of bipolar I disorder

AND

2 - Patient is 10 years of age or older

AND

3 - ONE of the following:

3.1 Inadequate response (minimum 30 day trial) or adverse reaction to ONE, or contraindication to ALL of the following:

- Aripiprazole
- Lamotrigine
- Lithium
- Lurasidone
- Olanzapine
- Risperidone
- Valproate

OR

3.2 One of the following:

3.2.1 The patient has been receiving treatment with the requested medication, and is new to the plan (enrollment effective date within the past 90 days)

OR

3.2.2 The patient is currently receiving treatment with requested medication in the hospital and must continue upon discharge

Product Name:Non-Preferred: Bysanti, Fanapt, Lybalvi	
Diagnosis	Bipolar I Disorder
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of bipolar I disorder

AND

2 - Patient is 18 years of age or older

AND

3 - ONE of the following:

3.1 Inadequate response (minimum 30 day trial) or adverse reaction to THREE, or contraindication to ALL of the following:

- Aripiprazole
- Lamotrigine
- Lithium
- Lurasidone
- Olanzapine
- Risperidone
- Valproate

OR

3.2 One of the following:

3.2.1 The patient has been receiving treatment with the requested medication, and is new to the plan (enrollment effective date within the past 90 days)

OR

3.2.2 The patient is currently receiving treatment with requested medication in the hospital and must continue upon discharge

AND

4 - For Lybalvi requests ONLY, One of the following:

- Patient has a BMI of 30 kg/m2 or greater

- Patient has a BMI of 27 kg/m2 or greater with a weight-related comorbidity (e.g., dyslipidemia, hypertension, type 2 diabetes, sleep apnea)
- Patient has a documented history of weight gain of greater than or equal to 10% of their baseline weight after initiating antipsychotic medication
- Physician has provided clinical rationale for requiring samidorphan in addition to olanzapine therapy

AND

5 - For Bysanti requests ONLY, history of failure to Fanapt

Product Name:Preferred: Vraylar	
Diagnosis	Bipolar Depression
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of bipolar depression

AND

2 - ONE of the following:

2.1 Inadequate response (minimum 30 day trial) or adverse reaction to ONE, or contraindication to ALL of the following:

- Lurasidone
- Quetiapine
- Olanzapine plus fluoxetine
- Valproate monotherapy
- Combination therapy (i.e., lithium plus lamotrigine/valproate, lurasidone plus lithium/valproate, quetiapine plus lithium/valproate)

OR

2.2 One of the following:

2.2.1 The patient has been receiving treatment with the requested medication, and is new to the plan (enrollment effective date within the past 90 days)

OR

2.2.2 The patient is currently receiving treatment with requested medication in the hospital and must continue upon discharge

Product Name:Non-Preferred: Caplyta	
Diagnosis	Bipolar Depression
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of bipolar depression

AND

2 - ONE of the following:

2.1 Inadequate response (minimum 30 day trial) or adverse reaction to THREE, or contraindication to ALL of the following:

- Lurasidone
- Quetiapine
- Olanzapine plus fluoxetine
- Valproate monotherapy
- Combination therapy (i.e., lithium plus lamotrigine/valproate, lurasidone plus lithium/valproate, quetiapine plus lithium/valproate)

OR

2.2 One of the following:

2.2.1 The patient has been receiving treatment with the requested medication, and is new to the plan (enrollment effective date within the past 90 days)

OR

2.2.2 The patient is currently receiving treatment with requested medication in the hospital and must continue upon discharge

Product Name:Preferred: Vraylar	
Diagnosis	Major Depressive Disorder (MDD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Major depressive disorder (MDD)
- Treatment resistant depression

AND

2 - One of the following:

2.1 Inadequate response (minimum 30 day trial) or adverse reaction to TWO different antidepressants from the following classes (antidepressants MUST be from TWO different classes):

- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
- New Generation Antidepressants (e.g., bupropion, mirtazapine, etc)
- Tricyclic Antidepressants (TCAs)

OR

2.2 One of the following:

2.2.1 The patient has been receiving treatment with the requested medication, and is new to the plan (enrollment effective date within the past 90 days)

OR

2.2.2 The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Non-Preferred: Caplyta, Rexulti	
Diagnosis	Major Depressive Disorder (MDD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Major depressive disorder (MDD)

AND

2 - One of the following:

2.1 BOTH of the following:

2.1.1 Inadequate response (minimum 30 day trial) or adverse reaction to TWO different antidepressants from the following classes (antidepressants MUST be from TWO different classes):

- Selective Serotonin Reuptake Inhibitors (SSRIs)
- Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)
- New Generation Antidepressants (e.g., bupropion, mirtazapine, etc)
- Tricyclic Antidepressants (TCAs)

AND

2.1.2 Inadequate response (minimum 30 day trial) or adverse reaction to TWO of the following:

- aripiprazole
- quetiapine ER
- risperidone
- Augmented therapy (e.g., addition of lithium, another antidepressant from a different class, thyroid hormone to current antidepressant regimen)

OR

2.2 One of the following:

2.2.1 The patient has been receiving treatment with the requested medication, and is new to the plan (enrollment effective date within the past 90 days)

OR

2.2.2 The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

Product Name:Non-Preferred: Rexulti	
Diagnosis	Agitation Associated With Dementia Due To Alzheimer's Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The requested medication is being used for treatment of agitation associated with dementia due to Alzheimer's disease

Product Name:Preferred: Vraylar; Non-Preferred: Bysanti, Caplyta, Cobenfy, Fanapt, Lybalvi, Rexulti	
Diagnosis	Requests Exceeding Quantity Limit*
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - ONE of the following:

1.1 The requested drug must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.2 The use of this drug is supported by information from one of the following appropriate compendia of current literature:

- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia – Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

AND

2 - ONE of the following:

2.1 The drug is being prescribed within the manufacturer’s published dosing guidelines

OR

2.2 The requested dose falls within dosing guidelines found in one of the following compendia of current literature:

- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols

- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia – Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

AND

3 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation

AND

4 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program

AND

5 - Physician has provided rationale for needing to exceed the quantity limit (QL) of one of the following:

- For Caplyta requests, QL of 1 capsule/day
- For Cobenfy capsule requests, QL of 2 capsules/day
- For Cobenfy starter pack requests, QL of 2 packs/365 days
- For Bysanti and Fanapt tablet requests, QL of 2 tablets/day
- For Bysanti and Fanapt titration pack requests, QL of 1 pack/180 days
- For Lybalvi requests, QL of 1 tablet/day
- For Rexulti requests, QL of 1 tablet/day
- For Vraylar 0.5 mg, 0.75 mg, 4.5 mg and 6 mg requests, QL of 1 capsule/day
- For Vraylar 1.5 mg and 3 mg requests, QL of 2 capsules/day
- For Vraylar therapy pack requests, 2 packs/365 days

Notes	*Prior authorization requests should be reviewed using the above crite ria. This section is for quantity limit requests only.

2 . Revision History

Date	Notes
9/11/2026	Vraylar to PDL, updated criteria throughout

Prior Authorization Guideline

Guideline ID	GL-161707
Guideline Name	HIV (Fuzeon, Selzentry)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name:Brand Selzentry tablets, generic maraviroc 150mg and 300mg tablets, Selzentry oral solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Diagnosis of CCR5-tropic HIV-1 infection as confirmed by a highly sensitive tropism assay

AND

1.1.2 Patient is currently taking or will be prescribed an optimized background antiretroviral therapy regimen

AND

1.1.3 Prescribed by or in consultation with a clinician with HIV expertise

OR

1.2 For continuation of prior therapy

AND

2 - For Brand Selzentry ONLY; history of failure or intolerance to generic maraviroc tablets

Product Name:Fuzeon	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Patient has been diagnosed with multidrug-resistant HIV-1 infection

AND

1.1.2 Patient is currently taking or will be prescribed an optimized background antiretroviral therapy regimen

AND

1.1.3 Prescribed by or in consultation with a clinician with HIV expertise

OR

1.2 For continuation of prior therapy

2 . Revision History

Date	Notes
12/6/2024	generic maraviroc to preferred. Brand Selzentry to NP.

Prior Authorization Guideline

Guideline ID	GL-99465
Guideline Name	Hydroxychloroquine
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Plaquenil, generic hydroxychloroquine	
Guideline Type	Quantity Limit

Approval Criteria

1 - ONE of the following:

1.1 Treatment of chronic discoid lupus erythematosus or systemic lupus erythematosus

OR

1.2 Treatment of rheumatoid arthritis **OR** **1.3** Prophylaxis of malaria in geographic areas where chloroquine resistance is not reported **OR** **1.4** Treatment of uncomplicated malaria	
Notes	Authorization will be issued for 6 months up to a quantity of 120 tablets per 30 days.

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona standard to Medicaid Arizona

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Prior Authorization Guideline

Guideline ID	GL-114463
Guideline Name	Hyftor (sirolimus) topical gel
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Hyftor	
Approval Length	4 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of facial angiofibroma associated with tuberous sclerosis complex

AND

2 - Patient is 6 years of age or older

AND

3 - Patient is not a candidate for laser therapy or surgical treatments

AND

4 - Prescribed by or in consultation with a dermatologist

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

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., improvement in size or redness of facial angiofibroma)

2 . Revision History

Date	Notes
9/26/2022	New program

Prior Authorization Guideline

Guideline ID	GL-589222
Guideline Name	Icotyde (icotrokinra)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Icotyde	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderate to severe plaque psoriasis (PsO)

AND

2 - Both of the following:

- Patient is 12 years of age or older
- Patient weighs at least 40 kg

AND

3 - One of the following:

- Greater than or equal to 3% body surface area involvement
- Severe scalp psoriasis
- Palmoplantar (i.e., palms, soles), facial, or genital involvement

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to one of the following topical therapies:

- Corticosteroids (e.g., betamethasone, clobetasol)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

5 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following:

5.1 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

5.2 History of failure, contraindication, or intolerance to one of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

5.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Otezla (apremilast)
- A preferred ustekinumab biosimilar

AND

6 - Prescribed by or in consultation with a dermatologist

Product Name:Icotyde	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by ONE of the following:

- Reduction in the body surface area (BSA) involvement from baseline
- Improvement in symptoms (e.g., pruritus, inflammation) from baseline

AND

2 - Prescribed by or in consultation with a dermatologist

2 . Revision History

Date	Notes
4/30/2026	New program

Prior Authorization Guideline

Guideline ID	GL-110775
Guideline Name	Igalmi (dexmedetomidine)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/15/2022

1 . Criteria

Product Name:Igalmi	
Approval Length	14 Days [A]
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Schizophrenia
- Bipolar I or II disorder

AND

2 - For the treatment of acute agitation

AND

3 - Trial and failure, contraindication or intolerance to at least two preferred products used in acute agitation (e.g., olanzapine, ziprasidone)

AND

4 - Patient is currently being managed with maintenance medication for their underlying disorder (e.g., aripiprazole, olanzapine, quetiapine, lithium, valproic acid)

2 . Revision History

Date	Notes
8/4/2022	New Program

Prior Authorization Guideline

Guideline ID	GL-300288
Guideline Name	Ilaris (canakinumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Ilaris	
Diagnosis	Periodic Fever Syndromes [Cryopyrin-Associated Periodic Syndromes (CAPS), Tumor Necrosis Factor Receptor Associated Periodic Syndrome (TRAPS), Hyperimmunoglobulin D Syndrome (HIDS)/Mevalonate Kinase Deficiency(MKD), Familial Mediterranean Fever(FMF)]
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of one of the following periodic fever syndromes:

- Cryopyrin-associated periodic syndromes (CAPS), including familial cold autoinflammatory syndrome (FCAS) and Muckle-Wells syndrome (MWS)
- Tumor necrosis factor (TNF) receptor associated periodic syndrome (TRAPS)
- Hyperimmunoglobulin D (Hyper-IgD) syndrome (HIDS/mevalonate kinase deficiency (MKD)
- Familial Mediterranean Fever (FMF)

AND

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

- Rheumatologist
- Immunologist

AND

3 - Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

AND

4 - Patients diagnosed with Familial Mediterranean Fever (FMF) have a history of failure, contraindication, or intolerance to colchicine (applies to diagnosis of FMF ONLY)

Product Name:Ilaris	
Diagnosis	Periodic Fever Syndrome [CAPS, TRAPS, HIDS/MKD, FMF]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy [defined as a decrease in frequency or severity of attacks, or a decrease in index disease flare or normalization of CRP (C-reactive protein)]

AND

2 - Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

Product Name:Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active systemic juvenile idiopathic arthritis (SJIA)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:

- Minimum duration of a 3-month trial and failure of methotrexate

- Minimum duration of a 1-month trial of a nonsteroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen)
- Minimum duration of a 2-week trial of a systemic glucocorticoid (e.g., prednisone)

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to a preferred tocilizumab biosimilar

AND

4 - Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

AND

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

- Rheumatologist
- Immunologist

Product Name:Ilaris	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by at least one of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in clinical features or symptoms (e.g., pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline

AND

2 - Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

Product Name:Ilaris	
Diagnosis	Still's Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of Still’s Disease, including Adult-Onset Still’s Disease (AOSD)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to one of the following: [1-3]

- Corticosteroids (e.g., prednisone)
- Methotrexate
- Nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen)

AND

3 - Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

AND

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

- Rheumatologist
- Immunologist

Product Name:Ilaris	
Diagnosis	Still's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Both of the following:

- Patient is not receiving concomitant treatment with Tumor Necrosis Factor (TNF) inhibitors (e.g., Enbrel [etanercept], Humira [adalimumab], Remicade [infliximab])
- Patient is not receiving concomitant treatment with Interleukin-1 inhibitor (e.g., Arcalyst [rilonacept], Kineret [anakinra])

Product Name:Ilaris

Diagnosis	Gout Flares
Approval Length	12 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of gout flares

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ALL of the following:

- Nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen)
- Colchicine
- Corticosteroids (e.g., prednisone)

AND

3 - Patient has not received Ilaris in the last 12 weeks [A]

AND

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

- Rheumatologist
- Nephrologist

2 . Definitions

Definition	Description

Cryopyrin-Associated Periodic Syndromes (CAPS):	A group of rare, autosomal dominantly inherited auto-inflammatory conditions comprising of Familial-Cold Auto-inflammatory Syndrome (FCAS), Muckle-Wells Syndrome (MWS), Neonatal-Onset Multisystem Inflammatory Disease (NOMID) or also known as Chronic Infantile Neurologic Cutaneous Articular Syndrome (CINCA), which are caused by the CIAS1 gene mutation and characterized by recurrent symptoms (urticaria-like skin lesions, fever chills, arthralgia, profuse sweating, sensorineural hearing/vision loss, and increased inflammation markers the blood). Approximately 300 people in the United States are affected by CAPS. [1, 4, 5]
Familial Cold Autoinflammatory Syndrome (FCAS):	The mildest form of CAPS, is characterized by cold-induced, daylong episodes of fever associated with rash, arthralgia, headaches and less frequently conjunctivitis, but without other signs of CNS inflammation. Symptoms usually begin during the first 6 months of life and are predominantly triggered by cold exposure. Duration of episodes usually is less than 24 hours. [5]
Muckle-Wells Syndrome (MWS):	A subtype of CAPS, which is characterized by episodic attacks of inflammation associated with a generalized urticaria-like rash, fever, malaise, arthralgia, and progressive hearing loss. Duration of symptoms usually lasts from 24-48 hours. [5]

3 . Endnotes

A. The recommended dose of Ilaris for adult patients with a gout flare is 150 mg administered subcutaneously. In patients who require re-treatment, there should be an interval of at least 12 weeks before a new dose of Ilaris may be administered [1].

4 . Revision History

Date	Notes
7/3/2025	SJIA: Added step through preferred tocilizumab biosimilar

Prior Authorization Guideline

Guideline ID	GL-152432
Guideline Name	Ilumya (tildrakizumab-asmn)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/20/2024

1 . Criteria

Product Name:Ilumya	
Diagnosis	Chronic Moderate to Severe Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

1.1.1 Diagnosis of chronic moderate to severe plaque psoriasis

AND

1.1.2 Greater than or equal to 3 percent body surface area involvement, palmoplantar, facial, genital involvement, or severe scalp psoriasis

AND

1.1.3 Submission of medical records (e.g., chart notes) or paid claims documenting history of failure, to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Anthralin
- Coal tar

AND

1.1.4 Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.1.5 Submission of medical records (e.g., chart notes) or paid claims documenting history of failure, contraindication, or intolerance to ALL of the following preferred biologic products:

- A preferred adalimumab biosimilar
- Enbrel (etanercept)
- Otezla (apremilast)

AND

1.1.6 Patient is NOT receiving Ilumya in combination with ONE of the following:

- Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

AND

1.1.7 Prescribed by or in consultation with a dermatologist

OR

1.2 ALL of the following:

1.2.1 Submission of medical records (e.g., chart notes) or paid claims documenting patient is currently on the requested therapy

AND

1.2.2 Diagnosis of chronic moderate to severe plaque psoriasis

AND

1.2.3 Patient is NOT receiving Ilumya in combination with ONE of the following:

- Biologic DMARD [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

AND

1.2.4 Prescribed by or in consultation with a dermatologist

Product Name:Ilumya	
Diagnosis	Chronic Moderate to Severe Plaque Psoriasis

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

Approval Criteria

1 - Documentation of positive clinical response to Ilumya therapy

AND

2 - Patient is NOT receiving Ilumya in combination with ONE of the following:

- Biologic DMARD (disease modifying anti-rheumatic drug) [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Orencia (abatacept)]
- Janus kinase inhibitor [e.g., Xeljanz (tofacitinib)]
- Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

AND

3 - Prescribed by or in consultation with a dermatologist

2 . Revision History

Date	Notes
8/20/2024	Updated submission of medical records verbiage in criteria

Prior Authorization Guideline

Guideline ID	GL-363221
Guideline Name	Iluvien (fluocinolone implant)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Iluvien	
Diagnosis	Uveitis
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming one of the following diagnoses:

- Intermediate uveitis
- Posterior uveitis

- Panuveitis

AND

2 - Inflammation is chronic

AND

3 - Inflammation is not due to an infection

Product Name:Iluvien	
Diagnosis	Diabetic macular edema
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of diabetic macular edema

AND

2 - Patient has previously been treated with a course of corticosteroids

AND

3 - Patient has NOT had a clinically significant rise in intraocular pressure

2 . Revision History

Date	Notes

8/28/2025	New program

Prior Authorization Guideline

Guideline ID	GL-749237
Guideline Name	Imaavy (nipocalimab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Imaavy	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of generalized myasthenia gravis (gMG)

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ONE of the following:

2.1 Both of the following:

2.1.1 Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

2.1.2 One of the following:

2.1.2.1 Trial and failure, contraindication, or intolerance to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

OR

2.1.2.2 Both of the following:

2.1.2.2.1 Trial and failure, contraindication, or intolerance to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

2.1.2.2.2 Trial and failure, contraindication, or intolerance to one of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)

OR

2.2 Submission of medical records (e.g., chart notes) or verification of paid claims documenting BOTH of the following:

2.2.1 Patient is anti-muscle-specific tyrosine kinase (MuSK) antibody positive

AND

2.2.2 One of the following:

2.2.2.1 Trial and failure, contraindication, or intolerance to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

OR

2.2.2.2 Both of the following:

2.2.2.2.1 Trial and failure, contraindication, or intolerance to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

2.2.2.2.2 Trial and failure, contraindication, or intolerance to one of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)
- Rituximab

AND

3 - Patient is 12 years of age or older

AND

4 - Prescribed by or in consultation with a neurologist

AND

5 - Requested medication is not being used in combination with any one of the following:

- Another neonatal Fc Receptor (FcRn) blocker (e.g., Rystiggo, Vyvgart, Vyvgart Hytrulo)
- Complement inhibitor (e.g., eculizumab, Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)
- B-cell depletion therapy (e.g., Uplizna)

Product Name:Imaavy	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - Requested medication is not being used in combination with any one of the following:

- Another neonatal Fc Receptor (FcRn) blocker (e.g., Rystiggo, Vyvgart, Vyvgart Hytrulo)
- Complement inhibitor (e.g., eculizumab, Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)
- B-cell depletion therapy (e.g., Uplizna)

Product Name:Imaavy	
Diagnosis	warm Autoimmune Hemolytic Anemia (wAIHA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of warm autoimmune hemolytic anemia (wAIHA)

AND

1.2 wAIHA has been present for at least 3 months

AND

1.3 Patient has evidence of hemolysis (e.g., elevated lactate dehydrogenase (LDH), bilirubin level above the normal reference range, increased reticulocyte count, decreased haptoglobin levels)

AND

1.4 Patient has a hemoglobin level less than or equal to 10.0 gram per deciliter (g/dL) prior to treatment initiation

AND

1.5 Patient has a positive monospecific direct antiglobulin test (DAT)

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming patient is currently receiving or has previously received treatment with a corticosteroid (e.g., prednisone)

AND

3 - Patient is 12 years of age or older

AND

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

- hematologist
- hematologist/oncologist

Product Name:Imaavy	
Diagnosis	warm Autoimmune Hemolytic Anemia (wAIHA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., hemoglobin level greater than or equal to 10 gram per deciliter (g/dL) or an increase of at least 2g/dL from baseline)

2 . Revision History

Date	Notes
10/28/2026	Added criteria for new indication of wAIHA

Prior Authorization Guideline

Guideline ID	GL-620193
Guideline Name	Imcivree (setmelanotide)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Imcivree	
Diagnosis	POMC, PCSK1, LEPR Deficiency
Approval Length	n/a- Requests for indications other than Bardet-Biedl syndrome (BBS) and Hypothalamic Obesity (HO) are excluded from coverage and will not be approved.
Guideline Type	Prior Authorization
Approval Criteria **1** - Requests for indications other than Bardet-Biedl syndrome (BBS) and Hypothalamic Obesity (HO) are excluded from coverage and will not be approved.	

Notes	Requests for indications other than Bardet-Biedl syndrome (BBS) and Hypothalamic Obesity (HO) are excluded from coverage and will not b e approved.

Product Name:Imcivree	
Diagnosis	Bardet-Biedl syndrome (BBS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Both of the following:

- Diagnosis of Bardet-Biedl syndrome (BBS)
- Molecular genetic testing to confirm homozygous variants in a BBS gene that are interpreted as pathogenic or likely pathogenic (results of genetic testing must be submitted)

AND

1.2 One of the following:

1.2.1 Patient has at least three of the following primary features of the disease:

- Rod-cone dystrophy
- polydactyly
- learning disabilities
- hypogonadotropic hypogonadism and/or genitourinary anomalies
- renal anomalies

OR

1.2.2 Both of the following:

1.2.2.1 Patient has at least two of the following primary features of the disease:

- Rod-cone dystrophy
- polydactyly
- learning disabilities
- hypogonadotropic hypogonadism and/or genitourinary anomalies
- renal anomalies

AND

1.2.2.2 Patient has at least two of the following secondary features of the disease:

- Speech disorder/delay
- strabismus/cataracts/astigmatism
- brachydactyly/syndactyly
- developmental delay
- ataxia/poor coordination/imbalance
- mild spasticity (especially lower limbs)
- diabetes mellitus
- dental crowding/hypodontia/small roots/high arched palate
- left ventricular hypertrophy/congenital heart disease
- hepatic fibrosis

AND

1.3 Patient has been diagnosed with obesity defined by one of the following:

- BMI greater than or equal to 30 kg/m2 for adults 18 years of age or older
- Weight greater than or equal to 95th percentile using growth chart assessments for pediatric patients

AND

1.4 Patient is 2 years of age or older

AND

1.5 Other causes or types of obesity have been ruled out (e.g., obesity due to suspected POMC, PCSK1, or LEPR deficiency with POMC, PCSK1, or LEPR variants classified as benign or likely benign; obesity associated with other genetic syndromes; polygenic obesity)

AND **2** - Prescribed by or in consultation with an endocrinologist	
Notes	Requests for indications other than Bardet-Biedl syndrome (BBS) and Hypothalamic Obesity (HO) are excluded from coverage and will not b e approved.

Product Name:Imcivree	
Diagnosis	Bardet-Biedl syndrome (BBS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting BOTH of the following: **1.1** Patient has been on therapy for 12 months or more **AND** **1.2** Weight loss of greater than or equal to 5% of baseline body weight or BMI	
Notes	Requests for indications other than Bardet-Biedl syndrome (BBS) and Hypothalamic Obesity (HO) are excluded from coverage and will not b e approved.

Product Name:Imcivree	
Diagnosis	Hypothalamic Obesity (HO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of acquired hypothalamic obesity (HO)

AND

2 - Submission of medical records (e.g., chart notes) supporting HO diagnosis as evidenced by both of the following:

- Documented acquired hypothalamic injury supported by neuroimaging or neurosurgical history
- Accelerated and sustained weight gain with hyperphagia or clear change in energy balance temporally linked to the injury

AND

3 - Patient is 4 years of age or older

AND

4 - Submission of medical records (e.g., chart notes) confirming both of the following:

4.1 Weight gain is associated with hypothalamic injury (e.g., traumatic brain injury, neurosurgery, brain tumor)

AND

4.2 Other causes or types of obesity have been excluded (e.g., PPL [POMC, PCSK1, LEPR, collectively], BBS, obesity associated with other genetic syndromes; polygenic obesity)

AND

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

- BMI greater than or equal to 30 kg/m2 for adults 18 years of age or older

- BMI greater than or equal to 95th percentile using growth assessment charts for pediatric patients

AND

6 - Submission of medical records (e.g., chart notes) confirming patient's BMI z-score has been recorded at baseline

Notes	Requests for indications other than Bardet-Biedl syndrome (BBS) and Hypothalamic Obesity (HO) are excluded from coverage and will not b e approved.

Product Name:Imcivree	
Diagnosis	Hypothalamic Obesity (HO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

- Patient is 18 years of age or older
- Submission of medical records (e.g., chart notes) confirming reduction in BMI of greater than or equal to 5% from baseline

OR

2 - BOTH of the following:

- Patient is 4 years of age to less than 18 years of age
- Submission of medical records (e.g., chart notes) confirming reduction in BMI z-score of greater than or equal to 0.2 points from baseline

Notes	Requests for indications other than Bardet-Biedl syndrome (BBS) and Hypothalamic Obesity (HO) are excluded from coverage and will not b e approved.

2 . Revision History

Date	Notes
6/25/2026	Added criteria for new indication of HO, updated coverage notes for all indications to specify only BBS and HO indications are covered.

Prior Authorization Guideline

Guideline ID	GL-525296
Guideline Name	Immune Globulins - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Asthma (severe, persistent, high-dose steroid-dependent)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following diagnoses:	

- Severe asthma
- Persistent asthma
- High-dose steroid-dependent asthma

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Patient is receiving optimal conventional asthma therapy (e.g., high-dose inhaled glucocorticoids, short- and long-acting inhaled β agonists)

AND

4 - History of failure, contraindication, or intolerance to at least TWO of the following:

- Anti-IgE therapy [e.g., Xolair (omalizumab)]
- Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]
- Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Cinqair (resilizumab), Fasenra (benralizumab)]

AND

5 - Patient has required continuous oral glucocorticoid therapy for a minimum of 2 months prior to the decision to initiate immune globulin therapy

AND

6 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

AND

7 - Prescribed by or in consultation with a pulmonologist or allergist or immunologist

AND

8 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Asthma (severe, persistent, high-dose steroid-dependent)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Autoimmune Bullous Disease [pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane (cicatricial) pemphigoid, epidermolysis bullosa acquisita, pemphigoid gestationis, linear IgA bullous dermatosis]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Autoimmune Bullous Disease [pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane (cicatricial) pemphigoid, epidermolysis bullosa acquisita, pemphigoid gestationis, linear IgA bullous dermatosis]

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Extensive and debilitating disease

AND

4 - History of failure, contraindication, or intolerance to systemic corticosteroids with concurrent immunosuppressive treatment (e.g., azathioprine, cyclophosphamide, mycophenolate mofetil)

AND

5 - Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 to 2,000 milligrams (mg) per kilogram (kg) per month divided into 3 equal doses, each given over 3 consecutive days or 400 mg per kg per day given over 5 consecutive days per month. IVIG administration may be repeated monthly as needed for patients requiring maintenance therapy. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

6 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

AND

7 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen

- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Autoimmune Bullous Disease [pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane (cicatricial) pemphigoid, epidermolysis bullosa acquisita, pemphigoid gestationis, linear IgA bullous dermatosis]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Bone Marrow Transplant (BMT)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following uses:

- Prevention of acute graft vs. host disease (GVHD)
- Prevention of infection

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Confirmed allogeneic bone marrow transplant within the last 100 days

AND

4 - Documented severe hypogammaglobulinemia [Immunoglobulin (IgG) less than 400 milligrams (mg) per deciliter (dL)]

AND

5 - Intravenous immunoglobulin (IVIG) dose does not exceed 500 mg per kilogram (kg) once weekly for the first 90 days of therapy, then monthly up to 360 days after transplantation

AND

6 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Bone Marrow Transplant (BMT)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Chronic Inflammatory Demyelinating Polyneuropathy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic inflammatory demyelinating polyneuropathy as confirmed by ALL of the following:

1.1 Progressive symptoms present for at least 2 months

AND

1.2 Symptomatic polyradiculoneuropathy as indicated by progressive or relapsing motor or sensory impairment of more than one limb

AND

1.3 Electrodiagnostic findings [consistent with European Federation of Neurological Societies/Peripheral Nerve Society (EFNS/PNS) guidelines for definite chronic inflammatory demyelinating polyradiculoneuropathy (CIDP)] indicating at least ONE of the following criteria are present:

- Motor distal latency prolongation in 2 nerves
- Reduction of motor conduction velocity in 2 nerves
- Prolongation of F-wave latency in 2 nerves
- Absence of F-waves in at least 1 nerve
- Partial motor conduction block of at least 1 motor nerve
- Abnormal temporal dispersion in at least 2 nerves
- Distal compound muscle action potential (CMAP) duration increase in at least 1 nerve

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 consecutive days administered in up to six monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities.

AND

5 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo

Diagnosis	Chronic Inflammatory Demyelinating Polyneuropathy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as measured by an objective scale [e.g., Rankin, Modified Rankin, Medical Research Council (MRC) scale]

AND

2 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 consecutive days. IVIG administration may be repeated monthly as needed to prevent exacerbation. Dosing interval may need to be adjusted in patients with severe comorbidities.

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Prevention of infection in B-cell Chronic Lymphocytic Leukemia (CLL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of B-cell chronic lymphocytic leukemia (CLL)

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - ONE of the following:

- Documented hypogammaglobulinemia [Immunoglobulin (IgG) less than 500 milligrams (mg) per deciliter (dL)]
- History of bacterial infection(s) associated with B-cell CLL

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 400 milligrams (mg) per kilogram (kg) every 3 to 4 weeks

AND

5 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex

- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Prevention of infection in B-cell Chronic Lymphocytic Leukemia (CLL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Dermatomyositis or polymyositis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of dermatomyositis or polymyositis

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - History of failure, contraindication, or intolerance to immunosuppressive therapy (e.g., azathioprine, corticosteroids, cyclophosphamide, methotrexate)

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 consecutive days administered as monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

5 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

AND

6 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Dermatomyositis or polymyositis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Diabetes Mellitus
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is newly diagnosed with insulin dependent (type 1) diabetes mellitus

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Patient is not a candidate for or is refractory to insulin therapy

AND

4 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex

- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Diabetes Mellitus
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Feto-neonatal Alloimmune Thrombocytopenia (AIT)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 For pregnant women ALL of the following:

1.1.1 Diagnosis of feto-neonatal alloimmune thrombocytopenia (AIT)

AND

1.1.2 ONE of the following:

- Previously affected pregnancy
- Family history of the disease
- Platelet alloantibodies found on screening

AND

1.1.3 ONE of the following:

1.1.3.1 Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 milligrams (mg) per kilogram (kg) once weekly until delivery

OR

1.1.3.2 BOTH of the following:

- Fetus or newborn is considered to be at high risk for developing intracranial hemorrhage or other severe complication of AIT
- IVIG dose does not exceed 2,000 mg/kg once weekly until delivery

OR

1.2 For newborns BOTH of the following:

1.2.1 Diagnosis of feto-neonatal alloimmune thrombocytopenia

AND

1.2.2 Thrombocytopenia that persists after transfusion of antigen-negative compatible platelets

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Feto-neonatal Alloimmune Thrombocytopenia (AIT)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Graves' ophthalmopathy Guillain-Barré syndrome (GBS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Guillain-Barré Syndrome

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Severe disease requiring aid to walk

AND

4 - Onset of neuropathic symptoms within the last four weeks

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 consecutive days. IVIG administration may be repeated in up to three monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

7 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

AND

8 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig

- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Graves' ophthalmopathy Guillain-Barré syndrome (GBS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC,

Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Prevention of bacterial infection in pediatric HIV
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of HIV disease

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Patient age less than or equal to 13 years of age

AND

4 - ONE of the following:

- Documented hypogammaglobulinemia [Immunoglobulin (IgG) less than 400 milligrams (mg) per deciliter (dL)]
- Functional antibody deficiency as demonstrated by either poor specific antibody titers or recurrent bacterial infections

AND

5 - Intravenous immunoglobulin (IVIG) dose does not exceed 400 mg per kilogram (kg) every 28 days

AND

6 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Prevention of bacterial infection in pediatric HIV
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Immune thrombocytopenia [Idiopathic thrombocytopenic purpura (ITP)]
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 ALL of the following:

- Diagnosis of acute thrombocytopenic purpura (ITP)
- Documented platelet count less than 50 x 10^9 per Liter (L) (obtained within the past 30 days)
- Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 milligrams (mg) per kilogram(kg) per day for 1 to 2 days

OR

1.2 All of the following:

1.2.1 Diagnosis of chronic thrombocytopenic purpura (ITP)

AND

1.2.2 History of failure, contraindication, or intolerance to at least ONE of the following:

- Corticosteroids
- Splenectomy

AND

1.2.3 IVIG dose does not exceed 2,000 mg per kg per month given over 2 to 5 consecutive days. IVIG administration may be repeated monthly as needed to prevent exacerbation. Dosing interval should be adjusted depending upon response and titrated to the minimum effective dose that can be given at maximum intervals to maintain safe platelet levels.

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC,

Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Immune thrombocytopenia [Idiopathic thrombocytopenic purpura (ITP)]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Kawasaki Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Kawasaki disease

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Intravenous immunoglobulin (IVIG) dose does not exceed 4,000 milligrams (mg) per kilograms (kg) for five consecutive days or a single dose of 2,000 mg per kg

AND

4 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Kawasaki Disease
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Lambert-Eaton Myasthenic Syndrome (LEMS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Lambert-Eaton myasthenic syndrome (LEMS)

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - History of failure, contraindication, or intolerance to immunomodulator monotherapy (e.g., azathioprine, corticosteroids)

AND

4 - Concomitant immunomodulator therapy (e.g., azathioprine, corticosteroids), unless contraindicated, will be used for long-term management of LEMS

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Intravenous Immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 consecutive days. IVIG administration may be repeated monthly as needed to prevent exacerbation. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

7 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

AND

8 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Lambert-Eaton Myasthenic Syndrome (LEMS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Lennox Gastaut Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - History of failure, contraindication or intolerance to initial treatment with traditional anti-epileptic pharmacotherapy (e.g., lamotrigine, phenytoin, valproic acid)

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 400 milligrams (mg) per kilogram (kg) per day given for 4 to 5 consecutive days. IVIG administration may be repeated monthly as needed in patients requiring maintenance therapy. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

5 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

AND

6 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Lennox Gastaut Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Multifocal Motor Neuropathy (MMN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multifocal motor neuropathy as confirmed by ALL of the following:

- Weakness with slowly progressive or stepwise progressive course over at least one month
- Asymmetric involvement of two or more nerves
- Absence of motor neuron signs and bulbar signs

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,400 milligram (mg) per kilogram (kg) per month given over 2 to 5 consecutive days. IVIG administration may be repeated monthly as needed to prevent exacerbation. Dosing interval may need to be adjusted in patients with severe comorbidities.

AND

5 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Multifocal Motor Neuropathy (MMN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as measured by an objective scale [e.g., Rankin, Modified Rankin, Medical Research Council (MRC) scale]

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,400 milligram (mg) per kilogram (kg) per month given over 2 to 5 consecutive days. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

4 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Prevention of infection in Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple myeloma

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - ONE of the following:

- Documented hypogammaglobulinemia [immunoglobulin (IgG) less than 500 milligrams (mg) per deciliter (dL)]
- History of bacterial infection(s) associated with multiple myeloma

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 400 mg per kilogram (kg) every 3 to 4 weeks

AND

5 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo

Diagnosis	Prevention of infection in Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Relapsing Multiple Sclerosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of relapsing forms of multiple sclerosis (MS) (e.g., relapsing-remitting MS, secondary- progressive MS with relapses, progressive-relapsing MS with relapses)

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Documentation of an MS exacerbation or progression (worsening) of the patient's clinical status from the visit prior to the one prompting the decision to initiate immune globulin therapy

AND

4 - History of failure, contraindication, or intolerance to at least TWO of the following agents:

- Avonex (interferon beta-1a)
- Briumvi
- Brand Copaxone
- generic dalfampridine
- generic dimethyl fumarate
- generic fingolimod
- Kesimpta
- Ocrevus (ocrelizumab)/Ocrevus Zunovo
- Rebif (interferon beta-1a)
- generic teriflunomide
- Tysabri (natalizumab)

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Induction, when indicated, does not exceed a dose of 400 milligrams (mg) per kilogram (kg) daily for up to five days

AND

7 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Relapsing Multiple Sclerosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Medical records, including findings of interval examination including neurological deficits incurred and assessment of disability [e.g., Expanded Disability Status Scale (EDSS), Functional Systems Score (FSS), Multiple Sclerosis Functional Composite (MSFC), Disease Steps (DS)]

AND

2 - Stable or improved disability score (e.g., EDSS, FSS, MSFC, DS)

AND

3 - Documentation of decreased number of relapses since starting immune globulin therapy

AND

4 - Diagnosis continues to be the relapsing forms of multiple sclerosis (MS)

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 milligram (mg) per kilogram (kg) monthly

AND

7 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Myasthenia Gravis - Exacerbation
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of generalized myasthenia gravis

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Evidence of myasthenia exacerbation, defined by at least ONE of the following symptoms in the last month

- Difficulty swallowing
- Acute respiratory failure
- Major functional disability responsible for the discontinuation of physical activity
- Recent immunotherapy treatment with a checkpoint inhibitor [e.g., Keytruda (pembrolizumab), Opdivo (nivolumab), Tecentriq (atezolizumab)]

AND

4 - ONE of the following:

- History of failure, contraindication, or intolerance to immunomodulator therapy (e.g., azathioprine, mycophenolate mofetil, cyclosporine) for long-term management of myasthenia gravis
- Currently receiving immunomodulator therapy (e.g., azathioprine, mycophenolate mofetil, cyclosporine) for long-term management of myasthenia gravis

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days administered in up to three monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities.

AND

7 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembfiy

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Refractory Myasthenia Gravis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of refractory generalized myasthenia gravis by or in consultation with a physician or center with expertise in management of myasthenia gravis

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Documentation that the disease status is unchanged or worsening (persistent or worsening symptoms that limit functioning) despite failure, contraindication, or intolerance to BOTH of the following (used in adequate doses and duration):

- Corticosteroids
- Two immunomodulator therapies (e.g., azathioprine, mycophenolate mofetil, cyclosporine, methotrexate, tacrolimus)

AND

4 - Currently receiving immunomodulator therapy (e.g., corticosteroids, azathioprine, mycophenolate mofetil, cyclosporine, methotrexate, tacrolimus), used in adequate doses, for long-term management of myasthenia gravis

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days administered in up to three monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities.

AND

7 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Myasthenia Gravis –Exacerbation and Refractory Myasthenia Gravis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Neuromyelitis Optica
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values, etc.) to support the diagnosis of neuromyelitis optica spectrum disorder (NMOSD) by a neurologist confirming ALL of the following:

1.1 Serologic testing for anti-aquaporin-4 immunoglobulin G (AQP4-IgG) or Neuromyelitis optica immunoglobulin G (NMO-IgG) antibodies has been performed

AND

1.2 ONE of the following:

1.2.1 If AQP4-IgG/NMO-IgG positive, past medical history of ONE of the following:

- Optic neuritis
- Acute myelitis
- Area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting
- Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
- Symptomatic cerebral syndrome with NMOSD-typical brain lesions

OR

1.2.2 If AQP4-IgG/NMO-IgG negative, past medical history of TWO of the following:

- Optic neuritis
- Acute myelitis
- Area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting

- Acute brainstem syndrome
- Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions
- Symptomatic cerebral syndrome with NMOSD-typical brain lesions

AND

1.3 Diagnosis of multiple sclerosis or other diagnoses have been ruled out

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - History of failure, contraindication, or intolerance to at least TWO of the following:

- Azathioprine
- Corticosteroids
- Mycophenolate mofetil
- Rituximab
- Soliris (eculizumab)

AND

4 - Patient is not receiving immune globulin in combination with either of the following:

- Rituximab
- Soliris (eculizumab)

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligram (mg) per kilogram (kg) per month given over 2 to 5 days administered in up to six monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities.

AND

7 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Neuromyelitis Optica
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has previously been treated with immune globulin

AND

2 - Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a positive clinical response from baseline as demonstrated by BOTH of the following:

2.1 Reduction in the number and or severity of relapses or signs and symptoms of neuromyelitis optica spectrum disorder (NMOSD)

AND

2.2 Maintenance, reduction, or discontinuation of dose(s) of any baseline immunosuppressive therapy (IST) prior to starting immune globulin. (NOTE: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat NMOSD or exacerbation of symptoms while on immune globulin therapy will be considered as treatment failure.)

AND

3 - Patient is not receiving immune globulin in combination with either of the following:

- Rituximab
- Soliris (eculizumab)

AND

4 - Prescribed by or in consultation with a neurologist

AND

5 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days administered in up to six monthly infusions. Dosing interval may need to be adjusted in patients with severe comorbidities

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo

Diagnosis	Posttransfusion Purpura
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of posttransfusion purpura

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 milligrams (mg) per kilogram (kg) for 2 days

AND

4 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen

- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Posttransfusion Purpura
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Post B-Cell Targeted Therapies
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation confirming previous treatment of B-cell targeted therapy within the last 100 days [e.g., CAR-T (e.g., Kymriah), Rituxan (rituximab), Besponsa (inotuzumab ozogamicin)]

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - BOTH of the following:

- Documented hypogammaglobulinemia [immunoglobulin (IgG) less than 500 milligrams (mg) per deciliter (dL)]
- History of bacterial infection(s) associated with B-cell depletion

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 400 mg per kilogram (kg) every 4 weeks, up to 360 days after discontinuation of B-cell depleting therapy

AND

5 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked

- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Post B-Cell Targeted Therapies
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Primary Immunodeficiency Syndromes
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary immunodeficiency

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Clinically significant functional deficiency of humoral immunity as evidenced by ONE of the following:

- Documented failure to produce antibodies to specific antigens
- History of significant recurrent infections

AND

4 - Initial intravenous immunoglobulin (IVIG) dose is 200 to 800 milligrams (mg) per kilogram (kg) every 3 to 4 weeks, based on product prescribing information, and titrated based upon patient response (For subcutaneous immune globulin (SCIG) products, FDA-labeled dosing and conversion guidelines will used to determine benefit coverage.)

AND

5 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig

- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Primary Immunodeficiency Syndromes
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC,

Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Rasmussen Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of ONE of the following demonstrating that:

- Short term amelioration of encephalitis is needed prior to definitive surgical therapy
- Disease symptoms (e.g., seizures) persist despite surgical treatment
- The patient is not a candidate for surgical treatment

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days

AND

4 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid

- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Rasmussen Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Stiff-Person Syndrome

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

Approval Criteria

1 - Diagnosis of stiff-person syndrome

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - History of failure, contraindication or intolerance to GABAergic (gamma-aminobutyric acid analogs) medication (e.g., baclofen, benzodiazepines)

AND

4 - Prescribed by or in consultation with a neurologist

AND

5 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days. IVIG administration may be repeated monthly as needed for patients requiring maintenance therapy. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

6 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Stiff-Person Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical improvement from baseline

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligrams (mg) per kilogram (kg) per month given over 2 to 5 days. IVIG administration may be repeated monthly

as needed for patients requiring maintenance therapy. Dosing interval may need to be adjusted in patients with severe comorbidities

AND

4 - For long term treatment, documentation of titration to the minimum dose and frequency needed to maintain a sustained clinical effect

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Thrombocytopenia, secondary to Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV), or pregnancy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- Diagnosis of thrombocytopenia secondary to Hepatitis C Virus (HCV) infection
- Patient is receiving concurrent antiviral therapy, unless contraindicated

OR

1.2 Both of the following:

- Diagnosis of thrombocytopenia secondary Human Immunodeficiency Virus (HIV) infection
- Patient is receiving concurrent antiviral therapy, unless contraindicated

OR

1.3 Diagnosis of thrombocytopenia secondary to pregnancy

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - Documented platelet count less than 50 x 10^9 per liter (L) (obtained within the past 30 days)

AND

4 - Intravenous immunoglobulin (IVIG) dose does not exceed 1,000 milligrams (mg) per kilogram (kg) per day for 1 to 2 days

AND

5 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	Thrombocytopenia, secondary to Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV), or pregnancy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- Diagnosis of thrombocytopenia secondary to Hepatitis C Virus (HCV) infection
- Patient is receiving concurrent antiviral therapy, unless contraindicated

OR

1.2 Both of the following:

- Diagnosis of thrombocytopenia secondary Human Immunodeficiency Virus (HIV) infection
- Patient is receiving concurrent antiviral therapy, unless contraindicated

OR

1.3 Diagnosis of thrombocytopenia secondary to pregnancy

AND

2 - Intravenous immunoglobulin (IVIG) dose does not exceed 2,000 milligram (mg) per kilogram (kg) per month given over 2 to 5 consecutive days. IVIG administration may be repeated monthly as needed to prevent exacerbation. Dosing interval should be adjusted depending upon response and titrated to the minimum effective dose that can be given at maximum intervals to maintain safe platelet levels.

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	All other indications
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Autoimmune Uveitis
- Cytomegalovirus (CMV) induced pneumonitis in solid organ transplants
- Enteroviral Meningoencephalitis
- IgM antimyelin-associated glycoprotein paraprotein-associated peripheral neuropathy
- Lymphoproliferative disease (treatment of bacterial infections)
- Monoclonal gammopathy
- Paraproteinemic neuropathy
- Renal transplantation (prevention or treatment of acute humoral rejection)
- Severe Rheumatoid arthritis
- Rotaviral enterocolitis
- Staphylococcal toxic shock
- Toxic epidermal necrolysis or Stevens-Johnson syndrome
- Urticaria (delayed pressure)

AND

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

- History and physical examination documenting the severity of the condition, including frequency and severity of infections where applicable
- Laboratory results or diagnostic evidence supporting the indication for which immune globulin is requested

AND

3 - If the request is for a non-preferred product, there must be a history of failure, contraindication or intolerance to ALL the following products:

- Bivigam
- Cutaquig
- Flebogamma
- Gammagard Liquid
- Gammagard S-D
- Gammaked
- Gammaplex
- Gamunex-C
- Hizentra
- Octagam
- Privigen
- Xembify

Product Name:Alyglo, Asceniv, Bivigam, Carimune NF Nanofiltered, Cutaquig, Cuvitru, Flebogamma Dif, Gamastan, Gamastan S-D, Gammagard liquid, Gammagard liquid ERC, Gammagard S-D, Gammaked, Gammaplex, Gamunex-C, Hizentra, HyQvia, Octagam, Qivigy, Panzyga, Privigen, Xembify, Yimmugo	
Diagnosis	All other indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to immune globulin therapy

AND

2 - Statement of expected frequency and duration of proposed immune globulin treatment

AND

3 - For long term treatment, documentation of titration to the minimum effective dose and frequency needed to maintain a sustained clinical response

2 . Revision History

Date	Notes
3/5/2026	January P&T changes: Cutaquig, Gammaplex to PDL, updated prefe rred prerequisites. Added Gammagard ERC and Qivigy as NPD.

Prior Authorization Guideline

Guideline ID	GL-99466
Guideline Name	Inbrija
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Inbrija	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Parkinson’s disease

AND

2 - Inbrija will be used as intermittent treatment for OFF episodes

AND

3 - Prescribed by, or in consultation with, a neurologist or specialist in the treatment of Parkinson's disease

AND

4 - Patient is currently on a stable dose of a carbidopa/levodopa-containing medication and will continue receiving treatment with a carbidopa/levodopa-containing medication while on therapy

AND

5 - Patient continues to experience greater than or equal to 2 hours of OFF time per day despite optimal management of carbidopa/levodopa therapy including BOTH of the following:

- Taking carbidopa/levodopa on an empty stomach or at least one half-hour or more before or one hour after a meal or avoidance of high protein diet
- Dose and dosing interval optimization

AND

6 - History of failure, contraindication, or intolerance to TWO anti-Parkinson's disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., selegiline)

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

Approval Criteria

1 - Documentation of positive clinical response to Inbrija therapy

AND

2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona standard to Medicaid Arizona

Prior Authorization Guideline

Guideline ID	GL-322197
Guideline Name	Infliximab Products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active RA

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:

- methotrexate
- leflunomide
- sulfasalazine

AND

4 - Used in combination with methotrexate

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab ma nufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by at least one of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab ma nufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active PsA

AND

2 - One of the following:

- Actively inflamed joints
- Dactylitis
- Enthesitis
- Axial disease
- Active skin and/or nail involvement

AND

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

- Dermatologist
- Rheumatologist

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab ma nufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by at least one of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline
- Reduction in the body surface area (BSA) involvement from baseline

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab ma nufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of chronic severe (i.e., extensive and/or disabling) plaque psoriasis

AND

2 - One of the following:

- Greater than or equal to 3% body surface area involvement
- Severe scalp psoriasis
- Palmoplantar (i.e., palms, soles), facial, or genital involvement

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies:

- corticosteroids (e.g., betamethasone, clobetasol)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

4 - Prescribed by or in consultation with a dermatologist

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab manufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to infliximab therapy as evidenced by ONE of the following:

- Reduction the body surface area (BSA) involvement from baseline
- Improvement in symptoms (e.g., pruritus, inflammation) from baseline

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab manufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active ankylosing spondylitis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a minimum duration of one month trial and failure, contraindication, or intolerance to two different NSAIDs (e.g., ibuprofen, naproxen) at maximally tolerated doses

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab ma nufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by improvement from baseline for least one of the following:

- Disease activity (e.g., pain, fatigue, inflammation, stiffness)
- Lab values (erythrocyte sedimentation rate, C-reactive protein level)
- Function
- Axial status (e.g., lumbar spine motion, chest expansion)

• Total active (swollen and tender) joint count	
Notes	*Note: Please approve at NDC level (NDC for preferred infliximab manufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Crohn's Disease (CD) or Fistulizing Crohn's Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of one of the following:

- Moderately to severely active Crohn's disease
- Fistulizing Crohn's disease

AND

2 - One of the following:

- Frequent diarrhea and abdominal pain
- At least 10% weight loss
- Complications such as obstruction, fever, abdominal mass
- Abnormal lab values (e.g., C-reactive protein [CRP])
- CD Activity Index (CDAI) greater than 220

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to one of the following conventional therapies:

- 6-mercaptopurine
- Azathioprine
- Corticosteroids (e.g., prednisone)
- Methotrexate

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab ma nufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Crohn's Disease (CD) or Fistulizing Crohn's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by at least one of the following:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab ma nufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis

AND

2 - One of the following:

- Greater than 6 stools per day
- Frequent blood in the stools
- Frequent urgency
- Presence of ulcers
- Abnormal lab values (e.g., hemoglobin, ESR, CRP)
- Dependent on, or refractory to, corticosteroids

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to one of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
- Azathioprine
- Corticosteroids (e.g., prednisone)

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab ma nufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by at least one of the following:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab ma nufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Sarcoidosis [Off-label]
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of sarcoidosis

AND

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

- Pulmonologist
- Dermatologist
- Ophthalmologist

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to one corticosteroid (e.g., prednisone)

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to one immunosuppressant (e.g., methotrexate, cyclophosphamide, or azathioprine)

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab ma nufactured by Janssen: 57894016001)

Product Name:Preferred: Infliximab (Janssen manufacturer)*	
Diagnosis	Sarcoidosis [Off-label]
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Notes	*Note: Please approve at NDC level (NDC for preferred infliximab ma nufactured by Janssen: 57894016001)

Product Name:Non-Preferred*: Avsola, Inflectra, Remicade, Renflexis, Zymfentra, and newly launched infliximab products	
Approval Length	Requests for Non-Preferred biosimilars are not approved at this time
Guideline Type	Prior Authorization

Approval Criteria

1 - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred product is Infliximab biosimilar (manufactured by Janssen). **Please note: The drug(s) listed above may require additional review.

Notes	*Patients must use preferred infliximab biosimilar.

2 . Revision History

Date	Notes
7/16/2025	Added note to approve preferred infliximab at NDC level. Updated cri teria throughout. Updated NP section verbiage.

Prior Authorization Guideline

Guideline ID	GL-155390
Guideline Name	Ingrezza (valbenazine)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Ingrezza	
Diagnosis	Moderate to Severe Tardive Dyskinesia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe tardive dyskinesia (TD) secondary to a centrally acting dopamine receptor blocking agent (DRBA)

AND

2 - Prescribed by or in consultation with a psychiatrist or neurologist

AND

3 - Patient is 18 years of age or older

AND

4 - Patient has an Abnormal Involuntary Movement Scale (AIMS) score of 3 or 4 on any one of the AIMS items 1 through 9

AND

5 - Ingrezza is not prescribed concurrently with Austedo or tetrabenazine

AND

6 - Dose does not exceed 80 mg per day

Notes	*NOTE: Patients will be approved for ONE strength of Ingrezza ONLY : Approve ALL requests at GPI-14. Confirm there is only 1 active PA o n file for ALL Ingrezza products. End-date/Retire all other active PA's f or Ingrezza products.

Product Name:Ingrezza	
Diagnosis	Moderate to Severe Tardive Dyskinesia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is responding positively to therapy as evidenced by a reduction in the baseline AIMS score in any one of the AIMS items 1 through 9

AND

2 - Ingrezza is not prescribed concurrently with Austedo or tetrabenazine

AND

3 - Dose does not exceed 80 mg per day

Notes	*NOTE: Patients will be approved for ONE strength of Ingrezza ONLY : Approve ALL requests at GPI-14. Confirm there is only 1 active PA o n file for ALL Ingrezza products. End-date/Retire all other active PA's f or Ingrezza products.

Product Name:Ingrezza	
Diagnosis	Chorea Associated with Huntington’s Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chorea in patients with Huntington's disease

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Patient is 18 years of age or older

AND **4** - Dose does not exceed 80 mg per day

Notes	*NOTE: Patients will be approved for ONE strength of Ingrezza ONLY : Approve ALL requests at GPI-14. Confirm there is only 1 active PA o n file for ALL Ingrezza products. End-date/Retire all other active PA's f or Ingrezza products.

Product Name:Ingrezza	
Diagnosis	Chorea Associated with Huntington’s Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Dose does not exceed 80 mg per day.

Notes	*NOTE: Patients will be approved for ONE strength of Ingrezza ONLY : Approve ALL requests at GPI-14. Confirm there is only 1 active PA o n file for ALL Ingrezza products. End-date/Retire all other active PA's f or Ingrezza products.

2 . Revision History

Date	Notes
9/24/2024	Added note for PA Team, only 1 strength of Ingrezza can be approve d.

Prior Authorization Guideline

Guideline ID	GL-589212
Guideline Name	Inhaled Corticosteroids - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Preferred: Brand Arnuity Ellipta, Asmanex HFA/Twisthaler, Qvar Redihaler; Non-Preferred: generic fluticasone furoate, Alvesco, Beclomethasone Dipropionate HFA	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of asthma **AND**	

2 - For Non-Preferred requests only: History of failure, contraindication, intolerance to a majority (not more than 3) of the preferred inhaled corticosteroids:

- Brand Arnuity Ellipta
- Asmanex HFA/Twisthaler (mometasone)
- Brand or generic Flovent Diskus (fluticasone)
- Brand or generic Flovent HFA (fluticasone)
- Pulmicort Flexhaler (budesonide)
- budesonide respule (generic)
- Qvar Redihaler (beclomethasone)

AND

3 - For generic fluticasone furoate requests only: trial and failure or intolerance to Brand Arnuity Ellipta

AND

4 - For Beclomethasone Dipropionate HFA requests only: trial and failure or intolerance to Qvar Redihaler

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

2 . Revision History

Date	Notes
4/30/2026	Added new Brand Beclomethasone Dipropionate HFA as NP (Qvar is Brand Only). Added B over G note for PA team.

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-731215
Guideline Name	Injectable Oncology Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:*Injectable Oncology Drugs: Abecma, Abraxane, Adcetris, Adstiladrin, Brand Alimta, generic pemetrexed, Anktiva, Brand Arranon, generic nelarabine, Aucatzyl, Brand Avgemsi, generic gemcitabine, Brand Avopef, generic etoposide, Brand Axtle, generic pemetrexed, Bavencio, Beizray, Belrapzo, Brand Bendamustine, Bendeka, Besponsa, Blenrep, Blincyto, Brand Bicnu, generic carmustine, Bizengri, Brand Bortezomib, Breyanzi, Boruzu, carboplatin, Brand Carmustine, Carvykti, Columvi, cyclophosphamide, Darzalex, Darzalex Faspro, Datroway, Decnupaz, Docetaxel, Brand Doxil, generic doxorubicin, Elahere, Elrexfio, Emrelis, Enhertu, Epkinly, Evdi, Brand Faslodex, generic fulvestrant, Favlyxa, fludarabine, Brand Folotyn, generic pralatrexate, Gazyva, Grafapex, Brand Hycamtin injection, generic topotecan injection, Imdelltra, Imfinzi, Imjudo, Inlexzo, Ivra, Jemperli, Keytruda, Keytruda Qlex, Kymriah, Kyprolis, Kyxata, Libtayo, Loqtorzi, Lunsumio, Lunsumio Velo, Lymphir, Lynozyfic, methotrexate, Monjuvi, Onivyde, Opdivo, Opdivo Qvantig, Paclitaxel, Padcev, Brand Pemetrexed, Brand Pemfexy, Pemrydi RTU, Polivy, Revtorpyk, Romidepsin, Rybrevant, Rybrevant Faspro, Sarclisa, Sarclisa Escena, Synribo, Talvey, Tecartus, Tecelra, Tecentriq, Tecentriq Hybreza, Tecvayli, Temodar IV, Brand Tepadina, generic thiotepa, Tepylute, Tevimbra, Tivdak, Brand Treanda, generic bendamustine, Tregzi, Trodelvy, Tudriqev, Unloxcyt, Vectibix, Brand Velcade, generic bortezomib, Brand Vidaza,

generic azacitidine, Vivimusta, Brand Vykoura, generic leucovorin, Vyloy, Yervoy, Yescarta, Zepzelca, Ziihera, Zusduri, Zynyz	
Diagnosis	Cancer Indications
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The drug is being used as indicated by National Comprehensive Cancer Network (NCCN) guidelines with a Category of Evidence and Consensus of 1, 2A, or 2B	
Notes	*For medical PA, Final approval must be approved by the member's pl an. If approved, the transaction will go through POS. PA Team Note: To approve products designated "Only Brand Covere d" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to " Y", approve at MSC "O".

2 . Revision History

Date	Notes
9/23/2026	Added Tudriqev as target.

Prior Authorization Guideline

Guideline ID	GL-99682
Guideline Name	Inlyta
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021
P&T Approval Date:	
P&T Revision Date:	

1 . Criteria

Product Name:Inlyta	
Diagnosis	Advanced Renal Cell Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of renal cell cancer

AND

2 - One of the following:

2.1 Disease has relapsed

OR

2.2 Diagnosis of Stage IV disease

Product Name:Inlyta	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following diagnosis:

- Follicular Carcinoma
- Hürthle Cell Carcinoma
- Papillary Carcinoma

AND

2 - ONE of the following:

- Unresectable recurrent
- Persistent locoregional disease
- Metastatic disease

AND

3 - Disease is refractory to radioactive iodine treatment

Product Name:Inlyta	
Diagnosis	Advanced Renal Cell Carcinoma, Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Inlyta therapy

Product Name:Inlyta	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Inlyta will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Inlyta	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Inlyta therapy

2 . Revision History

Date	Notes
4/8/2021	7/1 Implementation

Prior Authorization Guideline

Guideline ID	GL-154074
Guideline Name	Insulins, Concentrated- Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Humulin R U-500 vial and kwikpen	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - History of failure, intolerance, or contraindication to ALL of the following:

- Insulin aspart or insulin lispro
- Lantus

OR **2** - There is a reason or special circumstance the patient needs to use a concentrated insulin product

2 . Revision History

Date	Notes
9/24/2024	Updated embedded step requirement

Prior Authorization Guideline

Guideline ID	GL-152668
Guideline Name	Iqirvo (elafibranor)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Iqirvo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of primary biliary cholangitis (PBC) (also known as primary biliary cirrhosis)

AND

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

2.1 Both of the following:

2.1.1 Patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal (ULN) after at least 12 consecutive months of treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol)

AND

2.1.2 Used in combination with ursodeoxycholic acid (UDCA)

OR

2.2 History of contraindication or intolerance to ursodeoxycholic acid (UDCA)

AND

3 - Requested drug will not be used in combination with Ocaliva (obeticholic acid)

AND

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

- Hepatologist
- Gastroenterologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., ALP level less than 1.67 times ULN, total bilirubin less than or equal to ULN, ALP decrease greater than or equal to 15% from baseline)

AND

2 - Requested drug will not be used in combination with Ocaliva (obeticholic acid)

2 . Revision History

Date	Notes
8/27/2024	New Program

Prior Authorization Guideline

Guideline ID	GL-104870
Guideline Name	Iron Chelators
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/17/2022

1 . Criteria

Product Name:Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic iron overload (e.g., sickle cell anemia, thalassemia, etc.) due to blood transfusion

Product Name:Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Brand Ferriprox, generic deferiprone	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following

1.1 Diagnosis of transfusional iron overload due to thalassemia syndromes

AND

1.2 Current chelation therapy is inadequate [e.g., Desferal (deferoxamine), Exjade (deferasirox)]

Product Name:Brand Ferriprox, generic deferiprone	
Diagnosis	Chronic Iron Overload due to Blood Transfusion
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of chronic iron overload in non-transfusion dependent thalassemia syndrome

AND

1.2 Patient has liver iron (Fe) concentration (LIC) levels consistently greater than or equal to 5 mg Fe per gram of dry weight prior to initiation of treatment with Exjade or Jadenu

AND

1.3 Patient has serum ferritin levels consistently greater than 300 micrograms per liter prior to initiation of treatment with Exjade or Jadenu

Product Name:Brand Exjade, Brand Jadenu, generic deferasirox	
Diagnosis	Chronic Iron Overload in Non-Transfusion Dependent Thalassemia Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy	

2 . Revision History

Date	Notes
3/16/2022	Added new generic deferiprone tabs

Prior Authorization Guideline

Guideline ID	GL-99468
Guideline Name	Irritable Bowel Syndrome-Diarrhea
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Lotronex, generic alosetron	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

AND

2 - Symptoms for at least 6 months

AND

3 - Patient was female at birth

AND

4 - Age greater than or equal to 18 years

AND

5 - History of failure, contraindication, or intolerance to TWO of the following:

- Antispasmodic agent (e.g. dicyclomine)
- Antidiarrheal agents (e.g. loperamide)
- Tricyclic antidepressant (e.g. amitriptyline)

Product Name:Brand Lotronex, generic alosetron	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Lotronex therapy

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

Approval Criteria

1 - Diagnosis of irritable bowel syndrome with diarrhea (IBS-D)

AND

2 - History of failure, contraindication, or intolerance to TWO of the following:

- Antispasmodic agent (e.g. dicyclomine)
- Antidiarrheal agents (e.g. loperamide)
- Tricyclic antidepressant (e.g. amitriptyline)

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

Approval Criteria

1 - Documentation of positive clinical response to Viberzi therapy

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona standard to Medicaid Arizona

Prior Authorization Guideline

Guideline ID	GL-269200
Guideline Name	Isotretinoin - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Brand Absorica, Absorica LD, Accutane, Amnesteem, Claravis, generic isotretinoin, Myorisan, Zenatane	
Diagnosis	Oncology Uses (Off Label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Used for oncology indication meeting National Comprehensive Cancer Network (NCCN) with a Category of Evidence and Consensus of 1, 2A, or 2B. or from ONE of the following appropriate compendia of current literature: American Hospital Formulary Service Drug Information, Thomson Micromedex DrugDex, or Clinical Pharmacology

Product Name:Brand Absorica, Absorica LD, Accutane, Amnesteem, Claravis, generic isotretinoin, Myorisan, Zenatane	
Approval Length	5 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of severe recalcitrant nodular acne unresponsive to conventional therapy

OR

1.2 Diagnosis of treatment resistant acne

AND

2 - History of failure, contraindication, or intolerance to an adequate trial on TWO of the following conventional therapy regimens:

- Topical retinoid or retinoid-like agent [eg,Retin-A/Retin-A Micro (tretinoin)]
- Oral antibiotic [eg, Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)]
- Topical antibiotic with or without benzoyl peroxide [eg, Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

AND

3 - If the request is for a non-preferred medication, there must be a reason or special circumstance that the patient must be treated with a non-preferred medication (see table in Background section)

Product Name:Brand Absorica, Absorica LD, Accutane, Amnesteem, Claravis, generic isotretinoin, Myorisan, Zenatane	
Diagnosis	Persistent or Recurring Acne After 2 Months Off Therapy
Approval Length	5 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - After greater than or equal to 2 months OFF therapy, persistent or recurring severe recalcitrant nodular acne is still present	
Notes	Authorization will be given only by clinical pharmacist review for up to 5 months.

Product Name:Brand Absorica, Absorica LD, Accutane, Amnesteem, Claravis, generic isotretinoin, Myorisan, Zenatane	
Diagnosis	Dose Titration
Approval Length	1 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Confirmation that the cumulative dose is less than 150 mg/kg (there is little therapeutic benefit to be gained by increasing the cumulative dose beyond 150 mg/kg)*	
Notes	Authorization will be given only by clinical pharmacist review for 1 mo nth to allow for titration up to the target dose *See background section for dosing regimens

2 . Background

Benefit/Coverage/Program Information

Formulary

Preferred Agents:

Accutane, Myorisan (isotretinoin), Claravis (isotretinoin), Amnesteem (isotretinoin), Zenatane (isotretinoin), generic isotretinoin

Non-Preferred Agents:

Absorica (isotretinoin)

Absorica LD (isotretinoin)

Dosing by Body Weight (based on administration with food):

Body Weight		Daily Dose		
Kg	Lbs	0.5 mg/kg/day	1 mg/kg/day	2 mg/kg/day
40	88	20	40	80
50	110	25	50	100
60	132	30	60	120
70	154	35	70	140
80	176	40	80	160
90	198	45	90	180
100	220	50	100	200

3 . Revision History

Date	Notes
5/29/2025	Added GPI for Amnesteem 30mg

Prior Authorization Guideline

Guideline ID	GL-269196
Guideline Name	Isturisa (osilodrostat)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Isturisa	
Diagnosis	Cushing’s Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Cushing's syndrome	

AND

2 - Used for treatment of endogenous hypercortisolemia

AND

3 - One of the following:

- Patient is not a candidate for surgery (e.g., adrenalectomy, transsphenoidal surgery)
- Surgery has not been curative for the patient

Product Name:Isturisa	
Diagnosis	Cushing's Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease)

Product Name:Isturisa	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Isturisa will be approved for uses supported by The National Comprehensive Cancer

Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

2 . Revision History

Date	Notes
5/29/2025	Updated Cushing's syndrome criteria due to revised indication, removed reauth for NCCN approved indications section (NCCN auth is 12 months).

Prior Authorization Guideline

Guideline ID	GL-135329
Guideline Name	Izervay (avacincaptad pegol)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2023

1 . Criteria

Product Name:Izervay	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of geographic atrophy (GA) secondary to age-related macular degeneration (AMD) as confirmed by one of the following:

- Fundus photography (e.g. fundus autofluorescence [FAF])

- Optical coherence tomography (OCT)
- Fluorescein angiography

AND

2 - GA is not secondary to any other conditions (e.g., Stargardt disease, cone rod dystrophy, toxic maculopathies)

AND

3 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Product Name:Izervay	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in growth rate of GA lesion)

AND

2 - Patient has not exceeded a total of 12 months treatment

2 . Revision History

Date	Notes
10/23/2023	New program

Prior Authorization Guideline

Guideline ID	GL-143522
Guideline Name	Jesduvroq (daprodustat)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2024

1 . Criteria

Product Name:Jesduvroq	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD)

AND

2 - Patient has been on dialysis for at least 4 months

AND

3 - Adequate iron stores confirmed by both of the following:

- Patient's ferritin level is greater than 100mcg/L
- Patient's transferrin saturation (TSAT) is greater than 20%

AND

4 - Hemoglobin level less than 11 g/dL

AND

5 - Trial and failure, contraindication or intolerance to one of the following:

- Epogen
- Procrit
- Retacrit

AND

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

- hematologist
- nephrologist

AND

7 - Patient is not on concurrent treatment with an erythropoeitin stimulating agent [ESA] (e.g., Aranesp, Epogen, Procrit)

Product Name:Jesduvroq	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., increase in hemoglobin)

AND

2 - Hemoglobin level does not exceed 12g/dL

AND

3 - Adequate iron stores confirmed by both of the following:

- Patient's ferritin level is greater than 100mcg/L
- Patient's transferrin saturation (TSAT) is greater than 20%

AND

4 - Patient is not on concurrent treatment with an erythropoeitin stimulating agent [ESA] (e.g., Aranesp, Epogen, Procrit)

2 . Revision History

Date	Notes
2/28/2024	New program

Prior Authorization Guideline

Guideline ID	GL-749240
Guideline Name	Joenja (leniolisib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Joenja	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS)

AND

1.2 Molecular genetic testing confirms mutations in the PIK3CD or PIK3R1 gene

AND

1.3 Both of the following:

- Presence of nodal and/or extranodal proliferation (e.g., lymphadenopathy, splenomegaly, hepatomegaly)
- Presence of other clinical findings and manifestations consistent with APDS (e.g., recurrent sino-pulmonary infections, bronchiectasis, enteropathy)

AND

1.4 Trial and failure, contraindication, or intolerance to at least one standard of care treatment for APDS (e.g., Immunoglobulin replacement therapy, antimicrobial prophylaxis [e.g., azithromycin, bactrim], rituximab, tacrolimus, etc.)

AND

2 - One of the following:

2.1 Patient is 12 years of age or older

OR

2.2 Both of the following:

- Patient is 4 years of age or older but less than 12 years of age
- Patient weighs greater than or equal to 27kg

AND

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

- Hematologist
- Immunologist

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

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduced lymph node size, increased naïve B-cell percentage, decreased severity or frequency of infections/hospitalizations)

2 . Revision History

Date	Notes
10/28/2026	Added new GPIs and updated age/weight criterion due to expanded i ndication

Prior Authorization Guideline

Guideline ID	GL-490255
Guideline Name	Journavx (suzetrigine)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Brand Journavx	
Approval Length	14 Days (PTD of 28 tablets per 14 days)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Patient is experiencing a new episode of moderate to severe pain

AND

3 - The request is not for chronic pain

AND

4 - One of the following:

4.1 Patient does not have severe hepatic impairment (Child-Pugh Class C)

OR

4.2 Both of the following:

- Patient has moderate hepatic impairment
- A lower dose will be prescribed

AND

5 - Both of the following:

- Treatment duration request is for no longer than 14 days
- Requested quantity does not exceed 28 tablets

AND

6 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming patient has tried and failed ALL of the following, at maximum doses, in the past 30 days:

- Celecoxib
- Diclofenac Sodium or Diclofenac Potassium
- Ketorolac

AND

7 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming patient has tried and failed ONE of the following, at maximum doses, in the past 30 days:

- Ibuprofen
- Fenoprofen
- Ketoprofen
- Naproxen Sodium

AND

8 - Medication will not be used in combination with opioid products (e.g. oxycodone, hydrocodone)

AND

9 - Medication will not be used in combination with strong CYP3A inhibitors (e.g., clarithromycin, itraconazole, ketoconazole, mifepristone, ritonavir, darunavir)

AND

10 - For female patients with reproductive potential (aged 14-44 years), prescriber attests to BOTH of the following:

- Patient is not pregnant prior to initiation of therapy
- Patients taking concomitant hormonal contraceptives containing progestins other than levonorgestrel and norethindrone have been advised to use alternative contraceptives during Journavx treatment and for 28 days after discontinuation of therapy

2 . Revision History

Date	Notes
1/28/2026	Updated step prerequisites

Prior Authorization Guideline

Guideline ID	GL-589206
Guideline Name	Juxtapid - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of homozygous familial hypercholesterolemia (HoFH) as confirmed by BOTH of the following:*

1.1 ONE of the following:

- Pre-treatment low density lipoprotein cholesterol (LDL-C) greater than 500 milligrams per deciliter
- Treated LDL-C greater than 300 milligrams per deciliter

AND

1.2 ONE of the following:

- Xanthoma before 10 years of age
- Evidence of heterozygous familial hypercholesterolemia (HeFH) in both parents

AND

2 - Used as an adjunct to a low-fat diet and exercise

AND

3 - Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe, LDL apheresis)

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Patient has tried, failed or intolerant to Repatha and Praluent

AND

6 - Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor

Notes	Results of prior genetic testing can be submitted as confirmation of di agnosis of HoFH.

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

Approval Criteria

1 - Patient is continuing a low-fat diet and exercise regimen

AND

2 - Patient continues to receive other lipid-lowering therapy (e.g., statin, low density lipoprotein [LDL] apheresis)

AND

3 - Submission of medical records (e.g. chart notes, laboratory values) documenting low density lipoprotein cholesterol (LDL-C) reduction while on Juxtapid therapy

AND

4 - Prescribed by ONE of the following:

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

5 - Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor

2 . Revision History

Date	Notes
4/30/2026	Added GPI for new 2mg strength.

Prior Authorization Guideline

Guideline ID	GL-300315
Guideline Name	Jynarque (tolvaptan)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Brand Jynarque, Brand Jynarque Pak, generic tolvaptan, generic tolvaptan pack	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of autosomal dominant polycystic kidney disease (ADPKD)	

AND

2 - For generic tolvaptan requests ONLY: trial and failure, or intolerance to Brand Jynarque (verified via paid pharmacy claims or submitted chart notes) APPLIES TO GENERIC TOLVAPTAN REQUESTS ONLY

Product Name:Brand Jynarque, Brand Jynarque Pak, generic tolvaptan, generic tolvaptan pack	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - For generic tolvaptan requests ONLY: trial and failure, or intolerance to Brand Jynarque (verified via paid pharmacy claims or submitted chart notes) APPLIES TO GENERIC TOLVAPTAN REQUESTS ONLY

2 . Revision History

Date	Notes
7/16/2025	Added generic tolvaptan as NP target.

Prior Authorization Guideline

Guideline ID	GL-135314
Guideline Name	Kalydeco (ivacaftor)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2023

1 . Criteria

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

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Submission of laboratory results confirming that patient has ONE of the mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene listed in the table in the Background section:

AND

3 - Prescribed by, or in consultation with, a specialist affiliated with a CF care center

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

Approval Criteria

1 - Provider attests that the patient has achieved a clinically meaningful response while on Kalydeco therapy to ONE of the following:

- Lung function as demonstrated by percent predicted expiratory volume in 1 second (ppFEV1)
- Body mass index (BMI)
- Pulmonary exacerbations
- Quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score

AND

2 - Prescribed by, or in consultation with, specialist affiliated with a cystic fibrosis (CF) care center

2 . Background

Benefit/Coverage/Program Information

CFTR Gene Mutations that are Responsive to Kalydeco				
List of *CFTR* Gene Mutations that Produce CFTR Protein and are Responsive to KALYDE				
*711+3A→G **	*F311del*	*I148T*	*R75Q*	*S589N*
*2789+5G→A **	*F311L*	*I175V*	*R117C **	*S737F*
*3272-26A→G **	*F508C*	*I807M*	*R117G*	*S945L **
*3849+10kbC→T **	*F508C;S1251N † **	*I1027T*	*R117H **	*S977F **
A120T	*F1052V*	*I1139V*	*R117L*	*S1159F*
A234D	*F1074L*	*K1060T*	*R117P*	*S1159P*
A349V	*G178E*	*L206W **	*R170H*	*S1251N **
*A455E **	*G178R **	*L320V*	*R347H **	*S1255P **
A1067T	*G194R*	*L967S*	*R347L*	*T338I*
D110E	*G314E*	*L997F*	*R352Q **	*T1053I*
D110H	*G551D **	*L1480P*	*R553Q*	*V232D*
D192G	*G551S **	*M152V*	*R668C*	*V562I*
*D579G **	*G576A*	*M952I*	*R792G*	*V754M*
D924N	*G970D*	*M952T*	*R933G*	*V1293G*
*D1152H **	*G1069R*	*P67L **	*R1070Q*	*W1282R*
D1270N	*G1244E **	*Q237E*	*R1070W **	*Y1014C*
E56K	*G1249R*	*Q237H*	*R1162L*	*Y1032C*
E193K	*G1349D **	*Q359R*	*R1283M*	
E822K	*H939R*	*Q1291R*	*S549N **	
*E831X **	*H1375P*	*R74W*	*S549R **	

** Clinical data exist for these mutations.*

† Complex/compound mutations where a single allele of the CFTR gene has multiple mutations these exist independent of the presence of mutations on the other allele.

3 . Revision History

Date	Notes
10/23/2023	Added GPI for 5.8 mg packs

Prior Authorization Guideline

Guideline ID	GL-669275
Guideline Name	Kebilidi (eladocagene exuparvovec-tneq)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Kebilidi	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of aromatic L-amino acid decarboxylase (AADC) deficiency

AND

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

2.1 Presence of mutations in the DDC (DOPA decarboxylase) gene as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

OR

2.2 CSF (cerebrospinal fluid) analysis showing a pattern of all of the following:

- Reduced levels of 5-hydroxyindoleacetic acid (5-HIAA), homovanillic acid (HVA) and 3-methoxy-4- hydroxyphenylglycol (MHPG)
- High concentrations of 3-O-methyldopa (3-OMD), L-Dopa, and 5- OH tryptophan (5-HTP)
- Normal pterins (e.g., neopterin, biopterin)

OR

2.3 Analysis of plasma showing reduced aromatic L-amino acid decarboxylase (AADC) activity

AND

3 - Patient presents with the clinical signs and symptoms of the disease (e.g., hypotonia, oculogyric crises, developmental delays)

AND

4 - Assess skull maturity prior to the administration of Kebilidi

AND

5 - Prescribed by a provider in a medical treatment center with expertise in gene therapy

AND

6 - Prescribed by one of the following:

- Neurologist
- Specialist with expertise in the diagnosis and management of aromatic L-amino acid decarboxylase (AADC) deficiency

AND

7 - Patient has never received Kebilidi treatment in their lifetime

2 . Revision History

Date	Notes
7/28/2026	New program

Prior Authorization Guideline

Guideline ID	GL-136964
Guideline Name	Kepivance (palifermin)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/1/2023

1 . Criteria

Product Name:Kepivance	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Medication will be used to prevent or treat severe (WHO Grade 3 or higher) oral mucositis

AND

1.2 Inadequate response to an oral mouthwash formulated with diphenhydramine/antacid and lidocaine (e.g., magic or miracle mouthwash)

AND

2 - Prescribed by a hematologist or oncologist

2 . Revision History

Date	Notes
12/1/2023	New program

Prior Authorization Guideline

Guideline ID	GL-396205
Guideline Name	Kerendia (finerenone)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Kerendia	
Diagnosis	Chronic Kidney Disease Associated with Type 2 Diabetes
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D)

AND

2 - Urine albumin-to-creatinine ratio (UACR) greater than or equal to 30 mg/g

AND

3 - Estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m2

AND

4 - Serum potassium level less than or equal to 5.0 mEq/L prior to initiating treatment

AND

5 - One of the following:

5.1 Minimum 30-day supply trial of a maximally tolerated dose and will continue therapy with one of the following:

- Generic angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- Generic angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

OR

5.2 Patient has a contraindication or intolerance to ACE inhibitors and ARBs

AND

6 - One of the following:

6.1 Patient is on a stable dose and will continue therapy with a sodium-glucose cotransporter-2 (SGLT2) inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

OR

6.2 Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

Product Name:Kerendia	
Diagnosis	Chronic Kidney Disease Associated with Type 2 Diabetes
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - One of the following:

2.1 Patient continues to be on a maximally tolerated dose of ACE inhibitor or ARB

OR

2.2 Patient has a contraindication or intolerance to ACE inhibitors and ARBs

AND

3 - One of the following:

3.1 Patient continues to be on an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

OR

3.2 Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

Product Name:Kerendia	
Diagnosis	Heart Failure with Left Ventricular Ejection Fraction (LVEF) ≥ 40%
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of heart failure

AND

2 - Patient has left ventricular ejection fraction (LVEF) greater than or equal to 40%

AND

3 - Patient has New York Heart Association (NYHA) Class II, III, or IV symptoms

AND

4 - Estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m2

AND

5 - Serum potassium level less than or equal to 5.0 mEq/L prior to initiating treatment

AND

6 - Both of the following:

6.1 Patient is on diuretic treatment (e.g., bumetanide, furosemide) for the management of symptoms of heart failure for at least 30 days prior to initiating treatment

AND

6.2 Patient is not receiving drug in combination with spironolactone or eplerenone

AND

7 - One of the following:

7.1 Patient is on a stable dose and will continue therapy with a sodium-glucose cotransporter-2 (SGLT2) inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

OR

7.2 Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

AND

8 - Prescribed by or in consultation with a cardiologist

Product Name:Kerendia	
Diagnosis	Heart Failure with Left Ventricular Ejection Fraction (LVEF) ≥ 40%
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - One of the following:

2.1 Patient continues to be on an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

OR

2.2 Patient has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin])

2 . Revision History

Date	Notes
9/25/2025	Added criteria for new indication, added new strength. Added step thr ough SGLT2 for CKD indication.

Prior Authorization Guideline

Guideline ID	GL-99621
Guideline Name	Keveyis
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - ONE of the following:

1.1 Diagnosis of primary hyperkalemic periodic paralysis or related variant

OR **1.2** Diagnosis of primary hypokalemic periodic paralysis or related variant

Product Name:Keveyis	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Keveyis therapy	

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-329255
Guideline Name	Kevzara (sarilumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Kevzara	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g. chart notes) or verification of paid claims documenting ALL of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred tocilizumab biosimilar

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Kevzara	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least one of the following

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Kevzara	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - Patient weighs at least 63 kg

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming a minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:

- leflunomide
- methotrexate

AND

5 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet
- A preferred tocilizumab biosimilar

Product Name:Kevzara	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least one of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Kevzara	
Diagnosis	Polymyalgia Rheumatica (PMR)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of polymyalgia rheumatica (PMR)

AND

2 - One of the following:

2.1 Patient has had an inadequate response to corticosteroids (e.g., prednisone)

OR

2.2 Patient cannot tolerate tapering of corticosteroids (e.g., prednisone)

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name:Kevzara	
Diagnosis	Polymyalgia Rheumatica (PMR)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least one of the following:

- Improvement in symptoms (e.g., pain, stiffness) or lab values (e.g., C-reactive protein) from baseline

- Reduced need for corticosteroids (e.g., prednisone)

AND

2 - Prescribed by or in consultation with a rheumatologist

2 . Revision History

Date	Notes
7/16/2025	Updated preferred/embedded steps for RA and PJIA, removed COT f or RA. PJIA: removed "SC" from Orencia

Prior Authorization Guideline

Guideline ID	GL-104978
Guideline Name	Kimmtrak (tebentafusp-tebn)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2022

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of uveal melanoma

AND

2 - Disease is unresectable or metastatic

AND

3 - Patient is HLA-A*02:01 genotype positive as determined by a high-resolution genotyping test [2]

AND

4 - Prescribed by or in consultation with an oncologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting patient does not show evidence of progressive disease while on therapy

2 . Revision History

Date	Notes
3/22/2022	New Program mirrors ORx with Submission of Records added to initi al and reauth

Prior Authorization Guideline

Guideline ID	GL-300290
Guideline Name	Kineret (anakinra)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Kineret	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 History of failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred tocilizumab biosimilar

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Kineret	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Kineret	
Diagnosis	Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming the diagnosis of neonatal-onset multisystem inflammatory disease (NOMID)

AND

2 - Diagnosis of NOMID has been confirmed by one of the following:

2.1 NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3-gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation

OR

2.2 Both of the following:

2.2.1 Two of the following clinical symptoms:

- Urticaria-like rash
- Cold/stress triggered episodes
- Sensorineural hearing loss
- Musculoskeletal symptoms (e.g., arthralgia, arthritis, myalgia)
- Chronic aseptic meningitis
- Skeletal abnormalities (e.g., epiphyseal overgrowth, frontal bossing)

AND

2.2.2 Elevated acute phase reactants (e.g., erythrocyte sedimentation rate [ESR], C-reactive protein [CRP], serum amyloid A [SAA])

AND

3 - Prescribed by or in consultation with one of the following

- Allergist/Immunologist
- Rheumatologist
- Pediatrician

Product Name:Kineret	
Diagnosis	Neonatal-Onset Multisystem Inflammatory Disease (NOMID)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Kineret	
Diagnosis	Deficiency of Interleukin-1 Receptor Antagonist (DIRA)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming the diagnosis of deficiency of interleukin-1 receptor antagonist (DIRA)

Product Name:Kineret	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming the diagnosis of active systemic juvenile idiopathic arthritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to ONE of the following:

- Nonsteroidal anti-inflammatory drug (NSAID) (e.g., Motrin [ibuprofen], Naprosyn [naproxen])
- Systemic glucocorticoid (e.g., prednisone)

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to a preferred tocilizumab biosimilar

Product Name:Kineret	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria
1 - Documentation of positive clinical response to therapy **AND** **2** - Prescribed by or in consultation with a rheumatologist

2 . Revision History

Date	Notes
7/3/2025	Updated preferred agents/embedded steps and criteria for RA and S JIA.

Prior Authorization Guideline

Guideline ID	GL-99622
Guideline Name	Korlym
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Korlym	
Diagnosis	Endogenous Cushing's Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of Endogenous Cushing's Syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)

AND

1.2 ONE of the following:

- Diagnosis of type 2 diabetes mellitus
- Diagnosis of glucose intolerance

AND

1.3 ONE of the following:

- Patient has failed surgery
- Patient is not a candidate for surgery

Product Name:Korlym	
Diagnosis	Endogenous Cushing's Syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of ONE of the following:

- Patient has improved glucose tolerance while on Korlym therapy
- Patient has stable glucose tolerance while on Korlym therapy

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-107424
Guideline Name	Korsuva (difelikefalin)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2022

1 . Criteria

Product Name:Korsuva	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting all of the following:

1.1 Diagnosis of chronic kidney disease (CKD)

AND

1.2 Patient is currently undergoing hemodialysis (HD) at an optimal dialysis dose (e.g., Kt/V greater than or equal to 1.2)

AND

1.3 Patient is experiencing moderate to severe pruritus associated with CKD (CKD-aP)

AND

1.4 Exclusion of other causes of pruritus (e. g., eczema, infections, drug-induced skin dryness)

AND

1.5 Trial and failure, contraindication, or intolerance to ONE topical anti-pruritic treatment:

- emollient cream
- analgesics (e.g., pramoxine lotion, capsaicin)
- corticosteroids (e.g., hydrocortisone, triamcinolone)

AND

1.6 Trial and failure, contraindication, or intolerance to ONE oral treatment*:

- antihistamine (e.g., diphenhydramine, hydroxyzine, loratadine)
- gabapentin
- pregabalin

AND

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

- Nephrologist

• Dermatologist	
Notes	*PA may be required

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting both of the following:

1.1 Patient is currently undergoing hemodialysis

AND

1.2 Documentation of positive clinical response to therapy (e.g., improved quality of life, improved worst itching intensity numerical rating score from baseline)

2 . Revision History

Date	Notes
5/24/2022	New Program

Prior Authorization Guideline

Guideline ID	GL-417211
Guideline Name	Krystexxa (pegloticase)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

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

Approval Criteria

1 - Diagnosis of gout

AND

2 - Submission of medical records (e.g., chart notes) confirming trial and failure, contraindication, or intolerance to maximum recommended doses to both of the following conventional therapies:

- Xanthine oxidase inhibitor (i.e., allopurinol, febuxostat)
- Uricosuric agent (e.g., probenecid)

AND

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

- History of at least two gout flares in the previous 12 months
- At least 1 gouty tophus

AND

4 - Prescribed by or in consultation with a rheumatologist or nephrologist

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

Approval Criteria

1 - Submission of medical records (e.g, chart notes) documenting positive clinical response to Krystexxa therapy demonstrated by both of the following:

- Serum urate level has decreased since initiating therapy
- Clinical improvement in the signs and symptoms of gout (e.g., decrease in tophi size or frequency of gouty flares per year from baseline or improvement in chronic arthropathy or quality of life)

2 . Revision History

Date	Notes
10/29/2025	Added new GPI

Prior Authorization Guideline

Guideline ID	GL-620187
Guideline Name	Kygevvi (doxecitine/doxribtimine)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of thymidine kinase 2 deficiency (TK2d)

AND

2 - Submission of medical records (e.g., chart notes) confirming the presence of a mutation in the TK2 gene as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

3 - Submission of medical records (e.g., chart notes) confirming the patient experienced symptom onset on or before 12 years of age

AND

4 - Prescribed by or in consultation with a clinical specialist knowledgeable in the treatment of TK2d (e.g., geneticist, neurologist)

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

Approval Criteria

1 - Provider attests the patient would benefit from continued therapy

AND

2 - Prescribed by or in consultation with a clinical specialist knowledgeable in the treatment of TK2d (e.g., geneticist, neurologist)

2 . Revision History

Date	Notes
5/27/2026	New program

Prior Authorization Guideline

Guideline ID	GL-269199
Guideline Name	LAMA, LABA - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Brand Anoro Ellipta, Brand Umeclidinium-vilanterol, Bevespi, Stiolto	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2 - One of the following:

2.1 History of failure, contraindication, or intolerance to treatment with a 30 day trial of a long-acting beta-agonist (e.g. Foradil, Serevent, Striverdi, Arcapta)

OR

2.2 History of failure, contraindication, or intolerance to treatment with a 30 day trial of an orally inhaled anticholinergic agent (e.g. Spiriva, Atrovent, Combivent, Tudorza)

AND

3 - For Bevespi requests ONLY: history of failure, contraindication, or intolerance to treatment with a 30 day trial of both of the following Preferred drugs:

- Brand Anoro Ellipta
- Stiolto Respimat

AND

4 - For Umeclidinium-vilanterol requests ONLY, history of failure or intolerance to Brand Anoro Ellipta

2 . Revision History

Date	Notes
5/29/2025	Added umeclidinium-vilanterol as NP target, with step through Brand Anoro Ellipta

Prior Authorization Guideline

Guideline ID	GL-125941
Guideline Name	Lamzede (velmanase alfa-tycv)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2023

1 . Criteria

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

Approval Criteria

1 - Diagnosis of alpha-mannosidosis

AND

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

- Deficiency in alpha-mannosidase enzyme activity as measured in fibroblasts or leukocytes
- Molecular genetic testing confirms mutations in the MAN2B1 gene

AND

3 - Treatment is only for non-central nervous system disease manifestations (e.g., large head, prominent forehead, protruding jaw, skeletal abnormalities)

Product Name:Lamzede	
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming patient does not show evidence of progressive disease while on therapy as evidenced by one of the following:

- Reduction in serum oligosaccharide concentration from baseline
- Improvement in clinical signs and symptoms from baseline (e.g., 3-minute stair climbing test, 6-minute walking test, pulmonary function, quality of life)

2 . Revision History

Date	Notes
5/22/2023	New program

Prior Authorization Guideline

Guideline ID	GL-136956
Guideline Name	Lantidra (donislecel-jujn)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/1/2023

1 . Criteria

Product Name:Lantidra	
Approval Length	One Time Approval
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of Type 1 diabetes

AND

1.2 Patient is insulin dependent

AND

1.3 Patient is unable to approach target HbA1c because of current repeated episodes of severe hypoglycemia despite intensive diabetes management and education

AND

1.4 Patient has reduced awareness of hypoglycemia, as defined by the absence of adequate autonomic symptoms at glucose levels of less than 54 mg/dL

AND

1.5 Patient has had at least one episode of severe hypoglycemia in the past 3 years with both of the following:

1.5.1 Patient required assistance of another person

AND

1.5.2 One of the following:

1.5.2.1 Symptoms were associated with a blood glucose level less than 50 mg/dL

OR

1.5.2.2 Prompt recovery after oral carbohydrate, intravenous glucose, or glucagon administration

AND

1.6 Patient will be on concomitant immunosuppression (e.g., daclizumab, sirolimus, tacrolimus, etanercept, mycophenolate mofetil, etc.)

AND

2 - Prescribed by or in consultation with an endocrinologist

Product Name:Lantidra	
Approval Length	One Time Approval
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that patient has not achieved independence from exogenous insulin within one year of infusion or within one year after losing independence from exogenous insulin after previous infusion

AND

2 - Patient has not had more than three infusions of Lantidra in their lifetime*

Notes	*There are no data regarding the effectiveness or safety for patients r eceiving more than three infusions.

2 . Revision History

Date	Notes
11/27/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-147672
Guideline Name	Lenmeldy (atidarsagene autotemcel)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2024

1 . Criteria

Product Name:Lenmeldy	
Approval Length	1 Time Authorization in Lifetime*
Guideline Type	Prior Authorization

Approval Criteria

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

- Diagnosis of metachromatic leukodystrophy (MLD)
- Molecular genetic testing confirms mutation in the arylsulfatase A (ARSA) gene

AND

2 - Disease is one of the following:

2.1 Pre-symptomatic late infantile (PSLI) as confirmed by both of the following:

2.1.1 Disease onset at less than or equal to 30 months of age

AND

2.1.2 One of the following:

- Absence of neurological signs and symptoms of MLD (e.g., peripheral neuropathy, gait difficulties, hypotonia)
- Abnormal reflexes or abnormalities on brain magnetic resonance imaging (MRI) and/or nerve conduction tests not associated with functional impairment (e.g., no tremor, no peripheral ataxia)

OR

2.2 Pre-symptomatic early juvenile (PSEJ) as confirmed by both of the following:

2.2.1 Disease onset at greater than 30 months and less than 7 years of age

AND

2.2.2 One of the following:

- Absence of neurological signs and symptoms of MLD (e.g., peripheral neuropathy, gait difficulties, hypotonia)
- Abnormal reflexes or abnormalities on brain magnetic resonance imaging (MRI) and/or nerve conduction tests not associated with functional impairment (e.g., no tremor, no peripheral ataxia)

OR

2.3 Early-symptomatic early juvenile (ESEJ) as confirmed by all of the following:

- Disease onset at greater than 30 months and less than 7 years of age

- Gross motor function classification (GMFC)-MLD score less than or equal to 1
- Intelligence quotient (IQ) of greater than or equal to 85

AND

3 - Prescribed by a specialist with expertise in MLD at an authorized treatment center

AND

4 - Both of the following:

- Patient has never received Lenmeldy treatment in their lifetime
- Patient has never received prior hematopoietic stem cell transplant (HSCT)

Notes	*Per prescribing information, Lenmeldy is for one-time, single dose intravenous use only.

2 . Revision History

Date	Notes
5/23/2024	New program

Prior Authorization Guideline

Guideline ID	GL-545200
Guideline Name	Leqvio (inclisiran)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Leqvio	
Diagnosis	Heterozygous Familial Hypercholesterolemia (HeFH), Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting one of the following diagnoses:	

1.1 Heterozygous familial hypercholesterolemia (HeFH) as confirmed by one of the following:

1.1.1 Both of the following:

1.1.1.1 Untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 190 mg/dL

AND

1.1.1.2 One of the following:

- Family history of myocardial infarction in first-degree relative less than 60 years of age
- Family history of myocardial infarction in second-degree relative less than 50 years of age
- Family history of LDL-C greater than 190 mg/dL in first- or second-degree relative
- Family history of familial hypercholesterolemia in first- or second-degree relative
- Family history of tendinous xanthomata and/or arcus cornealis in first- or second-degree relative

OR

1.1.2 Both of the following:

1.1.2.1 Untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 190 mg/dL

AND

1.1.2.2 One of the following:

- Functional mutation in the LDL receptor, ApoB, or PCSK9 gene
- Tendinous xanthomata
- Arcus cornealis before age 45

OR

1.2 Atherosclerotic cardiovascular disease (ASCVD) as confirmed by one of the following:

- Acute coronary syndromes
- History of myocardial infarction
- Stable or unstable angina
- Coronary or other arterial revascularization

- Stroke
- Transient ischemic attack
- Peripheral arterial disease presumed to be of atherosclerotic origin

AND

2 - One of the following:

- For diagnosis of HeFH: Patient is 12 years of age or older
- For diagnosis of ASCVD: Patient is 18 years of age or older

AND

3 - One of the following:

3.1 Patient has been receiving at least 12 consecutive weeks of HIGH-INTENSITY statin therapy [i.e., atorvastatin 40-80 mg, rosuvastatin 20-40 mg] and will continue to receive a HIGH-INTENSITY statin at maximally tolerated dose

OR

3.2 Both of the following:

3.2.1 Patient is unable to tolerate high-intensity statin as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times upper limit of normal [ULN])

AND

3.2.2 One of the following:

- Patient has been receiving at least 12 consecutive weeks of MODERATE-INTENSITY statin therapy [i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, Lescol XL (fluvastatin XL) 80 mg, fluvastatin 40 mg twice daily, or Livalo (pitavastatin) 2-4 mg] and will continue to receive a MODERATE-INTENSITY statin at maximally tolerated dose
- Patient has been receiving at least 12 consecutive weeks of LOW-INTENSITY statin therapy [i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin

20-40 mg, Livalo (pitavastatin) 1 mg] and will continue to receive a LOW-INTENSITY statin at maximally tolerated dose

OR

3.3 Patient is unable to tolerate low- or moderate-, and high-intensity statins as evidenced by one of the following intolerable and persistent (i.e., more than 2 weeks) symptoms for low- or moderate-, and high-intensity statins:

- Myalgia (muscle symptoms without CK elevations)
- Myositis (muscle symptoms with CK elevations less than 10 times ULN)

OR

3.4 Patient has a labeled contraindication to all statins

OR

3.5 Patient has experienced rhabdomyolysis or muscle symptoms with statin treatment with CK elevations greater than 10 times ULN

AND

4 - One of the following:

4.1 Patient has been receiving at least 12 consecutive weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy

OR

4.2 Patient has a history of contraindication or intolerance to ezetimibe

AND

5 - Patient is unable to maintain adherence to proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor therapy

AND

6 - Submission of medical records (e.g., chart notes) documenting one of the following LDL-C values while on maximally tolerated lipid lowering therapy within the last 120 days:

- LDL-C greater than or equal to 55 mg/dL for diagnosis of ASCVD [2]
- LDL-C greater than or equal to 100 mg/dL for diagnosis of HeFH [3]

AND

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

- Cardiologist
- Endocrinologist
- Lipid specialist

AND

8 - Medication will not be used in combination with PCSK9 inhibitor therapy

Product Name:Leqvio	
Diagnosis	Heterozygous Familial Hypercholesterolemia (HeFH), Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting LDL-C reduction from baseline while on therapy

AND

2 - One of the following:

2.1 Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose

OR

2.2 Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)

AND

3 - Medication will not be used in combination with PCSK9 inhibitor therapy

Product Name:Leqvio	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of Homozygous familial hypercholesterolemia (HoFH) as confirmed by one of the following:

1.1 Genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (i.e., LDLRAP1 or ARH)

OR

1.2 Both of the following:

1.2.1 Untreated/pre-treatment LDL-cholesterol (LDL-C) greater than 400 mg/dL

AND

1.2.2 One of the following:

- Xanthoma before 20 years of age
- Evidence of heterozygous familial hypercholesterolemia in both parents

AND

2 - Patient is 12 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming one of the following:

- Patient is receiving other lipid-lowering therapy (e.g., statin, ezetimibe)
- Patient has a documented inability to take other lipid-lowering therapy (e.g., statin, ezetimibe)

AND

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

- Cardiologist
- Endocrinologist
- Lipid specialist

Product Name:Leqvio	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting LDL-C reduction from baseline while on therapy

AND

2 - One of the following:

2.1 Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe)

OR

2.2 Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)

2 . Revision History

Date	Notes
4/30/2026	Added criteria for HoFH, added age criterion for HeFH/ASCVD due t o new and expanded indications. Updated submission of records ver biage throughout.

Prior Authorization Guideline

Guideline ID	GL-709214
Guideline Name	Lerochol (lerodalcibep-liga)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Lerochol	
Diagnosis	Hypercholesterolemia [Including Heterozygous Familial Hypercholesterolemia (HeFH)], Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting one of the following diagnoses:	

- Heterozygous familial hypercholesterolemia (HeFH)
- Atherosclerotic cardiovascular disease (ASCVD) (e.g., history of acute coronary syndromes (ACS), myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack (TIA), or peripheral artery disease (PAD))
- Primary hyperlipidemia or hypercholesterolemia

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming one of the following:

- Patient has been receiving at least 12 consecutive weeks of highest tolerable dose of statin therapy and has not reached LDL-C goal
- Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase)
- Patient has an FDA labeled contraindication to all statins

AND

3 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming one of the following:

3.1 Patient has not achieved LDL-C goal while on maximally tolerated lipid-lowering therapy (e.g., statins) within the last 120 days as demonstrated by one of the following:

- Patient has LDL-C greater than or equal to 55 mg/dL with ASCVD
- Patient has LDL-C greater than or equal to 70 mg/dL without ASCVD but at high risk (e.g., with ASCVD risk factors [age greater than or equal to 65, current smoker, diabetes], subclinical atherosclerosis)
- Patient has LDL-C greater than or equal to 100 mg/dL without ASCVD and not at high risk

OR

3.2 Both of the following:

3.2.1 Patient has been receiving Lerochol as adjunct to maximally tolerated lipid lowering therapy (e.g., statins, ezetimibe)

AND

3.2.2 Patient has reached LDL-C goal

AND

4 - Will not be used in combination with another PCSK9 inhibitor (e.g., Repatha, Praluent)

Product Name:Lerochol	
Diagnosis	Hypercholesterolemia [Including Heterozygous Familial Hypercholesterolemia (HeFH)], Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming one of the following:

- Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe)
- Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)

AND

3 - Will not be used in combination with another PCSK9 inhibitor (e.g., Repatha, Praluent)

2 . Revision History

Date	Notes
8/26/2026	Added concomitant use criterion to align with Lipfendra, corrected typ o initial auth #1.

Prior Authorization Guideline

Guideline ID	GL-427190
Guideline Name	Leucovorin - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Leucovorin tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Methotrexate toxicity prophylaxis

OR

1.2 Treatment of hematologic toxicity from folic acid antagonists (i.e., pyrimethamine toxicity treatment or trimethoprim toxicity treatment)

OR

1.3 Submission of medical records (e.g., chart notes) documenting a diagnosis of cerebral folate deficiency (CFD)

2 . Revision History

Date	Notes
10/29/2025	Added criteria for diagnosis of CFD

Prior Authorization Guideline

Guideline ID	GL-288251
Guideline Name	Libervant, Nayzilam, Valtoco
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/5/2025

1 . Criteria

Product Name:Libervant, Nayzilam, Valtoco	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of epilepsy

AND

2 - Requested medication is being prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern

Product Name:Libervant, Nayzilam, Valtoco	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Nayzilam, Valtoco	
Diagnosis	Requests Exceeding Quantity Limit
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - One of the following*:

- For Nayzilam: Physician has provided rationale for needing to exceed the quantity limit of 2 boxes per 30 days
- For Valtoco: Physician has provided rationale for needing to exceed the quantity limit of 1 box per 30 days

AND

2 - The requested dose is within the FDA (Food and Drug Administration) maximum dose per day

Notes	*Nayzilam QL is 2 boxes (containing 2 doses each box) per 30 days. Valtoco QL is 1 box (containing 5 doses) per 30 days

2 . Revision History

Date	Notes
6/4/2025	Updated QL for Valtoco, added note for clarification.

Prior Authorization Guideline

Guideline ID	GL-117420
Guideline Name	Lidoderm (lidocaine) 5% patches
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/1/2022

1 . Criteria

Product Name:Brand Lidoderm patch, generic lidocaine patch	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 The requested drug must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia – Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

2 . Revision History

Date	Notes
11/29/2022	Updated approval duration

Prior Authorization Guideline

Guideline ID	GL-707205
Guideline Name	Lipfendra (enlicitide)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Lipfendra	
Diagnosis	Hypercholesterolemia [Including Heterozygous Familial Hypercholesterolemia (HeFH)], Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting one of the following diagnoses:	

- Heterozygous familial hypercholesterolemia (HeFH)
- Atherosclerotic cardiovascular disease (ASCVD) (e.g., history of acute coronary syndromes (ACS), myocardial infarction (MI), stable or unstable angina, coronary or other arterial revascularization, stroke, transient ischemic attack (TIA), or peripheral artery disease (PAD))
- Primary hyperlipidemia or hypercholesterolemia

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming one of the following:

- Patient has been receiving at least 12 consecutive weeks of highest tolerable dose of statin therapy and has not reached LDL-C goal
- Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase)
- Patient has an FDA labeled contraindication to all statins

AND

3 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming one of the following:

3.1 Patient has not achieved LDL-C goal while on maximally tolerated lipid-lowering therapy (e.g., statins) within the last 120 days as demonstrated by one of the following:

- Patient has LDL-C greater than or equal to 55 mg/dL with ASCVD
- Patient has LDL-C greater than or equal to 70 mg/dL without ASCVD but at high risk (e.g., with ASCVD risk factors [age greater than or equal to 65, current smoker, diabetes], subclinical atherosclerosis)
- Patient has LDL-C greater than or equal to 100 mg/dL without ASCVD and not at high risk

OR

3.2 Both of the following:

3.2.1 Patient has been receiving Lipfendra as adjunct to maximally tolerated lipid lowering therapy (e.g., statins, ezetimibe)

AND

3.2.2 Patient has reached LDL-C goal

AND

4 - Will not be used in combination with another PCSK9 inhibitor (e.g., Repatha, Praluent)

Product Name:Lipfendra	
Diagnosis	Hypercholesterolemia [Including Heterozygous Familial Hypercholesterolemia (HeFH)], Atherosclerotic Cardiovascular Disease (ASCVD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming one of the following:

- Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe)
- Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)

AND

3 - Will not be used in combination with another PCSK9 inhibitor (e.g., Repatha, Praluent)

2 . Revision History

Date	Notes
8/26/2026	New program

Prior Authorization Guideline

Guideline ID	GL-157798
Guideline Name	Livdelzi (seladelpar)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Livdelzi	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of primary biliary cholangitis (PBC) (also known as primary biliary cirrhosis)

AND

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

2.1 Both of the following:

2.1.1 Patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal (ULN) after at least 12 consecutive months of treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol)

AND

2.1.2 Used in combination with ursodeoxycholic acid (UDCA)

OR

2.2 History of contraindication or intolerance to ursodeoxycholic acid (UDCA)

AND

3 - Requested drug will not be used in combination with Ocaliva (obeticholic acid) or Iqirvo (elafibranor)

AND

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

- Hepatologist
- Gastroenterologist

Product Name:Livdelzi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., ALP level less than 1.67 times ULN, total bilirubin less than or equal to ULN, ALP decrease greater than or equal to 15% from baseline)

AND

2 - Requested drug will not be used in combination with Ocaliva (obeticholic acid) or Iqirvo (elafibranor)

2 . Revision History

Date	Notes
10/25/2024	New program

Prior Authorization Guideline

Guideline ID	GL-269195
Guideline Name	Livmarli (maralixibat)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

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

Approval Criteria

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

1.1 Diagnosis of Alagille Syndrome (ALGS)

AND

1.2 Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene

AND

2 - Documentation of ONE of the following:

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

AND

3 - Patient is experiencing moderate to severe cholestatic pruritus

AND

4 - Patient has had an inadequate response to at least two of the following treatments used for the relief of pruritus:

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

AND

5 - Patient is 3 months of age or older

AND

6 - Prescribed by or in consultation with a hepatologist

Product Name:Livmarli	
Diagnosis	Progressive Familial Intrahepatic Cholestasis (PFIC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of Progressive familial intrahepatic cholestasis (PFIC)

AND

1.2 Molecular genetic testing confirms mutations in the ATP8B1, ABCB11, ABCB4, TJP2, NR1H4, or MYO5B gene

AND

2 - Patient is experiencing both of the following:

- Moderate to severe pruritus
- Patient has a serum bile acid concentration above the upper limit of the normal reference for the reporting laboratory

AND

3 - Patient is 12 months of age or older

AND

4 - Patient has had an inadequate response to at least two of the following treatments used for the relief of pruritus:

- Ursodeoxycholic acid (e.g., Ursodiol)
- Antihistamines (e.g., diphenhydramine, hydroxyzine)

- Rifampin
- Bile acid sequestrants (e.g., Questran, Colestid, Welchol)

AND

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

- Hepatologist
- Gastroenterologist

Product Name:Livmarli	
Diagnosis	All indications listed above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduced bile acids, reduced pruritus severity score)

2 . Revision History

Date	Notes
5/29/2025	Added GPIs for new tablet formulations

Prior Authorization Guideline

Guideline ID	GL-113529
Guideline Name	Livtencity (maribavir)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/8/2022

1 . Criteria

Product Name:Livtencity	
Diagnosis	CMV infection/disease
Approval Length	8 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cytomegalovirus (CMV) infection/disease as confirmed by one of the following methods:

- quantitative polymerase chain reaction (qPCR)

- CMV pp65 antigenemia

AND

2 - Patient is a recipient of one of the following:

- Hematopoietic stem cell transplant
- Solid organ transplant

AND

3 - Trial and failure of a minimum 2 weeks duration, contraindication, or intolerance to one of the following therapies at an appropriately indicated dose:

- Intravenous (IV) ganciclovir
- Oral valganciclovir
- IV foscarnet
- IV cidofovir

AND

4 - Patient is 12 years of age or older

AND

5 - Patient weighs greater than or equal to 35kg

AND

6 - Prescribed by or in consultation with a provider who specializes in one of the following areas:

- Transplant
- Infectious Disease

2 . Revision History

Date	Notes
9/8/2022	Removed references and end note, no changes to clinical criteria.

Prior Authorization Guideline

Guideline ID	GL-620188
Guideline Name	Loargys (pegzilarginase-nbln)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of hyperargininemia

AND

2 - Submission of medical records (e.g., chart notes) confirming the presence of arginase 1 deficiency (ARG1-D) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

3 - Used in conjunction with dietary protein restriction

AND

4 - Patient is 2 years of age or older

AND

5 - Prescribed by or in consultation with a specialist with expertise in the treatment of metabolic disorders

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

Approval Criteria

1 - Patient demonstrates positive response to therapy, as evidenced by a reduction in plasma arginine concentration

AND

2 - Used in conjunction with dietary protein restriction

2 . Revision History

Date	Notes
5/27/2026	New Program

Prior Authorization Guideline

Guideline ID	GL-135381
Guideline Name	Lodoco (colchicine)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2023

1 . Criteria

Product Name:Lodoco	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cardiovascular disease (CV)

AND

2 - Used for the secondary prevention of CV disease (e.g., very high-risk patients – see Table 1)

AND

3 - Patient is on guideline therapy management for multiple risk factors (e.g., dyslipidemia, hypertension, hyperglycemia) associated with CV disease

AND

4 - Submission of medical records (e.g., chart notes) or paid claims documenting trial and failure or intolerance to colchicine 0.6 mg tablets

Product Name:Lodoco	
Approval Length	6 months [C, 4]
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy(e.g., reduced risk of cardiovascular death, myocardial infarction, ischemia-driven coronoary revascularization)

2 . Background

Clinical Practice Guidelines

Table 1 [3]

Definition of Very High-Risk
History of multiple major ASCVD events
OR

One Major ASCVD event AND 2 or more high risk conditions
Major ASCVD Events
Recent ACS (within the past 12 months)
History of MI (other than recent ACS events listed above)
History of ischemic stroke
Symptomatic peripheral artery disease (history of claudication with ABI <0.85, or previous revascularization or amputation)
High-Risk Conditions
Age 65 or older
Familial hypercholesterolemia
History of previous coronary artery bypass graft surgery or percutaneous coronary intervention outside of the major ASCVD event(s)
Diabetes
Hypertension
Chronic kidney disease (eGFR, 15–59 mL/min/1.73 m^2)
Current tobacco smoking
Persistently elevated LDL-C ≥100 mg/dL despite maximally tolerated statin therapy and ezetimibe
History of congestive heart failure

ABI indicates ankle brachial index;**ACS**, acute coronary syndrome; **ASCVD**, atherosclerotic cardiovascular disease; **CKD**, chronic kidney disease; **eGFR**, estimated glomerular filtration rate; **LDL-C,** low-density lipoprotein cholesterol; and **MI**, myocardial infarction.

3 . Revision History

Date	Notes
10/27/2023	New program

Prior Authorization Guideline

Guideline ID	GL-611235
Guideline Name	Long-Acting Opioid Products - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/19/2026

Note:

**PLEASE NOTE: This guideline contains criteria for multiple DUR rejection codes. PA Reviewers: Please confirm the correct criteria is being utilized for reviews based on Diagnosis and Guideline Type. Criteria for MME EXCEEDED rejections can be found towards the end of the guideline.

1 . Criteria

Product Name:fentanyl transdermal; generic morphine sulfate ER tablets; Brand Oxycontin, generic tramadol ER tablets; generic hydromorphone ER; Brand hydrocodone ER capsules; Brand Hysingla ER; generic hydrocodone ER tablets; Brand Methadose; generic methadone tablets/concentrate/soln/tablets for oral susp; Diskets; Brand morphine sulfate ER capsules; Brand MS Contin; generic tapentadol ER; Brand oxymorphone ER; Brand oxycodone ER; Brand Conzip; Brand tramadol ER 24HR biphasic capsules; Brand tramadol ER biphasic release tablets	
Diagnosis	PA REQUIRED for use of MAT and other Opioids (Reject 88)
Guideline Type	DUR

Approval Criteria

1 - Provider attests to notify the prescriber of the MAT therapy and the prescriber of the MAT therapy approves the concurrent opioid therapy.

AND

2 - The days supply does not exceed 14 days for a surgical procedure.

AND

3 - The days supply does not exceed 5 days for all other requests.

AND

4 - There has not been a previous approval in the last 6 months.

Notes	Approval Length: 14 Days for surgical procedure, 5 Days for all other requests

Product Name:PREFERRED: fentanyl transdermal 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr; generic morphine sulfate ER tablets; Brand Oxycontin, generic tramadol ER tablets, Brand Methadose; generic methadone tablets/concentrate/soln/tablets for oral susp	
Diagnosis	Cancer related pain/Hospice care/end-of-life care*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is being treated for cancer

OR

1.2 Patient is receiving hospice or end-of-life care

Notes	*Note: If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30 day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.

Product Name:NON-PREFERRED: fentanyl transdermal 37.5mcg/hr, 62.5mcg/hr, and 87.5mcg/hr; generic hydromorphone ER; Brand hydrocodone ER capsules; Brand Hysingla ER; generic hydrocodone ER tablets; Diskets; Brand morphine sulfate ER capsules; Brand MS Contin; generic tapentadol ER; Brand oxymorphone ER; Brand oxycodone ER	
Diagnosis	Cancer related pain/Hospice care/end-of-life care*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is being treated for cancer

OR

1.2 Patient is receiving hospice or end-of-life care

AND

2 - Both the following:

2.1 ONE of the following:

2.1.1 The patient has a history of failure, contraindication or intolerance to a trial of at least THREE of the following (Document drugs and date of trials):*

- morphine sulfate controlled release tablets (specifically generic MS Contin)
- preferred fentanyl transdermal (12mcg, 25mcg, 50mcg, 75mcg, 100mcg)**
- Brand Butrans (buprenorphine) transdermal
- Brand Oxycontin
- tramadol extended release tablets (non-biphasic release tablets)
- Brand Methadose or generic methadone tablets/concentrate/soln/tablets for oral susp

OR

2.1.2 Patient is established on pain therapy with the requested medication for cancer, hospice care, or end-of-life care pain, and the medication is not a new regimen for treatment of cancer, hospice care, or end-of-life care pain (Document date regimen was started)

AND

2.2 Prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided

Notes	*Note: If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *Note: If the request is for a non-preferred product and the member is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. **NOTE: Fentanyl transdermal 37.5mcg/hr, 62.5mcg/hr, and 87.5mcg/hr are non-preferred. *Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial.

Product Name:NON-PREFERRED: Brand Conzip; Brand tramadol ER 24HR biphasic capsules; Brand tramadol ER biphasic release tablets	
Diagnosis	Cancer related pain/Hospice care/end-of-life care*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Patient is being treated for cancer

OR

1.2 Patient is receiving hospice or end-of-life care

AND

2 - BOTH of the following:

2.1 ONE of the following:

2.1.1 The patient has a history of failure, contraindication or intolerance to a trial of BOTH of the following (Document drugs and date of trials):*

- tramadol immediate release (IR)
- tramadol extended release tablets (non-biphasic release tablets)

OR

2.1.2 Patient is established on pain therapy with the requested medication for cancer, hospice care, or end-of-life care pain, and the medication is not a new regimen for treatment of cancer, hospice care, or end-of-life care pain (Document date regimen was started)

AND

2.2 Prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided

Notes	*Note: If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30-day authorization may be authorize

	d one time for the requested drug/strength combination up to the requ ested quantity for transition to an alternative treatment. *Note: Claims history may be used in conjunction as documentation of drug, date, an d duration of trial.

Product Name:PREFERRED: fentanyl transdermal 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr, 100 mcg/hr; generic morphine sulfate ER tablets; Brand Oxycontin, generic tramadol ER tablets, Brand Methadose; generic methadone tablets/concentrate/soln/tablets for oral susp	
Diagnosis	Non-cancer pain/Non-hospice care/Non-end-of-life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber attests to ALL of the following:

- The information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided
- Treatment goals are defined, including estimated duration of treatment
- Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
- Patient has been screened for substance abuse/opioid dependence
- If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression
- Pain is moderate to severe and expected to persist for an extended period of time
- Pain is chronic
- Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)
- Pain management is required around the clock with a long-acting opioid

AND

2 - ONE of the following:

2.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate

(minimum of 2 week) trial of a short-acting opioid within the last 30 days (Document drug(s) and date of trial)*

OR

2.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

2.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

AND

3 - If the request for neuropathic pain (examples of neuropathic pain include neuralgias, neuropathies, fibromyalgia), BOTH of the following:

3.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (Document date of trial)*

AND

3.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose. (Document drug and date of trial)*

Notes	*Note: If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial **NOTE: Fentanyl transdermal 37.5mcg/hr, 62.5mcg/hr, and 87.5 mcg/hr are non-preferred.

Product Name:NON-PREFERRED: fentanyl transdermal 37.5mcg/hr, 62.5mcg/hr, and 87.5mcg/hr; generic hydromorphone ER; Brand hydrocodone ER capsules; Brand Hysingla

ER; generic hydrocodone ER tablets; Diskets; Brand morphine sulfate ER capsules; Brand MS Contin; generic tapentadol ER; Brand oxymorphone ER; Brand oxycodone ER	
Diagnosis	Non-cancer pain/Non-hospice care/Non-end-of-life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber attests to ALL of the following:

- The information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided
- Treatment goals are defined, including estimated duration of treatment
- Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
- Patient has been screened for substance abuse/opioid dependence
- If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression
- Pain is moderate to severe and expected to persist for an extended period of time
- Pain is chronic
- Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)
- Pain management is required around the clock with a long-acting opioid

AND

2 - ONE of the following:

2.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days (Document drug(s) and date of trial)*

OR

2.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

2.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

AND

3 - The patient has a history of failure, contraindication or intolerance to at least THREE of the following (Document drugs and date of trials):*

- morphine sulfate controlled release tablets (specifically generic MS Contin)
- preferred fentanyl transdermal (12mcg, 25mcg, 50mcg, 75mcg, 100mcg)**
- Brand Butrans (buprenorphine) transdermal
- Brand Oxycontin
- tramadol extended release tablets (non-biphasic release tablets)
- Brand Methadose or generic methadone tablets/concentrate/soln/tablets for oral susp

AND

4 - If the request for neuropathic pain (examples of neuropathic pain include neuralgias, neuropathies, fibromyalgia), BOTH of the following:

4.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (Document date of trial))*

AND

4.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose. (Document drug and date of trial))*

Notes	*Note: If the member is currently taking the requested long-acting opio id for at least 30 days and does not meet the medical necessity author ization criteria requirements for treatment with an opioid, a denial sho uld be issued and a maximum 30-day authorization may be authorize d one time for the requested drug/strength combination up to the requ ested quantity for transition to an alternative treatment. *Note: If the re quest is for a non-preferred product and the member is currently takin

	g the requested long-acting opioid for at least 30 days and has met th e medical necessity authorization criteria requirements for treatment w ith an opioid, but has not tried the preferred alternatives a denial shoul d be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the reques ted quantity for transition to an alternative treatment. Additionally **NO TE: Fentanyl transdermal 37.5mcg/hr, 62.5mcg/hr, and 87.5 mcg/hr ar e non-preferred. *Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial.

Product Name:NON-PREFERRED: Brand Conzip; Brand tramadol ER 24HR biphasic capsules; Brand tramadol ER biphasic release tablets	
Diagnosis	Non-cancer pain/Non-hospice care/Non-end-of-life care pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescriber attests to ALL of the following:

- The information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided
- Treatment goals are defined, including estimated duration of treatment
- Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
- Patient has been screened for substance abuse/opioid dependence
- If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression
- Pain is moderate to severe and expected to persist for an extended period of time
- Pain is chronic
- Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)
- Pain management is required around the clock with a long-acting opioid

AND

2 - ONE of the following:

2.1 Prior to the start of therapy with the long-acting opioid, the patient has failed an adequate (minimum of 2 week) trial of a short-acting opioid within the last 30 days (Document drug(s) and date of trial)*

OR

2.2 The patient is already receiving chronic opioid therapy prior to surgery for postoperative pain

OR

2.3 Postoperative pain is expected to be moderate to severe and persist for an extended period of time

AND

3 - If the request for neuropathic pain (examples of neuropathic pain include neuralgias, neuropathies, fibromyalgia), BOTH of the following:

3.1 Unless it is contraindicated, the patient has not exhibited an adequate response to 8 weeks of treatment with gabapentin titrated to a therapeutic dose (Document date of trial)*

AND

3.2 Unless it is contraindicated, the patient has not exhibited an adequate response to at least 6 weeks of treatment with a tricyclic antidepressant titrated to the maximum tolerated dose. (Document drug and date of trial)*

AND

4 - The patient has a history of failure, contraindication or intolerance to BOTH of the following (Document drugs and date of trials):)*

- tramadol immediate release (IR)**
- tramadol extended release tablets (non-biphasic release tablets)**

Notes	*Note: If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *Note: If the request is for tramadol extended release capsules or tramadol extended release biphasic release tablets and the member is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *Drug may require prior authorization *Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial.

Product Name:fentanyl transdermal; generic morphine sulfate ER tablets; Brand Oxycontin, generic tramadol ER tablets; generic hydromorphone ER; Brand hydrocodone ER capsules; Brand Hysingla ER; generic hydrocodone ER tablets; Brand Methadose; generic methadone tablets/concentrate/soln/tablets for oral susp; Diskets; Brand morphine sulfate ER capsules; Brand MS Contin; generic tapentadol ER; Brand oxymorphone ER; Brand oxycodone ER; Brand Conzip; Brand tramadol ER 24HR biphasic capsules; Brand tramadol ER biphasic release tablets	
Diagnosis	Non-cancer pain/Non-hospice care/Non-end-of-life care pain*
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates meaningful improvement in pain and function (Document improvement in function or pain score improvement)

AND

2 - Identify rationale for not tapering and discontinuing opioid (Document rationale)

AND

3 - Prescriber attests to ALL of the following:

- The information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided
- Treatment goals are defined, including estimated duration of treatment
- Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
- Patient has been screened for substance abuse/opioid dependence
- If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression
- Pain is moderate to severe and expected to persist for an extended period of time
- Pain is chronic
- Pain is not postoperative (unless the patient is already receiving chronic opioid therapy prior to surgery, or if the postoperative pain is expected to be moderate to severe and persist for an extended period of time)
- Pain management is required around the clock with a long-acting opioid

Notes	*Note: If the member is currently taking the requested long-acting opioid for at least 30 days and does not meet the medical necessity authorization criteria requirements for treatment with an opioid, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment. *Note: If the request is for a non-preferred product and the member is currently taking the requested long-acting opioid for at least 30 days and has met the medical necessity authorization criteria requirements for treatment with an opioid, but has not tried the preferred alternatives a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested drug/strength combination up to the requested quantity for transition to an alternative treatment.**NOTE: Fentanyl transdermal 37.5mcg/hr, 62.5mcg/hr, and 87.5m cg/hr are non-preferred.

Product Name:fentanyl transdermal; generic morphine sulfate ER tablets; Brand Oxycontin, generic tramadol ER tablets; generic hydromorphone ER; Brand hydrocodone ER capsules; Brand Hysingla ER; generic hydrocodone ER tablets; Brand Methadose; generic methadone tablets/concentrate/soln/tablets for oral susp; Diskets; Brand morphine sulfate ER capsules; Brand MS Contin; generic tapentadol ER; Brand oxymorphone ER; Brand oxycodone ER; Brand Conzip; Brand tramadol ER 24HR biphasic capsules; Brand tramadol ER biphasic release tablets	
Diagnosis	Criteria for Quantity Limit Reviews*
Guideline Type	Quantity Limit

Approval Criteria

1 - The requested dose cannot be achieved by moving to a higher strength of the product

AND

2 - The requested dose is within the Food and Drug Administration (FDA) maximum dose per day, where an FDA maximum dose per day exists (see Table 1 in the Background section)

Notes	*Note: Authorization will be issued for • Cancer pain/hospice/end-of-life related pain: 12 months • All Tramadol ER requests: 6 months • Non-cancer pain/non-hospice/non-end-of-life related pain: 6 months

Product Name:fentanyl transdermal; generic morphine sulfate ER tablets; Brand Oxycontin, generic tramadol ER tablets; generic hydromorphone ER; Brand hydrocodone ER capsules; Brand Hysingla ER; generic hydrocodone ER tablets; Brand Methadose; generic methadone tablets/concentrate/soln/tablets for oral susp; Diskets; Brand morphine sulfate ER capsules; Brand MS Contin; generic tapentadol ER; Brand oxymorphone ER; Brand oxycodone ER; Brand Conzip; Brand tramadol ER 24HR biphasic capsules; Brand tramadol ER biphasic release tablets	
Diagnosis	Opioid Naïve (Not having filled an opioid in the past 120 days)*
Guideline Type	Morphine Milligram Equivalents (MME)** MME 50.00 exceeded; PA Required for dosage above 50 MEDD

Approval Criteria

1 - Opioid naïve members may receive greater than 50 morphine milligram equivalent (MME) based on the following:

1.1 If the request is for 50 MME to 90 MME, ONE of the following (NOTE: If the request exceeds 90 MME please skip this section and proceed to the Exceeding the 90 MME Cumulative Threshold Reviews section):

1.1.1 Diagnosis of ONE of the following:

- Cancer
- End of life pain (including hospice care)
- Palliative care

- Sickle cell anemia

OR

1.1.2 Patient is currently exceeding 50 MME and prescriber attests patient has been on a short-acting opioid in the past 120 days

OR

1.1.3 Document ALL of the following:

- The diagnosis associated with the need for pain management with opioid
- If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression
- The prescriber has acknowledged that they have completed an addiction risk and risk of overdose assessment
- Prescriber attests the member requires more than 50 MME per day to adequately control pain

Product Name:fentanyl transdermal; generic morphine sulfate ER tablets; Brand Oxycontin, generic tramadol ER tablets; generic hydromorphone ER; Brand hydrocodone ER capsules; Brand Hysingla ER; generic hydrocodone ER tablets; Brand Methadose; generic methadone tablets/concentrate/soln/tablets for oral susp; Diskets; Brand morphine sulfate ER capsules; Brand MS Contin; generic tapentadol ER; Brand oxymorphone ER; Brand oxycodone ER; Brand Conzip; Brand tramadol ER 24HR biphasic capsules; Brand tramadol ER biphasic release tablets	
Diagnosis	Doses Exceeding the Cumulative MME of 90 mg - Cancer/Hospice/End-of-Life/Palliative Care/Skilled Nursing Facility/Traumatic Injury Related Pain*
Approval Length	12 month(s)
Guideline Type	Morphine Milligram Equivalent (MME)** (MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit)

Approval Criteria

1 - Doses exceeding the cumulative morphine milligram equivalent (MME) of 90 milligrams

will be approved up to the requested amount for ALL opioid products if the patient has one of the following conditions:

- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Skilled nursing facility care
- Traumatic injury, including burns and excluding post-surgical procedure

AND

2 - Provider attests patient has been prescribed naloxone (may also be verified via paid pharmacy claims)

Notes	*Note: Authorization will be issued for 12 months for one of the above conditions. The authorization should be entered for an MME of 9999 s o as to prevent future disruptions in therapy if the patient's dose is incr eased.

Product Name:fentanyl transdermal; generic morphine sulfate ER tablets; Brand Oxycontin, generic tramadol ER tablets; generic hydromorphone ER; Brand hydrocodone ER capsules; Brand Hysingla ER; generic hydrocodone ER tablets; Brand Methadose; generic methadone tablets/concentrate/soln/tablets for oral susp; Diskets; Brand morphine sulfate ER capsules; Brand MS Contin; generic tapentadol ER; Brand oxymorphone ER; Brand oxycodone ER; Brand Conzip; Brand tramadol ER 24HR biphasic capsules; Brand tramadol ER biphasic release tablets	
Diagnosis	Doses- Exceeding the Cumulative MME of 90 mg - Non-cancer/non-hospice/non-end-of-life/non-palliative care/non-skilled Nursing Facility/Traumatic Injury Related Pain*
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalent (MME)** MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit

Approval Criteria

1 - Prescriber attests to ALL of the following:

- The information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided

- Treatment goals are defined, including estimated duration of treatment
- Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
- Patient has been screened for substance abuse/opioid dependence
- if used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression

AND

2 - BOTH of the following:

2.1 Patient has tried and failed non-opioid pain medication (document drug name and date of trial)

AND

2.2 Opioid medication doses of less than 90 morphine milligram equivalent (MME) have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)

AND

3 - Provider attests patient has been prescribed naloxone (may also be verified via paid pharmacy claims)

Notes	*Note: If the member has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 30 -day authorization may be authorized one time for the requested MME dose. **Note: Authorization will be issued for 6 months for non-cancer/non-hospice/non-end-of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain up to the current requested MME plus 90 MME.

Product Name:fentanyl transdermal; generic morphine sulfate ER tablets; Brand Oxycontin, generic tramadol ER tablets; generic hydromorphone ER; Brand hydrocodone ER capsules; Brand Hysingla ER; generic hydrocodone ER tablets; Brand Methadose; generic methadone tablets/concentrate/soln/tablets for oral susp; Diskets; Brand morphine sulfate ER capsules; Brand MS Contin; generic tapentadol ER; Brand oxymorphone ER; Brand oxycodone ER;

Brand Conzip; Brand tramadol ER 24HR biphasic capsules; Brand tramadol ER biphasic release tablets	
Diagnosis	Doses Exceeding the Cumulative MME of 90 mg - Non-cancer/non-hospice/non-end-of-life/non-palliative Nursing Facility/Traumatic Injury Related Pain* care/non-skilled
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalent (MME)** MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit

Approval Criteria

1 - Prescriber attests to ALL of the following:

- The information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided
- Treatment goals are defined, including estimated duration of treatment
- Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
- Patient has been screened for substance abuse/opioid dependence
- if used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression

AND

2 - Identify rationale for not tapering and discontinuing opioid (Document rationale)

AND

3 - Patient demonstrates meaningful improvement in pain and function (Document improvement in function or pain score improvement)

AND

4 - Provider attests patient has been prescribed naloxone (may also be verified via paid pharmacy claims)	
Notes	*Note: If the member has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 30 -day authorization may be authorized one time for the requested MME dose. **Note: Authorization will be issued for 6 months for non-cancer/non-hospice/non-end-of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain up to the current requested MME plus 90 MME.

2 . Background

Benefit/Coverage/Program Information

Table 1. CDC Recommended Long-Acting Opioid Maximum Milligram Morphine Equivalents per Day*

Active Ingredient	FDA Label Max Daily Doses
Morphine	None
Hydromorphone	None
Fentanyl transdermal, mcg/hr	None
Hydrocodone	None
Methadone	None
Tapentadol	500mg ER
Oxymorphone	None
*Doses are not considered equianalgesic and table does not represent a dose conversion chart.	

Max MME is the maximum dose per day based on morphine milligram equivalents allowed without consultation or prescription by a pain specialist. Max MME is based upon the CDC guidelines and adjusted for currently available product strengths. Fentanyl is dosed in mcg/hr rather than mg/day

3 . Revision History

Date	Notes
5/19/2026	Brand Methadose products moved to preferred, Diskets added as NP D.

Prior Authorization Guideline

Guideline ID	GL-154516
Guideline Name	Lucemyra (lofexidine)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Brand Lucemyra, generic lofexidine	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For symptoms of abrupt opioid withdrawal

AND

2 - Opioids have been discontinued

AND

3 - History of failure, contraindication, or intolerance to clonidine as verified by recent clonidine claims history in the past 180 days

AND

4 - Prescriber must verify patient has been screened for hepatic and renal impairment and that dosing is appropriate for the patient's degree of hepatic and renal function

AND

5 - Prescriber must verify patient's vital signs have been monitored and that the patient is capable of and has been instructed on self-monitoring for hypotension, orthostasis, bradycardia, and associated symptoms

AND

6 - Patient does not have severe coronary insufficiency, a recent myocardial infarction, cerebrovascular disease, chronic renal failure, or marked bradycardia

AND

7 - Patient does not have congenital long QT syndrome

AND

8 - For Brand Lucemyra requests ONLY, history of failure or intolerance to generic lofexidine

2 . Revision History

Date	Notes

9/24/2024	Added step through generic lofexidine, removed bypass for step thro ugh clonidine. Updated guideline name

Prior Authorization Guideline

Guideline ID	GL-99471
Guideline Name	Lumizyme -Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Lumizyme	
Diagnosis	Pompe disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Pompe disease (acid alpha-glucosidase [GAA] deficiency)	

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona standard to Medicaid Arizona

Prior Authorization Guideline

Guideline ID	GL-707203
Guideline Name	Lumvoa (veligrotug-vvze)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Lumvoa	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of moderate-to-severe thyroid eye disease (TED), confirmed by both of the following:

- Clinical Activity Score (CAS) ≥ 4
- Orbital imaging (CT or MRI) confirming extraocular muscle or orbital fat involvement

AND

2 - Trial and failure (minimum of 12 weeks), contraindication, or intolerance to at least 4.5 g IV glucocorticoid therapy (e.g., IV methylprednisolone)

AND

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

- Endocrinologist
- Specialist with expertise in the treatment of TED
- Ophthalmologist

AND

4 - Treatment with Lumvoa has not exceeded a total of 5 infusions over 12 week course

AND

5 - Requested drug will not be used in combination with Tepezza (teprotumumab)

2 . Revision History

Date	Notes
8/26/2026	New Program

Prior Authorization Guideline

Guideline ID	GL-153491
Guideline Name	Lupkynis (voclosporin)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

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

Approval Criteria

1 - Diagnosis of active lupus nephritis

AND

2 - Provider attests to ONE of the following:

- Diagnosis is biopsy proven
- Biopsy is contraindicated in the patient

AND

3 - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)

AND

4 - Patient is NOT receiving Lupkynis in combination with either of the following:

- Cyclophosphamide
- Benlysta (belimumab)

AND

5 - Prescribed by ONE of the following:

- Nephrologist
- Rheumatologist

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

Approval Criteria

1 - Documentation of positive clinical response to Lupkynis therapy

AND

2 - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)

AND

3 - Patient is NOT receiving Lupkynis in combination with either of the following:

- Cyclophosphamide
- Benlysta (belimumab)

AND

4 - Prescribed by ONE of the following:

- Nephrologist
- Rheumatologist

AND

5 - ONE of the following:

5.1 Patient has been on Lupkynis therapy for less than 12 months

OR

5.2 BOTH of the following:

5.2.1 Patient has completed 12 or more months of Lupkynis therapy

AND

5.2.2 The provider attests that the benefit of continuation of therapy exceeds the risk in light of the patient's treatment response and risk of worsening nephrotoxicity

2 . Revision History

Date	Notes
9/26/2024	New program

Prior Authorization Guideline

Guideline ID	GL-406247
Guideline Name	Lyfgenia (lovotibeglogene autotemcel)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Lyfgenia	
Approval Length	1 Time Authorization in Lifetime*
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of sickle cell disease (SCD) confirmed by patient genotype including βS/βS, βS/β0, or βS/β+

AND

2 - Patient is 12 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to hydroxyurea (defined as being unable to take hydroxyurea per health care professional judgement) at any point in the past

AND

4 - Provider attests that patient is clinically stable and eligible to undergo hematopoietic stem cell transplant (HSCT)

AND

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

5.1 Patient has a history of at least 4 vaso-occlusive events (VOEs) in the past 24 months defined by one of following scenarios:

- an episode of acute pain with no medically determined cause other than vaso-occlusion, lasting more than 2 hours
- acute chest syndrome (ACS)
- acute hepatic sequestration
- acute splenic sequestration
- VOE requiring a hospitalization or multiple visits to an emergency department/urgent care over 72 hours and receiving intravenous medications at each visit
- priapism requiring any level of medical attention

OR

5.2 Patient is currently receiving chronic transfusion therapy for recurrent Vaso-Occlusive Events (VOEs)

AND

6 - Prescribed by a provider at a SCD treatment center with expertise in gene therapy

AND **7** - Prescribed by or in consultation with a board-certified hematologist with SCD expertise **AND** **8** - Patient has never received any previous sickle cell gene therapy treatment in their lifetime (i.e., Casgevy, Lyfgenia)

Notes	*Per prescribing information, Lyfgenia is for one-time, single dose intr avenous use only.

2 . Revision History

Date	Notes
9/30/2025	Updated criterion 1 verbiage (added "including"), no change to clinica l intent.

Prior Authorization Guideline

Guideline ID	GL-707202
Guideline Name	Lynavoy (linerixibat)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Lynavoy	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of cholestatic pruritus associated with primary biliary cholangitis (PBC)

AND

2 - PBC is confirmed by both of the following:

- Antimitochondrial antibodies (AMA) or other PBC-specific autoantibodies (e.g., sp100 or gp210) as detected by serologic blood test
- Biochemical evidence of cholestasis (e.g., elevated alkaline phosphatase (ALP), elevated gamma-glutamyl transferase (GGT), mildly elevated alanine aminotransferase (ALT), mildly elevated aspartate aminotransferase (AST))

AND

3 - Presence of moderate to severe itch

AND

4 - Patient is receiving concurrent therapy for PBC (e.g., Ursodiol, Iqirvo, Livdelzi), unless there is a contraindication or intolerance to these medications

AND

5 - Trial and failure, contraindication or intolerance to at least two of the following treatments from different mechanisms of action used for the relief of pruritus:

- Antihistamines (e.g., diphenhydramine, hydroxyzine)
- Rifampin
- Bile acid sequestrants (i.e., cholestyramine, colestipol)
- Opioid antagonists (e.g., naltrexone)

AND

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

- Hepatologist
- Gastroenterologist

Product Name:Lynavoy	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by a reduction in itch severity

AND

2 - Patient is receiving therapy for PBC (e.g., Ursodiol, Iqirvo, Livdelzi), unless there is a contraindication or intolerance to these medications

AND

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

- Hepatologist
- Gastroenterologist

2 . Revision History

Date	Notes
8/26/2026	New program

Prior Authorization Guideline

Guideline ID	GL-105529
Guideline Name	Lyrica
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2022

1 . Criteria

Product Name:Brand Lyrica	
Diagnosis	Seizure Disorder
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of seizure disorder

AND

2 - History of failure, contraindication, or intolerance to generic pregabalin immediate-release capsules or generic pregabalin solution

Product Name:Brand Lyrica	
Diagnosis	Neuropathic Pain Associated with Spinal Cord Injury
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of neuropathic pain associated with spinal cord injury

AND

2 - One of the following:

- History of failure to generic pregabalin immediate-release capsules or solution at a minimum dose of 300mg daily for 4 weeks
- Contraindication or intolerance to generic pregabalin immediate-release capsules or solution

Product Name:Brand Lyrica	
Diagnosis	Fibromyalgia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of fibromyalgia

AND

2 - One of the following:

- History of failure to generic pregabalin immediate-release capsules or solution at a minimum dose of 300mg daily for 4 weeks
- Contraindication or intolerance to generic pregabalin immediate-release capsules or solution

Product Name:Brand Lyrica	
Diagnosis	Diabetic peripheral neuropathy (DPN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of diabetic peripheral neuropathy (DPN)

AND

2 - One of the following:

- History of failure to generic pregabalin immediate-release capsules or solution at a minimum dose of 300mg daily for 4 weeks
- Contraindication or intolerance to generic pregabalin immediate-release capsules or solution

Product Name:Brand Lyrica	
Diagnosis	Post herpetic neuralgia (PHN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of post herpetic neuralgia (PHN)

AND

2 - One of the following:

- History of failure to generic pregabalin immediate-release capsules or solution at a minimum dose of 300mg daily for 4 weeks
- Contraindication or intolerance to generic pregabalin immediate-release capsules or solution

Product Name:Lyrica CR	
Diagnosis	Diabetic peripheral neuropathy (DPN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of diabetic peripheral neuropathy (DPN)

AND

2 - History of failure, contraindication, or intolerance to gabapentin (generic Neurontin) at a minimum dose of 1800 milligrams daily for 4 weeks

AND

3 - History of failure, contraindication, or intolerance to treatment with ONE of the following:

- Tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks, or intolerance to a tricyclic antidepressant
- Serotonin and norepinephrine reuptake inhibitor (SNRI) antidepressant (i.e. duloxetine, venlafaxine)

AND

4 - History of failure, contraindication, or intolerance to generic pregabalin immediate-release capsules or generic pregabalin solution

Product Name:Lyrica CR	
Diagnosis	Post herpetic neuralgia (PHN)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of post herpetic neuralgia (PHN)

AND

2 - History of failure, contraindication, or intolerance to gabapentin (generic Neurontin) at a minimum dose of 1800 milligrams daily for 4 weeks

AND

3 - History of failure, contraindication, or intolerance to a tricyclic antidepressant at the maximum tolerated dose for 6 to 8 weeks

AND

4 - History of failure, contraindication, or intolerance to generic pregabalin immediate-release capsules or generic pregabalin solution

2 . Revision History

Date	Notes

3/31/2022	Added step through generic for seizure indication. Updated all indicat ions to allow for any manufacturer of generic immediate-release caps ules or solution.

Prior Authorization Guideline

Guideline ID	GL-99473
Guideline Name	Lysteda
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Lysteda, generic tranexamic acid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cyclic heavy menstrual bleeding	

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona standard to Medicaid Arizona

Prior Authorization Guideline

Guideline ID	GL-114911
Guideline Name	Makena- AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/5/2022

1 . Criteria

Product Name:Brand Makena*, generic hydroxyprogesterone caproate*	
Guideline Type	Prior Authorization
Approval Criteria **1** - Current singleton pregnancy **AND** **2** - History of a prior spontaneous preterm birth of a singleton pregnancy	

AND **3** - Treatment is initiated between 16 weeks, 0 days of gestation and 20 weeks, 6 days of gestation **AND** **4** - Administration is to continue weekly until week 37 (through 36 weeks, 6 days) of gestation or delivery, whichever occurs first **AND** **5** - Applies to generic hydroxyprogesterone caproate ONLY: patient has a history of failure, contraindication or intolerance to Brand Makena	
Notes	*NOTE: Approval duration is up to 21 weeks; approval duration should take into account gestation week when Makena will be started and only authorized up to week 37.

2 . Revision History

Date	Notes
10/4/2022	Updated gestational days for drug initiation to align w PI

Prior Authorization Guideline

Guideline ID	GL-398214
Guideline Name	Marinol (dronabinol)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Brand Marinol	
Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is receiving cancer chemotherapy

AND

2 - History of failure, contraindication, or intolerance to preferred generic dronabinol

AND

3 - History of failure, contraindication, or intolerance to a 5HT-3 (5-hydroxytriptamine) receptor antagonist [eg, Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)]

AND

4 - History of failure, contraindication, or intolerance to ONE of the following:

- Ativan (lorazepam)
- Compazine (prochlorperazine)
- Decadron (dexamethasone)
- Haldol (haloperidol)
- Phenergan (promethazine)
- Reglan (metoclopramide)
- Zyprexa (olanzapine)

Product Name:Generic dronabinol	
Diagnosis	Chemotherapy-induced nausea and vomiting
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is receiving cancer chemotherapy

AND

2 - History of failure, contraindication, or intolerance to a 5HT-3 (5-hydoxytriptamine) receptor antagonist [eg, Anzemet (dolasetron), Kytril (granisetron), or Zofran (ondansetron)]

AND

3 - History of failure, contraindication, or intolerance to ONE of the following:

- Ativan (lorazepam)
- Compazine (prochlorperazine)
- Decadron (dexamethasone)
- Haldol (haloperidol)
- Phenergan (promethazine)
- Reglan (metoclopramide)
- Zyprexa (olanzapine)

Product Name:Brand Marinol	
Diagnosis	Anorexia in Patients with AIDS
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of anorexia with weight loss in patients with AIDS (acquired immunodeficiency syndrome)

AND

2 - Patient is on antiretroviral therapy

AND

3 - ONE of the following:

3.1 Patient is 65 years of age or greater

OR

3.2 BOTH of the following:

- Patient is less than 65 years of age
- History of failure, contraindication, or intolerance to Megace (megestrol)

AND

4 - History of failure, contraindication, or intolerance to preferred generic dronabinol

Product Name:Generic dronabinol	
Diagnosis	Anorexia in Patients with AIDS
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of anorexia with weight loss in patients with AIDS (acquired immunodeficiency syndrome)

AND

2 - Patient is on antiretroviral therapy

AND

3 - ONE of the following:

3.1 Patient is 65 years of age or greater

OR

3.2 BOTH of the following:

- Patient is less than 65 years of age

- History of failure, contraindication, or intolerance to Megace (megestrol)

2 . Revision History

Date	Notes
9/25/2025	Anorexia/AIDS indication: Updated verbiage in embedded step for Br and Marinol to align with N/V indication.

Prior Authorization Guideline

Guideline ID	GL-99474
Guideline Name	Mepron
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Mepron, generic atovaquone	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

1.1.1 The patient has a diagnosis (e.g. human immunodeficiency virus [HIV]) warranting Pneumocystis jirovecii pneumonia (PCP) infection prophylaxis

AND

1.1.2 The patient has a documented intolerance or contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) and dapsone

OR

1.2 BOTH of the following:

1.2.1 The patient has a diagnosis of mild to moderate pneumonia caused by P. jirovecii

AND

1.2.2 The patient has a documented intolerance, contraindication, or history of treatment failure to TMP-SMX

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona standard to Medicaid Arizona

Prior Authorization Guideline

Guideline ID	GL-115355
Guideline Name	Metformin products - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/13/2022

1 . Criteria

Product Name:generic metformin 625 mg immediate-release tablets	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - History of greater than or equal to 12 week trial of preferred metformin immediate-release products	

Product Name:generic metformin extended-release (generic for Fortamet and generic for Glumetza)

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 History of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR)

AND

1.2 ONE of the following:

1.2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Glucophage XR), in diabetic patients, as evidenced by the hemoglobin A1c level being above the patient's goal

OR

1.2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

1.3 History of greater than or equal to 12 week trial of metformin immediate-release

AND

1.4 One of the following:

1.4.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin immediate-release, in diabetic patients, as evidenced by the hemoglobin A1c level being above the patient's goal

OR

1.4.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

Product Name:Brand Glumetza, Brand Fortamet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 History of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR)

AND

1.2 ONE of the following:

1.2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Glucophage XR), in diabetic patients, as evidenced by the hemoglobin A1c level being above the patient's goal

OR

1.2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

1.3 History of greater than or equal to 12 week trial of metformin extended-release (generic Fortamet)

AND

1.4 One of the following:

1.4.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin extended-release (generic Fortamet), in diabetic patients, as evidenced by the hemoglobin A1c level being above the patient's goal

OR

1.4.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin extended-release (generic Fortamet) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

1.5 History of greater than or equal to 12 week trial of metformin immediate-release

AND

1.6 One of the following:

1.6.1 Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate response to metformin immediate-release, in diabetic patients, as evidenced by the hemoglobin A1c level being above the patient's goal

OR

1.6.2 Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance to metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

AND

1.7 Submission of article(s) published in the peer-reviewed medical literature showing that the requested drug is likely to be more efficacious to this patient than metformin extended-release (generic Glucophage XR)

2 . Revision History

Date	Notes
10/13/2022	Removed Brand Glucophage XR as target

Prior Authorization Guideline

Guideline ID	GL-756212
Guideline Name	Mimrylo (rusfertide)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

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

Approval Criteria

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

1.1 Diagnosis of polycythemia vera

AND

1.2 Patient has absolute erythrocytosis (i.e., hemoglobin > 16.5 g/dL for men or hemoglobin > 16.0 g/dL for women, or hematocrit > 49% for men or hematocrit > 48% for women)

AND

1.3 One of the following:

- Presence of JAK2 V617F or JAK2 exon 12 mutation
- Patient has subnormal serum erythropoietin level

AND

1.4 Requested drug will be used for the treatment of erythrocytosis

AND

1.5 Patient has inadequate hematocrit control with frequent phlebotomy or has intolerance to phlebotomy

AND

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

- Hematologist
- Oncologist

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

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy (e.g., hematocrit levels < 45%)

2 . Revision History

Date	Notes
10/28/2026	New program

Prior Authorization Guideline

Guideline ID	GL-240207
Guideline Name	Miplyffa (arimoclomol)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/15/2025

1 . Criteria

Product Name:Miplyffa	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes documenting a diagnosis of Niemann-Pick disease type C (NPC)

AND

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

2.1 Genetically confirmed (deoxyribonucleic acid [DNA] sequence analysis) by mutations in both alleles of NPC1 or NPC2

OR

2.2 Mutation in only one allele of NPC1 or NPC2 plus either positive filipin staining or elevated cholestane triol/oxysterols (>2 x upper limit of normal)

AND

3 - Patient has at least one neurological symptom of the disease (e.g., hearing loss, vertical supranuclear gaze palsy, ataxia, dementia, dystonia, seizures, dysarthria, or dysphagia)

AND

4 - Patient is 2 years of age or older

AND

5 - Requested drug will be used in combination with miglustat

AND

6 - Requested drug will NOT be used in combination with Aqneursa (levacetylleucine). *The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the same time and the lack of a Miplyffa and Aqneursa head-to-head study.

AND

7 - Prescribed by or in consultation with a specialist knowledgeable in the treatment of Niemann-Pick disease type C

Notes	*The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the sam e time and the lack of a Miplyffa and Aqneursa head-to-head study.

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., slowing of disease progression, improvement in neurological symptoms of the disease)

AND

2 - Requested drug will be used in combination with miglustat

AND

3 - Requested drug will NOT be used in combination with Aqneursa (levacetylleucine). *The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the same time and the lack of a Miplyffa and Aqneursa head-to-head study.

Notes	*The use of both Miplyffa and Aqneursa concomitantly is not covered due to lack of evidence to support the use of both products at the sam e time and the lack of a Miplyffa and Aqneursa head-to-head study.

2 . Revision History

Date	Notes

4/15/2025	Added verbiage regarding concomitant use with Aqneursa, no chang e to clinical criteria

Prior Authorization Guideline

Guideline ID	GL-525289
Guideline Name	Mitapivat Products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Pyrukynd	
Diagnosis	Hemolytic Anemia with Pyruvate Kinase (PK) Deficiency
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of hemolytic anemia confirmed by the presence of chronic hemolysis (e.g.,

increased indirect bilirubin, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count)

AND

1.2 Diagnosis of pyruvate kinase deficiency confirmed by molecular testing of ALL the following mutations on the PKLR gene:

- Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least 1 was a missense variant
- Patients is not homozygous for the c.1436G>A (p.R479H) variant
- Patient does not have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene

AND

1.3 Hemoglobin is less than or equal to 10g/dL

AND

1.4 Patient has symptomatic anemia or is transfusion dependent

AND

1.5 Exclusion of other causes of hemolytic anemias (e. g., infections, toxins, drugs)

AND

2 - Prescribed by or in consultation with a hematologist

Product Name:Pyrukynd	
Diagnosis	Hemolytic Anemia with Pyruvate Kinase (PK) Deficiency
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy [e.g., hemoglobin greater than or equal to 1.5g/dL from baseline, reduction in transfusions of greater than or equal to 33% in the number of red blood cell units transfused during the fixed dose period compared with the patient's historical transfusion burden, improvement in markers of hemolysis from baseline (e.g., bilirubin, lactated dehydrogenase [LDH], haptoglobin, reticulocyte count)]

AND

2 - Prescribed by or in consultation with a hematologist

Notes	If the member does not meet the medical necessity reauthorization criteria requirements, a denial should be issued and a 1-month authorization should be issued one time for Pyrukynd gradual therapy discontinuation.

Product Name:Aqvesme	
Diagnosis	Anemia with alpha- or beta-thalassemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of anemia with alpha or beta-thalassemia

AND

1.2 Hemoglobin is less than or equal to 10g/dL

AND

1.3 Patient has symptomatic anemia or is transfusion dependent

AND

1.4 Patient does not have liver disease (e.g., cirrhosis - Child Pugh Class A, B, or C, Hepatitis B virus [HBV], Hepatitis C virus [HCV], Human Immunodeficiency virus [HIV -1 or HIV-2])

AND

1.5 Both of the following:

- Patient has not had prior exposure to gene therapy (e.g., Casgevy [exagamglogene autotemcel], Zynteglo [betibeglogene autotemcel])
- Patient has not had prior bone marrow or stem cell transplantation

AND

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

- hematologist
- hepatologist

AND

3 - Patient is not on concurrent treatment with any of the following:

- Reblozyl (luspatercept-aamt)
- Hematopoietic stimulating agents (e.g., Epogen [epoetin alfa], Aranesp [darbepoetin alfa])
- Pyrukynd (mitapivat)

Diagnosis	Anemia with alpha- or beta-thalassemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in RBC transfusion burden, improvement in fatigue, increase in Hb concentration greater than or equal to 1g/dL from baseline)

AND

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

- hematologist
- hepatologist

AND

3 - Patient is not on concurrent treatment with any of the following:

- Reblozyl (luspatercept-aamt)
- Hematopoietic stimulating agents (e.g., Epogen [epoetin alfa], Aranesp [darbepoetin alfa])
- Pyrukynd (mitapivat)

2 . Revision History

Date	Notes
2/26/2026	Added Aqvesme as target, updated guideline name, updated submis sion of records verbiage throughout.

Prior Authorization Guideline

Guideline ID	GL-540208
Guideline Name	Molluscum Contagiosum Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/6/2026

1 . Criteria

Product Name:Ycanth	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of molluscum contagiosum

AND

2 - Patient is 2 years of age or older

AND

3 - Patient has single or multiple, 2- to 5-mm-diameter, flesh-colored to translucent, dome-shaped papules, some with central umbilication

AND

4 - One of the following:

- Patient has eczema (e.g., atopic dermatitis)
- Patient is immunocompromised
- Patient has extensive involvement or experiences bleeds, secondary infections or discomfort from the lesions

AND

5 - Lesions have not resolved within six months of diagnosis

AND

6 - Trial and failure, contraindication, or intolerance to ALL of the following:

- imiquimod
- topical salicylic acid
- topical tretinoin
- podofilox (e.g., Condylox gel, podofilox solution)
- cimetidine
- Tea Tree oil preparations

AND

7 - One of the following:

7.1 Patient is treating new lesions that have not previously been treated with Ycanth

OR

7.2 Lesions have previously been treated with Ycanth and will not exceed a total of 4 treatments of Ycanth

AND

8 - Medication is not being used concurrently with other FDA approved therapies (e.g., Zelsuvmi) on the same lesion for the treatment of molluscum contagiosum

AND

9 - Prescribed by or in consultation with a dermatologist

Product Name:Zelsuvmi	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of molluscum contagiosum

AND

2 - Patient is 1 year of age or older

AND

3 - Patient has single or multiple, 2- to 5-mm-diameter, flesh-colored to translucent, dome-shaped papules, some with central umbilication

AND

4 - One of the following:

- Patient has eczema (e.g., atopic dermatitis)
- Patient is immunocompromised
- Patient has extensive involvement or experiences bleeds, secondary infections or discomfort from the lesions

AND

5 - Lesions have not resolved within six months of diagnosis

AND

6 - Trial and failure, contraindication, or intolerance to ALL of the following:

- imiquimod
- topical salicylic acid
- topical tretinoin
- podofilox (e.g., Condylox gel, podofilox solution)
- cimetidine
- Tea Tree oil preparations

AND

7 - Patient is treating new lesions that have not previously been treated with Zelsuvmi

AND

8 - Medication is not being used concurrently with other FDA approved therapies (e.g., Ycanth) on the same lesion for the treatment of molluscum contagiosum

AND

9 - Prescribed by or in consultation with a dermatologist

2 . Revision History

Date	Notes
3/6/2026	Removed cantharidin as prerequisite

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-707210
Guideline Name	Monoclonal Antibody Agents for Alzheimer's Disease
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Aduhelm	
Diagnosis	Alzheimer's Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria, one of the following:

- Diagnosis of mild cognitive impairment due to Alzheimer's disease
- Diagnosis of probable Alzheimer's disease dementia

AND

1.2 Submission of medical records (e.g., chart notes) confirming both of the following:

- Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4
- Mini-Mental State Examination score of 24-30

AND

2 - Submission of medical records (e.g., chart notes) confirming the presence of beta-amyloid protein deposition, as evidenced by one of the following:

2.1 Positive amyloid positron emission tomography (PET) scan

OR

2.2 Both of the following:

- Attestation that the patient does not have access to amyloid PET scanning
- Cerebrospinal fluid (CSF) biomarker or blood testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., Aβ42 level, Aβ42:Aβ40 ratio)

AND

3 - Provider attests that the patient's ApoE e4 carrier status is known prior to initiating treatment and a shared decision-making conversation regarding the results has been completed

AND

4 - Other differential diagnoses (e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy, etc.) have been ruled out

AND

5 - Both of the following:

- Patient is not currently taking an anticoagulant or antiplatelet agent (unless aspirin 325 mg/day or less)
- Patient has no history of transient ischemic attack (TIA) or stroke within previous year prior to initiating treatment

AND

6 - Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIA-E and ARIA-H) and patient and/or caregiver are aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting

AND

7 - Submission of medical records (e.g., chart notes) confirming a baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment

AND

8 - Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Leqembi)

AND

9 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

Product Name:Aduhelm	
Diagnosis	Alzheimer's Disease
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is benefitting from therapy as defined by both of the following:

1.1 Based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria, one of the following:

- Patient continues to have a diagnosis of mild cognitive impairment due to Alzheimer's disease
- Patient continues to have a diagnosis of probable Alzheimer's disease dementia

AND

1.2 Submission of medical records (e.g., chart notes) confirming both of the following:

- Clinical Dementia Rating-Global (CDR-G) score of 0.5 or Clinical Dementia Rating Sum of Boxes (CDR-SB) score of 0.5-4
- Mini-Mental State Examination score of 24-30

AND

2 - Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy prior to the 5th infusion treatment to show one of the following:

2.1 Both of the following:

- Less than 10 new incident microhemorrhages
- 2 or less focal areas of superficial siderosis

OR

2.2 If 10 or more new incident microhemorrhages or greater than 2 focal areas of superficial siderosis are present then both of the following:

- Patient has been clinically evaluated for ARIA related signs or symptoms (e.g., dizziness, visual disturbances)
- Follow-up MRI demonstrates radiographic stabilization (i.e., no increase in size or number of ARIA-H)

AND

3 - Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Leqembi)

AND

4 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

Product Name:Kisunla	
Diagnosis	Alzheimer's Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Diagnosis of one of the following, based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria:

- Mild cognitive impairment due to Alzheimer's disease
- Mild dementia due to Alzheimer's disease

AND

1.2 Submission of medical records (e.g., chart notes) confirming Mini-Mental State Examination score of 20-28

AND

2 - Submission of medical records (e.g., chart notes) confirming the presence of beta-amyloid protein deposition, as evidenced by one of the following:

- Positive amyloid positron emission tomography (PET) scan
- Attestation that patient does not have access to amyloid PET scanning and cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., Aβ42 level, Aβ42:Aβ40 ratio, Tau, p-Tau)

AND

3 - Both of the following:

- Provider attests that testing regarding the patient's ApoE e4 carrier status has been performed prior to initiating treatment
- Prior to testing, a shared decision-making conversation has occurred, regarding the risk of amyloid-related imaging abnormalities (ARIA), across genotypes, and the implications of genetic testing results

AND

4 - Submission of medical records (e.g., chart notes) confirming a baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment

AND

5 - Other differential diagnoses (e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy) have been ruled out

AND

6 - Both of the following:

- Patient is not currently taking an anticoagulant (e.g., warfarin, dabigatran)
- Patient has no history of intracerebral hemorrhage (e.g., transient ischemic attack [TIA], stroke) prior to initiating treatment

AND

7 - Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Aduhelm, Leqembi)

AND

8 - Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIA-E and ARIA-H) and patient and/or caregiver are aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting

AND

9 - Provider will enroll patient in a registry [e.g., Alzheimer's Network for Treatment and Diagnostics (ALZ-Net)]

AND

10 - Patient is not being treated with Kisunla as part of a clinical trial

AND

11 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

Product Name:Kisunla	
Diagnosis	Alzheimer's Disease
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Patient continues to have one of the following diagnoses based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria:

- Mild cognitive impairment due to Alzheimer's disease

- Mild dementia due to Alzheimer's disease

AND

1.2 Submission of medical records (e.g., chart notes) confirming Mini-Mental State Examination score of 20-28

AND

2 - Submission of medical records (e.g., chart notes) confirming that at least one amyloid PET brain scan is performed every 6 months and the result is positive for amyloid based on visual read

AND

3 - Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy prior to the 5th and 7th infusion treatment to show one of the following radiographic evidence of amyloid related imaging abnormalities (i.e, ARIA-E, ARIA-H):

- Patient has mild radiographic severity of Aria – E on MRI and is asymptomatic
- Patient has mild radiographic severity of Aria – E on MRI and has mild clinical symptoms
- Patient has mild radiographic severity of Aria-H on MRI and is asymptomatic
- ARIA (i.e. ARIA E, ARIA H) has not been observed on MRI

AND

4 - Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Aduhelm, Leqembi)

AND

5 - Patient is not being treated with Kisunla as part of a clinical trial

AND

6 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

Product Name:Leqembi Intravenous solution, Leqembi IQLIK 250mg/1.25mL subcutaneous solution*	
Diagnosis	Alzheimer's Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Submission of medical records (e.g., chart notes) confirming diagnosis of one of the following, based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria:

- Mild cognitive impairment due to Alzheimer's disease
- Mild dementia due to Alzheimer's disease

AND

1.2 Submission of medical records (e.g., chart notes) confirming all of the following:

- Global Clinical Dementia Rating (CDR) score of 0.5 or 1.0
- CDR Memory Box score of 0.5 or greater
- Mini-Mental State Examination score of 22 or greater

AND

2 - Submission of medical records (e.g., chart notes) confirming the presence of beta-amyloid protein deposition, as evidenced by one of the following:

- Positive amyloid positron emission tomography (PET) scan
- Attestation that patient does not have access to amyloid PET scanning and cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., Aβ42 level, Aβ42:Aβ40 ratio, Tau, p-Tau)

AND

3 - Both of the following:

- Provider attests that testing regarding the patient's ApoE e4 (apolipoproteinE e4) carrier status has been performed prior to initiating treatment
- Prior to testing, a shared decision-making conversation has occurred, regarding the risk of amyloid-related imaging abnormalities (ARIA), across genotypes, and the implications of genetic testing results

AND

4 - Submission of medical records (e.g., chart notes) confirming a baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment

AND

5 - Other differential diagnoses (e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy) have been ruled out

AND

6 - Both of the following:

- Patient is not currently taking an anticoagulant (e.g., warfarin, dabigatran)
- Patient has no history of intracerebral hemorrhage (e.g., transient ischemic attack [TIA], stroke) prior to initiating treatment

AND

7 - Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Aduhelm, Kisunla)

AND

8 - Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIA-

E and ARIA-H) and patient and/or caregiver are aware to monitor for headache, confusion, dizziness, visual changes, nausea, and gait difficulty

AND

9 - Provider will enroll patient in a registry [e.g., Alzheimer's Network for Treatment and Diagnostics (ALZ-Net)]

AND

10 - Patient is not being treated with Leqembi as part of a clinical trial

AND

11 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

Notes	* If patient meets criteria above, please approve at GPI-14

Product Name:Leqembi Intravenous solution, Leqembi IQLIK 250mg/1.25mL subcutaneous solution*	
Diagnosis	Alzheimer's Disease
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Submission of medical records (e.g., chart notes) confirming patient continues to have one of the following diagnoses based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria:

- Mild cognitive impairment due to Alzheimer's disease
- Mild dementia due to Alzheimer's disease

AND

1.2 Submission of medical records (e.g., chart notes) confirming all of the following:

- Global Clinical Dementia Rating (CDR) score of 0.5 or 1.0
- CDR Memory Box score of 0.5 or greater
- Mini-Mental State Examination score of 22 or greater

AND

2 - Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy prior to the 5th and 7th infusion treatment to show one of the following radiographic evidence of amyloid related imaging abnormalities (i.e, ARIA-E, ARIA-H):

- Patient has mild radiographic severity of Aria – E on MRI and is asymptomatic
- Patient has mild radiographic severity of Aria – E on MRI and has mild clinical symptoms
- Patient has mild radiographic severity of Aria-H on MRI and is asymptomatic
- ARIA (i.e. ARIA E, ARIA H) has not been observed on MRI

AND

3 - Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Aduhelm, Kisunla)

AND

4 - For Leqembi IQLIK 250mg/1.25mL subcutaneous solution: Will be used only for completion of 18 month induction phase

AND

5 - Patient is not being treated with Leqembi as part of a clinical trial

AND

6 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist	
Notes	* If patient meets criteria above, please approve at GPI-14

Product Name:Leqembi IQLIK 360mg/1.8mL subcutaneous solution*	
Diagnosis	Alzheimer's Disease
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Submission of medical records (e.g., chart notes) confirming diagnosis of one of the following, based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria:

- Mild cognitive impairment due to Alzheimer's disease
- Mild dementia due to Alzheimer's disease

AND

1.2 Submission of medical records (e.g., chart notes) confirming all of the following:

- Global Clinical Dementia Rating (CDR) score of 0.5 or 1.0
- CDR Memory Box score of 0.5 or greater
- Mini-Mental State Examination score of 22 or greater

AND

2 - Submission of medical records (e.g., chart notes) confirming the presence of beta-amyloid protein deposition, as evidenced by one of the following:

- Positive amyloid positron emission tomography (PET) scan

- Attestation that patient does not have access to amyloid PET scanning and cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., Aβ42 level, Aβ42:Aβ40 ratio, Tau, p-Tau)

AND

3 - Both of the following:

- Provider attests that testing regarding the patient's ApoE e4 (apolipoproteinE e4) carrier status has been performed prior to initiating treatment
- Prior to testing, a shared decision-making conversation has occurred, regarding the risk of amyloid-related imaging abnormalities (ARIA), across genotypes, and the implications of genetic testing results

AND

4 - Submission of medical records (e.g., chart notes) confirming a baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment

AND

5 - Other differential diagnoses (e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy) have been ruled out

AND

6 - Both of the following:

- Patient is not currently taking an anticoagulant (e.g., warfarin, dabigatran)
- Patient has no history of intracerebral hemorrhage (e.g., transient ischemic attack [TIA], stroke) prior to initiating treatment

AND

7 - Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Aduhelm, Kisunla)

AND

8 - Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIA-E and ARIA-H) and patient and/or caregiver are aware to monitor for headache, confusion, dizziness, visual changes, nausea, and gait difficulty

AND

9 - Provider will enroll patient in a registry [e.g., Alzheimer's Network for Treatment and Diagnostics (ALZ-Net)]

AND

10 - Patient is not being treated with Leqembi as part of a clinical trial

AND

11 - Will be used as a maintenance dose following completion of 18 months with either Leqembi intravenous or Leqembi Iqlik 250mg/1.25mL subcutaneous solution

AND

12 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

Notes	* If patient meets criteria above, please approve at GPI-14

Product Name:Leqembi IQLIK 360mg/1.8mL subcutaneous solution*	
Diagnosis	Alzheimer's Disease
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Submission of medical records (e.g., chart notes) confirming patient continues to have one of the following diagnoses based on the National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria:

- Mild cognitive impairment due to Alzheimer's disease
- Mild dementia due to Alzheimer's disease

AND

1.2 Submission of medical records (e.g., chart notes) confirming all of the following:

- Global Clinical Dementia Rating (CDR) score of 0.5 or 1.0
- CDR Memory Box score of 0.5 or greater
- Mini-Mental State Examination score of 22 or greater

AND

2 - Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy prior to the 5th and 7th infusion treatment to show one of the following radiographic evidence of amyloid related imaging abnormalities (i.e, ARIA-E, ARIA-H):

- Patient has mild radiographic severity of Aria – E on MRI and is asymptomatic
- Patient has mild radiographic severity of Aria – E on MRI and has mild clinical symptoms
- Patient has mild radiographic severity of Aria-H on MRI and is asymptomatic
- ARIA (i.e. ARIA E, ARIA H) has not been observed on MRI

AND

3 - Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Aduhelm, Kisunla)

AND

4 - Will be used as a maintenance dose following completion of 18 months with either Leqembi intravenous or Leqembi Iqlik 250mg/1.25mL subcutaneous solution

AND **5** - Patient is not being treated with Leqembi as part of a clinical trial **AND** **6** - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist	
Notes	* If patient meets criteria above, please approve at GPI-14

2 . Revision History

Date	Notes
8/26/2026	Leqembi: Added new 250mg IQLIK formulation, updated criteria thro ughout due to revised indication.

Prior Authorization Guideline

Guideline ID	GL-108624
Guideline Name	Monurol
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/23/2022

1 . Criteria

Product Name:Monurol	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The provider has submitted labs showing the culture and sensitivity is positive for Monural and negative to Ciprofloxacin or Nitrofurantoin

OR

2 - Trial and failure, contraindication, or intolerance to ONE of the following:

- Ciprofloxacin
- Nitrofurantoin

2 . Revision History

Date	Notes
6/23/2022	Added product name to criteria section, no change to criteria

Prior Authorization Guideline

Guideline ID	GL-99625
Guideline Name	Mozobil
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Mozobil	
Approval Length	4 Days*
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

- Patients with non-Hodgkin's lymphoma (NHL) who will be undergoing autologous hematopoietic stem cell (HSC) transplantation
- Patients with multiple myeloma (MM) who will be undergoing autologous HSC transplantation

AND **2** - Used in combination with granulocyte-colony stimulating factor (G-CSF) [e.g., Zarxio (filgrastim)] **AND** **3** - Prescribed by, or in consultation with, a hematologist/oncologist	
Notes	*Authorization will be issued for 1 course of therapy (up to four days of therapy).

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-715190
Guideline Name	MS Agents - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:PREFERRED: Avonex, Briumvi, generic dalfampridine, generic dimethyl fumarate capsules, generic fingolimod, generic glatiramer, Glatopa, Kesimpta, Rebif, generic teriflunomide	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of multiple sclerosis (MS)	

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:NON-PREFERRED: Brand Ampyra, Brand Aubagio, Bafiertam, Betaseron, Brand Copaxone, Extavia, Brand Gilenya, Brand Mavenclad, generic cladribine, Mayzent, Ocrevus, Ocrevus Zunovo, Plegridy, Ponvory, Tascenso ODT, Brand Tecfidera capsules, Brand Tecfidera starter packs, generic dimethyl fumarate starter packs, Vumerity	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis (MS)

AND

2 - One of the following:

2.1 Patient has a history of failure, contraindication, or intolerance to a trial of at least TWO of the preferred alternatives * (May require PA) (Verified via pharmacy paid claims or submission of medical records)

- Avonex
- Briumvi
- generic glatiramer or Glatopa
- generic dalfampridine
- generic dimethyl fumarate
- generic fingolimod
- Kesimpta
- Rebif
- generic teriflunomide
- Tysabri

OR

2.2 Patient is currently established on requested medication as documented by claims history or medical records (document drug, date, and duration of therapy)

Notes	*NOTE: Preferred Drug May Require PA

Product Name:PREFERRED: Avonex, Briumvi, generic dalfampridine, generic dimethyl fumarate capsules, generic fingolimod, generic glatiramer, Glatopa, Kesimpta, Rebif, generic teriflunomide; NON-PREFERRED: Brand Ampyra, Brand Aubagio, Bafiertam, Betaseron, Brand Copaxone, Extavia, Brand Gilenya, Brand Mavenclad, generic cladribine, Mayzent, Ocrevus, Ocrevus Zunovo, Plegridy, Ponvory, Tascenso ODT, Brand Tecfidera capsules, Brand Tecfidera starter packs, generic dimethyl fumarate starter packs, Vumerity	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)	
Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

2 . Revision History

Date	Notes
9/11/2026	10/1 changes: Glatiramer and Glatopa to PDL, Copaxone to NPD, Ocrevus/Ocrevus Zunovo to NPD

Prior Authorization Guideline

Guideline ID	GL-99476
Guideline Name	Multaq
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Multaq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 All of the following:

1.1.1 Diagnosis of ONE of the following:

- Paroxysmal Atrial Fibrillation (AF)

- Persistent AF defined as AF less than 6 months duration

AND

1.1.2 ONE of the following:

- Patient is in sinus rhythm
- Patient is planned to undergo cardioversion to sinus rhythm

AND

1.1.3 Patient does not have New York Heart Association (NYHA) Class IV heart failure

AND

1.1.4 Patient does not have symptomatic heart failure with recent decompensation requiring hospitalization

OR

1.2 For continuation of current therapy

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona standard to Medicaid Arizona

Prior Authorization Guideline

Guideline ID	GL-99626
Guideline Name	Myalept
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - Diagnosis of ONE of the following:

- Congenital generalized lipodystrophy associated with leptin deficiency
- Acquired generalized lipodystrophy associated with leptin deficiency

AND

2 - Used as an adjunct to diet modification

AND

3 - Prescribed by an endocrinologist

AND

4 - Documentation demonstrates that patient has at least ONE of the following:

4.1 Diabetes mellitus or insulin resistance with persistent hyperglycemia (hemoglobin A1C greater than 7.0%) despite BOTH of the following:

- Dietary intervention
- Optimized insulin therapy at maximum tolerated doses

OR

4.2 Persistent hypertriglyceridemia (triglycerides greater than 250 milligrams per deciliter) despite BOTH of the following:

- Dietary intervention
- Optimized therapy with at least two triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses

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

Approval Criteria

1 - Documentation of positive clinical response to Myalept therapy

AND

2 - Used as an adjunct to diet modification

AND

3 - Prescribed by an endocrinologist

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-118559
Guideline Name	Myfembree (relugolix, estradiol, and norethindrone acetate), Oriahnn (elagolix, estradiol, and norethindrone acetate capsules; elagolix capsules)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2023

1 . Criteria

Product Name:Oriahnn, Myfembree	
Diagnosis	Heavy Menstrual Bleeding Associated With Uterine Leiomyomas (Fibroids)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids)

AND

2 - Patient is premenopausal

AND

3 - One of the following:

3.1 History of inadequate control of bleeding following a trial of at least 3 months, or history of intolerance or contraindication to one of the following:

- Combination (estrogen/progestin) contraceptive
- Progestins
- Tranexamic acid

OR

3.2 Patient has had a previous interventional therapy to reduce bleeding

AND

4 - Treatment duration of therapy has not exceeded a total of 24 months

Product Name:Oriahnn, Myfembree	
Diagnosis	Heavy Menstrual Bleeding Associated With Uterine Leiomyomas (Fibroids)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has improvement in bleeding associated with uterine leiomyomas (fibroids) (e.g., significant/sustained reduction in menstrual blood loss per cycle, improved quality of life, etc.)

AND

2 - Treatment duration of therapy has not exceeded a total of 24 months

Product Name:Myfembree	
Diagnosis	Pain Associated With Endometriosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - Patient is premenopausal

AND

3 - ONE of the following:

3.1 History of inadequate pain control response following a trial of 30 days, or history of intolerance or contraindication to one of the following:

- Danazol
- Combination (estrogen/progestin) contraceptive
- Progestins

OR

3.2 Patient has had surgical ablation to prevent recurrence

AND

4 - Treatment duration of Myfembree has not exceeded a total of 24 months

Product Name:Myfembree	
Diagnosis	Pain Associated With Endometriosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and nonmenstrual pelvic pain)

AND

2 - Treatment duration of Myfembree has not exceeded a total of 24 months

2 . Revision History

Date	Notes
12/19/2022	New Program

Prior Authorization Guideline

Guideline ID	GL-553400
Guideline Name	Myqorzo (aficamten)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Myqorzo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of obstructive hypertrophic cardiomyopathy (HCM)

AND

2 - Patient has New York Heart Association (NYHA) Class II or III symptoms (e.g., shortness of breath, chest pain)

AND

3 - Both of the following were measured prior to Myqorzo therapy:

3.1 Patient had a left ventricular ejection fraction of greater than or equal to 55%

AND

3.2 Patient had a valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation

AND

4 - Trial and inadequate response, contraindication, or intolerance to one of the following at a maximally tolerated dose:

- non-vasodilating beta blocker (e.g., bisoprolol, propranolol)
- calcium channel blocker (e.g., verapamil, diltiazem)

AND

5 - Requested drug will not be used in combination with another cardiac myosin inhibitor (e.g., Camzyos)

AND

6 - Prescribed by or in consultation with a cardiologist

Product Name:Myqorzo

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., improved symptom relief)

AND

2 - Patient has a left ventricular ejection fraction of greater than or equal to 50%

AND

3 - Requested drug will not be used in combination with another cardiac myosin inhibitor (e.g., Camzyos)

AND

4 - Prescribed by or in consultation with a cardiologist

2 . Revision History

Date	Notes
3/24/2026	New program

Prior Authorization Guideline

Guideline ID	GL-99477
Guideline Name	Mytesi
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Mytesi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS) associated diarrhea	

2 . Revision History

Date	Notes
3/11/2021	Bulk copy C&S Arizona standard to Medicaid Arizona

Prior Authorization Guideline

Guideline ID	GL-109903
Guideline Name	Nadolol
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2022

1 . Criteria

Product Name:Nadolol	
Diagnosis	PA required for patients 18 years of age or older
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - History of failure, contraindication, or intolerance to 3 of the following:

- atenolol
- atenolol/chlorthalidone
- bisoprolol fumarate

- bisoprolol/hydrochlorothiazide
- carvedilol
- labetalol HCl
- metoprolol succinate
- metoprolol tartrate
- metoprolol/hydrochlorothiazide
- propranolol HCl
- propranolol/hydrochlorothiazide
- sotalol HCl

2 . Revision History

Date	Notes
7/28/2022	Updated indication verbiage, no change to clinical criteria.

Prior Authorization Guideline

Guideline ID	GL-164377
Guideline Name	Namzaric (memantine/donepezil)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2025

1 . Criteria

Product Name:Brand Namzaric, generic memantine/donepezil	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 History of BOTH of the following:

1.1.1 Memantine (generic Namenda)

AND

1.1.2 Donepezil (generic Aricept)

AND

1.2 Patient is stabilized on 10mg of donepezil once daily

2 . Revision History

Date	Notes
1/30/2025	Added GPIs for new generic memantine/donepezil as NP target.

Prior Authorization Guideline

Guideline ID	GL-99627
Guideline Name	Natpara
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of hypocalcemia resulting from chronic hypoparathyroidism

AND

1.2 25-hydroxy vitamin D level is above the lower limit of the normal laboratory reference range

AND

1.3 Patient is currently on active vitamin D (calcitriol) therapy

AND

1.4 Total serum calcium level (albumin corrected) is above 7.5 milligrams per deciliter

AND

2 - ONE of the following:

2.1 Patient is currently on calcium supplementation of 1-2 grams per day of elemental calcium in divided doses

OR

2.2 Patient has a contraindication to calcium supplementation

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

Product Name:Natpara	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Total serum calcium level (albumin corrected) within the lower half of the normal range (approximately 8 to 9 milligrams per deciliter)

AND

2 - Patient continues to take concomitant calcium supplementation that is sufficient to meet daily requirements

AND

3 - Prescribed by ONE of the following:

- Endocrinologist
- Nephrologist

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-716253
Guideline Name	Nemluvio (nemolizumab-ilto)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Nemluvio	
Diagnosis	Prurigo Nodularis (PN)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of prurigo nodularis (PN)

AND

2 - Patient has at least 20 nodular lesions

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming trial and failure, contraindication, or intolerance to BOTH of the following:*

- One medium or higher potency topical corticosteroid
- Dupixent (dupilumab) (PA may be required)

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication

Product Name:Nemluvio	
Diagnosis	Prurigo Nodularis (PN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates a positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in the number of nodular lesions from baseline

- Improvement in symptoms (e.g., pruritus, inflammation) from baseline

AND

2 - Submission of medical records (e.g., chart notes) or paid claims confirming trial and failure, contraindication, or intolerance to BOTH of the following:*

- One medium or higher potency topical corticosteroid
- Dupixent (dupilumab) (PA may be required)

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication

Product Name:Nemluvio	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of moderate to severe atopic dermatitis (AD)

AND

2 - One of the following:

- Involvement of at least 10% body surface area (BSA)
- SCORing Atopic Dermatitis (SCORAD) index value of at least 25

AND

3 - Patient is 12 years of age or older

AND

4 - Submission of medical records (e.g., chart notes) or paid claims confirming history of failure, contraindication, or intolerance to ALL of the following:*

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)
- Opzelura (ruxolitinib)
- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

AND

5 - Will be used in combination with topical corticosteroids and/or calcineurin inhibitors (e.g., tacrolimus ointment)

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication

Product Name:Nemluvio	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates a positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in body surface area involvement from baseline
- Reduction in SCORing Atopic Dermatitis (SCORAD) index value from baseline

AND

2 - Will be used in combination with topical corticosteroids and/or calcineurin inhibitors (e.g., tacrolimus ointment)

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming history of failure, contraindication, or intolerance to ALL of the following:*

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)
- Opzelura (ruxolitinib)
- Adbry (tralokinumab-ldrm)
- Dupixent (dupilumab)

AND

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

- Dermatologist
- Allergist
- Immunologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and/or contraindication to medication

2 . Background

Benefit/Coverage/Program Information

Table 1: Relative potencies of topical corticosteroids

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025

	Flurandrenolide	Cream, ointment	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream	0.1
	Triamcinolone acetonide	Cream, ointment	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
9/9/2026	Dupixent preferred 10/1/26: updated steps for AD and PN

Prior Authorization Guideline

Guideline ID	GL-642235
Guideline Name	Nereus (tradipitant)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Nereus	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Used for the short-term prevention of vomiting induced by motion

AND

2 - Patient is 18 years of age or older

AND

3 - Dosing frequency will be limited to once daily dosing

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming trial and failure, contraindication, or intolerance to two conventional motion sickness therapies including but not limited to the following: environmental modification, transdermal scopolamine and antihistamines (e.g., dimenhydrinate, meclizine)

AND

5 - Requested drug is not being prescribed for off-label use (e.g., drug induced nausea and vomiting, morning sickness, vertigo)

2 . Revision History

Date	Notes
6/25/2026	New program

Prior Authorization Guideline

Guideline ID	GL-125301
Guideline Name	Nexiclon XR (clonidine ER)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2023

1 . Criteria

Product Name:Nexiclon XR, Brand Clonidine ER (Nexiclon XR ABA)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Requested medication is being used for treatment of hypertension

AND

2 - Trial and failure, contraindication, or intolerance to one of the following (verified via paid pharmacy claims or submitted chart notes):

- generic clonidine oral tablet
- generic clonidine topical patch

2 . Revision History

Date	Notes
5/25/2023	Added Nexiclon XR ABA as NP target. Updated dx criterion.

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-147690
Guideline Name	Nexletol (bempedoic acid) and Nexlizet (bempedoic acid-ezetimibe)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2024

1 . Criteria

Product Name:Nexletol, Nexlizet	
Diagnosis	Heterozygous familial hypercholesterolemia (HeFH) or primary hyperlipidemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Heterozygous familial hypercholesterolemia (HeFH)

- Primary Hyperlipidemia

AND

2 - One of the following:

- Patient has been receiving at least 12 consecutive weeks of highest tolerable dose of statin therapy
- Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase)
- Patient has an FDA labeled contraindication to all statins

AND

3 - One of the following LDL-C values while on maximally tolerated statin therapy within the last 120 days:

- LDL-C greater than or equal to 55 mg/dL with ASCVD
- LDL-C greater than or equal to 100 mg/dL without ASCVD

AND

4 - One of the following:

4.1 For Nexletol, ONE of the following:

- Patient has been receiving at least 12 consecutive weeks of generic ezetimibe therapy as adjunct to maximally tolerated statin therapy
- Patient has a history of contraindication or intolerance to ezetimibe

OR

4.2 For Nexlizet, patient has been receiving at least 12 consecutive weeks of generic ezetimibe therapy as adjunct to maximally tolerated statin therapy

Product Name:Nexletol, Nexlizet

Diagnosis	Heterozygous familial hypercholesterolemia (HeFH) or primary hyperlipidemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline while on therapy

AND

2 - One of the following:

- Patient continues to receive other lipid-lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose
- Patient has a documented inability to take other lipid-lowering therapy (e.g., statins, ezetimibe)

Product Name:Nexletol, Nexlizet	
Diagnosis	Established cardiovascular disease (CVD) or high risk for a CVD event but without established CVD
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Established cardiovascular disease (CVD) (e.g., coronary artery disease, symptomatic peripheral arterial disease, cerebrovascular atherosclerotic disease)

- A high risk for a CVD event but without established CVD [e.g., diabetes mellitus (type 1 or type 2) in females over 65 years of age or males over 60 years of age]

AND

2 - One of the following:

- Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase)
- Patient has an FDA labeled contraindication to all statins

AND

3 - One of the following LDL-C values within the last 120 days:

- LDL-C greater than or equal to 55 mg/dL with ASCVD
- LDL-C greater than or equal to 100 mg/dL without ASCVD

AND

4 - One of the following:

4.1 For Nexletol, ONE of the following:

- Patient has been receiving at least 12 consecutive weeks of generic ezetimibe therapy
- Patient has a history of contraindication or intolerance to ezetimibe

OR

4.2 For Nexlizet, patient has been receiving at least 12 consecutive weeks of generic ezetimibe therapy

Product Name:Nexletol, Nexlizet	
Diagnosis	Established cardiovascular disease (CVD) or high risk for a CVD event but without established CVD
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

2 . Revision History

Date	Notes
5/23/2024	Updated criteria due to indication updates in prescribing information. Added criteria for the new FDA approved indication.

Prior Authorization Guideline

Guideline ID	GL-700353
Guideline Name	Niktimvo (axatilimab-csfr)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of chronic graft versus host disease (cGVHD)

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting history of failure or inadequate response to at least two other systemic therapies [e.g., corticosteroids (e.g., prednisone, methylprednisolone), mycophenolate]

AND

3 - Patient weighs at least 40kg

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting patient does not show evidence of progressive disease while on therapy

2 . Revision History

Date	Notes
8/26/2026	Added new GPIs

Prior Authorization Guideline

Guideline ID	GL-554248
Guideline Name	Nitisinone Products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Nityr, Brand Orfadin, Generic nitisinone	
Diagnosis	Hereditary Tyrosinemia type 1 (HT-1)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of hereditary tyrosinemia type 1 (HT-1)	

AND

2 - Diagnosis confirmed by the presence of succinylacetone in the plasma or urine

AND

3 - Used in combination with dietary restriction of tyrosine and phenylalanine

AND

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

- Gastroenterologist
- Hepatologist
- Other specialist with experience in treating inborn errors of metabolism

AND

5 - Applies to Nityr only; trial and intolerance to Orfadin (nitisinone) capsules or suspension

Product Name:Nityr, Brand Orfadin, Generic nitisinone	
Diagnosis	Hereditary Tyrosinemia type 1 (HT-1)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates a positive clinical response to therapy

AND

2 - Applies to Nityr only; trial and intolerance to Orfadin (nitisinone) capsules or suspension

Product Name:Harliku	
Diagnosis	Alkaptonuria (AKU)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of alkaptonuria (AKU)

AND

2 - Used for the reduction of urine homogentisic acid (HGA)

AND

3 - Disease is confirmed by one of the following:

- Presence of a mutation in the homogentisate 1,2-dioxygenase (HGD) gene
- Presence of elevated homogentisic acid (HGA) levels in urine greater than 0.4 g/24h

AND

4 - Trial (of a minimum 30-day supply) or intolerance to generic nitisinone 2mg capsules

AND

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

- Rheumatologist
- Geneticist

- Specialist experienced in the treatment of inborn errors of metabolism

Product Name:Harliku	
Diagnosis	Alkaptonuria (AKU)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., reduced levels of urinary HGA)

AND

2 - Trial (of a minimum 30-day supply) or intolerance to generic nitisinone 2mg capsules

2 . Revision History

Date	Notes
3/24/2026	New program: combines criteria for Nityr, Orfadin, Harliku.

Prior Authorization Guideline

Guideline ID	GL-99505
Guideline Name	Nocdurna
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Nocdurna	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of nocturia due to nocturnal polyuria (as defined by nighttime urine production that exceeds one-third of the 24-hour urine production)

AND

2 - Patient wakes at least twice per night on a reoccurring basis to void

AND

3 - Documented serum sodium level is currently within normal limits of the normal laboratory reference range and has been within normal limits over the previous six months

AND

4 - The patient has been evaluated for other medical causes and has either not responded to, tolerated, or has a contraindication to treatments for identifiable medical causes [e.g., overactive bladder, benign prostatic hyperplasia/lower urinary tract symptoms (BPH/LUTS), elevated post-void residual urine, and heart failure]

AND

5 - Prescriber attests that the risks have been assessed and benefits outweigh the risks

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient has routine monitoring for serum sodium levels

AND **3** - Prescriber attests that the risks of hyponatremia have been assessed and benefits outweigh the risks

2 . Revision History

Date	Notes
3/11/2021	Bulk copy from C&S Medicaid to Arizona Medicaid for 7/1 eff

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Prior Authorization Guideline

Guideline ID	GL-502256
Guideline Name	Non-hormonal Therapies for Vasomotor Symptoms
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Lynkuet, Veozah	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe vasomotor symptoms due to menopause

AND

2 - Submission of medical records (e.g., chart notes, paid claims history) documenting trial and failure, contraindication, or intolerance to both of the following (document drug, date, and duration of trial):

- Menopausal hormone therapy (e.g., Premarin, Bijuva, Estrogel, etc.)
- Non-hormonal therapy (e.g. paroxetine mesylate, venlafaxine, clonidine, etc.)

Product Name:Lynkuet, Veozah	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., decrease in frequency and severity of vasomotor symptoms from baseline, etc.)

2 . Revision History

Date	Notes
1/28/2026	Changed guideline name, added Lynkuet as target.

Prior Authorization Guideline

Guideline ID	GL-223223
Guideline Name	Non-Preferred Drugs - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:Non-Preferred Drugs	
Approval Length	12 months*
Guideline Type	Administrative

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following:

- If there are at least three preferred alternatives, history of trial per member's pharmacy claims resulting in a therapeutic failure, contraindication, or intolerance to at least THREE preferred alternatives (Prior trials of formulary/preferred drug list (PDL)

alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request)*

- If there are fewer than three preferred alternatives, the patient must have a history of trial per member's pharmacy claims resulting in a therapeutic failure, contraindication, or intolerance to ALL of the preferred products (Prior trials of formulary/preferred drug list (PDL) alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request)*
- There are no preferred formulary alternatives for the requested drug*

AND

1.2 If the request is for a multi-source brand medication (i.e., MSC O) ONE of the following:

1.2.1 BOTH of the following:

- The brand is being requested because of an adverse reaction, allergy or sensitivity to the generic and the prescriber must attest to submitting the FDA MedWatch Form for allergic reactions to the medications
- The patient has tried three generic formulations (if available) of the requested brand product

OR

1.2.2 ONE of the following:

- The brand is being requested due to a therapeutic failure with the generic (please provide reason for therapeutic failure)
- The brand is being requested because transition to the generic could result in destabilization of the patient (rationale must be provided)
- Special clinical circumstances exist that preclude the use of the generic equivalent of the multi-source brand medication for the patient (rationale must be provided)

AND

1.3 ONE of the following:

1.3.1 The requested drug must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.3.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- The requested drug must be used for a Food and Drug Administration (FDA)-approved indication
- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia – Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

AND

1.4 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program**

OR

2 - If the requested medication is a behavioral health medication, ONE of the following:

- The patient has been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan (enrollment effective date within the past 90 days)
- The patient is currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge

Notes	*Anti-infectives: Approve for the requested time frame, or if duration is not specified approve the request for 30 days. *Controlled Substances shall be approved for the requested time. If th ere is not a requested time period and it is not clear in the directions, approve for one time only. *Other medications: Approved for the requested time frame, or if durat ion is not specified, approve for 12 months.

	* For Non-Preferred Generics (i.e. MSC=Y) approvals: Please approv e at MSC=Y only. For preferred alternatives, use the non-preferred alternatives grid to id entify appropriate alternatives: https://uhgazure.sharepoint.com/sites/ CST/CSDM/Shared%20Documents/Forms/AllItems.aspx?FolderCTID =0x01200027C80175A8369D44AC45A99A99328B80&View=%7B4B 6D25AD%2D6A95%2D496D%2D9937%2D65CECD43AFE7%7D&vie wid=c2ad0afa%2D814c%2D499e%2Dbf25%2D3411fac9171f&id=%2 Fsites%2FCST%2FCSDM%2FShared%20Documents%2FAZM%2FN F%20Alt%20Tables **Medications used to treat obesity/weight loss, cosmetic (e.g., alopec ia, actinic keratosis, vitiligo), erectile dysfunction, or sexual dysfunctio n purposes are NOT medically accepted indications and are NOT rec ognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadal afil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes
3/26/2025	Updated note section regarding cosmetic/excluded use.

Prior Authorization Guideline

Guideline ID	GL-754196
Guideline Name	Non-Solid Oral Dosage Forms
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

Note:

The purpose of this guideline is to target high-cost oral solution formulations that are duplicative in clinical nature. For oral solutions without preferred alternatives available, member may receive the requested drug if they demonstrate inability to swallow. For oral solutions with preferred alternatives that only exist in solid oral dosage formulations (e.g., capsules, tablets), members will be asked to try the preferred solid oral dosage formulation unless they have an inability to swallow. Not all oral solutions that fit the criteria above will be added to this PA guideline. Certain oral solutions may have drug-specific PA criteria applied if the drug-specific PA criteria can provide more tailored and/or robust clinical review.

1 . Criteria

Product Name:Subvenite oral suspension	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Requested drug is FDA-approved for the condition being treated

OR

1.2 If requested for an off-label indication, the off-label guideline approval criteria have been met

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming one of the following:

2.1 Trial and failure, or intolerance to generic lamotrigine tablet or lamotrigine ODT

OR

2.2 Patient is unable to swallow a solid dosage form (e.g., oral tablet, capsule) due to one of the following:

- Age
- Physical impairment (e.g., difficulties with motor or oral coordination)
- Dysphagia
- Patient is using a feeding tube or nasal gastric tube

OR

2.3 For continuation of prior therapy defined as no more than a 45-day gap in therapy

Product Name:Arbli, Atmeksi, Atorvaliq, butalbital/APAP/caffeine solution, Eliquis sprinkle capsule, Eliquis tablet for oral suspension, Elyxyb, Gloperba, Inzirqo, Javadin, Katerzia, Likmez, Lopressor oral solution, Norliqva, Ontralfy, Sdamlo, Tezruly, Tonmya, Vyscoxa	
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Requested drug is FDA-approved for the condition being treated

OR

1.2 If requested for an off-label indication, the off-label guideline approval criteria have been met

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming one of the following:

2.1 Trial and failure, or intolerance to a generic equivalent of the requested drug in a solid dosage form

OR

2.2 Patient is unable to swallow a solid dosage form (e.g., oral tablet, capsule) due to one of the following:

- Age
- Physical impairment (e.g., difficulties with motor or oral coordination)
- Dysphagia
- Patient is using a feeding tube or nasal gastric tube

AND

3 - For Norliqva and Sdamlo requests ONLY: trial and failure, contraindication, or intolerance to Katerzia (verified via paid pharmacy claims or submitted chart notes) APPLIES TO NORLIQVA AND SDAMLO REQUESTS ONLY

2 . Revision History

Date	Notes
10/28/2026	Added Elyxyb as target

Prior Authorization Guideline

Guideline ID	GL-99629
Guideline Name	Northera
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Northera	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of symptomatic neurogenic orthostatic hypotension (nOH) as defined by ONE of the following when an upright position is assumed or when using a head-up tilt-table testing at an angle of at least 60 degrees:

- At least a 20 millimeters of mercury (mm Hg) fall in systolic pressure

- At least a 10 mm Hg fall in diastolic pressure

AND

2 - nOH caused by ONE of the following:

- Primary autonomic failure (e.g., Parkinson's disease, multiple system atrophy, and pure autonomic failure)
- Dopamine beta-hydroxylase deficiency
- Non-diabetic autonomic neuropathy

AND

3 - Diagnostic evaluation has excluded other causes associated with orthostatic hypotension (e.g., congestive heart failure, fluid restriction, malignancy)

AND

4 - The patient has tried at least TWO of the following non-pharmacologic interventions:

- Discontinuation of drugs which can cause orthostatic hypotension [e.g., diuretics, antihypertensive medications (primarily sympathetic blockers), anti-anginal drugs (nitrates), alpha-adrenergic antagonists, and antidepressants]
- Raising the head of the bed 10 to 20 degrees
- Compression garments to the lower extremities or abdomen
- Physical maneuvers to improve venous return (e.g., regular modest-intensity exercise)
- Increased salt and water intake, if appropriate
- Avoiding precipitating factors (e.g., overexertion in hot weather, arising too quickly from supine to sitting or standing)

AND

5 - No previous diagnosis of supine hypertension

AND

6 - Prescribed by, or in consultation with, ONE of the following specialists:

- Cardiologist

- Neurologist
- Nephrologist

AND

7 - History of failure (after a trial of at least 30 days), contraindication or intolerance to BOTH of the following medications:

- Florinef (fludrocortisone)
- ProAmatine (midodrine)

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

Approval Criteria

1 - Documentation of positive clinical response to Northera therapy

AND

2 - Physiological countermeasures for neurogenic orthostatic hypotension (nOH) continue to be employed

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-99481
Guideline Name	Nourianz
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Nourianz	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Parkinson’s disease

AND

2 - Used as adjunctive treatment to levodopa/carbidopa in patients experiencing “off” episodes

AND

3 - History of failure, contraindication, or intolerance to TWO anti-Parkinson’s disease therapies from the following adjunctive pharmacotherapy classes (trial must be from two different classes):

- Dopamine agonists (e.g., pramipexole, ropinirole)
- Catechol-O-methyl transferase (COMT) inhibitors (e.g., entacapone)
- Monoamine oxidase (MAO) B inhibitors (e.g., rasagiline, selegiline)

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

Approval Criteria

1 - Documentation of positive clinical response to Nourianz therapy

AND

2 - Patient will continue to receive treatment with a carbidopa/levodopa-containing medication

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-642275
Guideline Name	Nucala (mepolizumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Nucala	
Diagnosis	Severe Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 6 years of age or older

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of severe asthma

AND

3 - Asthma is an eosinophilic phenotype as defined by one of the following:

- Baseline (pre-treatment) peripheral blood eosinophil level is greater than or equal to 150 cells/microliter
- Peripheral blood eosinophil levels were greater than or equal to 300 cells/microliter within the past 12 months

AND

4 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting one of the following:

4.1 Patient has had at least two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months

OR

4.2 Prior asthma-related hospitalization within the past 12 months

AND

5 - Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications (verified via paid pharmacy claims):

5.1 Both of the following:

- High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)

OR

5.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

AND

6 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to ALL of the following:

- Dupixent (dupilumab)
- Fasenra (benralizumab)
- Xolair (omalizumab)

AND

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

- Pulmonologist
- Allergist/Immunologist

Product Name:Nucala	
Diagnosis	Severe Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications) [C]

AND

2 - Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications (verified via paid pharmacy claims)

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to ALL of the following:

- Dupixent (dupilumab)
- Fasenra (benralizumab)
- Xolair (omalizumab)

AND

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

- Pulmonologist
- Allergist/Immunologist

Product Name:Nucala	
Diagnosis	Chronic rhinosinusitis with nasal polyps (CRSwNP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Submission of documentation (e.g., chart notes) confirming ALL of the following:

2.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by ALL of the following:

2.1.1 TWO or more of the following symptoms for greater than or equal to 12 weeks duration:

- Mucopurulent discharge
- Nasal obstruction and congestion
- Decreased or absent sense of smell
- Facial pressure or pain

AND

2.1.2 ONE of the following:

- Evidence of inflammation on paranasal sinus examination or computed tomography (CT)
- Evidence of purulence coming from paranasal sinuses or ostiomeatal complex

AND

2.1.3 The presence of nasal polyps

AND

2.2 ONE of the following:

- Patient has required prior sino-nasal surgery
- Patient has required systemic corticosteroids in the previous 2 years

AND

2.3 Patient has been unable to obtain symptom relief after trial of ALL of the following agents/classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g. fluticasone, mometasone, triamcinolone, etc.)
- Antileukotriene agents (e.g. montelukast, zafirlukast, zileuton)

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Dupixent (dupilumab)
- Xolair (omalizumab)

AND

4 - Patient will receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids

AND

5 - Patient is NOT receiving Nucala in combination with another biologic medication [e.g., Xolair (omalizumab), Dupixent (dupilumab)]

AND

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

- Otolaryngologist
- Allergist
- Pulmonologist

Product Name:Nucala	
Diagnosis	Chronic rhinosinusitis with nasal polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to Nucala therapy

AND

2 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Dupixent (dupilumab)
- Xolair (omalizumab)

AND

3 - Patient will continue to receive Nucala as add-on maintenance therapy in combination with intranasal corticosteroids

AND

4 - Patient is NOT receiving Nucala in combination with another biologic medication [e.g., Xolair (omalizumab), Dupixent (dupilumab)]

AND

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

- Otolaryngologist
- Allergist
- Pulmonologist

Product Name:Nucala	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of eosinophilic granulomatosis with polyangiitis (EGPA)

AND

2 - Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy)

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Fasenra (benralizumab)

AND

4 - Patient is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone)

AND

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

- Pulmonologist
- Rheumatologist
- Allergist/Immunologist

Product Name:Nucala	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	6 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., increase in remission time)

AND

2 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Fasenra (benralizumab)

Product Name:Nucala	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of hypereosinophilic syndrome (HES)

AND

2 - Patient has been diagnosed for at least 6 months

AND

3 - Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy)

AND

4 - Patient is Fip1-like1-platelet-derived growth factor receptor alpha (FIP1L1-PDGFRA)-negative

AND

5 - Patient has uncontrolled HES defined as both of the following:

- History of 2 or more flares within the past 12 months [I]
- Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter

AND

6 - Trial and failure, contraindication, or intolerance to one of the following:

- Corticosteroid therapy (e.g., prednisone)
- Cytotoxic/immunosuppressive therapy (e.g., hydroxyurea, cyclosporine, imatinib)

AND

7 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Fasenra (benralizumab)

AND

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

- Allergist/Immunologist
- Hematologist

Product Name:Nucala	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 Months

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., reduction in flares, decreased blood eosinophil count, reduction in corticosteroid dose)

AND

2 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Fasenra (benralizumab)

Product Name:Nucala	
Diagnosis	Chronic obstructive pulmonary disease (COPD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Submission of medical records (e.g., chart notes) confirming diagnosis of chronic obstructive pulmonary disease (COPD)

AND

3 - Submission of medical records (e.g., chart notes) confirming the presence of Type 2

inflammation evidenced by blood eosinophils greater than or equal to 300 cells per microliter at baseline

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming the patient is receiving one of the following therapies at maximally tolerated doses:

- Triple therapy (i.e., an inhaled corticosteroid (ICS), a long-acting muscarinic antagonist (LAMA) and a long-acting beta agonist (LABA)
- If ICS are contraindicated, a LAMA and a LABA

AND

5 - Patient must have post-bronchodilator forced expiratory volume [FEV1] / forced vital capacity [FVC] ratio less than 0.70

AND

6 - Patient has had BOTH of the following within the past 12 months:

- At least two exacerbations where systemic corticosteroids [intramuscular, intravenous, or oral (e.g., prednisone)] were required at least once
- A COPD-related hospitalization

AND

7 - Submission of medical records (e.g., chart notes) confirming the patient experiences dyspnea during everyday activities (e.g., needs to stop for breath when walking on level ground)

AND

8 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Dupixent (dupilumab)

Product Name:Nucala

Diagnosis	Chronic obstructive pulmonary disease (COPD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a positive clinical response to therapy (e.g., improved lung function, a reduction in COPD exacerbations)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming the patient continues to receive one of the following therapies:

- Triple therapy (i.e., an inhaled corticosteroid (ICS), a long-acting muscarinic antagonist (LAMA) and a long-acting beta agonist (LABA)
- If ICS are contraindicated, a LAMA and a LABA

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to Dupixent (dupilumab)

2 . Background

Clinical Practice Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 1. Low, medium and high daily doses of inhaled corticosteroids in adolescents and adults 12 years and older [6]

Inhaled corticosteroid	Total Daily ICS Dose (mcg)

	Low	Medium	High
Beclometasone dipropionate (pMDI, standard particle, HFA)	200-500	> 500-1000	> 1000
Beclometasone dipropionate (pMDI, extrafine particle*, HFA)	100-200	> 200-400	> 400
Budesonide (DPI)	200-400	> 400-800	> 800
Ciclesonide (pMDI, extrafine particle*, HFA)	80-160	> 160-320	> 320
Fluticasone furoate (DPI)	100		200
Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (pMDI, standard particle, HFA)	100-250	> 250-500	> 500
Mometasone furoate (DPI)	200		400
Mometasone furoate (pMDI, standard particle, HFA)	200-400		> 400

DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information.

***This is not a table of equivalence**,* but instead, suggested total daily doses for the 'low', 'medium' and 'high' dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country -specific depending on local availability, regulatory labelling and clinical guidelines.

For new preparations, including generic ICS, the manufacturer's information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.

3 . Revision History

Date	Notes

6/24/2026	Dupixent Preferred 10/1/26: Added step through Dupixent for Asthma /CRSwNP/COPD. Added step through Fasenra (new indication) for H ES.

Prior Authorization Guideline

Guideline ID	GL-700349
Guideline Name	Nuedexta (dextromethorphan HBr/quinidine)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Preferred: Brand Nuedexta	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of pseudobulbar affect (PBA)	

Product Name:Non-Preferred: generic dextromethorphan HBr/quinidine	
Approval Length	N/A - Requests for generic dextromethorphan HBr/quinidine should not be approved

Guideline Type	Prior Authorization
Approval Criteria **1** - Requests for generic dextromethorphan HBr/quinidine are not authorized and will not be approved	
Notes	N/A - Requests for generic dextromethorphan HBr/quinidine should not be approved. Patients need to use Brand Nuedexta or other preferred alternatives.

2 . Revision History

Date	Notes
8/26/2026	Added generic as NPD target, Brand Nuedexta is Brand Only

Prior Authorization Guideline

Guideline ID	GL-99483
Guideline Name	Nuplazid
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - Diagnosis of Parkinson’s disease

AND

2 - Patient is currently experiencing hallucinations and delusions associated with Parkinson's disease psychosis (i.e., hallucination and delusion symptoms started after Parkinson's disease diagnosis)

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

Approval Criteria

1 - Documentation of positive clinical response to Nuplazid therapy

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-99522
Guideline Name	Nuzyra
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Nuzyra	
Diagnosis	Community-Acquired Bacterial Pneumonia
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 ALL of the following:

1.3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

1.3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

AND

1.3.3 History of failure, contraindication, or intolerance to THREE of the following antibiotics or antibiotic regimens:

- Amoxicillin
- A macrolide
- Doxycycline
- A fluoroquinolone
- Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

Product Name:Nuzyra	
Diagnosis	Acute Bacterial Skin and Skin Structure Infections
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 ALL of the following:

1.3.1 ONE of the following diagnoses:

1.3.1.1 BOTH of the following:

- Acute bacterial skin and skin structure infections
- Infection caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report

OR

1.3.1.2 BOTH of the following:

- Empirical treatment of patients with acute bacterial skin and skin structure infections
- Presence of MRSA infection is likely

AND

1.3.2 History of failure, contraindication, or intolerance to linezolid (generic Zyvox)

AND

1.3.3 History of failure, contraindication, or intolerance to ONE of the following antibiotics:

- Sulfamethoxazole-trimethoprim (SMZ-TMP)

- A tetracycline
- Clindamycin

OR

1.4 ALL of the following:

1.4.1 Diagnosis of acute bacterial skin and skin structure infections

AND

1.4.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

AND

1.4.3 History of failure, contraindication, or intolerance to THREE of the following antibiotics:

- A penicillin
- A cephalosporin
- A tetracycline
- Sulfamethoxazole-trimethoprim (SMZ-TMP)
- Clindamycin

Product Name:Nuzyra	
Diagnosis	Off-Label Uses*
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication **OR** **1.3** The medication is being prescribed by or in consultation with an infectious disease specialist.	
Notes	*Note: Authorization duration based on provider treatment durations, not to exceed 6 months.

2 . Revision History

Date	Notes
5/13/2021	Arizona Medicaid 7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-642198
Guideline Name	OAB - Overactive Bladder Agents - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Generic darifenacin ER, Brand Detrol, Brand Detrol LA, Brand Ditropan XL, Flavoxate, Gelnique, Gemtesa, Brand Myrbetriq, generic mirabegron, generic oxybutynin 2.5mg IR tablet, Oxytrol (Rx) patch, trospium IR/ER, Brand Toviaz, Brand Vesicare	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a history of failure, contraindication, or intolerance to a trial of THREE preferred products

- fesoterodine ER
- oxybutynin (generic Ditropan) 5 mg tablet or 5mg/5ml oral solution

- oxybutynin ER (generic Ditropan XL)
- solifenacin (generic Vesicare)
- tolterodine
- tolterodine ER

2 . Revision History

Date	Notes
6/25/2026	Added generic Myrbetriq (mirabegron) granules for suspension as N PD

Prior Authorization Guideline

Guideline ID	GL-99630
Guideline Name	Ocaliva
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - Diagnosis of primary biliary cholangitis (aka primary biliary cirrhosis)

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 Patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal after at least 12 consecutive months of treatment with ursodeoxycholic acid(e.g., Urso, ursodiol)

AND

2.1.2 Used in combination with ursodeoxycholic acid (e.g., Urso, ursodiol)

OR

2.2 History of contraindication or intolerance to ursodeoxycholic acid (e.g., Urso, ursodiol)

AND

3 - Prescribed by ONE of the following:

- Hepatologist
- Gastroenterologist

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

Approval Criteria

1 - Submission of medical records (e.g., laboratory values) documenting a reduction in alkaline phosphatase (ALP) level from pre-treatment baseline (i.e., prior to Ocaliva therapy) while on Ocaliva therapy

AND

2 - Prescribed by ONE of the following:

- Hepatologist
- Gastroenterologist

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-242218
Guideline Name	Octreotide Products - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Brand Sandostatin, Generic octreotide, Sandostatin LAR, Bynfezia	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of acromegaly	

AND

2 - One of the following:

2.1 Inadequate response to one of the following:

- Surgery
- Pituitary irradiation

OR

2.2 Not a candidate for surgical resection or pituitary irradiation

AND

3 - Trial and failure, contraindication, or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses

AND

4 - One of the following:

4.1 Patient has had a trial of short-acting generic octreotide and responded to and tolerated therapy (Applies to Sandostatin LAR only)

OR

4.2 Trial and failure, or intolerance to generic octreotide (Applies to Brand Sandostatin and Bynfezia only)

Product Name:Mycapssa	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acromegaly

AND

2 - One of the following:

2.1 Inadequate response to one of the following:

- Surgery
- Pituitary irradiation

OR

2.2 Not a candidate for surgical resection or pituitary irradiation

AND

3 - Patient has responded to and tolerated treatment with generic octreotide or lanreotide

Product Name:Brand Sandostatin, Generic octreotide, Sandostatin LAR, Bynfezia, Mycapssa	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size)

Product Name:Brand Sandostatin, Generic octreotide, Sandostatin LAR, Bynfezia	
Diagnosis	Carcinoid Tumors, for Symptomatic Treatment of Diarrhea or Flushing
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes

AND

2 - One of the following:

2.1 Patient has had a trial of short-acting generic octreotide and responded to and tolerated therapy (Applies to Sandostatin LAR only)

OR

2.2 Trial and failure, or intolerance to generic octreotide (Applies to Brand Sandostatin and Bynfezia only)

Product Name:Brand Sandostatin, Generic octreotide, Sandostatin LAR, Bynfezia	
Diagnosis	Carcinoid Tumors, for Symptomatic Treatment of Diarrhea or Flushing
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of an improvement in the number of diarrhea or flushing episodes

Product Name:Brand Sandostatin, Generic octreotide, Sandostatin LAR, Bynfezia	
Diagnosis	Vasoactive Intestinal Peptide Tumors, for Symptomatic Treatment of Diarrhea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea

AND

2 - One of the following:

2.1 Patient has had a trial of short-acting generic octreotide and responded to and tolerated therapy (Applies to Sandostatin LAR only)

OR

2.2 Trial and failure, or intolerance to generic octreotide (Applies to Brand Sandostatin and Bynfezia only)

Product Name:Brand Sandostatin, Generic octreotide, Sandostatin LAR, Bynfezia	
Diagnosis	Vasoactive Intestinal Peptide Tumors, for Symptomatic Treatment of Diarrhea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of an improvement in the number of diarrhea episodes

2 . Revision History

Date	Notes
4/24/2025	Added octreotide 10mg kit

Prior Authorization Guideline

Guideline ID	GL-156840
Guideline Name	Ohtuvayre (ensifentrine)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

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

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease

AND

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

- Post-bronchodilator FEV1 % predicted greater than or equal to 30% and less than 80%
- Post-bronchodilator forced expiratory volume (FEV1) / forced vital capacity (FVC) ratio less than 0.7

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following (document name):

- A LABA/LAMA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat)
- A long-acting antimuscarinic agent [LAMA (e.g., Spiriva Respimat/HandiHaler)]
- A long-acting beta-agonist [LABA (e.g., Serevent Diskus)]
- An ICS/LABA/LAMA (i.e., Breztri Aerosphere, Trelegy Ellipta)

AND

3.1.2 ONE of the following:

3.1.2.1 ALL of the following:

- FEV1 less than 50% of predicted
- History of chronic bronchitis
- History of failure, contraindication, or intolerance to a selective phosphodiesterase 4 (PDE4) inhibitor [i.e., roflumilast (Daliresp)]

OR

3.1.2.2 FEV1 is less than 80% of predicted but greater than or equal to 50% of predicted

OR

3.2 BOTH of the following:

3.2.1 Patient has a failure, contraindication, or intolerance to ALL of the following (document name and date tried):

- A long-acting beta-agonist [LABA (e.g., Serevent Diskus)]
- A long-acting antimuscarinic agent [LAMA (e.g., Spiriva Respimat/HandiHaler)]
- A LABA/LAMA (e.g., Anoro Ellipta, Bevespi Aerosphere, Stiolto Respimat),
- An ICS/LABA/LAMA (i.e., Breztri Aerosphere, Trelegy Ellipta)

AND

3.2.2 ONE of the following:

3.2.2.1 ALL of the following:

- FEV1 less than 50% of predicted
- History of chronic bronchitis
- History of failure, contraindication, or intolerance to a selective phosphodiesterase 4 (PDE4) inhibitor [i.e., roflumilast (Daliresp)]

OR

3.2.2.2 FEV1 is less than 80% of predicted but greater than or equal to 50% of predicted

OR

3.3 ALL of the following:

3.3.1 Patient is unable to use a metered-dose, dry powder or slow mist inhaler (e.g. Spiriva Respimat) to control their COPD due to ONE of the following:

- Cognitive or physical impairment limiting coordination of handheld devices (e.g., cognitive decline, arthritis in the hands) (Document impairment)
- Patient is unable to generate adequate inspiratory force (e.g., peak inspiratory flow rate (PIFR) resistance is <60 L/min)

AND

3.3.2 Patient requires the use of BOTH of the following (document date)

- A nebulized LABA [i.e., arformoterol (generic Brovana), formoterol (generic Perforomist)]
- A nebulized long-acting antimuscarinic agent [LAMA (i.e.,Yupelri)]

AND

3.3.3 ONE of the following:

3.3.3.1 ALL of the following:

- FEV1 less than 50% of predicted
- History of chronic bronchitis
- History of failure, contraindication, or intolerance to a selective phosphodiesterase 4 (PDE4) inhibitors [i.e., roflumilast (Daliresp)]

OR

3.3.3.2 FEV1 is less than 80% of predicted but greater than or equal to 50% of predicted

AND

4 - Patient experiences dyspnea during everyday activities (e.g., short of breath when walking up a slight hill)

AND

5 - Prescribed by or in consultation with a Pulmonologist

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

Approval Criteria

1 - Documentation of positive clinical response to Ohtuvayre therapy demonstrated by BOTH of the following:

- Improved COPD symptoms (e.g., dyspnea)
- Improved FEV1

2 . Revision History

Date	Notes
10/1/2024	Updated reauth guideline type to Prior Authorization

Prior Authorization Guideline

Guideline ID	GL-136958
Guideline Name	Ojjaara (momelotinib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/1/2023

1 . Criteria

Product Name:Ojjaara	
Diagnosis	Myelofibrosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of one of the following:

- Primary myelofibrosis
- Post-polycythemia vera myelofibrosis
- Post-essential thrombocythemia myelofibrosis

AND

1.2 Disease is intermediate or high risk

AND

1.3 Patient has anemia

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., symptom improvement, spleen volume reduction)

2 . Revision History

Date	Notes
11/27/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-300291
Guideline Name	Olumiant (baricitinib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Olumiant	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 History of failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred tocilizumab biosimilar

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Olumiant	
Diagnosis	Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Olumiant	
Diagnosis	Coronavirus disease 2019 (COVID-19)
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of COVID-19

AND

2 - Patient is hospitalized (Olumiant is only FDA approved when used for COVID-19 patients in an inpatient setting)

AND

3 - Patient requires one of the following:

- Supplemental oxygen
- Non-invasive mechanical ventilation
- Invasive mechanical ventilation
- Extracorporeal membrane oxygenation (ECMO)

Notes	NOTE: Olumiant is only FDA approved when used for COVID-19 patients in an inpatient setting

Product Name:Olumiant	
Diagnosis	Alopecia Areata
Approval Length	N/A - Requests for non-approvable diagnoses should not be approved
Guideline Type	Prior Authorization

Approval Criteria

1 - Requests for coverage for diagnosis of Alopecia Areata are not authorized and will not be approved	
Notes	Approval Length: N/A - Requests for Alopecia Areata should not be approved. Deny as a benefit exclusion.

2 . Revision History

Date	Notes
7/3/2025	Updated criteria for RA (preferred agents/embedded steps, removed CoT)

Prior Authorization Guideline

Guideline ID	GL-642234
Guideline Name	Omisirge (omidubicel-onlv)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Omisirge	
Diagnosis	Hematologic Malignancies
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of hematologic malignancy

AND

2 - Patient is 12 years of age or older

AND

3 - Prescribed by a physician with expertise in the treatment of hematologic malignancies at a center with expertise in hematopoietic stem cell transplants with shared decision-making regarding the potential risks of treatment with Omisirge

AND

4 - Provider attests that patient has never received Omisirge treatment in their lifetime

Product Name:Omisirge	
Diagnosis	Severe Aplastic Anemia
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of severe aplastic anemia

AND

1.2 Both of the following:

1.2.1 Bone marrow cellularity of less than 25%

AND

1.2.2 Patient meets at least two of the following:

- Platelet count of less than 20,000/mcL
- Absolute neutrophil count of less than 500/mcL
- Absolute reticulocyte count of less than 60,000/mcL

AND

2 - Prescriber attests that other known causes of bone marrow failure (BMF) have been ruled out (e.g., immune thrombocytopenia [ITP], hodgkin lymphoma or non-hodgkin lymphoma, aplastic anemia associated with paroxysmal nocturnal hemoglobinuria [PNH])

AND

3 - Patient is 6 years of age or older

AND

4 - Prescribed by a physician with expertise in the treatment of severe aplastic anemia in a center with expertise in hematopoietic stem cell transplants with shared decision-making regarding the potential risks of treatment with Omisirge

AND

5 - Provider attests that patient has never received Omisirge treatment in their lifetime

2 . Revision History

Date	Notes
6/25/2026	New program

Prior Authorization Guideline

Guideline ID	GL-502261
Guideline Name	Omvoh (mirikizumab-mrkz)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Omvoh IV	
Diagnosis	Crohn’s disease (CD)
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active Crohn’s disease (CD)

AND

2 - One of the following:

- Frequent diarrhea and abdominal pain
- At least 10% weight loss
- Complications such as obstruction, fever, abdominal mass
- Abnormal lab values (e.g., C-reactive protein [CRP])
- CD Activity Index (CDAI) greater than 220

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Azathioprine
- Corticosteroids (e.g., prednisone)
- Methotrexate

AND

4 - One of the following:

4.1 Paid claims or submission of medical records (e.g., chart notes) confirming history of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- A preferred ustekinumab biosimilar

OR

4.2 Paid claims or submission of medical records (e.g., chart notes) confirming continuation of prior therapy, defined as no more than a 45-day gap in therapy

AND

5 - Will be administered as an intravenous induction dose

AND

6 - Prescribed by or in consultation with a gastroenterologist

Product Name:Omvoh SC	
Diagnosis	Crohn’s disease (CD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active Crohn’s disease (CD)

AND

2 - Will be used as a maintenance dose following the intravenous induction doses

AND

3 - Prescribed by or in consultation with a gastroenterologist

Product Name:Omvoh IV	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis

AND

2 - One of the following:

- Greater than 6 stools per day
- Frequent blood in the stools
- Frequent urgency
- Presence of ulcers
- Abnormal lab values (e.g., hemoglobin, erythrocyte sedimentation rate, C-reactive protein)
- Dependent on, or refractory to, corticosteroids

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
- Azathioprine
- Corticosteroids (e.g., prednisone)

AND

4 - One of the following:

4.1 Paid claims or submission of medical records (e.g., chart notes) confirming history of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

OR

4.2 Paid claims or submission of medical records (e.g., chart notes) confirming continuation of prior therapy, defined as no more than a 45-day gap in therapy

AND

5 - Will be administered as an intravenous induction dose

AND

6 - Prescribed by or in consultation with a gastroenterologist

Product Name:Omvoh SC	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis

AND

2 - Will be used as a maintenance dose following the intravenous induction doses

AND

3 - Prescribed by or in consultation with a gastroenterologist

Product Name:Omvoh SC	
Diagnosis	Crohn's Disease (CD), Ulcerative Colitis (UC)

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

2 . Revision History

Date	Notes
1/28/2026	Added new GPIs for SC formulations

Prior Authorization Guideline

Guideline ID	GL-139340
Guideline Name	Opfolda (miglustat)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2024

1 . Criteria

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

Approval Criteria

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

1.1 Diagnosis of late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency)

AND

1.2 Disease is confirmed by one of the following:

- Absence or deficiency (less than 40% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay
- Molecular genetic testing confirms mutations in the GAA gene

AND

1.3 Presence of clinical signs and symptoms of the disease (e.g., respiratory distress, skeletal muscle weakness, etc.)

AND

1.4 Medication is used in combination with Pombiliti (cipaglucosidase alfa-atga)

AND

1.5 Patient weight is greater than or equal to 40 kg

AND

2 - Opfolda is not substituted with other miglustat products (i.e., Zavesca, Yargesa)

Product Name:Opfolda	
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in FVC, improvement in 6-minute walk distance [6MWD])

AND

2 - Medication is used in combination with Pombiliti (cipaglucosidase alfa-atga)

AND

3 - Opfolda is not substituted with other miglustat products (i.e., Zavesca, Yargesa)

2 . Revision History

Date	Notes
1/23/2024	New program

Prior Authorization Guideline

Guideline ID	GL-417204
Guideline Name	Opzelura (ruxolitinib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Opzelura	
Diagnosis	Atopic Dermatitis
Approval Length	12 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of mild to moderate atopic dermatitis

AND

2 - One of the following:

- Greater than or equal to 3% body surface area (BSA) involvement
- Involvement of sensitive body areas (e.g., face, hands, feet, scalp, groin)

AND

3 - Patient is 2 years of age or older

AND

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

- Dermatologist
- Allergist/Immunologist

AND

5 - Trial and failure of a minimum 30-day supply of non-pharmacologic topical therapies (e.g., moisturizers)

AND

6 - Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to at least TWO of the following:

- Medium or higher potency topical corticosteroid
- Elidel (pimecrolimus) cream*
- Tacrolimus ointment
- Eucrisa (crisaborole) ointment*

AND

7 - Patient is not receiving Opzelura in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

8 - Opzelura will only be used for short-term and/or non-continuous chronic treatment

Notes	*Product may require step therapy

Product Name:Opzelura	
Diagnosis	Atopic Dermatitis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in body surface area involvement from baseline
- Reduction in pruritus severity from baseline
- Improvement in quality of life from baseline

AND

2 - Patient is not receiving Opzelura in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

3 - Opzelura will only be used for short-term and/or non-continuous chronic treatment

Product Name:Opzelura

Diagnosis	Nonsegmental Vitiligo
Approval Length	N/A - Requests for non-approvable diagnoses should not be approved
Guideline Type	Prior Authorization

Approval Criteria

1 - Requests for coverage for diagnosis of nonsegmental vitiligo are not authorized and will not be approved

Notes	Approval Length: N/A - Requests for nonsegmental vitiligo should not be approved. Deny as a benefit exclusion.

2 . Background

Clinical Practice Guidelines

Table 1. Relative potencies of topical corticosteroids [2]

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05

	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
10/29/2025	Updated age criterion due to expanded approval

Prior Authorization Guideline

Guideline ID	GL-747195
Guideline Name	Oral Oncology Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Oral Oncology Drugs: Brand Gleevec, generic imatinib, Imkeldi	
Diagnosis	Cancer Indications
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The drug is being used as indicated by National Comprehensive Cancer Network (NCCN) guidelines with a Category of Evidence and Consensus of 1, 2A, or 2B

AND

2 - If the request is for the non-preferred Brand (Brand Gleevec or Imkeldi), patient must have tried and failed the preferred generic counterpart (generic imatinib)

Product Name:Oral Oncology Drugs: Abirtega, Akeega, Alecensa, Alunbrig, Augtyro, Avmapki Fakzynja Co-Pack, Ayvakit, Balversa, Beqalzi, Bosulif capsules, Bosulif tablets, bosutinib tablets, Braftovi, Brukinsa, Cabometyx, Calquence, Caprelsa, Cavhanza, Cometriq, Copiktra, Cotellic, Danziten, Daurismo, Ensacove, Erivedge, Erleada, Etcamah, Farydak, Fruzaqla, Gavreto, Gilotrif, Brand Gleostine, generic lomustine, Gomekli, Hernexeos, Hycamtin capsules, Hyrnuo, Ibrance, Ibtrozi, Iclusig, Idhifa, Imbruvica, Inluriyo, Inlyta, Inqovi, Inrebic, Brand Iressa, generic gefitinib, Itovebi, Iwilfin, Jakafi, Jakafi XR, Jaypirca, Jideytro, Jylamvo, Kisqali, Kisqali-Femara Co-pack, Komzifti, Koselugo, Koselugo Sprinkle, Krazati, Lazcluze, Lenvima, Lifyorli, Lonsurf, Lorbrena, Lumakras, Lynparza, Lytgobi, Mekinist, Mektovi, Modeyso, Nerlynx, Brand Nexavar, generic sorafenib, nilotinib, Ninlaro, Nubeqa, Odomzo, Ogsiveo, Ojemda, Orserdu, Pemazyre, Phyrago, Piqray, Brand Pomalyst, generic pomalidomide, Brand Purixan, generic mercaptopurine suspension, Qinlock, Rasonque, Retevmo, Brand Revlimid, generic lenalidomide, Revuforj, Rezlidhia, Romvimza, Rozlytrek, Rubraca, Rydapt, Scemblix, Brand Sprycel, generic dasatinib, Stivarga, Tabrecta, Tafinlar, Tagrisso, Talzenna, Brand Tarceva, generic erlotinib, Tasigna, Tazverik, temozolomide capsules, Tepmetko, Tibsovo, Truqap, Tukysa, Turalio, Brand Tykerb, generic lapatinib, Vanflyta, Venclexta, Brand Vepesid, generic etoposide capsules, Veppanu, Verzenio, Vitrakvi, Vizimpro, Voranigo, Brand Votrient, generic pazopanib, Welireg, Xalkori, Xatmep, Brand Xeloda, generic capecitabine, Xospata, Xpovio, Xtandi, Yonsa, Zegfrovy, Zejula, Zelboraf, Zenbexus, Zolinza, Zydelig, Zykadia, Brand Zytiga, generic abiraterone

Diagnosis	Cancer Indications
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The drug is being used as indicated by National Comprehensive Cancer Network (NCCN) guidelines with a Category of Evidence and Consensus of 1, 2A, or 2B

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

2 . Revision History

Date	Notes
10/28/2026	Added Brand Vepesid and Zegfrovy as targets

Prior Authorization Guideline

Guideline ID	GL-136981
Guideline Name	Orencia (abatacept)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/1/2023

1 . Criteria

Product Name:Orencia IV or Orencia SC	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active rheumatoid arthritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Trial and failure, contraindication, or intolerance to ONE nonbiologic disease-modifying antirheumatic drug (DMARD) (e.g., methotrexate [Rheumatrex/Trexall], Arava [leflunomide], Azulfidine [sulfasalazine])

Product Name:Orencia IV or Orencia SC	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Orencia IV or Orencia SC	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Trial and failure, contraindication, or intolerance to ONE of the following nonbiologic disease modifying anti-rheumatic drugs (DMARDs):

- leflunomide (Arava)
- methotrexate (Rheumatrex/Trexall)

Product Name:Orencia IV or Orencia SC	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Orencia IV or Orencia SC	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis (PsA)

AND

2 - Patient is 2 years of age or older

AND

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

- Dermatologist
- Rheumatologist

Product Name:Orencia IV or Orencia SC	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Orencia IV	
Diagnosis	Prophylaxis for Acute Graft versus Host Disease (aGVHD)
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Used for prophylaxis of acute graft versus host disease (aGVHD)

AND

2 - Patient is 2 years of age or older

AND

3 - Patient will receive hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor

AND

4 - Recommended antiviral prophylactic treatment for Epstein-Barr Virus (EBV) reactivation (e.g., acyclovir) will be administered prior to Orencia and continued for six months after HSCT

AND

5 - Used in combination with both of the following:

- calcineurin inhibitor (e.g., cyclosporine, tacrolimus)
- methotrexate

2 . Revision History

Date	Notes
11/28/2023	Added age criterion to PsA indication

Prior Authorization Guideline

Guideline ID	GL-99485
Guideline Name	Orilissa
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Orilissa 150 mg	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - Patient is premenopausal

AND

3 - History of trial and failure (e.g., inadequate pain relief), contraindication or intolerance after a three month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen)

AND

4 - History of trial and failure, contraindication, or intolerance after a three month trial to ONE of the following:

- Hormonal contraceptives
- Progestins [e.g., norethindrone (generic Aygestin)]

AND

5 - Prescribed by or in consultation with ONE of the following:

- Obstetrics/Gynecologist (OB/GYN)
- Reproductive endocrinologist

Product Name:Orilissa 150 mg	
Approval Length	6 months*
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Impact to bone mineral density has been considered

AND

3 - Treatment duration has not exceeded a total of 24 months**

Notes	*NOTE: Authorization for Orilissa 150 mg will be issued for 6 months up to a maximum of 24 months. **NOTE: Orilissa 150 mg once daily is indicated for a maximum of 24 months.

Product Name:Orilissa 200 mg	
Approval Length	6 months*
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - Patient is premenopausal

AND

3 - History of trial and failure (e.g., inadequate pain relief), contraindication or intolerance after a three month trial of TWO analgesics (e.g., ibuprofen, meloxicam, naproxen)

AND

4 - History of trial and failure, contraindication, or intolerance after a three month trial to ONE of the following:

- Hormonal contraceptives

• Progestins [e.g., norethindrone (generic Aygestin)] **AND** **5** - Prescribed by or in consultation with ONE of the following: • Obstetrics/Gynecologist (OB/GYN) • Reproductive endocrinologist	
Notes	*NOTE: Orilissa 200 mg twice daily is indicated for a maximum of 6 m onths.

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-116122
Guideline Name	Orkambi - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2022

1 . Criteria

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

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Submission of laboratory results confirming that patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

AND

3 - Patient is 1 year of age or older

AND

4 - Prescribed by, or in consultation with, a specialist affiliated with a CF care center

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

Approval Criteria

1 - Provider attests that the patient has achieved a clinically meaningful response while on Orkambi therapy to ONE of the following:

- Lung function as demonstrated by percent predicted expiratory volume in 1 second (ppFEV1)
- Body mass index (BMI)
- Pulmonary exacerbations
- Quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score

AND

2 - Prescribed by, or in consultation with, a specialist affiliated with a cystic fibrosis (CF) care center

2 . Revision History

Date	Notes
10/27/2022	Updated age requirement, added new GPI

Prior Authorization Guideline

Guideline ID	GL-450249
Guideline Name	Orlynvah (sulopenem etzadroxil and probenecid)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Orlynvah	
Approval Length	5 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of an uncomplicated urinary tract infection (uUTI)

AND

2 - Patient is 18 years of age or older

AND

3 - Trial and inadequate response, contraindication or resistance to one alternative oral antibacterial treatment option (e.g., trimethoprim-sulfamethoxazole, ciprofloxacin)

AND

4 - Infection caused by one of the following:

- Escherichia coli
- Klebsiella pneumoniae
- Proteus mirabilis

2 . Revision History

Date	Notes
12/17/2025	Updated criterion 4 "infection with" to "infection caused by", no chang e to clinical intent.

Prior Authorization Guideline

Guideline ID	GL-99486
Guideline Name	Osphena - Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - Treatment of moderate to severe vaginal dryness, a symptom of vulvar and vaginal atrophy (VVA), due to menopause*

AND

2 - History of failure, contraindication, or intolerance to BOTH of the following:

- Estradiol vaginal cream
- Estradiol vaginal tablet

Notes	*Treatment of dyspareunia is a benefit exclusion.

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-707201
Guideline Name	Otarmeni (lunsotogene parvec-cwha)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Otarmeni	
Diagnosis	Sensorineural hearing loss
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of severe-to-profound or profound sensorineural hearing loss defined as any frequency greater than 90 decibel hearing level (dB HL)

AND

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

- Preserved outer hair cell function
- No prior cochlear implant in the same ear

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) confirming presence of biallelic variants in the OTOF gene

AND

4 - Prescribed by or in consultation with one of the following with shared-decision-making regarding treatment risks:

- Otolaryngologist
- Otologist/neurotologist

AND

5 - Will be administered at an authorized treatment center by a surgeon experienced in intracochlear surgery and trained in administration

AND

6 - Provider attests that patient has never received Otarmeni treatment in the target ear in their lifetime

2 . Revision History

Date	Notes
8/26/2026	New program

Prior Authorization Guideline

Guideline ID	GL-417202
Guideline Name	Otezla (apremilast)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Otezla, Otezla XR	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - Patient is 6 years of age or older

AND

3 - One of the following:

- Otezla: Patient weighs at least 20 kg
- Otezla XR: Patient weighs at least 50 kg

AND

4 - History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)*

AND

5 - Prescribed by or in consultation with ONE of the following:

- Rheumatologist
- Dermatologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial

Product Name:Otezla, Otezla XR	
Diagnosis	Behcet's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Behcet's Disease

AND

2 - Patient has active oral ulcers

AND

3 - History of failure, contraindication, or intolerance to one non-biologic (e.g., corticosteroids, colchicine) within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)*

AND

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

- Rheumatologist
- Dermatologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial

Product Name:Otezla, Otezla XR	
Diagnosis	Psoriatic Arthritis, Behcet's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

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

- Rheumatologist
- Dermatologist

Product Name:Otezla, Otezla XR	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of plaque psoriasis

AND

2 - Patient is 6 years of age or older

AND

3 - One of the following:

- Otezla: Patient weighs at least 20 kg
- Otezla XR: Patient weighs at least 50 kg

AND

4 - Both of the following:

4.1 History of failure to one of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial):*

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

4.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial)*

AND

5 - Prescribed by or in consultation with a dermatologist

Notes	*Note: Claims history may be used in conjunction as documentation of drug, date, and duration of trial

Product Name:Otezla, Otezla XR	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a dermatologist

2 . Revision History

Date	Notes
10/29/2025	Added Otezla XR as target, updated age/weight criteria for PsA and PsO. Updated PsO embedded step.

Prior Authorization Guideline

Guideline ID	GL-540209
Guideline Name	Oxervate (cenegermin-bkbj)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Oxervate	
Diagnosis	Neurotrophic keratitis
Approval Length	8 Weeks (maximum of 8 weeks per eye per lifetime)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Stage 2 or 3 neurotrophic keratitis

AND

2 - History of failure to at least one OTC ocular artificial tear product (e.g., Systane® Ultra, Akwa® Tears, Refresh Optive®, Soothe® XP) **AND** **3** - Prescribed by or in consultation with ONE of the following: • Ophthalmologist • Optometrist	
Notes	Note: Authorization maximum coverage is limited to one 8-week approval per eye. Oxervate is hard-coded with a quantity limit of 112 mL per lifetime.

2 . Revision History

Date	Notes
3/24/2026	Updated approval duration to specify 8 weeks per eye per lifetime. Added note for clarification.

Prior Authorization Guideline

Guideline ID	GL-224202
Guideline Name	Palforzia [Peanut (Arachis hypogaea)]
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

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

Approval Criteria

1 - Diagnosis and clinical history of peanut allergy as documented by BOTH of the following:

1.1 A serum peanut-specific IgE level of greater than or equal to 0.35 kUA/L (kilo units of allergen per liter)

AND

1.2 A meal wheal diameter that is at least 3mm (millimeters) larger than the negative control on skin-prick testing for peanut

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Patient is 1 to 17 years of age
- Patient is in the initial dose escalation phase of therapy

OR

2.2 BOTH of the following:

- Patient is 1 year of age and older
- Patient is in the up-dosing or maintenance phase of therapy

AND

3 - Used in conjunction with a peanut-avoidant diet

AND

4 - Patient does not have one of the following:

- History of eosinophilic esophagitis (EoE) or eosinophilic gastrointestinal disease
- History of severe or life-threatening episode(s) of anaphylaxis or anaphylactic shock within the past 2 months
- Severe or poorly controlled asthma

AND

5 - Prescribed by or in consultation with an allergist or immunologist

AND

6 - Prescriber is certified/enrolled in the Palforzia REMS (Risk Evaluation and Mitigation Strategy) Program

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

Approval Criteria

1 - Documentation of positive clinical response to Palforzia therapy

AND

2 - Used in conjunction with a peanut-avoidant diet

AND

3 - Prescribed by or in consultation with an allergist or immunologist

AND

4 - Prescriber is certified/enrolled in the Palforzia REMS (Risk Evaluation and Mitigation Strategy) Program

2 . Revision History

Date	Notes
3/26/2025	Added new GPIs.

Prior Authorization Guideline

Guideline ID	GL-481199
Guideline Name	Palsonify (paltusotine)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of acromegaly

AND

2 - One of the following:

2.1 Patient has an inadequate response to surgery

OR

2.2 Patient is not a candidate for surgery

AND

3 - Patient has responded to and tolerated treatment with generic octreotide or lanreotide

AND

4 - Prescribed by or in consultation with an endocrinologist

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., clinically significant reduction in IGF-1/GH levels, reduction in Total Acromegaly Symptoms Diary (ASD) score)

2 . Revision History

Date	Notes
12/17/2025	New program

Prior Authorization Guideline

Guideline ID	GL-553395
Guideline Name	Palynziq (pegvaliase-pqpz)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Palynziq	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of phenylketonuria (PKU)

AND

2 - Patient is 12 years of age or older

AND

2 - Patient is actively on a phenylalanine-restricted diet

AND

3 - Physician attestation that the patient will not be receiving Palynziq in combination with Kuvan (sapropterin dihydrochloride)

AND

5 - Submission of medical records (e.g. chart notes, laboratory values) documenting that the patient has a blood phenylalanine concentration greater than 600 micromoles per liter

Product Name:Palynziq	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is actively on a phenylalanine-restricted diet

AND

2 - ONE of the following:

2.1 Submission of medical records (e.g. chart notes, laboratory values) documenting that the patient has a blood phenylalanine concentration less than 600 micromoles per liter

OR

2.2 Submission of medical records (e.g. chart notes, laboratory values) documenting that the patient has achieved a 20% reduction in blood phenylalanine concentration from pre-treatment baseline

OR

2.3 BOTH of the following:

2.3.1 Patient is in initial titration/maintenance phase of dosing regimen (week 1-33)

AND

2.3.2 Patient will receive maximum labeled dosage of 40 milligrams (mg) once daily if response has not been obtained after 24 weeks of 20 mg once daily maintenance dosing

AND

3 - Submission of medical records (e.g. chart notes, laboratory values) documenting that the patient is not receiving Palynziq in combination with Kuvan (sapropterin dihydrochloride) [Prescription claim history that does not show any concomitant Kuvan claim within 60 days of reauthorization request may be used as documentation]

2 . Revision History

Date	Notes
3/24/2026	Added age criterion due to expanded indication.

Prior Authorization Guideline

Guideline ID	GL-99511
Guideline Name	Panretin
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021
P&T Approval Date:	
P&T Revision Date:	

1 . Criteria

Product Name:Panretin	
Diagnosis	AIDS-related Kaposi's Sarcoma (KS)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of acquired immunodeficiency syndrome (AIDS)-related Kaposi's Sarcoma (KS)	

AND

2 - Patient is not receiving systemic anti-KS treatment

Product Name:Panretin	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Panretin will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Panretin	
Diagnosis	NCCN Recommended Regimen
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Panretin therapy

2 . Revision History

Date	Notes

4/8/2021	7/1 Implementation

Prior Authorization Guideline

Guideline ID	GL-700344
Guideline Name	Papzimeos (zopapogene imadenovec-drba)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Papzimeos	
Approval Length	12 Weeks (One treatment course)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of recurrent respiratory papillomatosis

AND

2 - Patient has had, or is scheduled to have, surgical debulking of visible laryngotracheal papillomas associated with the current recurrence to establish minimal residual disease before the first dose of Papzimeos (Note: Historical debulking procedures associated with prior disease episodes do not satisfy this requirement)

AND

3 - Provider attests that patient has never received a treatment course with Papzimeos in their lifetime

AND

4 - Patient is 18 years of age or older

AND

5 - Prescribed by or in consultation with a specialist knowledgeable in the treatment of recurrent respiratory papillomatosis (e.g., otolaryngologist, pulmonologist, oncologist)

2 . Revision History

Date	Notes
8/26/2026	Updated debulking criteria to specify procedure is for a new episode of RRP

Prior Authorization Guideline

Guideline ID	GL-756214
Guideline Name	Pasatru (garetosmab-grts)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

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

Approval Criteria

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

1.1 Diagnosis of Fibrodysplasia Ossificans Progressiva (FOP)

AND

1.2 Disease is confirmed by clinical signs and symptoms of FOP (e.g., malformation of the great toes, episodic soft tissue swelling, progressive heterotopic ossification [HO])

AND

1.3 Submission of medical records (e.g., chart notes) confirming the presence of ACVR1 gene mutation

AND

1.4 Used to reduce formation of new heterotopic ossification (HO) lesions and clinician-assessed flare-ups

AND

2 - Patient is 18 years of age or older

AND

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

- Geneticist
- Orthopedic physician
- Rheumatologist
- Endocrinologist

AND

4 - Requested drug will not be used in combination with other treatments for FOP (e.g., Atebrioz, Sohonos)

Product Name:Pasatru

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates positive clinical response to therapy (e.g., reductions in the number of new heterotopic ossification [HO] lesions)

AND

2 - Requested drug will not be used in combination with other treatments for FOP (e.g., Atebrioz, Sohonos)

2 . Revision History

Date	Notes
10/28/2026	New program

Prior Authorization Guideline

Guideline ID	GL-105258
Guideline Name	Pediculicides - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2022

1 . Criteria

Product Name:Sklice, Brand Natroba, generic spinosad susp	
Diagnosis	Head lice
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of topical treatment of head lice infestations

AND

2 - For Brand Natroba requests ONLY: Trial and failure to generic spinosad suspension (verified via paid pharmacy claims or submission of medical records/chart notes)

2 . Revision History

Date	Notes
3/28/2022	Added step through generic for Brand Natroba.

Prior Authorization Guideline

Guideline ID	GL-120432
Guideline Name	Pedmark (sodium thiosulfate injection, solution)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2023

1 . Criteria

Product Name:Pedmark	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting diagnosis of solid tumors

AND

2 - Disease is BOTH of the following:

- Localized
- Non-Metastatic

AND

3 - Used for the prevention of ototoxicity due to cisplatin-based chemotherapy

AND

4 - Patient is 1 month of age or older

AND

5 - Prescribed by or in consultation with an oncologist

AND

6 - History of failure, or intolerance to generic sodium thiosulfate

2 . Revision History

Date	Notes
1/24/2023	New program

Prior Authorization Guideline

Guideline ID	GL-157795
Guideline Name	Piasky (crovalimab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)

AND

2 - Patient is 13 years of age or older

AND

3 - Patient weighs at least 40 kg

AND

4 - Submission of medical records (e.g., chart notes) or paid claims confirming trial and failure, contraindication, or intolerance to one of the following:

- Soliris (eculizumab)
- Ultomiris (ravulizumab)

AND

5 - Prescribed by or in consultation with a hematologist/oncologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions)

AND

2 - Submission of medical records (e.g., chart notes) or paid claims confirming trial and failure, contraindication, or intolerance to one of the following:

- Soliris (eculizumab)
- Ultomiris (ravulizumab)

2 . Revision History

Date	Notes
10/25/2024	New program

Prior Authorization Guideline

Guideline ID	GL-553398
Guideline Name	Pivya (pivmecillinam)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Pivya	
Approval Length	7 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of uncomplicated urinary tract infection (uUTI)

AND

2 - Infection susceptible to pivmecillinam

AND

3 - Patient is 18 years of age or older

AND

4 - Trial and inadequate response, contraindication or resistance to one alternative oral antibacterial treatment option (e.g., trimethoprim-sulfamethoxazole, ciprofloxacin)

AND

5 - Infection is caused by one of the following:

- Escherichia coli
- Proteus mirabilis
- Staphylococcus saprophyticus

2 . Revision History

Date	Notes
3/24/2026	New program

Prior Authorization Guideline

Guideline ID	GL-139338
Guideline Name	Pombiliti (cipaglucosidase alfa-atga)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2024

1 . Criteria

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

Approval Criteria

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

1.1 Diagnosis of late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency)

AND

1.2 Disease is confirmed by one of the following:

- Absence or deficiency (less than 40% of the lab specific normal mean) of GAA enzyme activity in lymphocytes, fibroblasts, or muscle tissues as confirmed by an enzymatic assay
- Molecular genetic testing confirms mutations in the GAA gene

AND

1.3 Presence of clinical signs and symptoms of the disease (e.g., respiratory distress, skeletal muscle weakness, etc.)

AND

1.4 Medication is used in combination with Opfolda (miglustat)

AND

1.5 Patient weight is greater than or equal to 40 kg

AND

2 - Not to be used in combination with other miglustat products (i.e., Zavesca, Yargesa)

Product Name:Pombiliti	
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in FVC, improvement in 6-minute walk distance [6MWD])

AND

2 - Medication is used in combination with Opfolda (miglustat)

AND

3 - Not to be used in combination with other miglustat products (i.e., Zavesca, Yargesa)

2 . Revision History

Date	Notes
1/23/2024	New program

Prior Authorization Guideline

Guideline ID	GL-700343
Guideline Name	Pradaxa Pellet Packs
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Pradaxa Pellet Packs	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Patient is 8 years of age or younger

OR

1.2 ALL of the following:

1.2.1 Patient is between 9 and 12 years of age

AND

1.2.2 Requested medication is being used for one of the following diagnoses:

- Treatment of venous thromboembolic events (VTE) in patients who have been treated with a parenteral anticoagulant for at least 5 days
- To reduce the risk of recurrence of VTE in patients who have been previously treated

AND

1.2.3 One of the following:

1.2.3.1 Trial and failure, contraindication, or intolerance to generic dabigatran capsules (verified via paid pharmacy claims or submitted chart notes)

OR

1.2.3.2 Patient is unable to swallow oral tablets/capsules

2 . Revision History

Date	Notes
8/26/2026	Updated step through Brand Pradaxa (now step through generic cap sules)

Prior Authorization Guideline

Guideline ID	GL-682498
Guideline Name	Praluent (alirocumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/7/2026

1 . Criteria

Product Name:Praluent	
Diagnosis	Atherosclerotic Cardiovascular Disease (ASCVD) and Prevention of Cardiovascular Events in patients at increased risk for a major adverse cardiovascular (CV) event
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is 18 years of age or older	

AND

2 - One of the following diagnoses:

2.1 Diagnosis of Atherosclerotic Cardiovascular Disease (ASCVD) defined as acute coronary syndrome, history of myocardial infarction (MI), stable or unstable angina, coronary or arterial revascularization (e.g., percutaneous coronary intervention or coronary artery bypass graft surgery), stroke, transient ischemic attack, and/or peripheral arterial disease presumed to be of atherosclerotic origin

OR

2.2 Patient is at increased risk for a major adverse cardiovascular (CV) event

AND

3 - Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

4.1 Patient has had an inadequate response to a high-intensity statin therapy as documented by ALL of the following:

- Inadequate response with a high-intensity statin (i.e., atorvastatin 40-80 mg or rosuvastatin 20-40 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to high-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

4.2 Patient has had an inadequate response to a moderate-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity statin therapy
- Inadequate response with a moderate-intensity statin (i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg twice daily, or pitavastatin 2-4 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to moderate-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

4.3 Patient has had an inadequate response to a low-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity and at least one moderate-intensity statin therapy
- Inadequate response with a low-intensity statin (i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, pitavastatin 1 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to low-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

4.4 Patient is statin intolerant (inability to tolerate any dose or increase the dose above the smallest tablet strength) or has a contraindication to all statins as documented by ONE of the following:

- Patient experienced statin-related rhabdomyolysis with CK elevations greater than or equal to 10 times the upper limit of normal (ULN)
- Patient experienced intolerable skeletal-related muscle symptoms (e.g., myopathy or myalgia) to at least two different statins at the lowest dose (one of the statin trials must include pravastatin or rosuvastatin) and the skeletal-related muscle symptoms (e.g., myopathy or myalgia) resolved upon discontinuation of each respective therapy
- Patient has a labeled contraindication to all statins

AND

5 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

5.1 Both of the following:

- Patient had an inadequate response with maximally tolerated statin plus ezetimibe (or ezetimibe therapy alone if statin intolerant) for at least three consecutive months
- Patient must be adherent to maximally tolerated statin plus ezetimibe therapy (or ezetimibe therapy alone, if statin intolerant), as evidenced by consistent pharmacy claims over the past three months

OR

5.2 Patient has a documented intolerance or contraindication to ezetimibe

AND

6 - Medication will be used as adjunct to low-fat diet and exercise

AND

7 - Patient's documented current LDL-C is greater than or equal to 55 mg/dL (within the last 30 days)

AND

8 - Praluent (alirocumab) will not be used in combination with another PCSK9 inhibitor (such as Repatha) or Juxtapid

Product Name:Praluent	
Diagnosis	Heterozygous familial hypercholesterolemia (HeFH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 8 years of age or older

AND

2 - Patient has a diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by ONE of the following:

- Genetic confirmation of a mutation in the LDL-receptor, apoB, or PCSK9
- Tendon xanthomas are present in the patient, first degree relative (parent, sibling, child), or second degree relative (grandparent, uncle, aunt) and the patient has a pretreatment/untreated total cholesterol (TC) greater than 290 mg/dL or LDL-C greater than 190 mg/dL
- WHO/Dutch Lipid Clinic Network Criteria with a score greater than 8 points

AND

3 - Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

4.1 Patient has had an inadequate response to a high-intensity statin therapy as documented by ALL of the following:

- Inadequate response with a high-intensity statin (i.e., atorvastatin 40-80 mg or rosuvastatin 20-40 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to high-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

4.2 Patient has had an inadequate response to a moderate-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity statin therapy

- Inadequate response with a moderate-intensity statin (i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg twice daily, or pitavastatin 2-4 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to moderate-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

4.3 Patient has had an inadequate response to a low-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity and at least one moderate-intensity statin therapy
- Inadequate response with a low-intensity statin (i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, pitavastatin 1 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to low-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

4.4 Patient is statin intolerant (inability to tolerate any dose or increase the dose above the smallest tablet strength) or has a contraindication to all statins as documented by ONE of the following:

- Patient experienced statin-related rhabdomyolysis with CK elevations greater than or equal to 10 times the upper limit of normal (ULN)
- Patient experienced intolerable skeletal-related muscle symptoms (e.g., myopathy or myalgia) to at least two different statins at the lowest dose (one of the statin trials must include pravastatin or rosuvastatin) and the skeletal-related muscle symptoms (e.g., myopathy or myalgia) resolved upon discontinuation of each respective therapy
- Patient has a labeled contraindication to all statins

AND

5 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

5.1 Both of the following:

- Patient had an inadequate response with maximally tolerated statin plus ezetimibe (or ezetimibe therapy alone if statin intolerant) for at least three consecutive months
- Patient must be adherent to maximally tolerated statin plus ezetimibe therapy (or ezetimibe therapy alone, if statin intolerant), as evidenced by consistent pharmacy claims over the past three months

OR

5.2 Patient has a documented intolerance or contraindication to ezetimibe

AND

6 - Medication will be used as adjunct to low-fat diet and exercise

AND

7 - Patient's documented current LDL-C is greater than or equal to 70 mg/dL (within the last 30 days)

AND

8 - Praluent (alirocumab) will not be used in combination with another PCSK9 inhibitor (such as Repatha) or Juxtapid

Product Name:Praluent	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Patient has a diagnosis of homozygous familial hypercholesterolemia (HoFH) confirmed by ONE of the following:

2.1 History of genetic testing confirming two mutant alleles at the LDLR, apoB, PCSK9 or ARH adapter gene locus

OR

2.2 Documented history of untreated LDL-C greater than 400 mg/dL and at least ONE of the following:

- Tendon and/or cutaneous xanthoma prior to 10 years of age
- Untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (LDL-C greater than or equal to 190 mg/dL)

AND

3 - Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

4.1 Patient has had an inadequate response to a high-intensity statin therapy as documented by ALL of the following:

- Inadequate response with a high-intensity statin (i.e., atorvastatin 40-80 mg or rosuvastatin 20-40 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to high-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

4.2 Patient has had an inadequate response to a moderate-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity statin therapy
- Inadequate response with a moderate-intensity statin (i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg twice daily, or pitavastatin 2-4 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to moderate-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

4.3 Patient has had an inadequate response to a low-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity and at least one moderate-intensity statin therapy
- Inadequate response with a low-intensity statin (i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, pitavastatin 1 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to low-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

4.4 Patient is statin intolerant (inability to tolerate any dose or increase the dose above the smallest tablet strength) or has a contraindication to all statins as documented by ONE of the following:

- Patient experienced statin-related rhabdomyolysis with CK elevations greater than or equal to 10 times the upper limit of normal (ULN)
- Patient experienced intolerable skeletal-related muscle symptoms (e.g., myopathy or myalgia) to at least two different statins at the lowest dose (one of the statin trials must include pravastatin or rosuvastatin) and the skeletal-related muscle symptoms (e.g., myopathy or myalgia) resolved upon discontinuation of each respective therapy
- Patient has a labeled contraindication to all statins

AND

5 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

5.1 Both of the following:

- Patient had an inadequate response with maximally tolerated statin plus ezetimibe (or ezetimibe therapy alone if statin intolerant) for at least three consecutive months
- Patient must be adherent to maximally tolerated statin plus ezetimibe therapy (or ezetimibe therapy alone, if statin intolerant), as evidenced by consistent pharmacy claims over the past three months

OR

5.2 Patient has a documented intolerance or contraindication to ezetimibe

AND

6 - Medication will be used as adjunct to low-fat diet and exercise

AND

7 - Patient's documented current LDL-C is greater than or equal to 70 mg/dL (within the last 30 days)

AND

8 - Praluent (alirocumab) will not be used in combination with another PCSK9 inhibitor (such as Repatha) or Juxtapid

Product Name:Praluent	
Diagnosis	Primary Hyperlipidemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Diagnosis of primary hyperlipidemia or hypercholesterolemia

AND

3 - ONE of the following:

- Patient has a coronary artery calcium or calcification score greater than or equal to 300 Agatston units
- Patient has diabetes

AND

4 - Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist

AND

5 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

5.1 Patient has had an inadequate response to a high-intensity statin therapy as documented by ALL of the following:

- Inadequate response with a high-intensity statin (i.e., atorvastatin 40-80 mg or rosuvastatin 20-40 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to high-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

5.2 Patient has had an inadequate response to a moderate-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity statin therapy
- Inadequate response with a moderate-intensity statin (i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg twice daily, or pitavastatin 2-4 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to moderate-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

5.3 Patient has had an inadequate response to a low-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity and at least one moderate-intensity statin therapy
- Inadequate response with a low-intensity statin (i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, pitavastatin 1 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to low-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Praluent therapy

OR

5.4 Patient is statin intolerant (inability to tolerate any dose or increase the dose above the smallest tablet strength) or has a contraindication to all statins as documented by ONE of the following:

- Patient experienced statin-related rhabdomyolysis with CK elevations greater than or equal to 10 times the upper limit of normal (ULN)
- Patient experienced intolerable skeletal-related muscle symptoms (e.g., myopathy or myalgia) to at least two different statins at the lowest dose (one of the statin trials must include pravastatin or rosuvastatin) and the skeletal-related muscle symptoms (e.g., myopathy or myalgia) resolved upon discontinuation of each respective therapy
- Patient has a labeled contraindication to all statins

AND

6 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

6.1 Both of the following:

- Patient had an inadequate response with maximally tolerated statin plus ezetimibe (or ezetimibe therapy alone if statin intolerant) for at least three consecutive months
- Patient must be adherent to maximally tolerated statin plus ezetimibe therapy (or ezetimibe therapy alone, if statin intolerant), as evidenced by consistent pharmacy claims over the past three months

OR

6.2 Patient has a documented intolerance or contraindication to ezetimibe

AND

7 - Medication will be used as adjunct to low-fat diet and exercise

AND

8 - Patient's documented current LDL-C is greater than or equal to 70 mg/dL (within the last 30 days)

AND

9 - Praluent (alirocumab) will not be used in combination with another PCSK9 inhibitor (such as Repatha) or Juxtapid

Product Name:Praluent	
Diagnosis	All indications listed above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 8 years of age or older

AND

2 - Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist

AND

3 - Patient continues to receive statin at maximally tolerated dose (unless unable to take statin)

AND

4 - Verification of paid claims confirming patient has remained adherent to therapy, as evidenced by consistent pharmacy claims over the past three months

AND

5 - Patient had a documented sustained reduction in LDL-C levels from pre-treatment baseline (i.e., prior to Praluent therapy)

AND

6 - Praluent (alirocumab) will not be used in combination with another PCSK9 inhibitor (such as Repatha) or Juxtapid

2 . Revision History

Date	Notes

8/7/2026	Added dx criterion for hyperlipidemia; updated header for ASCVD ind ication, updated reauth criteria.

Prior Authorization Guideline

Guideline ID	GL-356251
Guideline Name	Preferred Drugs - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Preferred Drugs	
Diagnosis	Prior Authorization Administrative Guideline for Preferred Drugs Without Drug-Specific Criteria
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - ALL of the following:

1.1 ONE of the following:

1.1.1 The requested drug must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology

AND

1.2 The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plans' program

AND

1.3 If the patient is less than FDA minimum age, the prescriber attests they are aware of FDA labeling and feels the treatment with the requested product is medically necessary. (Document rationale for use)

Notes	Medications used for anti-obesity/weight loss, cosmetic (e.g., alopecia , actinic keratosis, vitiligo), erectile dysfunction, and sexual dysfunctio n purposes are NOT medically accepted indications and are NOT rec ognized as a covered benefit. Erectile dysfunction drugs (Cialis/Tadal afil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes
8/28/2025	Removed the word "solely" from notes section, no change to clinical i ntent.

Prior Authorization Guideline

Guideline ID	GL-553397
Guideline Name	Presbyopia Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Qlosi, Vizz, Brand Vuity, generic pilocarpine 1.25%, Yuvezzi	
Approval Length	1 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of presbyopia

AND

2 - History of failure or intolerance to a preferred generic pilocarpine ophthalmic preparation

AND

3 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist
- Optometrist

AND

4 - Provider confirms valid clinical rationale, which excludes lifestyle choice, as to why patient is unable to use corrective lenses (e.g., eyeglasses or contact lenses)

Product Name:Qlosi, Vizz, Brand Vuity, generic pilocarpine 1.25%, Yuvezzi	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in near vision in low light conditions without lost of distance vision)

AND

2 - History of failure or intolerance to a preferred generic pilocarpine ophthalmic preparation

AND

3 - Prescribed by or in consultation with ONE of the following:

- Ophthalmologist

• Optometrist

2 . Revision History

Date	Notes
3/24/2026	Added Yuvezzi as NP target

Prior Authorization Guideline

Guideline ID	GL-99488
Guideline Name	Pretomanid
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Pretomanid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Diagnosis of pulmonary extensively drug resistant (XDR) tuberculosis (TB)

OR

1.2 Treatment-intolerant or nonresponsive multidrug-resistant (MDR) tuberculosis (TB) **AND** **2** - Pretomanid will be used in combination with bedaquiline and linezolid

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-427192
Guideline Name	Prevymis (letermovir)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Prevymis	
Diagnosis	CMV Prophylaxis in Hematopoietic Stem Cell Transplant (HSCT) Recipients
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

- Patient is 6 months of age or older

- Patient weighs at least 6 kg

AND

2 - BOTH of the following:

- Patient is a recipient of an allogeneic hematopoietic stem cell transplant
- Patient is cytomegalovirus (CMV) seropositive (R+)

AND

3 - Provider attests to BOTH of the following:

- Prevymis will be initiated between Day 0 and Day 28 post-transplantation (before or after engraftment), and continued through Day 100 post-transplant (in patients at risk for late CMV infection and disease, may continue through Day 200 post-transplant)
- Prevymis is being prescribed as prophylaxis and not treatment of CMV infection

Product Name:Prevymis	
Diagnosis	CMV Prophylaxis in Kidney Transplant Recipients
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

- Patient is 12 years of age or older
- Patient weighs at least 40 kg

AND

2 - BOTH of the following:

- Patient is a recipient of a kidney transplant

- Patient is cytomegalovirus (CMV) seronegative (Donor CMV seropositive/Recipient CMV seronegative [D+/R-])

AND

3 - Provider attests to BOTH of the following:

- Prevymis will be initiated between Day 0 and Day 7 post-transplantation, and continued through Day 200 post-transplant
- Prevymis is being prescribed as prophylaxis and not treatment of CMV infection

2 . Revision History

Date	Notes
10/29/2025	Updated attestation criteria to include dosing through 200 days post-transplant

Prior Authorization Guideline

Guideline ID	GL-242219
Guideline Name	Primary Hyperoxaluria (PH1) Agents [Oxlumo (lumasiran), Rivfloza (nedosiran)]
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Oxlumo	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of primary hyperoxaluria type 1 (PH1)	

AND

2 - Submission of medical records (e.g., chart notes) documenting diagnosis has been confirmed by both of the following:

2.1 One of the following:

- Elevated urinary oxalate excretion
- Elevated plasma oxalate concentration
- Spot urinary oxalate to creatinine molar ratio greater than normal for age

AND

2.2 One of the following:

- Genetic testing demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene
- Liver biopsy demonstrating absence or reduced alanine:glyoxylate aminotransferase (AGT) activity

AND

3 - Patient has not received a liver transplant

AND

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

- Hepatologist
- Nephrologist
- Urologist
- Geneticist
- Specialist with expertise in the treatment of PH1

Product Name:Rivfloza	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary hyperoxaluria type 1 (PH1)

AND

2 - Submission of medical records (e.g., chart notes) documenting diagnosis has been confirmed by both of the following:

2.1 One of the following:

- Elevated urinary oxalate excretion
- Elevated plasma oxalate concentration
- Spot urinary oxalate to creatinine molar ratio greater than normal for age

AND

2.2 One of the following:

- Genetic testing demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene
- Liver biopsy demonstrating absence or reduced alanine:glyoxylate aminotransferase (AGT) activity

AND

3 - Patient is 2 years of age or older

AND

4 - Patient has preserved kidney function (e.g., eGFR greater than or equal to 30mL/min/1.73m^2)

AND

5 - Patient has not received a liver transplant

AND

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

- Hepatologist
- Nephrologist
- Urologist
- Geneticist
- Specialist with expertise in the treatment of PH1

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy (e.g., decreased urinary oxalate excretion, decreased plasma oxalate concentration)

AND

2 - Patient has not received a liver transplant

AND

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

- Hepatologist

- Nephrologist
- Urologist
- Geneticist
- Specialist with expertise in the treatment of PH1

2 . Revision History

Date	Notes
4/24/2025	Updated age criterion for Rivfloza due to expanded indication

Prior Authorization Guideline

Guideline ID	GL-99725
Guideline Name	Procysbi
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - Diagnosis of nephropathic cystinosis

AND

2 - Patient is 1 year of age or older

AND

3 - History of failure or intolerance to Cystagon (immediate-release cysteamine bitartrate)*

Notes	*Note: AZM generally does not consider frequency of dosing and/or lack of compliance to dosing regimens, an indication of medical necessity

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

Approval Criteria

1 - Documentation of positive clinical response to Procysbi therapy

2 . Revision History

Date	Notes
5/14/2021	Arizona Medicaid 7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-99489
Guideline Name	Progesterone - Non-Oral
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Crinone, Endometrin	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Treatment is for non-infertility use (e.g., secondary amenorrhea, reduce the risk of recurrent spontaneous preterm birth)	

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-242221
Guideline Name	Proton Pump Inhibitors (PPIs)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:generic lansoprazole ODT, Brand Nexium granules/suspension packets, generic esomeprazole granules/suspension packets, Brand Protonix Pak, generic pantoprazole suspension packet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following: **1.1** Patient is less than 18 years of age	

OR

1.2 All of the following:

1.2.1 Patient is 18 years of age or older

AND

1.2.2 Patient is unable to swallow solid oral dosage forms (e.g., tablets) in the past 30 days

AND

1.2.3 History of failure to lansoprazole ODT (DOES NOT APPLY TO REQUESTS FOR LANSOPRAZOLE ODT)

AND

2 - For BRAND NEXIUM granules/suspension packets requests ONLY: history of failure or intolerance to generic esomeprazole granules/suspension packets

2 . Revision History

Date	Notes
4/24/2025	Added step through generic for Brand Nexium requests

Prior Authorization Guideline

Guideline ID	GL-731213
Guideline Name	Provigil, Nuvigil
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil	
Diagnosis	Narcolepsy, Obstructive Sleep Apnea, Shift Work Disorder, Idiopathic Hypersomnia (off label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - ONE of the following diagnoses:

- Narcolepsy
- Excessive sleepiness due to obstructive sleep apnea
- Excessive sleepiness due to shift work disorder (circadian rhythm sleep disorder, shift work type)
- Idiopathic hypersomnia

AND

3 - If the request is for Brand Provigil or Brand Nuvigil, the patient has a history of failure, contraindication, or intolerance to its preferred generic counterpart (i.e., generic modafinil or generic armodafinil)

AND

4 - One of the following:

4.1 Patient is NOT taking concomitant stimulant medication (e.g., methylphenidate, amphetamine-dextroamphetamine, lisdexamfetamine)

OR

4.2 Both of the following:

4.2.1 Patient is currently taking concomitant stimulant medication (e.g., methylphenidate, amphetamine-dextroamphetamine, lisdexamfetamine)

AND

4.2.2 Prescribed by or in consultation with one of the following:

- Psychiatrist
- Neurologist
- Pulmonologist specializing in sleep medicine

Product Name:Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil	
Diagnosis	Fatigue due to Multiple Sclerosis (off-label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Diagnosis of multiple sclerosis (MS)

AND

3 - Patient is experiencing fatigue

AND

4 - If the request is for Brand Provigil or Brand Nuvigil, the patient has a history of failure, contraindication, or intolerance to its preferred generic counterpart (i.e., generic modafinil or generic armodafinil)

AND

5 - One of the following:

5.1 Patient is NOT taking concomitant stimulant medication (e.g., methylphenidate, amphetamine-dextroamphetamine, lisdexamfetamine)

OR

5.2 Both of the following:

5.2.1 Patient is currently taking concomitant stimulant medication (e.g., methylphenidate, amphetamine-dextroamphetamine, lisdexamfetamine)

AND

5.2.2 Prescribed by or in consultation with one of the following:

- Psychiatrist
- Neurologist
- Pulmonologist specializing in sleep medicine

Product Name:Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil	
Diagnosis	Adjunctive Therapy for the Treatment of Major Depressive Disorder or Bipolar Depression (off-label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Treatment-resistant depression, defined as BOTH of the following:

2.1 Diagnosis of ONE of the following:

- Major depressive disorder (MDD)
- Bipolar depression

AND

2.2 History of failure, contraindication, or intolerance to at least TWO antidepressants from

different classes (e.g., SSRIs [selective serotonin reuptake inhibitors], SNRIs [serotonin-norepinephrine reuptake inhibitors], bupropion)

AND

3 - Used as adjunctive therapy

AND

4 - If the request is for Brand Provigil or Brand Nuvigil, the patient has a history of failure, contraindication, or intolerance to its preferred generic counterpart (i.e., generic modafinil or generic armodafinil)

AND

5 - One of the following:

5.1 Patient is NOT taking concomitant stimulant medication (e.g., methylphenidate, amphetamine-dextroamphetamine, lisdexamfetamine)

OR

5.2 Both of the following:

5.2.1 Patient is currently taking concomitant stimulant medication (e.g., methylphenidate, amphetamine-dextroamphetamine, lisdexamfetamine)

AND

5.2.2 Prescribed by or in consultation with one of the following:

- Psychiatrist
- Neurologist
- Pulmonologist specializing in sleep medicine

Product Name:Brand Provigil, generic modafinil, Brand Nuvigil, generic armodafinil

Diagnosis	Adjunctive Therapy for the Treatment of Major Depressive Disorder or Bipolar Depression (off-label)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Documentation of positive clinical response to therapy

AND

3 - Used as adjunctive therapy

AND

4 - If the request is for Brand Provigil or Brand Nuvigil, the patient has a history of failure, contraindication, or intolerance to its preferred generic counterpart (i.e., generic modafinil or generic armodafinil)

AND

5 - One of the following:

5.1 Patient is NOT taking concomitant stimulant medication (e.g., methylphenidate, amphetamine-dextroamphetamine, lisdexamfetamine)

OR

5.2 Both of the following:

5.2.1 Patient is currently taking concomitant stimulant medication (e.g., methylphenidate, amphetamine-dextroamphetamine, lisdexamfetamine)

AND

5.2.2 Prescribed by or in consultation with one of the following:

- Psychiatrist
- Neurologist
- Pulmonologist specializing in sleep medicine

2 . Revision History

Date	Notes
9/23/2026	Added specialist prescriber requirement for patients receiving conco mitant stimulant medication

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-756211
Guideline Name	Pulmonary Arterial Hypertension (PAH) Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:PREFERRED DRUGS: Alyq, generic tadalafil, generic ambrisentan, Orenitram, generic sildenafil suspension, generic sildenafil tablets, generic bosentan tablet for oral suspension, Yutrepia; NON-PREFERRED DRUGS: Brand Adcirca, Brand Adempas, generic riociguat, Brand Flolan, Brand Veletri, generic eprostenol, Brand Letairis, Brand Opsumit, generic macitentan, Opsynvi, Brand Remodulin, generic trepostinil, Brand Revatio tablets, Brand Revatio injection, generic sildenafil injection, Tadliq suspension, Brand Tracleer, generic bosentan tablet, Tyvaso DPI, Tyvaso inhaltion solution, Uptravi, Ventavis	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - One of the following:

2.1 Patient is 18 years of age or older

OR

2.2 One of the following:

- Requests for Tracleer/Bosentan: Patient is 3 years of age or older
- Requests for Uptravi tablets: Patient is 2 years of age or older

AND

3 - Pulmonary arterial hypertension is symptomatic

AND

4 - One of the following:

4.1 Diagnosis of pulmonary arterial hypertension was confirmed by right heart catheterization

OR

4.2 Patient is currently on any therapy for the diagnosis of pulmonary arterial hypertension

AND

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

- Pulmonologist

- Cardiologist

AND

6 - If the patient is requesting a non-preferred product, patient has a history of failure, contraindication or intolerance to BOTH of the following:

- A preferred Endothelin Receptor Antagonist (ERA) (e.g., generic ambrisentan, bosentan tablet for oral suspension)
- A preferred Phosphodiesterase 5 inhibitor (PDE5i) [e.g., Alyq or tadalafil, generic sildenafil tablet (generic for Revatio tablet), generic sildenafil suspension]

AND

7 - If the request is for Brand Adcirca, patient must have tried and failed generic tadalafil or Alyq

AND

8 - If the request is for Opsynvi, patient must have tried and failed both of the following as separate products:

- generic tadalafil
- Opsumit (may require PA)

Product Name:Brand Adempas, generic riociguat	
Diagnosis	Chronic Thromboembolic Pulmonary Hypertension (CTEPH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Diagnosis of inoperable or persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH)

AND

1.1.2 CTEPH is symptomatic

OR

1.2 Patient is currently on any therapy for the diagnosis of CTEPH

AND

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

- Pulmonologist
- Cardiologist

Product Name:PREFERRED DRUGS: Alyq, generic tadalafil, generic ambrisentan, Orenitram, generic sildenafil suspension, generic sildenafil tablets, generic bosentan tablet for oral suspension, Yutrepia; NON-PREFERRED DRUGS: Brand Adcirca, Brand Adempas, generic riociguat, Brand Flolan, Brand Veletri, generic eprostenol, Brand Letairis, Brand Opsumit, generic macitentan, Opsynvi, Brand Remodulin, generic trepostinil, Brand Revatio tablets, Brand Revatio injection, generic sildenafil injection, Tadliq suspension, Brand Tracleer, generic bosentan tablet, Tyvaso DPI, Tyvaso inhaltion solution, Uptravi, Ventavis	
Diagnosis	All indications listed above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Winrevair Injection	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pulmonary arterial hypertension

AND

2 - Pulmonary arterial hypertension is symptomatic

AND

3 - Patient is currently on at least TWO therapies indicated for the treatment of pulmonary arterial hypertension from the following different mechanisms of action, unless there is a contraindication or intolerance:

- Endothelin receptor antagonists (e.g., Bosentan, ambrisentan or macitentan)
- Phosphodiesterase 5 inhibitors (e.g., Tadalafil or sildenafil)

AND

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

- Pulmonologist
- Cardiologist

Product Name:Winrevair Injection	
Diagnosis	Pulmonary Arterial Hypertension
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient demonstrates positive clinical response to therapy	

2 . Revision History

Date	Notes
10/28/2026	Added generic riociguat as NPD target

Prior Authorization Guideline

Guideline ID	GL-99638
Guideline Name	Pulmozyme
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Pulmozyme	
Diagnosis	Cystic Fibrosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Cystic Fibrosis	

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-128982
Guideline Name	Qalsody (tofersen)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name:Qalsody	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis amyotrophic lateral sclerosis (ALS)

AND

1.2 Molecular genetic testing confirms mutation in the SOD1 gene

AND

1.3 Patient's baseline functional ability has been documented prior to initiating treatment (e.g., speech, walking, climbing stairs, etc.)

AND

1.4 Patient has a percent (%) slow vital capacity (%SVC) greater than or equal to 50% at the start of treatment [A]

AND

1.5 Patient does not require permanent noninvasive ventilation or invasive ventilation

AND

2 - Prescribed by or in consultation with a neurologist with expertise in the diagnosis of ALS

Product Name:Qalsody	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting slowed disease progression from baseline

AND **2** - Prescribed by or in consultation with a neurologist with expertise in the diagnosis of ALS

2 . Endnotes

A. Those in the faster-progressing subgroup, which the primary and key secondary endpoints were formally tested, were required to have a slow vital capacity (SVC) greater than or equal to 65% of predicted value for sex, age, and height (from the sitting position) at screening. [2]

3 . Revision History

Date	Notes
7/26/2023	New program

Prior Authorization Guideline

Guideline ID	GL-129071
Guideline Name	Qutenza (capsaicin)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2023

1 . Criteria

Product Name:Qutenza	
Diagnosis	Neuropathic pain associated with postherpetic neuralgia (PHN)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of neuropathic pain associated with postherpetic neuralgia (PHN)

AND

2 - Submission of medical records (e.g., chart notes, paid claims history) documenting trial and failure, contraindication, or intolerance to ALL of the following:

- gabapentin
- pregabalin
- minimum 60-day trial of a tricyclic antidepressant (e.g., amitriptyline, nortriptyline, desipramine)
- generic lidocaine 5% patch
- topical capsaicin cream

Product Name:Qutenza	
Diagnosis	Neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet

AND

2 - Submission of medical records (e.g., chart notes, paid claims history) documenting trial and failure, contraindication, or intolerance to ALL of the following:

- gabapentin
- pregabalin
- minimum 60-day trial of a tricyclic antidepressant (e.g., amitriptyline, nortriptyline, desipramine)
- generic lidocaine 5% patch
- topical capsaicin cream
- duloxetine

Product Name:Qutenza	
Diagnosis	All indications
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - It has been at least 3 months since the last application/administration [B]

AND

2 - Patient experienced pain relief with a prior course of therapy

AND

3 - Patient is experiencing a return of neuropathic pain

2 . Revision History

Date	Notes
7/28/2023	New program

Prior Authorization Guideline

Guideline ID	GL-163769
Guideline Name	Radicava (edaravone)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2025

1 . Criteria

Product Name:Radicava IV, Radicava ORS, generic edaravone	
Diagnosis	Amyotrophic Lateral Sclerosis (ALS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming diagnosis of “definite” or “probable” amyotrophic lateral sclerosis (ALS) per the revised EL Escorial and Airlie House diagnostic criteria

AND

2 - Prescribed by or in consultation with a neurologist with expertise in the diagnosis of ALS

AND

3 - Patient has scores greater than or equal to 2 in all items of the ALS Functional Rating Scale-Revised (ALSFRS-R) criteria at the start of treatment

AND

4 - Patient has a percent (%) forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment

Product Name:Radicava IV, Radicava ORS, generic edaravone	
Diagnosis	Amyotrophic Lateral Sclerosis (ALS)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to therapy (e.g., slowing in the decline of functional abilities)

AND

2 - Patient is not dependent on invasive ventilation or tracheostomy

2 . Revision History

Date	Notes
1/31/2025	Added generic edaravone as target

Prior Authorization Guideline

Guideline ID	GL-110773
Guideline Name	Ranolazine products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/15/2022

1 . Criteria

Product Name:Brand Ranexa, generic ranolazine	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - History of ONE of the following standard anti-angina treatments:

1.1 One beta-blocker [e.g. Lopressor (metoprolol), Inderal (propranolol)]

OR

1.2 One calcium channel blocker [e.g. Procardia XL (nifedipine ER), Cardizem LA/Cardizem CD (diltiazemER)]

OR

1.3 One long acting nitrate therapy [e.g. Imdur (isosorbide mononitrate), Isordil (isosorbide dinitrate), Nitro-Time/Nitro-Dur/Nitro-Bid (nitroglycerin ER)]

AND

2 - For Brand Ranexa requests ONLY: Trial and failure to generic ranolazine (verified via paid pharmacy claims or submission of medical records/chart notes)

Product Name:Aspruzyo Sprinkle	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - History of ONE of the following standard anti-angina treatments:

1.1 One beta-blocker [e.g. Lopressor (metoprolol), Inderal (propranolol)]

OR

1.2 One calcium channel blocker [e.g. Procardia XL (nifedipine ER), Cardizem LA/Cardizem CD (diltiazemER)]

OR

1.3 One long acting nitrate therapy [e.g. Imdur (isosorbide mononitrate), Isordil (isosorbide dinitrate), Nitro-Time/Nitro-Dur/Nitro-Bid (nitroglycerin ER)]

AND

2 - One of the following:

2.1 Trial and failure to generic ranolazine (verified via paid pharmacy claims or submission of medical records/chart notes)

OR

2.2 One of the following:

- Patient is 8 years of age or younger
- Patient is unable to swallow the oral tablet (solid formulation) due to swallowing difficulties

2 . Revision History

Date	Notes
8/4/2022	Added Aspruzyo Sprinkle as target. Updated guideline name to Rano lazine Products

Prior Authorization Guideline

Guideline ID	GL-356255
Guideline Name	Rayos
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Rayos	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 The requested drug must be used for a Food and Drug Administration (FDA)-approved indication

OR

1.2 The use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

AND

2 - The drug is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program*

AND

3 - Submission of medical records (e.g. chart notes, laboratory values) or claims history documenting an intolerance to generic prednisone tablets which is unable to be resolved with attempts to minimize the adverse effects where appropriate

AND

4 - History of failure, contraindication, or intolerance to TWO the following:

- Dexamethasone tablet, oral solution
- Hydrocortisone tablet
- Methylprednisolone tablet
- Prednisolone tablet, oral solution

Notes	*Note: Medications used for anti-obesity/weight loss, cosmetic (e.g., al opecia, actinic keratosis, vitiligo), erectile dysfunction, and sexual dysf unction purposes are NOT medically accepted indications and are NO T recognized as a covered benefit. Erectile dysfunction drugs (Cialis/T adalafil) are covered for clinical diagnoses other than ED.

2 . Revision History

Date	Notes
8/28/2025	Removed the word "solely" from notes section, no change to clinical i ntent.

Prior Authorization Guideline

Guideline ID	GL-135344
Guideline Name	Reblozyl (luspatercept-aamt)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2023

1 . Criteria

Product Name:Reblozyl	
Diagnosis	Beta Thalassemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

1.1.1 Diagnosis of beta thalassemia major

AND

1.1.2 Patient requires regular red blood cell (RBC) transfusions

OR

1.2 Diagnosis of transfusion-dependent beta thalassemia

AND

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

- Hematologist
- Oncologist

Product Name:Reblozyl	
Diagnosis	Beta Thalassemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy (e.g., reduction in RBC transfusion burden)

Product Name:Reblozyl	
Diagnosis	Myelodysplastic Syndromes, Myelodysplastic/Myeloproliferative Neoplasm (MDS-RS, MDS/MPN-RS-T)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

1.1 Very low-to intermediate-risk myelodysplastic syndrome with ring sideroblasts (MDS-RS)

OR

1.2 Myelodysplastic or myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)

AND

2 - Patient has failed an erythropoiesis stimulating agent [e.g., Epogen (epoetin alfa), Aranesp (darbepoetin)]

AND

3 - Patient requires transfusions of 2 or more red blood cell (RBC) units over 8 weeks

AND

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

- Hematologist
- Oncologist

Product Name:Reblozyl	
Diagnosis	Myelodysplastic Syndromes
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of very low- to intermediate-risk myelodysplastic syndromes (MDS)

AND

2 - Patient does not have previous erythropoiesis stimulating agent use (ESA-naïve)

AND

3 - Patient requires transfusions of 2 or more red blood cell (RBC) units over 8 weeks

AND

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

- Hematologist
- Oncologist

Product Name:Reblozyl	
Diagnosis	Myelodysplastic Syndromes, Myelodysplastic/Myeloproliferative Neoplasm
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy (e.g., RBC transfusion independence, improvement in hemoglobin levels)

2 . Revision History

Date	Notes
10/23/2023	Added criteria for new indication of treatment of anemia without previous erythropoiesis stimulating agent use (ESA-naïve).

Prior Authorization Guideline

Guideline ID	GL-102891
Guideline Name	Recorlev (levoketoconazole)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/4/2022

1 . Criteria

Product Name:Recorlev	
Diagnosis	Cushing’s Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Diagnosis of Cushing’s disease

AND

1.2 ONE of the following:

- Patient is not a candidate for pituitary surgery
- Pituitary surgery has not been curative

Product Name:Recorlev	
Diagnosis	Cushing's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive response to therapy

Product Name:Recorlev	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Recorlev will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Recorlev

Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
2/3/2022	New Program (mirrors Isturisa PA criteria)

Prior Authorization Guideline

Guideline ID	GL-99492
Guideline Name	Rectiv
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Rectiv	
Diagnosis	Pain Associated with Chronic Anal Fissures
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with chronic anal fissures

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-505202
Guideline Name	Redemplo (plozasiran)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Redemplo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of familial chylomicronemia syndrome (FCS) (type 1 hyperlipoproteinemia)

AND

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

2.1 Genetic confirmation of biallelic pathogenic variants in FCS-causing genes (i.e., LPL, GPIHBP1, APOA5, APOC2, or LMF1)

OR

2.2 A North American FCS (NAFCS) Score of greater than or equal to 45

OR

2.3 A Moulin score greater than 10

AND

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

3.1 One of the following:

3.1.1 Patient has tried or will receive treatment with standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid and a fibrate)

OR

3.1.2 Patient has an intolerance to standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid and a fibrate)

AND

3.2 Baseline fasting triglyceride levels are greater than or equal to 880 mg/dL prior to treatment with requested drug

AND

4 - Requested drug will be used as adjunct to a low-fat diet

AND

5 - Requested drug will not be used in combination with Tryngolza (olezarsen)

AND

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

- Cardiologist
- Endocrinologist
- Gastroenterologist
- Lipid specialist (lipidologist)

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in triglyceride levels from baseline)

AND

2 - Requested drug will not be used in combination with Tryngolza (olezarsen)

2 . Revision History

Date	Notes
1/28/2026	New program

Prior Authorization Guideline

Guideline ID	GL-102898
Guideline Name	Regranex
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/3/2022

1 . Criteria

Product Name:Regranex	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient has a lower extremity diabetic neuropathic ulcer	

2 . Revision History

Date	Notes
2/3/2022	Removed t/f Santyl prerequisite

Prior Authorization Guideline

Guideline ID	GL-756209
Guideline Name	Repatha (evolocumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

Product Name:Repatha	
Diagnosis	Atherosclerotic Cardiovascular Disease (ASCVD) and Prevention of Cardiovascular Events in patients at increased risk for a major adverse cardiovascular (CV) event
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is 18 years of age or older	

AND

2 - One of the following diagnoses:

2.1 Diagnosis of Atherosclerotic Cardiovascular Disease (ASCVD) defined as acute coronary syndrome, history of myocardial infarction (MI), stable or unstable angina, coronary revascularization, or any ischemia-driven arterial revascularization (e.g., percutaneous coronary intervention or coronary artery bypass graft surgery), stroke, transient ischemic attack, and/or peripheral arterial disease presumed to be of atherosclerotic origin

OR

2.2 Patient is at increased risk for a major adverse cardiovascular (CV) event

AND

3 - Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

4.1 Patient has had an inadequate response to a high-intensity statin therapy as documented by ALL of the following:

- Inadequate response with a high-intensity statin (i.e., atorvastatin 40-80 mg or rosuvastatin 20-40 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to high-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Repatha therapy

OR

4.2 Patient has had an inadequate response to a moderate-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity statin therapy
- Inadequate response with a moderate-intensity statin (i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg twice daily, or pitavastatin 2-4 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to moderate-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Repatha therapy

OR

4.3 Patient has had an inadequate response to a low-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity and at least one moderate-intensity statin therapy
- Inadequate response with a low-intensity statin (i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, pitavastatin 1 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to low-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Repatha therapy

OR

4.4 Patient is statin intolerant (inability to tolerate any dose or increase the dose above the smallest tablet strength) or has a contraindication to all statins as documented by ONE of the following:

- Patient experienced statin-related rhabdomyolysis with CK elevations ≥10 times the upper limit of normal (ULN)
- Patient experienced intolerable skeletal-related muscle symptoms (e.g., myopathy or myalgia) to at least two different statins at the lowest dose (one of the statin trials must include pravastatin or rosuvastatin) and the skeletal-related muscle symptoms (e.g., myopathy or myalgia) resolved upon discontinuation of each respective therapy
- Patient has a labeled contraindication to all statins

AND

5 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

5.1 Both of the following:

- Patient had an inadequate response with maximally tolerated statin plus ezetimibe (or ezetimibe therapy alone if statin intolerant) for at least three consecutive months
- Patient must be adherent to maximally tolerated statin plus ezetimibe therapy (or ezetimibe therapy alone, if statin intolerant), as evidenced by consistent pharmacy claims over the past three months

OR

5.2 Patient has a documented intolerance or contraindication to ezetimibe

AND

6 - Medication will be used as adjunct to low-fat diet and exercise

AND

7 - Patient's documented current LDL-C is greater than or equal to 55 mg/dL (within the last 30 days)

AND

8 - Repatha (evolocumab) will not be used in combination with another PCSK9 inhibitor (such as Praluent) or Juxtapid

Product Name:Repatha	
Diagnosis	Heterozygous Familial Hypercholesterolemia (HeFH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 10 years of age or older

AND

2 - Diagnosis of HeFH confirmed by ONE of the following:

2.1 Genetic confirmation of a mutation in the LDL-receptor, apoB, or PCSK9

OR

2.2 Both of the following:

- Tendon xanthomas are present in the patient, first degree relative (parent, sibling, child), or second degree relative (grandparent, uncle, aunt)
- Patient has a pretreatment/untreated total cholesterol (TC) greater than 290 mg/dL or LDL-C greater than 190 mg/dL

OR

2.3 WHO/Dutch Lipid Clinic Network Criteria with a score greater than 8 points

AND

3 - Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

4.1 Patient has had an inadequate response to a high-intensity statin therapy as documented by ALL of the following:

- Inadequate response with a high-intensity statin (i.e., atorvastatin 40-80 mg or rosuvastatin 20-40 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to high-intensity statin, as evidenced by consistent pharmacy claims over the past three months

- Statin therapy will be continued with Repatha therapy

OR

4.2 Patient has had an inadequate response to a moderate-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity statin therapy
- Inadequate response with a moderate-intensity statin (i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg twice daily, or pitavastatin 2-4 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to moderate-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Repatha therapy

OR

4.3 Patient has had an inadequate response to a low-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity and at least one moderate-intensity statin therapy
- Inadequate response with a low-intensity statin (i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, pitavastatin 1 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to low-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Repatha therapy

OR

4.4 Patient is statin intolerant (inability to tolerate any dose or increase the dose above the smallest tablet strength) or has a contraindication to all statins as documented by ONE of the following:

- Patient experienced statin-related rhabdomyolysis with CK elevations ≥10 times the upper limit of normal (ULN)
- Patient experienced intolerable skeletal-related muscle symptoms (e.g., myopathy or myalgia) to at least two different statins at the lowest dose (one of the statin trials must include pravastatin or rosuvastatin) and the skeletal-related muscle symptoms (e.g., myopathy or myalgia) resolved upon discontinuation of each respective therapy

- Patient has a labeled contraindication to all statins

AND

5 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

5.1 Both of the following:

- Patient had an inadequate response with maximally tolerated statin plus ezetimibe (or ezetimibe therapy alone if statin intolerant) for at least three consecutive months
- Patient must be adherent to maximally tolerated statin plus ezetimibe therapy (or ezetimibe therapy alone, if statin intolerant), as evidenced by consistent pharmacy claims over the past three months

OR

5.2 Patient has a documented intolerance or contraindication to ezetimibe

AND

6 - Medication will be used as adjunct to low-fat diet and exercise

AND

7 - Patient's documented current LDL-C is greater than or equal to 70 mg/dL (within the last 30 days)

AND

8 - Repatha (evolocumab) will not be used in combination with another PCSK9 inhibitor (such as Praluent) or Juxtapid

Product Name:Repatha	
Diagnosis	Homozygous Familial Hypercholesterolemia (HoFH)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 10 years of age or older

AND

2 - Diagnosis of HoFH confirmed by ONE of the following:

2.1 History of genetic testing confirming two mutant alleles at the LDLR, apoB, PCSK9, or ARH adapter gene locus

OR

2.2 Documented history of untreated LDL-C greater than 400 mg/dL and at least ONE of the following

- Tendon and/or cutaneous xanthoma prior to 10 years of age
- Untreated LDL-C levels consistent with heterozygous familial hypercholesterolemia in both parents (LDL-C greater than or equal to 190 mg/dL)

AND

3 - Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

4.1 Patient has had an inadequate response to a high-intensity statin therapy as documented by ALL of the following:

- Inadequate response with a high-intensity statin (i.e., atorvastatin 40-80 mg or rosuvastatin 20-40 mg) at the maximally tolerated dose for at least three consecutive months

- Patient must be adherent to high-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Repatha therapy

OR

4.2 Patient has had an inadequate response to a moderate-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity statin therapy
- Inadequate response with a moderate-intensity statin (i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg twice daily, or pitavastatin 2-4 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to moderate-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Repatha therapy

OR

4.3 Patient has had an inadequate response to a low-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity and at least one moderate-intensity statin therapy
- Inadequate response with a low-intensity statin (i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, pitavastatin 1 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to low-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Repatha therapy

OR

4.4 Patient is statin intolerant (inability to tolerate any dose or increase the dose above the smallest tablet strength) or has a contraindication to all statins as documented by ONE of the following:

- Patient experienced statin-related rhabdomyolysis with CK elevations ≥10 times the upper limit of normal (ULN)
- Patient experienced intolerable skeletal-related muscle symptoms (e.g., myopathy or myalgia) to at least two different statins at the lowest dose (one of the statin trials must

include pravastatin or rosuvastatin) and the skeletal-related muscle symptoms (e.g., myopathy or myalgia) resolved upon discontinuation of each respective therapy
- Patient has a labeled contraindication to all statins

AND

5 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

5.1 Both of the following:

- Patient had an inadequate response with maximally tolerated statin plus ezetimibe (or ezetimibe therapy alone if statin intolerant) for at least three consecutive months
- Patient must be adherent to maximally tolerated statin plus ezetimibe therapy (or ezetimibe therapy alone, if statin intolerant), as evidenced by consistent pharmacy claims over the past three months

OR

5.2 Patient has a documented intolerance or contraindication to ezetimibe

AND

6 - Medication will be used as adjunct to low-fat diet and exercise

AND

7 - Patient's documented current LDL-C is greater than or equal to 70 mg/dL (within the last 30 days)

AND

8 - Repatha (evolocumab) will not be used in combination with another PCSK9 inhibitor (such as Praluent) or Juxtapid

Product Name:Repatha	
Diagnosis	Primary Hyperlipidemia

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

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Diagnosis of primary hyperlipidemia or hypercholesterolemia

AND

3 - ONE of the following:

3.1 Patient has a coronary artery calcium or calcification score greater than or equal to 300 Agatston units

OR

3.2 Patient has diabetes

AND

4 - Prescribed by, or in consultation with, a cardiologist, endocrinologist, or lipid specialist

AND

5 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

5.1 Patient has had an inadequate response to a high-intensity statin therapy as documented by ALL of the following:

- Inadequate response with a high-intensity statin (i.e., atorvastatin 40-80 mg or rosuvastatin 20-40 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to high-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Repatha therapy

OR

5.2 Patient has had an inadequate response to a moderate-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity statin therapy
- Inadequate response with a moderate-intensity statin (i.e., atorvastatin 10-20 mg, rosuvastatin 5-10 mg, simvastatin 20-40 mg, pravastatin 40-80 mg, lovastatin 40 mg, fluvastatin XL 80 mg, fluvastatin 40 mg twice daily, or pitavastatin 2-4 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to moderate-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Repatha therapy

OR

5.3 Patient has had an inadequate response to a low-intensity statin therapy as documented by ALL of the following:

- Patient has a documented intolerance or contraindication to at least one high-intensity and at least one moderate-intensity statin therapy
- Inadequate response with a low-intensity statin (i.e., simvastatin 10 mg, pravastatin 10-20 mg, lovastatin 20 mg, fluvastatin 20-40 mg, pitavastatin 1 mg) at the maximally tolerated dose for at least three consecutive months
- Patient must be adherent to low-intensity statin, as evidenced by consistent pharmacy claims over the past three months
- Statin therapy will be continued with Repatha therapy

OR

5.4 Patient is statin intolerant (inability to tolerate any dose or increase the dose above the smallest tablet strength) or has a contraindication to all statins as documented by ONE of the following:

- Patient experienced statin-related rhabdomyolysis with CK elevations ≥10 times the upper limit of normal (ULN)
- Patient experienced intolerable skeletal-related muscle symptoms (e.g., myopathy or myalgia) to at least two different statins at the lowest dose (one of the statin trials must include pravastatin or rosuvastatin) and the skeletal-related muscle symptoms (e.g., myopathy or myalgia) resolved upon discontinuation of each respective therapy
- Patient has a labeled contraindication to all statins

AND

6 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ONE of the following:

6.1 Both of the following:

- Patient had an inadequate response with maximally tolerated statin plus ezetimibe (or ezetimibe therapy alone if statin intolerant) for at least three consecutive months
- Patient must be adherent to maximally tolerated statin plus ezetimibe therapy (or ezetimibe therapy alone, if statin intolerant), as evidenced by consistent pharmacy claims over the past three months

OR

6.2 Patient has a documented intolerance or contraindication to ezetimibe

AND

7 - Medication will be used as adjunct to low-fat diet and exercise

AND

8 - Patient's documented current LDL-C is greater than or equal to 70 mg/dL (within the last 30 days)

AND

9 - Repatha (evolocumab) will not be used in combination with another PCSK9 inhibitor (such as Praluent) or Juxtapid

Product Name:Repatha	
Diagnosis	All Indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 10 years of age or older

AND

2 - Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist

AND

3 - Patient continues to receive statin at maximally tolerated dose (unless unable to take statin)

AND

4 - Verification of paid claims confirming patient has remained adherent to therapy, as evidenced by consistent pharmacy claims over the past three months

AND

5 - Patient had a documented sustained reduction in LDL-C levels from pre-treatment baseline (i.e., prior to Repatha therapy)

AND

6 - Repatha (evolocumab) will not be used in combination with another PCSK9 inhibitor (such as Praluent) or Juxtapid

2 . Revision History

Date	Notes
10/28/2026	Updated ASCVD diagnosis verbiage due to expanded indication

Prior Authorization Guideline

Guideline ID	GL-589220
Guideline Name	Respiratory Syncytial Virus (RSV) Vaccines
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Abrysvo, Arexvy, mResvia	
Approval Length	14 days (1 injection per 2 years)
Guideline Type	Prior Authorization

Approval Criteria

1 - Vaccine is being used for the prevention of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV)

AND

2 - Patient has not received an RSV vaccine (i.e., Abrysvo, Arexvy, mResvia) in the previous 2 years

AND

3 - One of the following:

3.1 One of the following:

- For ABRYSVO requests: Age greater than or equal to 60 years*
- For AREXVY requests: Age greater than or equal to 50 years*
- For MRESVIA requests: Age greater than or equal to 60 years

OR

3.2 One of the following :

3.2.1 Both of the following (applies to ABRYSVO only):

- Will be used for active immunization of pregnant individuals at 32 through 36 weeks gestational age
- Will also be used for the prevention of severe LRTD caused by RSV in infants from birth through 6 months of age

OR

3.2.2 Both of the following:

- Patient is 18 to 59 years of age
- Patient is at increased risk for LRTD caused by RSV

Notes	*Prior authorization for ABRYSVO and MRESVIA is NOT required for patients 60 years and older. *Prior authorization for AREXVY is NOT r equired for patients 50 years and older.

2 . Revision History

Date	Notes

4/30/2026	Arexvy expanded indication: Updated criterion 3.2.2 (removed design ation specific to Mresvia and Abrysvo only note).

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-417195
Guideline Name	Retinal Vascular Disease Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Preferred: Byooviz*	
Diagnosis	Neovascular (wet) age-related macular degeneration (nAMD), Macular edema following retinal vein occlusion (RVO), Myopic Choroidal Neovascularization (mCNV)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting one of the following diagnoses:	

- Neovascular (wet) age-related macular degeneration (nAMD)
- Macular edema following retinal vein occlusion (RVO)
- Myopic Choroidal Neovascularization (mCNV)

AND

2 - Submission of medical records (e.g., chart notes) documenting treatment for a minimum of 90 days with compounded Avastin prepared by a 503(B) Outsourcing Facility has been ineffective in improvement of visual acuity, or not tolerated, or contraindicated (paid pharmacy claims may be used in conjunction with submitted documentation) NOTE: Ocular injections will continue to use Brand Avastin to compound the injection. The provider must Buy and Bill, and submit a medical claim for reimbursement.

AND

3 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Notes	*NOTE: Provider must Buy and Bill, and submit a medical claim for rei mbursement.

Product Name:Preferred: Cimerli*	
Diagnosis	Neovascular (wet) age-related macular degeneration (nAMD), Macular edema following retinal vein occlusion (RVO), Diabetic macular edema (DME), Diabetic retinopathy (DR), Myopic choroidal neovascularization (mCNV)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

- Neovascular (wet) age-related macular degeneration (nAMD)
- Macular edema following retinal vein occlusion (RVO)
- Diabetic macular edema (DME)

- Diabetic retinopathy (DR)
- Myopic choroidal neovascularization (mCNV)

AND

2 - Submission of medical records (e.g., chart notes) documenting treatment for a minimum of 90 days with compounded Avastin prepared by a 503(B) Outsourcing Facility has been ineffective in improvement of visual acuity, or not tolerated, or contraindicated (paid pharmacy claims may be used in conjunction with submitted documentation) NOTE: Ocular injections will continue to use Brand Avastin to compound the injection. The provider must Buy and Bill, and submit a medical claim for reimbursement.

AND

3 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Notes	*NOTE: Provider must Buy and Bill, and submit a medical claim for rei mbursement.

Product Name:Preferred: Pavblu*	
Diagnosis	Neovascular (wet) age-related macular degeneration (nAMD), Macular edema following retinal vein occlusion (RVO), Diabetic macular edema (DME), Diabetic retinopathy (DR)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

- Neovascular (wet) age-related macular degeneration (nAMD)
- Macular edema following retinal vein occlusion (RVO)
- Diabetic macular edema (DME)
- Diabetic retinopathy (DR)

AND

2 - Submission of medical records (e.g., chart notes) documenting treatment for a minimum of 90 days with compounded Avastin prepared by a 503(B) Outsourcing Facility has been ineffective in improvement of visual acuity, or not tolerated, or contraindicated (paid pharmacy claims may be used in conjunction with submitted documentation) NOTE: Ocular injections will continue to use Brand Avastin to compound the injection. The provider must Buy and Bill, and submit a medical claim for reimbursement.

AND

3 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Notes	*NOTE: Provider must Buy and Bill, and submit a medical claim for reimbursement.

Product Name:Preferred*: Byooviz, Cimerli, Pavblu	
Diagnosis	All indications listed above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., Improvement in Best Corrected Visual Acuity (BCVA) compared to baseline, stable vision)

Notes	*NOTE: Provider must Buy and Bill, and submit a medical claim for reimbursement.

Product Name:Preferred: Pavblu*	
Diagnosis	Retinopathy of Prematurity (ROP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of retinopathy of prematurity (ROP)

AND

2 - ONE of the following:

- Patient gestational age at birth less than or equal to 32 weeks
- Patient birth weight less than or equal to 1500 grams

AND

3 - Patient weight greater than 800 grams on day of treatment

AND

4 - Submission of medical records (e.g., chart notes) documenting retinopathy of prematurity (ROP) is present in at least one eye with one of the following classifications:

- ROP zone 1, stage 1 plus, 2 plus, 3, or 3 plus
- ROP zone 2, stage 2 plus or 3 plus
- AP - ROP (aggressive posterior ROP)

AND

5 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

Notes	*NOTE: Provider must Buy and Bill, and submit a medical claim for rei mbursement.

Product Name:Preferred: Pavblu*	
Diagnosis	Retinopathy of Prematurity (RoP)

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy as evidenced by the absence of active ROP and unfavorable structural outcomes (e.g., retinal detachment, macular dragging, macular fold, retrolental opacity)	
Notes	*NOTE: Provider must Buy and Bill, and submit a medical claim for reimbursement.

Product Name:Non-Preferred*: Beovu, Eylea, Eylea HD, Eylea injectable vial, Lucentis, Susvimo, Vabysmo, Opuviz, Yesafili, Ahzantive, Enzeevu, and other newly launched retinal vascular disease agents	
Approval Length	Requests for Non-Preferred biosimilars are not approved at this time
Guideline Type	Prior Authorization
Approval Criteria **1** - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred products are Byooviz, Cimerli, and Pavblu. **Please note: The drug(s) listed above may require additional review.	
Notes	*Patients must use preferred retinal vascular disease agent(s).

2 . Revision History

Date	Notes
10/29/2025	Added verbiage to note section and compounded Avastin step regarding Buy and Bill for providers. No change to clinical intent.

Prior Authorization Guideline

Guideline ID	GL-99639
Guideline Name	Revcovi - AZ
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - Diagnosis of severe combined immunodeficiency disease (SCID)

AND

2 - Deficiency of adenosine deaminase is confirmed by one of the following:

- Deficiency or absence of adenosine deaminase (ADA) in plasma, lysed erythrocytes, fibroblasts (cultured from amniotic fluid), or chorionic villus
- Increase in deoxyadenosine triphosphate (dATP) levels in erythrocyte lysates compared to laboratory standard
- Decrease in ATP (Adenosine triphosphate) concentration in erythrocytes
- Molecular genetic confirmation of mutations in both alleles of the ADA1 gene
- Positive screening by T cell receptor excision circles (TRECs)

AND

3 - One of the following:

- Patient is not a suitable candidate for hematopoietic cell transplantation (HCT)
- Patient has failed HCT
- Patient is awaiting HCT

AND

4 - Dosing is in accordance with the United States Food and Drug Administration approved labeling

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

Approval Criteria

1 - Patient has previously received treatment with Revcovi (elapegademase) therapy

AND

2 - Patient has experienced a positive clinical response to therapy (e.g., normalization of plasma ADA activity, erythrocyte dATP levels, improvement of disease symptoms, etc.)

AND **3** - Dosing is in accordance with the United States Food and Drug Administration approved labeling

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-99548
Guideline Name	Reyvow - Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - Diagnosis of moderate to severe migraine headaches with or without aura

AND

2 - Used for acute treatment of migraine

AND

3 - Patient is 18 years of age or older

AND

4 - Documentation of a one month trial resulting in therapeutic failure, contraindication, or intolerance to THREE ofthe following:

- naratriptan tablets
- rizatriptan tablets/ODT (oral disintegrating tablets)
- sumatriptan tablets/auto injection/cartridge or Imitrex nasal spray (Brand only)
- zolmitriptan tablets/ODT

AND

5 - Prescribed by or in consultation with one of the following specialists with expertise in the acute treatment of migraine:

- Neurologist
- Pain Specialist
- Headache Specialist*

AND

6 - Prescriber attests to ALL of the following:

- Patient has been informed the use of Reyvow may result in significant CNS impairment, and may impact the patient's ability to drive or operate machinery for 8 hours after each dose
- If used concurrently with a benzodiazepine or other drugs that could potentially cause central nervous system (CNS) depression, the prescriber has acknowledged that they have completed an assessment of increased risk for sedation and other cognitive and/or neuropsychiatric adverse events
- The information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided

AND

7 - Both of the following:

7.1 One of the following

7.1.1 The patient must have a history of therapeutic failure, contraindication, or intolerance to THREE of the following:

- Amitriptyline (Elavil)**
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)**
- Divalproex sodium [Depakote/Depakote ER (extended-release)]**
- Topiramate (Topamax)**
- VENLAFAXINE [EFFEXOR/EFFEXOR XR (EXTENDED-RELEASE)]**

OR

7.1.2 The patient must be currently treated with one of the following prophylactic therapies unless there is a contraindication or intolerance to ALL:

- Amitriptyline (Elavil)**
- A beta-blocker (i.e., atenolol, metoprolol, nadolol, propranolol, or timolol)**
- Divalproex sodium [Depakote/Depakote ER (extended-release)]**
- Topiramate (Topamax)**
- Venlafaxine [Effexor/Effexor XR (extended-release)]**

AND

7.2 Both of the Following

7.2.1 History of a therapeutic failure after 3 month trial, contraindication, or intolerance to two of the following biologic calcitonin gene-related peptide receptor (CGRP) antagonists for preventive treatment of migraine

- Ajovy (fremanezumab)
- Emgality (galcanezumab)
- Aimovig (erenumab)

AND

7.2.2 History of a therapeutic failure, contraindication, or intolerance to Ubrelvy

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS) **Drugs may require PA

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with one of the following specialists with expertise in the acute treatment of migraine:

- Neurologist
- Pain Specialist
- Headache Specialist*

Notes	*Headache specialists are physicians certified by the United Council f or Neurologic Subspecialties (UCNS)

2 . Revision History

Date	Notes
7/13/2021	Updated Guideline

Prior Authorization Guideline

Guideline ID	GL-700345
Guideline Name	Rezdiffra (resmetirom)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Rezdiffra	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH)

AND

2 - Patient does not have cirrhosis (e.g., decompensated cirrhosis)

AND

3 - Submission of medical records (e.g., chart notes) confirming disease is fibrosis stage F2 or F3 as confirmed by one of the following:

- Enhanced liver fibrosis (ELF) test
- Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g., FibroScan)
- FibroScan aspartate aminotransferase (FAST)
- MRI aspartate aminotransferase (MAST)
- Magnetic Resonance Elastography combined with fibrosis-4 index (MEFIB)
- Liver biopsy within the past 12 months

AND

4 - Presence of greater than or equal to 3 metabolic risk factors (e.g., Type 2 diabetes, hypertension, obesity)

AND

5 - Submission of medical records (e.g., chart notes) confirming drug is used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program)

AND

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

- Gastroenterologist
- Hepatologist

AND

7 - Medication will not be used in combination with Wegovy (semaglutide) for the treatment of MASH

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

Approval Criteria

1 - Patient demonstrates positive response to therapy (e.g., NASH resolution, fibrosis stage improvement, etc.)

AND

2 - Submission of medical records (e.g., chart notes) confirming drug will continue to be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program)

AND

3 - Submission of medical records (e.g., chart notes) confirming patient has not progressed to cirrhosis

AND

4 - Medication will not be used in combination with Wegovy (semaglutide) for the treatment of MASH

2 . Revision History

Date	Notes

8/26/2026	Updated confirmatory testing verbiage, added concomitant use criteri on

Prior Authorization Guideline

Guideline ID	GL-103329
Guideline Name	Rezurock (belumosudil)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2022

1 . Criteria

Product Name:Rezurock	
Diagnosis	Chronic graft-versus-host disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic graft-versus-host disease

AND

2 - Trial and failure of two or more lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.)

AND

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

- Hematologist
- Oncologist
- Physician experienced in the management of transplant patients

Product Name:Rezurock	
Diagnosis	Chronic graft-versus-host disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on therapy

Product Name:Rezurock	
Diagnosis	Chronic graft-versus-host disease - Twice daily (BID) Therapy
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - Patient is using medication concomitantly with one of the following:

- Strong CYP3A inducer (e.g., carbamazepine, phenobarbital, phenytoin, rifampin)
- Proton pump inhibitor (e.g., omeprazole, pantoprazole, lansoprazole)

2 . Revision History

Date	Notes
2/3/2022	New Program

Prior Authorization Guideline

Guideline ID	GL-700348
Guideline Name	Rezzayo (rezafungin)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Rezzayo	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of candidemia or invasive candidiasis with limited or no alternative options

AND

2 - Patient is 12 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid pharmacy claims confirming trial and failure, contraindication or intolerance to one of the following:

- generic caspofungin
- generic micafungin

2 . Revision History

Date	Notes
8/26/2026	Updated age criterion due to expanded indication

Prior Authorization Guideline

Guideline ID	GL-642276
Guideline Name	Rhapsido (remibrutinib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Rhapsido	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of documentation (e.g., chart notes) confirming diagnosis of chronic spontaneous urticaria	

AND

2 - Persistent symptoms (itching and hives) for at least 4 consecutive weeks despite titrating to an optimal dose with a second generation H1 antihistamine (e.g., cetirizine, fexofenadine), unless there is a contraindication or intolerance to H1 antihistamines

AND

3 - Paid claims or submission of documentation (e.g., chart notes) confirming concurrent use with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines

AND

4 - Paid claims or submission of documentation (e.g., chart notes) confirming patient has tried and had an inadequate response or intolerance to at least TWO of the following additional therapies:

- Doxepin
- H1 antihistamine
- H2 antagonist (e.g., famotidine, cimetidine)
- Hydroxyzine
- Leukotriene receptor antagonist (e.g., montelukast)

AND

5 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Dupixent (dupilumab)
- Xolair (omalizumab)

AND

6 - Prescribed by one of the following:

- Allergist/immunologist

- Dermatologist

Product Name:Rhapsido	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment

AND

2 - Submission of documentation (e.g., chart notes) confirming patient has experienced at least one of the following:

- Reduction in itching severity from baseline
- Reduction in the number of hives from baseline

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Dupixent (dupilumab)
- Xolair (omalizumab)

2 . Revision History

Date	Notes

6/24/2026	Dupixent Preferred 10/1/26, updated step for CSU.

Prior Authorization Guideline

Guideline ID	GL-669263
Guideline Name	Rhofade (oxymetazoline) cream
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Brand Rhofade, generic oxymetazoline cream	
Diagnosis	Persistent erythema associated with rosacea
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of persistent erythema associated with rosacea	

AND

2 - ONE of the following:

2.1 History of a 30 day or longer trial and failure of one of the following:

- metronidazole cream, gel, or lotion
- azelaic acid gel

OR

2.2 Contraindication or intolerance to both of the following:

- metronidazole cream, gel, or lotion
- azelaic acid gel

Product Name:Brand Rhofade, generic oxymetazoline cream	
Diagnosis	Persistent erythema associated with rosacea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to therapy

2 . Revision History

Date	Notes
7/28/2026	Added generic oxymetazoline cream as target

Prior Authorization Guideline

Guideline ID	GL-330209
Guideline Name	Rinvoq (upadacitinib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Rinvoq	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:**

3.1 History of failure to a 3 month trial of one non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced*

AND

3.2 History of failure, contraindication, or intolerance to ALL of the following:***

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Xeljanz oral tablet (tofacitinib) (IR or XR)
- A preferred tocilizumab biosimilar

AND

4 - Not used in combination with other Janus kinase (JAK) inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PA may be required ***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer sponsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

2 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq, Rinvoq LQ	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:**

3.1 Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:*

- methotrexate
- leflunomide

AND

3.2 History of failure, contraindication, or intolerance to ALL of the following:***

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet
- A preferred tocilizumab biosimilar

AND

4 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PA may be required ***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer sponsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq, Rinvoq LQ	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

2 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq, Rinvoq LQ	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active psoriatic arthritis (PsA)

AND

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

- Dermatologist
- Rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:**

3.1 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced*

AND

3.2 History of failure, contraindication, or intolerance to ALL of the following:***

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

AND

4 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PA may be required ***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the

	prescriber's office or any form of assistance from manufacturer sponsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq, Rinvoq LQ	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

2 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

AND

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

- Dermatologist
- Rheumatologist

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq	
Diagnosis	Ankylosing Spondylitis (AS), Non-radiographic Axial Spondyloarthritis (nr-AxSpA)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming one of the following diagnoses:

- Active ankylosing spondylitis (AS)
- Active non-radiographic axial spondyloarthritis (nr-AxSpA)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:**

3.1 Trial and failure, contraindication, or intolerance to TWO nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen)

AND

3.2 History of failure, contraindication, or intolerance to ALL of the following:***

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

4 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (eq

	uivalent to 10 mg or less of prednisone daily). **PA may be required ***Patients requesting initial authorization who were established on th erapy via the receipt of a manufacturer supplied sample at no cost in t he prescriber's office or any form of assistance from manufacturer spo nsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq	
Diagnosis	Ankylosing Spondylitis (AS), Non-radiographic Axial Spondyloarthritis (nr-AxSpA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

2 - Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine or cyclosporine)*

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhale d corticosteroids, and/or low stable dosages of oral corticosteroids (eq uivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq	
Diagnosis	Atopic Dermatitis (AD)

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderate to severe atopic dermatitis (AD)

AND

2 - Patient is 12 years of age or older

AND

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

- Involvement of at least 10% body surface area (BSA)
- SCORing Atopic Dermatitis (SCORAD) index value of at least 25

AND

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

- Dermatologist
- Allergist/Immunologist

AND

5 - Submission of medical records (e.g., chart notes) or paid claims history documenting ALL of the following:**

5.1 History of failure, contraindication, or intolerance to ALL of the following topical therapies:***

- One topical calcineurin inhibitor [e.g., Elidel (pimecrolimus), Protopic (tacrolimus)]
- Eucrisa (crisaborole)

- Opzelura (ruxolitinib) cream
- Vtama (tapinarof) cream
- Zoryve (roflumilast) 0.15% cream

AND

5.2 Submission of medical records (e.g., chart notes) or paid claims history documenting trial and failure of a minimum 12-week supply of Dupixent (dupilumab)***

AND

5.3 Submission of medical records (e.g., chart notes) or paid claims history documenting trial and failure of a minimum 12-week supply of Adbry (tralokinumab-ldrm)***

AND

6 - Not used in combination with other JAK inhibitors, biologic immunomodulators (e.g., Dupixent, Adbry), or other immunosuppressants (e.g., azathioprine, cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). ** PA may be required. ***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer sponsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in body surface area involvement from baseline
- Reduction in SCORing Atopic Dermatitis (SCORAD) index value from baseline

AND

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

- Dermatologist
- Allergist/Immunologist

AND

3 - Not used in combination with other JAK inhibitors, biologic immunomodulators (e.g., Dupixent, Adbry), or other immunosuppressants (e.g., azathioprine, cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:**

3.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
- Azathioprine
- Corticosteroids (e.g., prednisone)

AND

3.2 History of failure, contraindication, or intolerance to ALL of the following:***

- A preferred adalimumab biosimilar
- infliximab
- Xeljanz oral tablet (tofacitinib) (IR or XR)
- A preferred ustekinumab biosimilar

AND

4 - Not used in combination with other JAK inhibitors, biological therapies for UC, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PA may be required ***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer sponsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq	
Diagnosis	Ulcerative Colitis (UC)

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - Not used in combination with other JAK inhibitors, biological therapies for UC, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active Crohn's disease (CD)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting BOTH of the following:**

3.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Azathioprine
- Methotrexate
- Corticosteroids (e.g., prednisone)

AND

3.2 History of failure, contraindication, or intolerance to ALL of the following:***

- A preferred adalimumab biosimilar
- infliximab
- A preferred ustekinumab biosimilar

AND

4 - Not used in combination with other JAK inhibitors, biological therapies for CD, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily). **PA may be required ***Patients requesting initial authorization who were established on therapy via the receipt of a manufacturer supplied sample at no cost in the prescriber's office or any form of assistance from manufacturer spo

	nsored programs shall be required to meet initial authorization criteria as if patient were new to therapy.

Product Name:Rinvoq	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least one of the following:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - Not used in combination with other JAK inhibitors, biological therapies for CD, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of giant cell arteritis (GCA)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to BOTH of the following:

- A glucocorticoid (e.g., prednisone)
- A preferred tocilizumab biosimilar

AND

4 - Not used in combination with other JAK inhibitors, biological therapies, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*

Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

Product Name:Rinvoq	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria	
1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy **AND** **2** - Prescribed by or in consultation with a rheumatologist **AND** **3** - Not used in combination with other JAK inhibitors, biological therapies, or with potent immunosuppressants (e.g., azathioprine, cyclosporine)*	
Notes	*Rinvoq may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids (equivalent to 10 mg or less of prednisone daily).

2 . Background

Clinical Practice Guidelines

Table 1. Relative potencies of topical corticosteroids [5]

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment, gel	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
	Amcinonide	Cream, lotion, ointment	0.1

High Potency	Augmented betamethasone dipropionate	Cream, lotion	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment, lotion	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream, lotion	0.1
	Triamcinolone acetonide	Cream, ointment, lotion	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05

	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
7/16/2025	Updated preferred agents/embedded steps, added criteria for new G CA indication, updated criteria throughout

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-540210
Guideline Name	Rituximab
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:PREFERRED: Riabni, Ruxience	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	1 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of moderately- to severely-active rheumatoid arthritis

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming a minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:

- methotrexate
- leflunomide
- sulfasalazine

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming that medication is used in combination with methotrexate

Product Name:PREFERRED: Riabni, Ruxience	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	1 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

AND

2 - At least 16 weeks have elapsed since last course of therapy

Product Name:PREFERRED: Riabni, Ruxience

Diagnosis	Non-Hodgkin’s Lymphoma
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- Diagnosis of diffuse large B-cell, CD20-positive, non-Hodgkin’s lymphoma
- Used as first-line treatment in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) or other anthracycline-based chemotherapy regimens

OR

1.2 Both of the following:

- Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma
- Used as first-line treatment in combination with chemotherapy

OR

1.3 All of the following:

- Diagnosis of follicular, CD20-positive, B-cell non-Hodgkin's lymphoma
- Patient achieved a complete or partial response to a rituximab product in combination with chemotherapy
- Followed by rituximab used as monotherapy for maintenance therapy

OR

1.4 Both of the following:

1.4.1 Diagnosis of low-grade, CD20-positive, B-cell non-Hodgkin's lymphoma

AND

1.4.2 One of the following:

- Patient has stable disease following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy
- Patient achieved a partial or complete response following first-line treatment with CVP (cyclophosphamide, vincristine, prednisolone/ prednisone) chemotherapy

OR

1.5 Diagnosis of relapsed or refractory, low grade or follicular CD20-positive, B-cell non-Hodgkin's lymphoma.

OR

1.6 All of the following (off-label for Riabni):

1.6.1 Diagnosis of one of the following previously untreated, advanced stage indications:

- CD-20-positive diffuse large B-cell lymphoma (DLBCL)
- Burkitt lymphoma (BL)
- Burkitt-like lymphoma (BLL)
- Mature B-cell acute leukemia (B-AL)

AND

1.6.2 Patient is 6 months of age or older

AND

1.6.3 Used in combination with chemotherapy

Product Name:PREFERRED: Riabni, Ruxience	
Diagnosis	Chronic Lymphocytic Leukemia

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic lymphocytic leukemia

AND

2 - Used in combination with fludarabine and cyclophosphamide

Product Name:PREFERRED: Riabni, Ruxience	
Diagnosis	Wegener's Granulomatosis and Microscopic Polyangiitis
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following diagnoses:

- Granulomatosis with Polyangiitis (GPA) (Wegener's Granulomatosis)
- Microscopic Polyangiitis

AND

2 - Used in combination with glucocorticoids (e.g., prednisone) (NOTE: Duration of glucocorticoid treatment to be determined by provider)

Product Name:PREFERRED: Riabni, Ruxience	
Diagnosis	Pemphigus Vulgaris
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe Pemphigus Vulgaris

Product Name:PREFERRED: Riabni, Ruxience	
Diagnosis	Pemphigus Vulgaris
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

Product Name:PREFERRED: Riabni, Ruxience	
Diagnosis	Waldenstrom’s macroglobulinemia
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of relapsed/refractory Waldenstrom’s macroglobulinemia (off-label)

Product Name:PREFERRED: Riabni, Ruxience	
Diagnosis	Immune or Idiopathic Thrombocytopenic Purpura (Off-Label)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of immune or idiopathic thrombocytopenic purpura (off-label)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to at least ONE of the following:

- Glucocorticoids (e.g., prednisone, methylprednisolone)
- Immunoglobulins (e.g., IVIg)
- Splenectomy

AND

3 - Documented platelet count of less than 50 x 10^9 / L

Product Name:NON-PREFERRED*: Rituxan, Truxima, and newly launched rituximab products	
Approval Length	Requests for Non-Preferred biosimilars are not approved at this time
Guideline Type	Prior Authorization

Approval Criteria

1 - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred products are Riabni and Ruxience. **Please note: The drug(s) listed above may require additional review.

Notes	*Patients must use preferred rituximab products.

2 . Revision History

Date	Notes

3/24/2026	GPA indication, add note to glucocorticoids req (duration to be deter mined by provider)

Prior Authorization Guideline

Guideline ID	GL-669259
Guideline Name	Ryaltris (olopatadine-mometasone) nasal spray
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Ryaltris	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 6 years of age or older

AND

2 - Trial and failure to both of the following as separate agents:

- generic mometasone nasal spray
- azelastine or olopatadine nasal spray

2 . Revision History

Date	Notes
7/28/2026	Added age criterion.

Prior Authorization Guideline

Guideline ID	GL-669274
Guideline Name	Ryoncil (remestemcel-l-rknd)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Ryoncil	
Approval Length	1 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of acute graft versus host disease (aGVHD)

AND

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

2.1 Patient has Grade C or D aGVHD involving the skin, liver, and/or GI tract

OR

2.2 Patient has Grade B aGVHD involving the liver and/or GI tract with or without concomitant skin disease

AND

3 - Submission of medical records (e.g., chart notes) confirming disease is steroid refractory as defined by progression of aGVHD within 3 days or no improvement within 7 days of consecutive treatment with 2 mg/kg/day methylprednisolone or equivalent

AND

4 - Patient is 2 months of age to less than or equal to 17 years of age

AND

5 - Patient has not received any second line therapy to treat aGVHD (e.g., Jakafi, mycophenolate mofetil, etc.)

AND

6 - Both of the following;

6.1 Prescribed by a provider at a transplant center with expertise in gene therapy

AND

6.2 Prescribed by one of the following:

- Hematologist/oncologist
- Bone marrow transplant specialist
- Specialist with expertise in the diagnosis and management of steroid-refractory aGvHD (SR-aGvHD)

Product Name:Ryoncil	
Approval Length	1 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Both of the following:

- Patient has had a partial or mixed response to current Ryoncil treatment course
- Patient has not received more than 12 infusions

OR

1.2 Patient is experiencing a recurrence of GvHD after complete response with Ryoncil therapy

AND

2 - Both of the following:

2.1 Prescribed by a provider at a transplant center with expertise in gene therapy

AND

2.2 Prescribed by one of the following:

- Hematologist/oncologist
- Bone marrow transplant specialist
- Specialist with expertise in the diagnosis and management of steroid-refractory aGvHD (SR-aGvHD)

2 . Revision History

Date	Notes
7/28/2026	New Program

Prior Authorization Guideline

Guideline ID	GL-636307
Guideline Name	Rystiggo (rozanolixizumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Rystiggo	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of generalized myasthenia gravis (gMG)

AND

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

2.1 Both of the following:

2.1.1 Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

2.1.2 Both of the following:

2.1.2.1 Trial and failure, contraindication, or intolerance to two immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) (May be verified via paid pharmacy claims)

AND

2.1.2.2 Trial and failure, contraindication, or intolerance to one of the following: (May be verified via paid pharmacy claims)

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG) or immunoglobulin (IG) therapy

OR

2.2 Both of the following:

2.2.1 Patient is anti-muscle-specific tyrosine kinase (MuSK) antibody positive

AND

2.2.2 Both of the following:

2.2.2.1 Trial and failure, contraindication, or intolerance to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) (May be verified via paid pharmacy claims)

AND

2.2.2.2 Trial and failure, contraindication, or intolerance to one of the following: (May be verified via paid pharmacy claims)

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG) or immunoglobulin (IG) therapy
- Rituximab

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Requested medication is not being used in combination with any one of the following:

- Another neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Vyvgart, Vyvgart Hytrulo)
- Complement inhibitor (e.g., eculizumab, Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)
- B-cell depletion therapy (e.g., Uplizna)

Product Name:Rystiggo	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

2 - Requested medication is not being used in combination with any one of the following:

- Another neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Vyvgart, Vyvgart Hytrulo)
- Complement inhibitor (e.g., eculizumab, Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)
- B-cell depletion therapy (e.g., Uplizna)

2 . Revision History

Date	Notes
6/25/2026	Added combination therapy criteria to initial and reauth.

Prior Authorization Guideline

Guideline ID	GL-152667
Guideline Name	Rytelo (imetelstat)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2024

1 . Criteria

Product Name:Rytelo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of myelodysplastic syndrome

AND

1.2 Disease is low to intermediate-1 risk

AND

1.3 All of the following:

- Hemoglobin less than 10 g/dL
- Baseline absolute neutrophil count of 1.5 x 10^9 /L or greater
- Baseline platelet count of 75 x 10^9 /L or greater

AND

1.4 Both of the following:

- Patient does not have a confirmed mutation with deletion 5q [del(5q)]
- Patient has not received prior treatment with Revlimid (lenalidomide) or hypomethylating agents (e.g., azacitidine, decitabine)

AND

1.5 Patient requires 4 or more red blood cell units over 8 weeks

AND

1.6 One of the following:

- Previous treatment with an erythropoiesis stimulating agent shows no response
- Previous treatment with an erythropoiesis stimulating agent shows loss of response
- Patient is ineligible for treatment with an erythropoiesis stimulating agent

Product Name:Rytelo	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient does not show evidence of progressive disease while on therapy	

2 . Revision History

Date	Notes
8/27/2024	New program

Prior Authorization Guideline

Guideline ID	GL-99642
Guideline Name	Samsca
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Samsca, generic tolvaptan	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

- Diagnosis of clinically significant euvolemic hyponatremia
- Diagnosis of clinically significant hypervolemic hyponatremia

AND

2 - Patient has not responded to fluid restriction

AND

3 - Treatment has been initiated or re-initiated in a hospital setting prior to discharge

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-624209
Guideline Name	Saphnelo (anifrolumab-fnia)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Saphnelo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe systemic lupus erythematosus (SLE)

AND

2 - Patient is currently receiving standard of care treatment for SLE (e.g., antimalarials [e.g., Plaquenil (hydroxychloroquine)], corticosteroids [e.g., prednisone], or immunosuppressants [e.g., methotrexate, Imuran (azathioprine)])

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name:Saphnelo	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., decrease or stabilization of symptoms, improvement in functional impairment, decrease of corticosteroid dose, decrease in pain medications)

2 . Revision History

Date	Notes
5/27/2026	New program

Prior Authorization Guideline

Guideline ID	GL-479197
Guideline Name	Sapropterin products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Kuvan, generic sapropterin, Javygtor, Zelvysia	
Diagnosis	Phenylketonuria (PKU)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of phenylketonuria (PKU)

AND

2 - If the request is for Brand Kuvan, Javygtor, or Zelvysia; patient must have tried and failed generic sapropterin (Applies to Brand Kuvan, Javygtor, or Zelvysia only)

2 . Revision History

Date	Notes
12/17/2025	Added step through generic sapropterin

Prior Authorization Guideline

Guideline ID	GL-629212
Guideline Name	Sedative Hypnotics - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Preferred: generic ramelteon; Non-Preferred: Brand Rozerem	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - History of failure, contraindication, or intolerance to a trial of at least two of the following preferred agents:

- Eszopiclone (Generic Lunesta)
- Zolpidem/Zolpidem ER (Generic Ambien/Ambien CR)
- Temazepam 15/30mg capsules (Generic Restoril)

AND

2 - For Brand Rozerem requests ONLY, patient must have tried and failed generic ramelteon

Product Name:Non-Preferred Drugs: Brand Ambien, Brand Ambien CR, Edluar, Brand Intermezzo, generic zolpidem SL tablets, Zolpimist, Belsomra, Dayvigo, estazolam, flurazepam, Brand Halcion, generic triazolam, Brand Lunesta, Quviviq, Brand Restoril, generic temazepam 7.5 mg and 22.5 mg capsules, Brand Silenor, generic doxepin, generic zaleplon	
Diagnosis	Non-Preferred
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - History of failure, contraindication, or intolerance to a trial of at least two of the following preferred agents:

- Eszopiclone (Generic Lunesta)
- Zolpidem/Zolpidem ER (Generic Ambien/Ambien CR)
- Temazepam 15/30mg capsules (Generic Restoril)

Product Name:Brand Ambien, generic zolpidem, Brand Ambien CR, generic zolpidem ER, Edluar, Brand Intermezzo, generic zolpidem SL tablets, Zolpimist, Belsomra, Dayvigo, estazolam, flurazepam, Brand Halcion, generic triazolam, Brand Lunesta, generic eszopiclone, Quviviq, Brand Restoril, generic temazepam, Brand Rozerem, generic ramelteon, Brand Silenor, generic doxepin, generic zaleplon	
Diagnosis	Reject 75: Greater than 1 hypnotic in 30 days
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The requested medication is being used to adjust the dose of the drug

OR

2 - The requested medication will be used in place of the previously prescribed drug, and not in addition to it

OR

3 - The requested medication dosage form will be used in place of the previously prescribed medication dosage form, and not in addition to it

OR

4 - The physician attests they are aware of the multiple sedative hypnotics prescribed to the patient and feels treatment with both medications is medically necessary (Document rationale for use)

Product Name:Brand Ambien, generic zolpidem, Brand Ambien CR, generic zolpidem ER, Edluar, Brand Intermezzo, generic zolpidem SL tablets, Zolpimist, Belsomra, Dayvigo, estazolam, flurazepam, Brand Halcion, generic triazolam, Brand Lunesta, generic eszopiclone, Quviviq, Brand Restoril, generic temazepam, Brand Rozerem, generic ramelteon, Brand Silenor, generic doxepin, generic zaleplon	
Diagnosis	Requests for Patients less than 6 years of age
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is unresponsive to other treatment modalities, unless contraindicated (i.e. other medications or behavioral modification attempted)

AND

2 - The physician attests that the requested medication is medically necessary. (Document rationale for use)

2 . Revision History

Date	Notes
6/4/2026	Added generic ramelteon for preferred requests, added step through generic for Brand Rozerem requests.

Prior Authorization Guideline

Guideline ID	GL-479196
Guideline Name	Sephience (sepiapterin)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Sephience	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of phenylketonuria (PKU)

AND

2 - Used in conjunction with a phenylalanine (Phe)-restricted diet

AND

3 - Patient will have Phe blood levels measured within 2 weeks of therapy (new starts to therapy only) and periodically for up to 3 months of therapy to determine response

AND

4 - Trial and failure, contraindication, or intolerance to generic sapropterin

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

Approval Criteria

1 - Patient has had an objective response to therapy, defined as a 15% or greater reduction in phenylalanine (Phe) blood levels from baseline

AND

2 - Used in conjunction with a phenylalanine (Phe)-restricted diet

AND

3 - Patient will continue to have blood Phe levels measured periodically during therapy

2 . Revision History

Date	Notes
12/17/2025	Added step through generic sapropterin.

Prior Authorization Guideline

Guideline ID	GL-99495
Guideline Name	Serevent Diskus - Arizona
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Serevent Diskus	
Diagnosis	Asthma
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of asthma

AND

2 - Patient is 4 years of age or older

AND

3 - Patient is also receiving treatment with an inhaled corticosteroid

Product Name:Serevent Diskus	
Diagnosis	Exercise-Induced Bronchospasm
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of exercise-induced bronchospasm (EIB)

AND

2 - Being used for prevention

AND

3 - Patient is 4 years of age or older

Product Name:Serevent Diskus	
Diagnosis	Bronchospasm associated with chronic obstructive pulmonary disease (COPD)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of bronchospasm associated with chronic obstructive pulmonary disease (COPD)

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-589207
Guideline Name	SGLT-2 Inhibitors - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Brand Farxiga, generic dapagliflozin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

- Patient is 10 years of age or older
- Diagnosis of type 2 diabetes mellitus

- History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin

OR

1.2 One of the following:

- Diagnosis of chronic kidney disease (CKD)
- Diagnosis of heart failure (NYHA class II-IV) with reduced ejection fraction
- Diagnosis of heart failure (NYHA class II-IV) with preserved ejection fraction

AND

2 - For generic dapagliflozin requests ONLY: History of failure, intolerance, or contraindication to Brand Farxiga

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:Jardiance	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

- Patient is 10 years of age or older
- Diagnosis of type 2 diabetes mellitus
- History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin.

OR

1.2 Both of the following:

- Requested medication is being used to reduce the risk of cardiovascular death in adults with type 2 diabetes mellitus and established cardiovascular disease
- History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin.

OR

1.3 Requested medication is being used for one of the following:

- To reduce the risk of cardiovascular death and hospitalization for heart failure in adults with heart failure
- To reduce the risk of sustained decline in eGFR, end-stage kidney disease, cardiovascular death, and hospitalization in adults with chronic kidney disease at risk of progression.

Product Name:Synjardy, Synjardy XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

- Patient is 10 years of age or older
- Diagnosis of type 2 diabetes mellitus
- History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin

AND

2 - For Synjardy XR requests ONLY; History of failure, intolerance, or contraindication to ALL of the following:

- Brand Farxiga
- Jardiance

Product Name:Inovkana, Invokamet, Invokamet XR, Segluromet, Steglatro, Trijardy XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

- Diagnosis of type 2 diabetes mellitus
- History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin

AND

2 - History of failure, intolerance, or contraindication to ALL of the following:

- Brand Farxiga
- Jardiance

AND

3 - Patient is 10 years of age or older (applies to Invokana, Invokamet, Invokamet XR ONLY)

Product Name:Brand Xigduo XR, generic dapagliflozin-metformin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

- Patient is 10 years of age or older
- Diagnosis of type 2 diabetes mellitus

- History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin.

OR

1.2 One of the following:

- Diagnosis of chronic kidney disease (CKD)
- Diagnosis of heart failure (NYHA class II-IV) with reduced ejection fraction

AND

2 - For generic dapagliflozin-metformin requests ONLY: History of failure, intolerance, or contraindication to Brand Xigduo XR

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:Brand Bexagliflozin, Brenzavvy, Glyxambi, Qtern, Brand Dapagliflozin-Saxagliptin, Steglujan	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

- Diagnosis of type 2 diabetes mellitus
- History of failure to metformin at a minimum dose of 1500mg daily for 90 days, or contraindication or intolerance to metformin

AND

2 - History and failure, intolerance, or contraindication to ALL of the following:

- Janumet or Janumet XR
- Januvia

- Jentadueto
- Onglyza
- Tradjenta
- Trijardy XR

AND

3 - History of failure, intolerance, or contraindication to ALL of the following:

- Brand Farxiga
- Jardiance

Product Name:Inpefa	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Requested medication is being used to reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit in adults with one of the following:

- heart failure
- type 2 diabetes mellitus, chronic kidney disease, and other cardiovascular risk factors

AND

2 - History of failure, intolerance, or contraindication to Brand Farxiga

2 . Revision History

Date	Notes
4/30/2026	Added GPIs for generic dapaglifozin, dap/metformin and dapaglifozin -saxagliptin (Qtern) as NP targets. Added messaging for PA team for B over G approvals.

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-441190
Guideline Name	Shingrix (zoster vaccine recombinant, adjuvanted)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/5/2025

1 . Criteria

Product Name:Shingrix*	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Vaccine is being used for prevention of herpes zoster (shingles)

AND

2 - Both of the following:

2.1 Patient is between 18 to 49 years of age **AND** **2.2** Patient is or will be at increased risk of herpes zoster due to immunodeficiency or immunosuppression caused by known disease or therapy	
Notes	*Prior authorization is not required for patients 50 years of age and old er. PA TEAM NOTE: If PA is approved, please flip Medicaid Flag to Y an d flip all of the following flags to 'Y' in order for claim to pay: GPI List, GPI Period Fills, GPI Contingent Therapy, GPI Diagnosis List.

2 . Revision History

Date	Notes
11/5/2025	Updated notes for PA team, no change to clinical intent

Prior Authorization Guideline

Guideline ID	GL-709190
Guideline Name	Short-Acting Opioid Products - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

Note:

**PLEASE NOTE: This guideline contains criteria for multiple DUR rejection codes. PA Reviewers: Please confirm the correct criteria is being utilized for reviews based on Diagnosis and Guideline Type. Criteria for MME EXCEEDED rejections can be found towards the end of the guideline.

1 . Criteria

Product Name:PREFERRED: APAP-codeine tablets/soln, generic hydromorphone tablets, Hydrocodone-APAP soln, hydrocodone-APAP tablets, hydromorphone tablets, morphine sulfate IR tablets, Brand Oxaydo, oxycodone IR tablets/soln, Endocet, Oxycodone-APAP tablets, Brand Oxycodone-APAP 5mg-325mg soln, tramadol 50mg tablets, generic tramadol-APAP; NON-PREFERRED: Brand Apadaz, generic belladonna alkaloids-opium, Ascomp-codeine, generic butalbital-APAP-caff-codeine, generic butalbital-ASA-caff-codeine, Brand benzhydrocodone-APAP, butorphanol nasal spray, Brand APAP-caffeine-dihyrocodeine caps, codeine, Brand Dilaudid tablets/liquid, hydromorphone liquid/supp, Brand Fioricet-codeine, Hydrocodone-APAP 10mg-300mg soln, hydrocodone-IBP tablets, levorphanol, meperidine tablets/oral soln, morphine sulfate oral solution/supp, generic tapentadol, opium tincture,

oxycodone IR capsules, oxycodone 100mg/5ml conc, Brand Nalocet, Brand Prolate, Brand oxycodone-APAP oral son, Brand oxycodone abuse-deterrent IR tablets, Brand Oxycodone-APAP 10mg-300mg soln, oxymorphone tablets, generic pentazocine-naloxone, Brand Percocet, Brand Prolate oral soln, Qdolo, Brand Roxicodone, Brand Roxybond, Selgentis, Synapryn, Brand Tramadol oral soln, tramadol 25mg, 75mg, and 100mg tablets, Brand Trezix, Brand Tylenol/Codeine #4, Xyvona	
Diagnosis	PA REQUIRED for use of MAT and other Opioids (Reject 88)
Approval Length	*14 Days for surgical procedure, 5 Days for all other requests
Guideline Type	DUR

Approval Criteria

1 - Provider attests to notify the prescriber of the MAT therapy and the prescriber of the MAT therapy approves the concurrent opioid therapy.

AND

2 - The days supply does not exceed 14 days for a surgical procedure.

AND

3 - The days supply does not exceed 5 days for all other requests.

AND

4 - There has not been a previous approval in the last 6 months.

Notes	*Approval Length: 14 Days for surgical procedure, 5 Days for all other requests

Product Name:NON-PREFERRED: Brand Apadaz, generic belladonna alkaloids-opium, Ascomp-codeine, generic butalbital-APAP-caff-codeine, generic butalbital-ASA-caff-codeine, Brand benzhydrocodone-APAP, butorphanol nasal spray, Brand APAP-caffeine-dihyrocodeine caps, codeine, Brand Dilaudid tablets/liquid, hydromorphone liquid/supp, Brand Fioricet-codeine, Hydrocodone-APAP 10mg-300mg soln, hydrocodone-IBP tablets, levorphanol, meperidine tablets/oral soln, morphine sulfate oral solution/supp, generic tapentadol, opium tincture, oxycodone IR capsules, oxycodone 100mg/5ml conc, Brand Nalocet, Brand Prolate, Brand oxycodone-APAP oral son, Brand oxycodone abuse-deterrent

IR tablets, Brand Oxycodone-APAP 10mg-300mg soln, oxymorphone tablets, generic pentazocine-naloxone, Brand Percocet, Brand Prolate oral soln, Qdolo, Brand Roxicodone, Brand Roxybond, Selgentis, Synapryn, Brand Tramadol oral soln, tramadol 25mg, 75mg, and 100mg tablets, Brand Trezix, Brand Tylenol/Codeine #4, Xyvona	
Diagnosis	Non-Preferred Reviews*
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the request is for a non-preferred medication the patient must have a history of failure, contraindication or intolerance to a trial of at least FIVE preferred short -acting opioids:

- hydromorphone tablets (generic Dilaudid)
- morphine sulfate IR
- oxycodone IR
- tramadol 50mg tablets or tramadol-APAP tablets
- oxycodone w/ acetaminophen (generic Percocet)
- acetaminophen w/ codeine
- hydrocodone-acetaminophen

Notes	*This section does NOT apply to cough and cold products.

Product Name:PREFERRED: APAP-codeine tablets/soln, generic hydromorphone tablets, Hydrocodone-APAP soln, hydrocodone-APAP tablets, hydromorphone tablets, morphine sulfate IR tablets, Brand Oxaydo, oxycodone IR tablets/soln, Endocet, Oxycodone-APAP tablets, Brand Oxycodone-APAP 5mg-325mg soln, tramadol 50mg tablets, generic tramadol-APAP; NON-PREFERRED: Brand Apadaz, generic belladonna alkaloids-opium, Ascomp-codeine, generic butalbital-APAP-caff-codeine, generic butalbital-ASA-caff-codeine, Brand benzhydrocodone-APAP, butorphanol nasal spray, Brand APAP-caffeine-dihyrocodeine caps, codeine, Brand Dilaudid tablets/liquid, hydromorphone liquid/supp, Brand Fioricet-codeine, Hydrocodone-APAP 10mg-300mg soln, hydrocodone-IBP tablets, levorphanol, meperidine tablets/oral soln, morphine sulfate oral solution/supp, generic tapentadol, opium tincture, oxycodone IR capsules, oxycodone 100mg/5ml conc, Brand Nalocet, Brand Prolate, Brand oxycodone-APAP oral son, Brand oxycodone abuse-deterrent IR tablets, Brand Oxycodone-APAP 10mg-300mg soln, oxymorphone tablets, generic pentazocine-naloxone, Brand Percocet, Brand Prolate oral soln, Qdolo, Brand Roxicodone, Brand Roxybond, Selgentis, Synapryn, Brand Tramadol oral soln, tramadol 25mg, 75mg, and 100mg tablets, Brand Trezix, Brand Tylenol/Codeine #4, Xyvona	
Diagnosis	PA Required for > 2 Short Acting Opioids*
Approval Length	**Authorization will be issued for the requested duration, not to exceed 12 months.

Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 The requested medication is being used to adjust the dose of the previously prescribed drug

OR

1.2 The requested medication will be used in place of the previously prescribed drug, and not in addition to it

OR

1.3 The requested medication dosage form will be used in place of the previously prescribed medication dosage form, and not in addition to it

OR

1.4 The physician attests they are aware of the multiple short-acting opioids prescribed to the patient and feels treatment with all medications is medically necessary (Document rationale for use)

Notes	*This section does NOT apply to cough and cold products. ** Authorization will be issued for the requested duration, not to exceed 12 months.

Product Name:PREFERRED: APAP-codeine tablets/soln, generic hydromorphone tablets, Hydrocodone-APAP soln, hydrocodone-APAP tablets, hydromorphone tablets, morphine sulfate IR tablets, Brand Oxaydo, oxycodone IR tablets/soln, Endocet, Oxycodone-APAP tablets, Brand Oxycodone-APAP 5mg-325mg soln, tramadol 50mg tablets, generic tramadol-APAP; NON-PREFERRED: Brand Apadaz, generic belladonna alkaloids-opium, Ascomp-codeine, generic butalbital-APAP-caff-codeine, generic butalbital-ASA-caff-codeine, Brand benzhydrocodone-APAP, butorphanol nasal spray, Brand APAP-caffeine-dihyrocodeine caps, codeine, Brand Dilaudid tablets/liquid, hydromorphone liquid/supp, Brand Fioricet-codeine, Hydrocodone-APAP 10mg-300mg soln, hydrocodone-IBP tablets, levorphanol, meperidine tablets/oral soln, morphine sulfate oral solution/supp, generic tapentadol, opium tincture, oxycodone IR capsules, oxycodone 100mg/5ml conc, Brand Nalocet, Brand Prolate, Brand

oxycodone-APAP oral son, Brand oxycodone abuse-deterrent IR tablets, Brand Oxycodone-APAP 10mg-300mg soln, oxymorphone tablets, generic pentazocine-naloxone, Brand Percocet, Brand Prolate oral soln, Qdolo, Brand Roxicodone, Brand Roxybond, Selgentis, Synapryn, Brand Tramadol oral soln, tramadol 25mg, 75mg, and 100mg tablets, Brand Trezix, Brand Tylenol/Codeine #4, Xyvona	
Diagnosis	Quantity Limit*
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria **1** - The requested dose cannot be achieved by moving to a higher strength of the product **AND** **2** - The requested dose is within FDA (Food and Drug Administration) approved maximum dose per day, where an FDA maximum dose per day exists (See table in background section)	
Notes	*This section does NOT apply to cough and cold products.

Product Name:PREFERRED: APAP-codeine tablets/soln, generic hydromorphone tablets, Hydrocodone-APAP soln, hydrocodone-APAP tablets, hydromorphone tablets, morphine sulfate IR tablets, Brand Oxaydo, oxycodone IR tablets/soln, Endocet, Oxycodone-APAP tablets, Brand Oxycodone-APAP 5mg-325mg soln, tramadol 50mg tablets, generic tramadol-APAP; NON-PREFERRED: Brand Apadaz, generic belladonna alkaloids-opium, Ascomp-codeine, generic butalbital-APAP-caff-codeine, generic butalbital-ASA-caff-codeine, Brand benzhydrocodone-APAP, butorphanol nasal spray, Brand APAP-caffeine-dihyrocodeine caps, codeine, Brand Dilaudid tablets/liquid, hydromorphone liquid/supp, Brand Fioricet-codeine, Hydrocodone-APAP 10mg-300mg soln, hydrocodone-IBP tablets, levorphanol, meperidine tablets/oral soln, morphine sulfate oral solution/supp, generic tapentadol, opium tincture, oxycodone IR capsules, oxycodone 100mg/5ml conc, Brand Nalocet, Brand Prolate, Brand oxycodone-APAP oral son, Brand oxycodone abuse-deterrent IR tablets, Brand Oxycodone-APAP 10mg-300mg soln, oxymorphone tablets, generic pentazocine-naloxone, Brand Percocet, Brand Prolate oral soln, Qdolo, Brand Roxicodone, Brand Roxybond, Selgentis, Synapryn, Brand Tramadol oral soln, tramadol 25mg, 75mg, and 100mg tablets, Brand Trezix, Brand Tylenol/Codeine #4, Xyvona	
Diagnosis	Greater than 5 day supply requests for patients 18 years of age and older**
Approval Length	**Approvals are for 6 months for all of the above with the exception of post-surgical procedures which can be approved for a 14 day supply.

	Adults may obtain additional fills without PA if the refill is requested within 60 days from the initial fill.
Guideline Type	Quantity Limit

Approval Criteria

1 - ONE of the following conditions or care instances:

- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Skilled nursing facility care
- Traumatic injury, excluding post-surgical procedures
- Chronic conditions for which the provider has received PA approval
- Post-surgical procedures

Notes	**Approvals are for 6 months for all of the above with the exception of post-surgical procedures which can be approved for a 14 day supply. Adults may obtain additional fills without PA if the refill is requested wit hin 60 days from the initial fill.

Product Name:PREFERRED: APAP-codeine tablets/soln, generic hydromorphone tablets, Hydrocodone-APAP soln, hydrocodone-APAP tablets, hydromorphone tablets, morphine sulfate IR tablets, Brand Oxaydo, oxycodone IR tablets/soln, Endocet, Oxycodone-APAP tablets, Brand Oxycodone-APAP 5mg-325mg soln, tramadol 50mg tablets, generic tramadol-APAP; NON-PREFERRED: Brand Apadaz, generic belladonna alkaloids-opium, Ascomp-codeine, generic butalbital-APAP-caff-codeine, generic butalbital-ASA-caff-codeine, Brand benzhydrocodone-APAP, butorphanol nasal spray, Brand APAP-caffeine-dihyrocodeine caps, codeine, Brand Dilaudid tablets/liquid, hydromorphone liquid/supp, Brand Fioricet-codeine, Hydrocodone-APAP 10mg-300mg soln, hydrocodone-IBP tablets, levorphanol, meperidine tablets/oral soln, morphine sulfate oral solution/supp, generic tapentadol, opium tincture, oxycodone IR capsules, oxycodone 100mg/5ml conc, Brand Nalocet, Brand Prolate, Brand oxycodone-APAP oral son, Brand oxycodone abuse-deterrent IR tablets, Brand Oxycodone-APAP 10mg-300mg soln, oxymorphone tablets, generic pentazocine-naloxone, Brand Percocet, Brand Prolate oral soln, Qdolo, Brand Roxicodone, Brand Roxybond, Selgentis, Synapryn, Brand Tramadol oral soln, tramadol 25mg, 75mg, and 100mg tablets, Brand Trezix, Brand Tylenol/Codeine #4, Xyvona	
Diagnosis	Greater than 5 day supply requests for patients under 18 years of age*
Guideline Type	Quantity Limit

Approval Criteria

1 - ONE of the following conditions or care instances:

- Active oncology diagnosis
- Hospice care
- End-of-life care (other than hospice)
- Palliative care
- Children on opioid wean at time of hospital discharge
- Skilled nursing facility care
- Traumatic injury, excluding post-surgical procedures
- Chronic conditions for which the provider has received PA approval
- Post-surgical procedures

Notes	*Approvals are for 6 months for all of the above with the exception of post-surgical procedures which can be approved for a 14 day supply. Children and adolescents may obtain additional fills without PA for 5 d ays supply unless the submitted PA supports a longer duration for use .

Product Name:PREFERRED: APAP-codeine tablets/soln, generic hydromorphone tablets, Hydrocodone-APAP soln, hydrocodone-APAP tablets, hydromorphone tablets, morphine sulfate IR tablets, Brand Oxaydo, oxycodone IR tablets/soln, Endocet, Oxycodone-APAP tablets, Brand Oxycodone-APAP 5mg-325mg soln, tramadol 50mg tablets, generic tramadol-APAP; NON-PREFERRED: Brand Apadaz, generic belladonna alkaloids-opium, Ascomp-codeine, generic butalbital-APAP-caff-codeine, generic butalbital-ASA-caff-codeine, Brand benzhydrocodone-APAP, butorphanol nasal spray, Brand APAP-caffeine-dihyrocodeine caps, codeine, Brand Dilaudid tablets/liquid, hydromorphone liquid/supp, Brand Fioricet-codeine, Hydrocodone-APAP 10mg-300mg soln, hydrocodone-IBP tablets, levorphanol, meperidine tablets/oral soln, morphine sulfate oral solution/supp, generic tapentadol, opium tincture, oxycodone IR capsules, oxycodone 100mg/5ml conc, Brand Nalocet, Brand Prolate, Brand oxycodone-APAP oral son, Brand oxycodone abuse-deterrent IR tablets, Brand Oxycodone-APAP 10mg-300mg soln, oxymorphone tablets, generic pentazocine-naloxone, Brand Percocet, Brand Prolate oral soln, Qdolo, Brand Roxicodone, Brand Roxybond, Selgentis, Synapryn, Brand Tramadol oral soln, tramadol 25mg, 75mg, and 100mg tablets, Brand Trezix, Brand Tylenol/Codeine #4, Xyvona	
Diagnosis	Opioid Naïve (Not having filled an opioid in the past 120 days)*
Guideline Type	Morphine Milligram Equivalents (MME)** MME 50.00 exceeded; PA Required for dosage above 50 MEDD

Approval Criteria

1 - Opioid naïve members may receive greater than 50 morphine milligram equivalent (MME) based on the following:

1.1 If the request is for 50 MME to 90 MME, ONE of the following (NOTE: If the request exceeds 90 MME please skip this section and proceed to the Exceeding the 90 MME Cumulative Threshold Reviews section):

1.1.1 Diagnosis of ONE of the following:

- Cancer
- End of life pain (including hospice care)
- Palliative care
- Sickle cell anemia

OR

1.1.2 Patient is currently exceeding 50 MME and prescriber attests patient has been on a short-acting opioid in the past 120 days

OR

1.1.3 Document ALL of the following:

- The diagnosis associated with the need for pain management with opioid
- If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression
- The prescriber has acknowledged that they have completed an addiction risk and risk of overdose assessment
- Prescriber attests the member requires more than 50 MME per day to adequately control pain

Notes	*This section does NOT apply to cough and cold products. **Approval length for cancer, end of life, palliative care, or sickle cell pain will be i ssued for 12 months. All other approvals will be issued for one month.

Product Name:PREFERRED: APAP-codeine tablets/soln, generic hydromorphone tablets, Hydrocodone-APAP soln, hydrocodone-APAP tablets, hydromorphone tablets, morphine sulfate IR tablets, Brand Oxaydo, oxycodone IR tablets/soln, Endocet, Oxycodone-APAP tablets, Brand Oxycodone-APAP 5mg-325mg soln, tramadol 50mg tablets, generic tramadol-APAP; NON-PREFERRED: Brand Apadaz, generic belladonna alkaloids-opium, Ascomp-

codeine, generic butalbital-APAP-caff-codeine, generic butalbital-ASA-caff-codeine, Brand benzhydrocodone-APAP, butorphanol nasal spray, Brand APAP-caffeine-dihyrocodeine caps, codeine, Brand Dilaudid tablets/liquid, hydromorphone liquid/supp, Brand Fioricet-codeine, Hydrocodone-APAP 10mg-300mg soln, hydrocodone-IBP tablets, levorphanol, meperidine tablets/oral soln, morphine sulfate oral solution/supp, generic tapentadol, opium tincture, oxycodone IR capsules, oxycodone 100mg/5ml conc, Brand Nalocet, Brand Prolate, Brand oxycodone-APAP oral son, Brand oxycodone abuse-deterrent IR tablets, Brand Oxycodone-APAP 10mg-300mg soln, oxymorphone tablets, generic pentazocine-naloxone, Brand Percocet, Brand Prolate oral soln, Qdolo, Brand Roxicodone, Brand Roxybond, Selgentis, Synapryn, Brand Tramadol oral soln, tramadol 25mg, 75mg, and 100mg tablets, Brand Trezix, Brand Tylenol/Codeine #4, Xyvona	
Diagnosis	Cancer/Hospice/End of Life/ Palliative Care/Skilled Nursing Facility/Traumatic Injury Related Pain Exceeding the 90 MME Cumulative Threshold*
Approval Length	12 Months**
Guideline Type	Morphine Milligram Equivalents (MME) Reviews** (MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit)

Approval Criteria

1 - ONE of the following conditions:

- Active oncology diagnosis
- Hospice
- End-of-life care (other than hospice)
- Palliative care
- Skilled nursing facility care
- Traumatic injury, including burns and excluding post-surgical procedures

Notes	*This section does NOT apply to cough and cold products. ** The authorization should be entered for an MME of 9999 so as to prevent future disruptions in therapy if the patient's dose is increased.

Product Name:PREFERRED: APAP-codeine tablets/soln, generic hydromorphone tablets, Hydrocodone-APAP soln, hydrocodone-APAP tablets, hydromorphone tablets, morphine sulfate IR tablets, Brand Oxaydo, oxycodone IR tablets/soln, Endocet, Oxycodone-APAP tablets, Brand Oxycodone-APAP 5mg-325mg soln, tramadol 50mg tablets, generic tramadol-APAP; NON-PREFERRED: Brand Apadaz, generic belladonna alkaloids-opium, Ascomp-codeine, generic butalbital-APAP-caff-codeine, generic butalbital-ASA-caff-codeine, Brand benzhydrocodone-APAP, butorphanol nasal spray, Brand APAP-caffeine-dihyrocodeine caps, codeine, Brand Dilaudid tablets/liquid, hydromorphone liquid/supp, Brand Fioricet-codeine, Hydrocodone-APAP 10mg-300mg soln, hydrocodone-IBP tablets, levorphanol, meperidine tablets/oral soln, morphine sulfate oral solution/supp, generic tapentadol, opium tincture,

oxycodone IR capsules, oxycodone 100mg/5ml conc, Brand Nalocet, Brand Prolate, Brand oxycodone-APAP oral son, Brand oxycodone abuse-deterrent IR tablets, Brand Oxycodone-APAP 10mg-300mg soln, oxymorphone tablets, generic pentazocine-naloxone, Brand Percocet, Brand Prolate oral soln, Qdolo, Brand Roxicodone, Brand Roxybond, Selgentis, Synapryn, Brand Tramadol oral soln, tramadol 25mg, 75mg, and 100mg tablets, Brand Trezix, Brand Tylenol/Codeine #4, Xyvona	
Diagnosis	Non-cancer/non-hospice/non-end of life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain Exceeding the 90 MME Cumulative Threshold*
Approval Length	** Authorization will be issued for 6 months for non-cancer/non-hospice/non-end- of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain related pain up to the current requested MME plus 90 MME. ***If the member has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested MME dose.
Therapy Stage	Initial Authorization
Guideline Type	Morphine Milligram Equivalents (MME) Reviews** (MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit)

Approval Criteria

1 - Prescriber attests to ALL of the following:

- The information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided
- Treatment goals are defined, including estimated duration of treatment
- Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
- Patient has been screened for substance abuse/opioid dependence
- If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression

AND

2 - BOTH of the following:

- Patient has tried and failed non-opioid pain medication (document drug name and date of trial)

• Opioid medication doses of less than 90 morphine milligram equivalent (MME) have been tried and did not adequately control pain (document drug regimen or MME and dates of therapy)***	
Notes	*This section does NOT apply to cough and cold products. ** Authorization will be issued for 6 months for non-cancer/non-hospice/non-end-of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain related pain up to the current requested MME plus 90 MME. ***If the member has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested MME dose.

Product Name:PREFERRED: APAP-codeine tablets/soln, generic hydromorphone tablets, Hydrocodone-APAP soln, hydrocodone-APAP tablets, hydromorphone tablets, morphine sulfate IR tablets, Brand Oxaydo, oxycodone IR tablets/soln, Endocet, Oxycodone-APAP tablets, Brand Oxycodone-APAP 5mg-325mg soln, tramadol 50mg tablets, generic tramadol-APAP; NON-PREFERRED: Brand Apadaz, generic belladonna alkaloids-opium, Ascomp-codeine, generic butalbital-APAP-caff-codeine, generic butalbital-ASA-caff-codeine, Brand benzhydrocodone-APAP, butorphanol nasal spray, Brand APAP-caffeine-dihyrocodeine caps, codeine, Brand Dilaudid tablets/liquid, hydromorphone liquid/supp, Brand Fioricet-codeine, Hydrocodone-APAP 10mg-300mg soln, hydrocodone-IBP tablets, levorphanol, meperidine tablets/oral soln, morphine sulfate oral solution/supp, generic tapentadol, opium tincture, oxycodone IR capsules, oxycodone 100mg/5ml conc, Brand Nalocet, Brand Prolate, Brand oxycodone-APAP oral son, Brand oxycodone abuse-deterrent IR tablets, Brand Oxycodone-APAP 10mg-300mg soln, oxymorphone tablets, generic pentazocine-naloxone, Brand Percocet, Brand Prolate oral soln, Qdolo, Brand Roxicodone, Brand Roxybond, Selgentis, Synapryn, Brand Tramadol oral soln, tramadol 25mg, 75mg, and 100mg tablets, Brand Trezix, Brand Tylenol/Codeine #4, Xyvona	
Diagnosis	Non-cancer/non-hospice/non-end of life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain Exceeding the 90 MME Cumulative Threshold*
Approval Length	** Authorization will be issued for 6 months for non-cancer/non-hospice/non-end- of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain related pain up to the current requested MME plus 90 MME. *** If the member has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 30-day authorization may be authorized one time for the requested MME dose.
Therapy Stage	Reauthorization
Guideline Type	Morphine Milligram Equivalents (MME) Reviews** (MME 90.00 exceeded; PA REQUIRED; Dosage Above MEDD Limit)

Approval Criteria

1 - Prescriber attests to ALL of the following:

- The information provided is true and accurate to the best of their knowledge and they understand that OptumRx may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided
- Treatment goals are defined, including estimated duration of treatment
- Treatment plan includes the use of a non-opioid analgesic and/or non-pharmacologic intervention
- Patient has been screened for substance abuse/opioid dependence
- If used in patients with medical comorbidities or if used concurrently with a benzodiazepine or other drugs that could potentially cause drug-drug interactions, the prescriber has acknowledged that they have completed an assessment of increased risk for respiratory depression

AND

2 - Identify rationale for not tapering and discontinuing opioid (Document rationale)

AND

3 - Patient demonstrates meaningful improvement in pain and function (Document improvement in function or pain score improvement)***

Notes	*This section does NOT apply to cough and cold products. ** Authorization will be issued for 6 months for non-cancer/non-hospice/non-end-of-life/non-palliative care/non-skilled nursing facility/non-traumatic injury related pain related pain up to the current requested MME plus 90 MME. *** If the member has been established on the requested MME dose for at least 30 days and does not meet the medical necessity authorization criteria requirements, a denial should be issued and a maximum 30 day authorization may be authorized one time for the requested MME dose.

2 . Background

Benefit/Coverage/Program Information

CDC Recommended Opioid Maximum Morphine Milligram Equivalents per Day*

Active Ingredient	FDA Label Max Daily Doses
Morphine	None
Hydromorphone	None
Hydrocodone	None
Tapentadol	600mg IR products
Oxymorphone	None
Oxycodone	None
Codeine	360mg
Pentazocine	None
Tramadol	400mg IR products
Meperidine	600mg
Butorphanol nasal	None
Opium	4 suppositories/day Deodorized tincture: 24mg/day Camphorated tincture: 16mg/day
Acetaminophen	4g/day
Aspirin	2080mg/day
Ibuprofen	3200mg/day
Benzhydrocodone**	None
Levorphanol	None

*Doses are not considered equianalgesic and table does not represent a dose conversion chart.

**Morphine Milligram Equivalents is derived from the package insert.

3 . Revision History

Date	Notes
8/26/2026	Added tapentadol solution as NPD

Prior Authorization Guideline

Guideline ID	GL-99643
Guideline Name	Signifor
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - Both of the following:

1.1 Diagnosis of endogenous Cushing's disease (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)

AND

1.2 One of the following:

- Pituitary surgery has not been curative for the patient
- Patient is not a candidate for pituitary surgery

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

Approval Criteria

1 - Documentation of positive clinical response to Signifor therapy

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-450246
Guideline Name	Simponi, Simponi Aria (golimumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Simponi or Simponi Aria	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting all of the following:

1.1 Diagnosis of moderately to severely active rheumatoid arthritis (RA)

AND

1.2 One of the following:

1.2.1 Patient is receiving concurrent therapy with methotrexate (e.g., Rheumatrex, Trexall)

OR

1.2.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Infliximab (Janssen manufacturer)
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred tocilizumab biosimilar

AND

1.4 For Simponi Aria Requests: Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to self-administered Simponi (APPLIES TO REQUESTS FOR SIMPONI ARIA ONLY)

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Simponi or Simponi Aria	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting all of the following:

1.1 Diagnosis of active ankylosing spondylitis (AS)

AND

1.2 History of failure to two NSAIDs (non-steroidal anti-inflammatory drugs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Infliximab (Janssen manufacturer)
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

1.4 For Simponi Aria Requests: Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to self-administered Simponi (APPLIES TO REQUESTS FOR SIMPONI ARIA ONLY)

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Simponi or Simponi Aria	
Diagnosis	Rheumatoid Arthritis (RA), Ankylosing Spondylitis (AS)

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Simponi or Simponi Aria	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting all of the following:

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Infliximab (Janssen manufacturer)
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

AND

1.4 For Simponi Aria Requests: Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to self-administered Simponi (APPLIES TO REQUESTS FOR SIMPONI ARIA ONLY)

AND

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

- Rheumatologist
- Dermatologist

Product Name:Simponi or Simponi Aria	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating positive clinical response to therapy

AND

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

- Rheumatologist
- Dermatologist

Product Name:Simponi	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting all of the following:

1.1 Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

1.2 Patient weighs at least 15 kg

AND

1.3 One of the following:

1.3.1 Patient is corticosteroid dependent (i.e., an inability to successfully taper corticosteroids without a return of the symptoms of UC)

OR

1.3.2 History of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Aminosalicylates (e.g., mesalamine, sulfasalazine)

AND

1.4 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- Infliximab (Janssen manufacturer)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a gastroenterologist

Product Name:Simponi	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a gastroenterologist

Product Name:Simponi Aria

Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of active polyarticular juvenile idiopathic arthritis (PJIA)

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming a minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:

- methotrexate
- leflunomide

AND

3 - Submission of medical records (e.g., chart notes) documenting a history of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Orencia (abatacept)
- Xeljanz (tofacitinib) oral tablet
- A preferred tocilizumab biosimilar

AND

4 - Prescribed by or in consultation with a rheumatologist

Product Name:Simponi Aria	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating positive clinical response to therapy as evidenced by at least one of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline

AND

2 - Prescribed by or in consultation with a rheumatologist

2 . Revision History

Date	Notes
12/17/2025	Moved specialist prescriber requirement to its own criterion for RA, A S, PsA.

Prior Authorization Guideline

Guideline ID	GL-242220
Guideline Name	Sivextro (tedizolid)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Sivextro tablets	
Diagnosis	Skin and Skin Structure Infections
Approval Length	6 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication.

OR

1.3 ALL of the following:

1.3.1 Diagnosis of acute bacterial skin and skin structure infection (including diabetic foot infections)

AND

1.3.2 BOTH of the following:

- Patient is at least 26 weeks gestational age
- Patient weighs at least 1 kg

AND

1.3.3 ONE of the following diagnoses:

1.3.3.1 BOTH of the following:

- Acute bacterial skin and skin structure infections
- Infection caused by methicillin-resistant Staphylococcus aureus (MRSA) documented by culture and sensitivity report

OR

1.3.3.2 BOTH of the following:

- Empirical treatment of patients with acute bacterial skin and skin structure infections
- Presence of MRSA infection is likely

AND

1.3.4 History of failure, contraindication, or intolerance to linezolid (generic Zyvox)

AND

1.3.5 History of failure, contraindication, or intolerance to ONE of the following antibiotics:

- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A tetracycline
- Clindamycin

OR

1.4 ALL of the following:

1.4.1 Diagnosis of acute bacterial skin and skin structure infection(including diabetic foot infections)

AND

1.4.2 BOTH of the following:

- Patient is at least 26 weeks gestational age
- Patient weighs at least 1 kg

AND

1.4.3 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Sivextro

AND

1.4.4 History of failure, contraindication, or intolerance to linezolid (generic Zyvox)

AND

1.4.5 History of failure, contraindication, or intolerance to TWO of the following antibiotics:

- Dicloxacillin
- A cephalosporin
- A tetracycline
- Amoxicillin/clavulanate
- Clindamycin
- Sulfamethoxazole-trimethoprim (SMX-TMP)
- A fluoroquinolone

Product Name:Sivextro tablets	
Diagnosis	Off-Label Uses
Approval Length	60 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 BOTH of the following:

1.3.1 The medication is being prescribed by or in consultation with an infectious disease specialist

AND

1.3.2 History of failure, contraindication, or intolerance to linezolid (generic Zyvox), if culture and susceptibility confirm susceptibility.

2 . Revision History

Date	Notes
4/24/2025	Added age/weight criterion where applicable due to expanded indication.

Prior Authorization Guideline

Guideline ID	GL-143858
Guideline Name	Skyclarys (omaveloxolone)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2024

1 . Criteria

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

Approval Criteria

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

- Diagnosis of Friedreich's ataxia
- Confirmed presence of a mutation in the frataxin (FXN) gene

AND

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

- Neurologist
- Neurogeneticist
- Physiatrist (Physical Medicine and Rehabilitation Specialist)

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., slowed disease progression, improvement in or stabilization of speech or swallowing, upper/lower limb coordination, upright stability)

AND

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

- Neurologist
- Neurogeneticist
- Physiatrist (Physical Medicine and Rehabilitation Specialist)

2 . Revision History

Date	Notes
3/19/2024	Updated criteria to remove mFARS scoring. Added examples of posit ive response to tx in reauth.

Prior Authorization Guideline

Guideline ID	GL-683404
Guideline Name	Skyrizi (risankizumab-rzaa)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/5/2026

1 . Criteria

Product Name:Skyrizi SC 55mg*, Skyrizi SC 150 mg*	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of moderate to severe plaque psoriasis (PsO)

AND

1.2 Greater than or equal to 3 percent body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.3 Minimum duration of a 4-week trial and failure, contraindication, or intolerance to one of the following topical therapies:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to one of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Otezla (apremilast)
- A preferred ustekinumab biosimilar

AND

2 - Patient is 6 years of age or older

AND

3 - Prescribed by or in consultation with a dermatologist

Notes	*If patient meets criteria above, please approve at GPI-14*

Product Name:Skyrizi SC 55mg*, Skyrizi SC 150 mg*	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a dermatologist

Notes	*If patient meets criteria above, please approve at GPI-14*

Product Name:Skyrizi SC 55mg*, Skyrizi SC 150 mg*	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Otezla (apremilast)
- Brand Xeljanz/Brand Xeljanz XR
- A preferred ustekinumab biosimilar

AND

2 - Patient is 6 years of age or older

AND

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

- Dermatologist
- Rheumatologist

Notes	*If patient meets criteria above, please approve at GPI-14*

Product Name:Skyrizi SC 55mg*, Skyrizi SC 150 mg*	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

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

- Dermatologist
- Rheumatologist

Notes	*If patient meets criteria above, please approve at GPI-14*

Product Name:Skyrizi IV	
Diagnosis	Crohn's Disease (CD)
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of moderately to severely active Crohn's disease (CD)

AND

1.2 Trial and failure, contraindication, or intolerance to one of the following conventional therapies

- 6-mercaptopurine
- Azathioprine
- Methotrexate
- Corticosteroid (e.g., prednisone)

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- A preferred ustekinumab biosimilar

AND

2 - Will be administered as an intravenous induction dose

AND

3 - Prescribed by or in consultation with a gastroenterologist

Product Name:Skyrizi SC 180mg*, Skyrizi SC 360 mg*	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following

1.1 Diagnosis of moderately to severely active Crohn's disease (CD)

AND

1.2 History of failure, contraindication, or intolerance to one of the of the following conventional therapies:

- 6-mercaptopurine
- Azathioprine
- Methotrexate
- Corticosteroid (e.g., prednisone)

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- A preferred ustekinumab biosimilar

AND

2 - Will be used as a maintenance dose following the intravenous induction doses

AND

3 - Prescribed by or in consultation with a gastroenterologist

Notes	*If patient meets criteria above, please approve at GPI-14*

Product Name:Skyrizi IV	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

1.2 One of the following:

- Greater than 6 stools per day
- Frequent blood in the stools
- Frequent urgency
- Presence of ulcers
- Abnormal lab values (e.g., hemoglobin, erythrocyte sedimentation rate, C-reactive protein)
- Dependent on, or refractory to, corticosteroids

AND

1.3 Trial and failure, contraindication, or intolerance to one of the following conventional therapies

- 6-mercaptopurine
- Azathioprine
- Corticosteroid (e.g., prednisone)
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)

AND

1.4 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- Brand Xeljanz (IR or XR) tablet
- A preferred ustekinumab biosimilar

AND

2 - Will be administered as an intravenous induction dose

AND

3 - Prescribed by or in consultation with a gastroenterologist

Product Name:Skyrizi SC 180mg*, Skyrizi SC 360 mg*	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting ALL of the following

1.1 Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

1.2 History of failure, contraindication, or intolerance to one of the of the following conventional therapies:

- 6-mercaptopurine
- Azathioprine
- Corticosteroid (e.g., prednisone)
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- Brand Xeljanz (IR or XR) tablet
- A preferred ustekinumab biosimilar

AND

2 - Will be used as a maintenance dose following the intravenous induction doses

AND

3 - Prescribed by or in consultation with a gastroenterologist

Notes	*If patient meets criteria above, please approve at GPI-14*

Product Name:Skyrizi SC 180mg*, Skyrizi SC 360 mg*	
Diagnosis	Crohn's Disease (CD), Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by at least one of the following:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

AND

2 - Prescribed by or in consultation with a gastroenterologist

Notes	*If patient meets criteria above, please approve at GPI-14*

2 . Revision History

Date	Notes
8/5/2026	PsA: Updated Xeljanz in 1.3 (Brand Xeljanz/Brand Xeljanz XR).

Prior Authorization Guideline

Guideline ID	GL-427200
Guideline Name	Skysona (elivaldogene autotemcel suspension)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Skysona	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of early, active cerebral adrenoleukodystrophy (CALD)

AND

2 - Submission of medical records (e.g., chart notes) documenting molecular genetic testing confirms mutation in the ABCD1 gene

AND

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

- Patient has elevated very long chain fatty acid (VLCFA) levels
- Loes score between 0.5 and 9 (inclusive) based on brain MRI assessment [B, 4]
- Brain magnetic resonance imaging (MRI) utilizes Gadolinium enhancement (GdE +) and demonstrates demyelinating lesions [C, 5]
- Neurologic function score (NFS) less than or equal to 1

AND

4 - BOTH of the following:

- Patient is male sex
- Patient is 4 to 17 years of age

AND

5 - Patient does not have an available human leukocyte antigen (HLA)-matched donor for allogeneic hematopoietic stem cell transplant

AND

6 - Submission of medical records (e.g., chart notes) confirming patient has obtained a negative test result for all of the following prior to cell collection:

- Hepatitis B virus (HBV)
- Hepatitis C virus (HCV)
- Human T-lymphotropic virus 1 and 2 (HTLV-1/HTLV-2)
- Human immunodeficiency virus (HIV)

AND

7 - Patient does not have CALD secondary to head trauma

AND

8 - Discontinue prophylactic anti-retroviral medications (e.g., Truvada, Descovy) for at least one month prior to initiating medications for stem cell mobilization and until all cycles of apheresis are completed

AND

9 - Prescribed by a stem cell transplant physician from a qualified treatment center

AND

10 - Provider is aware of hematologic malignancy risk and attests they will complete adequate baseline hematologic assessments [e.g., complete blood count with differential, hematopathology review of peripheral blood smear, and bone marrow biopsy (core and aspirate) with flow cytometry] and monitoring as indicated in prescribing information

AND

11 - Patient has never received Skysona treatment in their lifetime

2 . Revision History

Date	Notes
10/29/2025	Updated criteria in line with latest prescribing information updates

Prior Authorization Guideline

Guideline ID	GL-163938
Guideline Name	Sodium Oxybate Products (Lumryz, Xyrem, Xywav)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2025

1 . Criteria

Product Name:Lumryz, Brand Xyrem, Generic sodium oxybate, Xywav	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g. chart notes, laboratory values) documenting a diagnosis of narcolepsy with cataplexy (i.e., Narcolepsy Type 1) with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) on a Multiple Sleep Latency Test (MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to BOTH of the following:

2.1 Patient has experienced cataplexy defined as more than one episode of sudden loss of muscle tone with retained consciousness

AND

2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications, or other sleep disorders)

AND

3 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

AND

4 - Patient is 7 years of age or older

Product Name:Lumryz, Brand Xyrem, Generic sodium oxybate, Xywav	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a reduction in frequency of cataplexy attacks associated with therapy

OR

2 - Documentation demonstrating reduction in symptoms of excessive daytime sleepiness associated with therapy

Product Name:Lumryz, Brand Xyrem, Generic sodium oxybate, Xywav	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g. chart notes, lab values) documenting a diagnosis of narcolepsy without cataplexy (i.e., Narcolepsy Type 2) with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a Multiple Sleep Latency Test

(MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT

AND

2 - Physician attestation to BOTH of the following:

2.1 Cataplexy is absent

AND

2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - History of failure, contraindication, or intolerance of ALL of the following (MUST be verified via paid pharmacy claims or submission of medical records):

3.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.2 Armodafanil (Nuvigil)

AND

3.3 Sunosi (solriamfetol)

AND

4 - Prescribed by ONE of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

AND

5 - Patient is 7 years of age or older

Product Name:Lumryz, Brand Xyrem, Generic sodium oxybate, Xywav	
Diagnosis	Narcolepsy without Cataplexy (i.e., Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting reduction in symptoms of excessive daytime sleepiness associated with therapy

Product Name:Xywav	
Diagnosis	Idiopathic Hypersomnia (IH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of idiopathic hypersomnia (IH) confirmed by ALL of the following:

1.1 Patient has experienced daily periods of irrepressible need for sleep or daytime lapses into sleep (i.e., excessive daytime sleepiness) for at least 3 months

AND

1.2 A multiple sleep latency test (MSLT) documents fewer than two sleep-onset rapid eye movement periods (SOREMPs), or no SOREMPs if the REM sleep latency on the preceding polysomnogram was ≤ 15 minutes

AND

1.3 The presence of at least one of the following:

- MSLT shows a mean sleep latency of ≤ 8 minutes
- Total 24-hour sleep time is ≥ 660 minutes (typically 12 to 14 hours) on 24-hour polysomnography or by wrist actigraphy in association with a sleep log

AND

2 - Physician attestation to BOTH of the following:

2.1 Cataplexy is absent

AND

2.2 Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - Prescribed by with one of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

AND

4 - History of failure, contraindication, or intolerance of ALL of the following (MUST be verified via paid pharmacy claims or submission of medical records):

- An amphetamine or methylphenidate based stimulant
- modafinil
- armodafinil

Product Name:Xywav	
Diagnosis	Idiopathic Hypersomnia (IH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting reduction in symptoms of excessive daytime sleepiness associated with therapy

2 . Revision History

Date	Notes
1/31/2025	IH: Updated prescriber requirement verbiage

Prior Authorization Guideline

Guideline ID	GL-322195
Guideline Name	Sofdra (sofpironium)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Sofdra	
Diagnosis	Primary Axillary Hyperhidrosis
Approval Length	6 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of primary axillary hyperhidrosis	

AND

2 - Patient has experienced symptoms of disease for a duration of at least 6 months

AND

3 - Patient is 9 years of age or older

AND

4 - Provider attests other causes of axillary hyperhidrosis have been ruled out (e.g., menopause, medications)

AND

5 - Disease frequently interferes with daily activities (e.g., lower productivity at work, lower psychosocial wellbeing)

AND

6 - Trial and failure (minimum 6 weeks supply), contraindication, or intolerance to a topical prescription strength drying agent [e.g., Drysol, Xerac AC (aluminum chloride hexahydrate)]

AND

7 - Trial and failure, contraindication, or intolerance to Botox

AND

8 - Prescribed by or in consultation with a dermatologist

Product Name:Sofdra

Diagnosis	Primary Axillary Hyperhidrosis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., improvement in productivity, improvement in psychosocial wellbeing)

2 . Revision History

Date	Notes
7/16/2025	Removed Qbrexza as prerequisite.

Prior Authorization Guideline

Guideline ID	GL-756215
Guideline Name	Sohonos (palovarotene)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

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

Approval Criteria

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

1.1 Diagnosis of Fibrodysplasia Ossificans Progressiva (FOP)

AND

1.2 Molecular genetic testing confirms mutation in the ACVR1 gene

AND

1.3 One of the following:

1.3.1 Both of the following:

- Patient is female
- Patient is 8 years of age or older

OR

1.3.2 Both of the following:

- Patient is male
- Patient is 10 years of age or older

AND

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

- Geneticist
- Orthopedic physician
- Rheumatologist
- Endocrinologist

AND

3 - Requested drug will not be used in combination with other treatments for FOP (e.g., Atebrioz, Pasatru)

Product Name:Sohonos	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates positive clinical response to therapy (e.g., reduction of volume in new abnormal bone growth)

AND

2 - Requested drug will not be used in combination with other treatments for FOP (e.g., Atebrioz, Pasatru)

2 . Revision History

Date	Notes
10/28/2026	Added concomitant use criterion due to launch of Pasatru and Atebri oz. Updated initial auth duration to 12 months.

Prior Authorization Guideline

Guideline ID	GL-157634
Guideline Name	Somatuline Depot (lanreotide)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Brand Somatuline Depot, generic lanreotide	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of acromegaly

AND

2 - One of the following:

2.1 Inadequate response to one of the following:

- Surgery
- Radiotherapy

OR

2.2 Not a candidate for one of the following:

- Surgery
- Radiotherapy

AND

3 - Prescribed by or in consultation with an endocrinologist

AND

4 - Trial and failure, or intolerance to generic octreotide

Product Name:Brand Somatuline Depot, generic lanreotide	
Diagnosis	Acromegaly
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive

clinical response to therapy, such as a reduction or normalization of IGF-1/GH level for same age and sex

Product Name:Brand Somatuline Depot 120mg/0.5mL, generic lanreotide 120mg/0.5ml	
Diagnosis	Advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NET)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of gastroenteropancreatic neuroendocrine tumor (GEP-NET)

AND

2 - Disease is one of the following:

- Unresectable, locally advanced
- Metastatic

AND

3 - Prescribed by or in consultation with an oncologist

Product Name:Brand Somatuline Depot 120mg/0.5mL, generic lanreotide 120mg/0.5ml	
Diagnosis	Advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NET)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting patient does not show evidence of progressive disease while on therapy

Product Name:Brand Somatuline Depot 120mg/0.5mL, generic lanreotide 120mg/0.5ml	
Diagnosis	Carcinoid Syndrome
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of carcinoid syndrome

AND

2 - Used to reduce the frequency of short-acting somatostatin analog rescue therapy

AND

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

- Endocrinologist
- Oncologist

AND

4 - Trial and failure, or intolerance to generic octreotide

Product Name:Brand Somatuline Depot 120mg/0.5mL, generic lanreotide 120mg/0.5ml

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy

2 . Revision History

Date	Notes
10/25/2024	Updated naming conventions of targets, removed off-label designation for lanreotide/carcinoid syndrome

Prior Authorization Guideline

Guideline ID	GL-99644
Guideline Name	Somavert
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - All of the following:

1.1 Diagnosis of acromegaly by ONE of the following:

- Serum GH (growth hormone) level greater than 1 ng/mL (nanograms per milliliter) after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis
- Elevated serum IGF-1 (Insulin-like growth factor-1) levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis

AND

1.2 One of the following:

1.2.1 Inadequate response to one of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

OR

1.2.2 Not a candidate for all of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

AND

1.3 Inadequate response, intolerance, or contraindication to one of the following somatostatin analogs:

- Sandostatin (octreotide) or Sandostatin LAR
- Somatuline Depot (lanreotide)

OR

2 - Patient is currently on Somavert therapy for acromegaly

Product Name:Somavert	
Diagnosis	Acromegaly

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

Approval Criteria

1 - Documentation of positive clinical response to Somavert therapy

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-99496
Guideline Name	Soriatane
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Soriatane, Generic acitretin	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe psoriasis

AND

2 - Prescribed or recommended by a dermatologist

AND

3 - One of the following:

3.1 Patient is unresponsive to other therapies (e.g., topical corticosteroids, topical vitamin D analogs, tazarotene, methotrexate)

OR

3.2 Other therapies are contraindicated based on the patient's clinical condition

AND

4 - One of the following:

- Greater than or equal to 10% body surface area involvement
- Palmoplantar, facial, or genital involvement
- Severe scalp psoriasis

Product Name:Brand Soriatane, Generic acitretin	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Soriatane therapy

AND

2 - Prescribed or recommended by a dermatologist

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-589219
Guideline Name	Sotyktu (deucravacitinib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Sotyktu	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of moderate to severe plaque psoriasis (PsO)

AND

1.2 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.3 History of failure to one of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- corticosteroids (e.g., betamethasone, clobetasol)
- vitamin D analogs (e.g., calcitriol, calcipotriene)
- tazarotene
- calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure of a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to one of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Infliximab
- Otezla (apremilast)
- A preferred ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a dermatologist

AND

3 - Not used in combination with other potent immunosuppressants (e.g., azathioprine, cyclosporine, biologic DMARDs)*

Notes	*Sotyktu may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids.

Product Name:Sotyktu	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by ONE of the following:

- Reduction the body surface area (BSA) involvement from baseline
- Improvement in symptoms (e.g., pruritus, inflammation) from baseline

AND

2 - Prescribed by or in consultation with a dermatologist

AND

3 - Not used in combination with other potent immunosuppressants (e.g., azathioprine, cyclosporine, biologic DMARDs)*

Notes	*Sotyktu may be used with concomitant methotrexate, topical or inhal ed corticosteroids, and/or low stable dosages of oral corticosteroids.

Product Name:Sotyktu	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming ALL of the following:

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 One of the following:

- Actively inflamed joints
- Dactylitis
- Enthesitis
- Axial disease
- Active skin and/or nail involvement

AND

1.3 History of failure of a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.4 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)

- Infliximab
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

AND

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

- Dermatologist
- Rheumatologist

AND

3 - Not used in combination with other potent immunosuppressants (e.g., azathioprine, cyclosporine, biologic DMARDs)*

Notes	*Sotyktu may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids.

Product Name:Sotyktu	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming positive clinical response to therapy as evidenced by at least ONE of the following:

- Reduction in the total active (swollen and tender) joint count from baseline
- Improvement in symptoms (e.g., pain, stiffness, pruritus, inflammation) from baseline
- Reduction in the body surface area (BSA) involvement from baseline

AND

2 - Prescribed by or in consultation with one of the following: • Dermatologist • Rheumatologist **AND** **3** - Not used in combination with other potent immunosuppressants (e.g., azathioprine, cyclosporine, biologic DMARDs)*	
Notes	*Sotyktu may be used with concomitant methotrexate, topical or inhaled corticosteroids, and/or low stable dosages of oral corticosteroids.

2 . Revision History

Date	Notes
4/30/2026	Added criteria for new PsA indication, updated DMARD criterion and note throughout.

Prior Authorization Guideline

Guideline ID	GL-357234
Guideline Name	Spevigo (spesolimab-sbzo)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

Product Name:Spevigo IV	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of generalized pustular psoriasis (GPP)

AND

2 - Submission of medical records (e.g., chart notes) confirming patient has a moderate to severe GPP flare based on one of the following:

- Presence of fresh pustules (new appearance or worsening of pustules)
- At least 5% of body surface area (BSA) covered with erythema and the presence of pustules
- A Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of at least 3 (moderate)
- GPPPGA pustulation sub score of at least 2 (mild)

AND

3 - Both of the following:

- Patient is 12 years of age or older
- Patient weighs at least 40 kg

AND

4 - Prescribed by or in consultation with a dermatologist

AND

5 - Patient has not already received two infusions of Spevigo for a single flare

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of generalized pustular psoriasis (GPP) as defined by both of the following:

- Primary, sterile, macroscopically visible pustules on non-acral skin (excluding cases where pustulation is restricted to psoriatic plaques)
- Disease is relapsing (> 1 episode) or persistent (> 3 months)

AND

2 - Subcutaneous formulation will not be used to treat GPP flare

AND

3 - Both of the following:

- Patient is 12 years of age or older
- Patient weighs at least 40 kg

AND

4 - Prescribed by or in consultation with a dermatologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in number of flares)

2 . Revision History

Date	Notes

8/28/2025	Added GPI for 300mg SC syringe

Prior Authorization Guideline

Guideline ID	GL-614199
Guideline Name	Spinraza - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Spinraza	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of spinal muscular atrophy (SMA) type I, II, or III made by, or in consultation with, a neurologist with expertise in the diagnosis of SMA

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) confirming both of the following:

2.1 The mutation or deletion of genes in chromosome 5q resulting in one of the following:

- Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13)
- Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])

AND

2.2 Patient has at least 2 copies of SMN2

AND

3 - Patient is not dependent on invasive ventilation or tracheostomy

AND

4 - Patient is not dependent on use of non-invasive ventilation beyond use for naps and nightime sleep

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) or claims history of the baseline exam of one of the following exams (based on patient age and motor ability) to establish baseline motor ability:

- Hammersmith Infant Neurological Exam Part 2 (HINE-2) (infant to early childhood)
- Hammersmith Functional Motor Scale Expanded (HFMSE)
- Upper Limb Module (ULM) Test (Non ambulatory)
- Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)

AND

6 - Prescribed by, or in consultation with, a neurologist with expertise in the treatment of SMA

AND

7 - One of the following:

7.1 Patient has not previously received gene replacement therapy for the treatment of SMA

OR

7.2 One of the following:

7.2.1 Both of the following:

7.2.1.1 Patient recently received gene replacement therapy within the previous 6 months

AND

7.2.1.2 Patient has experienced a declination in clinical status since receipt of gene replacement therapy

OR

7.2.2 Both of the following:

7.2.2.1 Patient has previously received gene replacement therapy

AND

7.2.2.2 Patient has experienced a declination in clinical status that represents a potential abatement of gene therapy efficacy

AND

8 - Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures

AND

9 - Spinraza dosing for SMA is within accordance with the United States Food and Drug Administration approved labeling

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

Approval Criteria

1 - Diagnosis of spinal muscular atrophy (SMA) type I, II, or III made by, or in consultation with, a neurologist with expertise in the diagnosis of SMA

AND

2 - Submission of medical records (e.g., chart notes, laboratory values) or claims history confirming both of the following:

2.1 The mutation or deletion of genes in chromosome 5q resulting in one of the following:

- Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13)
- Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2])

AND

2.2 Patient has at least 2 copies of SMN2

AND

3 - Patient is not dependent on invasive ventilation or tracheostomy

AND

4 - Patient is not dependent on use of non-invasive ventilation beyond use for naps and nightime sleep

AND

5 - One of the following:

5.1 Patient has not previously received gene replacement therapy for the treatment of SMA

OR

5.2 Both of the following:

5.2.1 Patient has previously received gene replacement therapy

AND

5.2.2 Patient has experienced a declination in clinical status that represented a potential failure or abatement of gene therapy efficacy

AND

6 - Submission of medical records (e.g., chart notes, laboratory values) or claims history with the most recent results (less than 1 month prior to request) documenting a positive clinical response from pretreatment baseline status to Spinraza therapy as demonstrated by one of the following exams:

6.1 Both of the following for Hammersmith Infant Neurological Exam Part 2 (HINE-2) milestones:

6.1.1 One of the following:

- Improvement or maintenance of previous improvement of at least 2 point (or maximal score) increase in ability to kick
- Improvement or maintenance of previous improvement of at least 1 point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp

AND

6.1.2 One of the following:

- The patient exhibited improvement or maintenance of previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)
- Achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

OR

6.2 One of the following for Hammersmith Functional Motor Scale Expanded (HFMSE):

- Improvement or maintenance of previous improvement of at least a 3 point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

6.3 One of the following for Upper Limb Module (ULM):

- Improvement or maintenance of previous improvement of at least a 2 point increase in score from pretreatment baseline
- Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

6.4 One of the following for Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND):

6.4.1 Improvement or maintenance of previous improvement of at least a 4 point increase in score from pretreatment baseline

OR

6.4.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so

OR

6.4.3 Both of the following:

- Patient was prescribed Spinraza due to clinical declination after receipt of gene therapy
- Patients clinical status has stabilized after receipt of Spinraza therapy

AND

7 - Prescribed by, or in consultation with, a neurologist with expertise in the treatment of SMA

AND

8 - Spinraza is to be administered intrathecally by, or under the direction of, healthcare professionals experienced in performing lumbar punctures

AND

9 - Spinraza dosing for SMA is within accordance with the United States Food and Drug Administration approved labeling

2 . Revision History

Date	Notes

5/19/2026	Added new GPIs, updated dosing criterion verbiage due to new high dose regimen

Prior Authorization Guideline

Guideline ID	GL-703318
Guideline Name	Spravato, ketamine - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Spravato, ketamine	
Diagnosis	Major Depressive Disorder (Treatment-Resistant) as Monotherapy
Approval Length	N/A: Requests for the indication of Major Depressive Disorder (Treatment-Resistant) as Monotherapy are excluded from coverage and will not be approved.
Guideline Type	Prior Authorization
Approval Criteria **1** - Requests for the indication of Major Depressive Disorder (Treatment-Resistant) as Monotherapy are excluded from coverage and will not be approved.	

Notes	Requests for the indication of Major Depressive Disorder (Treatment-Resistant) as Monotherapy are excluded from coverage and will not b e approved.

Product Name:Spravato, ketamine	
Diagnosis	Major Depressive Disorder (Treatment-Resistant) in conjunction with an oral antidepressant
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a confirmed diagnosis of major depressive disorder as defined by the DSM-V (Diagnostic and Statistical Manual of Mental Disorders) criteria and is treatment resistant

AND

2 - Patient is 18 years of age or older

AND

3 - Requested medication is prescribed by, or in consultation with, a psychiatric provider

AND

4 - ONE of the following:

4.1 Patient does not have an active substance use disorder (SUD)

OR

4.2 BOTH of the following:

- Patient has an active substance use disorder

- Patient is currently receiving treatment

AND

5 - ONE of the following:

5.1 Patient has experienced an inadequate response during the current depressive episode with BOTH of the following therapies:

5.1.1 Two antidepressants from at least two different classes [must include one of each AHCCCS (Arizona Health Care Cost Containment System) preferred agents: SSRI (selective serotonin reuptake inhibitor), SNRI (serotonin-norepinephrine reuptake inhibitor), or bupropion] having different mechanisms of action at the maximally tolerated labeled dose, each used for at least 4-6 weeks

AND

5.1.2 At least TWO augmentation therapies below for at least 4 weeks:

- SSRI or SNRI, and a second-generation antipsychotic used concomitantly (aripiprazole, quetiapine, risperidone, olanzapine)
- SSRI or SNRI, and lithium used concomitantly
- SSRI or SNRI, and liothyronine (T3) used concomitantly
- SSRI or SNRI, and mirtazapine
- SSRI and bupropion and buspirone

OR

5.2 Patient has active suicidal ideation and urgent symptom control is necessary

AND

6 - Requested medication is used in combination with an oral antidepressant (e.g., duloxetine, escitalopram, sertraline, venlafaxine). Note: Requests for the indication of Major Depressive Disorder (Treatment-Resistant) as Monotherapy are excluded from coverage and will not be approved.

AND

7 - Requested medication is administered under the direct supervision of a healthcare provider

AND

8 - Provider is certified in the Spravato REMS (risk evaluation and mitigation strategy) program (Applies to Spravato requests ONLY)

AND

9 - Patient must be monitored by a health care provider for at least 2 hours after administration

Product Name:Spravato, ketamine	
Diagnosis	Major Depressive Disorder (Treatment-Resistant) in conjunction with an oral antidepressant
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Provider attests that the patient has documented improvement or sustained improvement in depressive symptoms from baseline

AND

2 - Patient use of requested medication is in combination with an oral antidepressant. Note: Requests for the indication of Major Depressive Disorder (Treatment-Resistant) as Monotherapy are excluded from coverage and will not be approved.

AND

3 - Patient administers requested medication under the direct supervision of a healthcare provider

AND

4 - Provider is certified in the Spravato REMS (risk evaluation and mitigation strategy) program (applies to Spravato requests ONLY)

AND

5 - Patient must continue to be monitored by a health care provider for at least 2 hours after administration

Product Name:Spravato, ketamine	
Diagnosis	Depressive symptoms in an adult with major depressive disorder (MDD) with acute suicidal ideation or behavior
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of major depressive disorder according to the current Diagnostic and Statistical Manual of Mental Disorders (DSM) (i.e., DSM-5) criteria

AND

2 - Patient is experiencing an acute suicidal ideation or behavior

AND

3 - Patient is receiving newly initiated or optimized oral antidepressant

AND

4 - Provider and/or the provider's healthcare setting is certified in the Spravato REMS (Risk Evaluation and Mitigation Strategy) program (applies to Spravato requests ONLY)

2 . Background

Benefit/Coverage/Program Information

HCPCS Codes

CODE	DESCRIPTION	LAY DESCRIPTION
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	A physician or an assistant under direct physician supervision infuses a hydration solution (prepackaged fluid and electrolytes) for 31 minutes to one hour through an intravenous catheter inserted by needle into a patient's vein or by infusion through an existing indwelling intravascular access catheter or port. Report 96361 for each additional hour beyond the first hour. Intravenous infusion for hydration lasting 30 minutes or less is not reported.
96361	Intravenous infusion, hydration; each additional hour (List separately in addition to code for primary procedure)	See 96360
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify	A physician or an assistant under direct physician supervision injects or infuses a therapeutic, prophylactic (preventive), or diagnostic medication other than chemotherapy

	substance or drug); initial, up to 1 hour	or other highly complex drugs or biologic agents via intravenous route. Infusions are administered through an intravenous catheter inserted by needle into a patient's vein or by injection or infusion through an existing indwelling intravascular access catheter or port. Report 96365 for the initial hour and 96366 for each additional hour. Report 96367 for each additional sequential infusion of a different substance or drug, up to one hour, and 96368 for each concurrent infusion of substances other than chemotherapy or other highly complex drugs or biologic agents.
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	See 96365
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)	See 96365
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (List separately in	A physician or an assistant under direct physician supervision injects or infuses a therapeutic, prophylactic (preventive), or diagnostic medication other than chemotherapy or other highly complex drugs or

	addition to code for primary procedure)	biologic agents via intravenous route. Infusions are administered through an intravenous catheter inserted by needle into a patient's vein or by injection or infusion through an existing indwelling intravascular access catheter or port. Report 96365 for the initial hour and 96366 for each additional hour. Report 96367 for each additional sequential infusion of a different substance or drug, up to one hour, and 96368 for each concurrent infusion of substances other than chemotherapy or other highly complex drugs or biologic agents.
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	The physician or an assistant under direct physician supervision administers a therapeutic, prophylactic, or diagnostic substance by subcutaneous or intramuscular injection (96372), intra-arterial injection (96373), or by push into an intravenous catheter or intravascular access device (96374 for a single or initial substance, 96375 for each additional sequential IV push of a new substance, and 96376 for each additional sequential IV push of the same substance after 30 minutes have elapsed). The push technique involves an infusion of less than 15 minutes. Code 96376 may be reported only by facilities.
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List	See 96374

	separately in addition to code for primary procedure)	
96376	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of the same substance/drug provided in a facility (List separately in addition to code for primary procedure)	See 96374 Code 96376 may be reported only by facilities.
96379	Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion	

3 . Revision History

Date	Notes
8/26/2026	Removed criteria for Requests for Patients less than 6 years of age

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-99646
Guideline Name	Strensiq
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Strensiq	
Diagnosis	perinatal/infantile or juvenile-onset hypophosphatasia (HPP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia based on all of the following:

1.1.1 One of the following:

- Onset of clinical signs and symptoms of hypophosphatasia prior to age 18 years (e.g., respiratory insufficiency, vitamin B6 responsive seizures, hypotonia, failure to thrive, delayed walking, waddling gait, dental abnormalities, low trauma fractures)
- Radiographic evidence supporting the diagnosis of hypophosphatasia at the age of onset prior to age 18 years (e.g., craniosynostosis, infantile rickets, non-traumatic fractures)

AND

1.1.2 One of the following:

1.1.2.1 Both of the following:

- Patient has low level activity of serum alkaline phosphatase (ALP) evidenced by an ALP level below the age-adjusted normal range
- Patient has an elevated level of tissue non-specific alkaline phosphatase (TNSALP) substrate (e.g. serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level])

OR

1.1.2.2 Confirmation of tissue-nonspecific alkaline phosphatase (TNSALP) gene mutation by ALPL genomic DNA testing*

AND

1.2 Prescribed by one of the following:

- Endocrinologist
- A specialist experienced in the treatment of metabolic bone disorders

AND

1.3 One of the following:

1.3.1 Both of the following:

- Diagnosis of perinatal/infantile-onset hypophosphatasia

- Coverage will be provided up to a maximum supply limit of 9 mg/kg/week

OR

1.3.2 Both of the following:

- Diagnosis of juvenile-onset hypophosphatasia
- Coverage will be provided up to a maximum supply limit of 6 mg/kg/week

AND

1.4 One of the following:

1.4.1 Patient is prescribed Strensiq 18 mg/0.45 mL, Strensiq 28 mg/0.7 mL, or Strensiq 40 mg/mL vials

OR

1.4.2 Both of the following:

- Patient is prescribed Strensiq 80 mg/0.8 mL vial
- Patient's weight is greater than or equal to 40 kg

AND

1.5 Prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided

Notes	*Results of prior genetic testing can be submitted as confirmation of di agnosis of HPP, however please note that the provider should confirm coverage status of any new genetic testing under the patient's United Healthcare plan prior to ordering

Product Name:Strensiq	
Diagnosis	perinatal/infantile or juvenile-onset hypophosphatasia (HPP)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - All of the following:

1.1 Clinically relevant decrease from baseline in tissue non-specific alkaline phosphatase (TNSALP) substrate (e.g. serum pyridoxal 5'-phosphate [PLP] level, serum or urine phosphoethanolamine [PEA] level, urinary inorganic pyrophosphate [PPi level])

AND

1.2 Prescribed by one of the following:

- Endocrinologist
- A specialist experienced in the treatment of metabolic bone diseases

AND

1.3 One of the following:

1.3.1 Both of the following:

- Diagnosis of perinatal/infantile-onset hypophosphatasia
- Coverage will be provided up to a maximum supply limit of 9 mg/kg/week

OR

1.3.2 Both of the following:

- Diagnosis of juvenile-onset hypophosphatasia
- Coverage will be provided up to a maximum supply limit of 6 mg/kg/week

AND

1.4 One of the following:

1.4.1 Patient is prescribed Strensiq 18 mg/0.45 mL, Strensiq 28 mg/0.7 mL, or Strensiq 40 mg/mL vials

OR

1.4.2 Both of the following

- Patient is prescribed Strensiq 80 mg/0.8 mL vials
- Patient's weight is greater than or equal to 40 kg

AND

1.5 Prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-221194
Guideline Name	Sublingual Immunotherapy (SLIT)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2025

1 . Criteria

Product Name:All products	
Diagnosis	Patients 21 years of age and older
Approval Length	N/A - All requests for patients 21 years of age and older should be DENIED as benefit exclusion
Guideline Type	Prior Authorization
Approval Criteria **1** - Requests for patients 21 years of age and older are not covered	
Notes	Approval Length: N/A - All requests for patients 21 years of age and older should be denied as a benefit exclusion.

Product Name:Grastek	
Diagnosis	Grass pollen-induced allergic rhinitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis

AND

2 - Diagnosis confirmed by one of the following:

- Positive skin test to Timothy grass or cross-reactive grass pollens (eg, Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop)
- in vitro testing for pollen-specific IgE antibodies for Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop)

AND

3 - Treatment is started or will be started at least 12 weeks before the beginning of the grass pollen season

AND

4 - History of failure, contraindication, or intolerance to two of the following:

- oral antihistamine [e.g. cetirizine (Zyrtec)]
- intranasal antihistamine [e.g. azelastine (Astelin)]
- intranasal corticosteroid [e.g. fluticasone (Flonase)]
- leukotriene inhibitor [e.g. montelukast (Singulair)]

AND

5 - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Oralair)

AND

6 - Patient does not have unstable and/or uncontrolled asthma

AND

7 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name:Grastek	
Diagnosis	Grass pollen-induced allergic rhinitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Grastek therapy

Product Name:Oralair	
Diagnosis	Grass pollen-induced allergic rhinitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe grass pollen-induced allergic rhinitis

AND

2 - Diagnosis confirmed by one of the following:

- Positive skin test to any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]
- in vitro testing for pollen-specific IgE antibodies for any of the five grass species contained in Oralair [(i.e., Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue grass mixed pollens) or cross-reactive grass pollens (e.g., Cocksfoot, Meadow Fescue, or Redtop)]

AND

3 - Treatment is started or will be started at least 4 months before the beginning of the grass pollen season

AND

4 - History of failure, contraindication, or intolerance to two of the following:

- oral antihistamine [e.g. cetirizine (Zyrtec)]
- intranasal antihistamine [e.g. azelastine (Astelin)]
- intranasal corticosteroid [e.g. fluticasone (Flonase)]
- leukotriene inhibitor [e.g. montelukast (Singulair)]

AND

5 - Not received in combination with similar cross-reactive grass pollen immunotherapy (e.g., Grastek)

AND

6 - Patient does not have unstable and/or uncontrolled asthma

AND

7 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name:Oralair	
Diagnosis	Grass pollen-induced allergic rhinitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Oralair therapy

Product Name:Ragwitek	
Diagnosis	Short ragweed pollen-induced allergic rhinitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe short ragweed pollen-induced allergic rhinitis

AND

2 - Diagnosis confirmed by one of the following:

- Positive skin test to short ragweed pollen
- in vitro testing for pollen-specific IgE antibodies for short ragweed pollen

AND

3 - Treatment is started or will be started at least 12 weeks before the beginning of the short ragweed pollen season

AND

4 - History of failure, contraindication, or intolerance to two of the following:

- oral antihistamine [e.g. cetirizine (Zyrtec)]
- intranasal antihistamine [e.g. azelastine (Astelin)]
- intranasal corticosteroid [e.g. fluticasone (Flonase)]
- leukotriene inhibitor [e.g. montelukast (Singulair)]

AND

5 - Patient does not have unstable and/or uncontrolled asthma

AND

6 - Prescribed by or in consultation with a specialist in allergy and immunology

Product Name:Ragwitek	
Diagnosis	Short ragweed pollen-induced allergic rhinitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ragwitek therapy

Product Name:Odactra	
Diagnosis	House dust mite (HDM)-induced allergic rhinitis
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of house dust mite (HDM)-induced allergic rhinitis.

AND

2 - Diagnosis confirmed by one of the following:

- Positive skin test to licensed house dust mite allergen extracts
- in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites

AND

3 - History of failure, contraindication, or intolerance to two of the following:

- oral antihistamine [e.g. cetirizine (Zyrtec)]
- intranasal antihistamine [e.g. azelastine (Astelin)]
- intranasal corticosteroid [e.g. fluticasone (Flonase)]
- leukotriene inhibitor [e.g. montelukast (Singulair)]

AND

4 - Patient does not have unstable and/or uncontrolled asthma

AND

5 - Prescribed by or in consultation with a specialist in allergy and immunology

AND

6 - Patient is between 5 and 20 years of age*

Notes	*Odactra is not covered in patients 21 years of age or older

Product Name:Odactra	
Diagnosis	House dust mite (HDM)-induced allergic rhinitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Odactra therapy **AND** **2** - Patient is between 5 and 20 years of age*	
Notes	*Odactra is not covered in patients 21 years of age or older

2 . Revision History

Date	Notes
3/26/2025	Updated age criterion for Odactra due to expanded approval.

Prior Authorization Guideline

Guideline ID	GL-157633
Guideline Name	Sublocade, Brixadi - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2024

1 . Criteria

Product Name:Brixadi, Sublocade	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 All of the following:

1.1.1 Patient has severe Opioid Use Disorder (OUD) as defined by the DSM-5 (Diagnostic

and Statistical Manual of Mental Disorders, Fifth Edition) OUD Diagnostic Tool and has a demonstrated history of non-adherence to oral medications

AND

1.1.2 Patient is currently maintained on 8mg to 24mg per day dose of oral, sublingual, or transmucosal buprenorphine product equivalent prior to initiation of Brixadi or Sublocade

AND

1.1.3 Patient will not receive supplemental oral, sublingual, or transmucosal buprenorphine for greater than 6 weeks after initiation of Brixadi or Sublocade

AND

1.1.4 Patient is receiving psychosocial interventions as part of a comprehensive medication assisted treatment (MAT) program

AND

1.1.5 Prescriber checks the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database prior to each monthly injection of Brixadi or Sublocade

AND

1.1.6 Dosing of Brixadi or Sublocade is in accordance with the U. S. Food and Drug Administration approved labeling

OR

1.2 Brixadi or Sublocade is being requested due to circumstances other than non-adherence to oral medications. Document circumstance(s).

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

Approval Criteria

1 - Physician documentation that the patient has experienced a positive clinical response to Brixadi or Sublocade therapy, as defined by the provider

AND

2 - One of the following:

2.1 All of the following:

2.1.1 Patient will not receive supplemental oral, sublingual, or transmucosal buprenorphine for greater than 6 weeks after Brixadi or Sublocade therapy initiation

AND

2.1.2 Patient is receiving psychosocial interventions as part of a comprehensive medication assisted treatment (MAT) program

AND

2.1.3 Prescriber checks the Arizona State Board of Pharmacy Controlled Substance Prescription Monitoring Program (CSPMP) database prior to each monthly injection of Brixadi or Sublocade

AND

2.1.4 Dosing of Brixadi or Sublocade is in accordance with the U. S. Food and Drug Administration approved labeling

OR

2.2 Brixadi or Sublocade is being requested due to circumstances other than non-adherence to oral medications. Document circumstance(s).

2 . Revision History

Date	Notes
10/25/2024	Remove min day requirement for buprenorphine prior to initiation fro m 1.1.2

Prior Authorization Guideline

Guideline ID	GL-479198
Guideline Name	Suboxone - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Generic buprenorphine-naloxone film	
Approval Length	N/A - Requests for generic buprenorphine hcl-naloxone film should not be approved
Guideline Type	Prior Authorization
Approval Criteria **1** - Requests for generic buprenorphine-naloxone film are not authorized and will not be approved	
Notes	Approval Length: N/A - Requests for generic buprenorphine-naloxone film should not be approved. Patient need to use Brand Suboxone film or other preferred alternatives.

Product Name:Zubsolv	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a Diagnostic and Statistical Manual, Fifth Edition, Text Revision, (DSM-V-TR) diagnosis of opioid use disorder

AND

2 - The patient must have a reason or special circumstance that they cannot use the preferred products

- brand Suboxone Film
- buprenorphine sublingual tablet (generic Subutex) *PA Required - Except Pregnant and Postpartum Women
- buprenorphine HCl/naloxone Tab (Generic Suboxone Tab)
- naloxone
- naltrexone
- Narcan (naloxone)
- Sublocade (buprenorphine)
- Vivitrol (naltrexone microspheres)

Notes	*Up to 24 mg per day of Suboxone, or equivalent dosing of an alternative medication, will be authorized for the initial period.

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

Approval Criteria

1 - The patient has been prescribed a buprenorphine product for the purpose of opioid use disorder maintenance therapy

AND

2 - The patient must have a reason or special circumstance that they cannot use the preferred products

AND

3 - Patient must have tried Suboxone film or buprenorphine-naloxone ODT tablets

Notes	* Up to 16 mg per day of Suboxone, or equivalent dosing of an alternative medication, will be authorized for the reauthorization period.

Product Name:Brand suboxone, generic buprenorphine hcl-naloxone, buprenorphine/naloxone sublingual tablet, Zubsolv*	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Quantity Limit

Approval Criteria

1 - Physician has provided rationale for needing to exceed the buprenorphine daily limit

AND

2 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation

Notes	* This criteria applies to requests exceeding 24 mg of buprenorphine or equivalent

Product Name:Brand suboxone, generic buprenorphine hcl-naloxone, buprenorphine/naloxone sublingual tablet, Zubsolv*

Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Quantity Limit

Approval Criteria

1 - Physician has provided rationale for needing to exceed the buprenorphine daily limit

AND

2 - The requested dosage cannot be achieved using the plan accepted quantity limit of a different dose or formulation

Notes	*This criteria applies to requests exceeding 16 mg of buprenorphine or equivalent

2 . Revision History

Date	Notes
12/17/2025	Removed Bunavail as target (inactive), added note for Zubsolv that PA is required for buprenorphine SL tabs (except pregnant/postpartum women)

Prior Authorization Guideline

Guideline ID	GL-164414
Guideline Name	Sucraid
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2025

1 . Criteria

Product Name:Sucraid	
Approval Length	N/A- Requests for drugs not covered by Medicaid must be obtained through manufacturer for Compassionate Use
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital sucrase-isomaltase deficiency (CSID) as confirmed by one of the following:

1.1 Duodenal biopsy showing low sucrose activity and normal amounts of other disaccharides

OR

1.2 All of the following:

- Stool pH less than 6
- Negative lactose breath test
- Increase in breath hydrogen greater than 10 ppm (parts per million) when challenged with sucrose after fasting

AND

2 - Prescribed by or in consultation with a gastroenterologist or rare disease specialist

AND

3 - Will be used with a sucrose-free, low starch diet

AND

4 - Provider attests that the requested medication will be obtained under compassionate use*

Notes	*Approval Length: N/A- Requests for drugs not covered by Medicaid must be obtained through manufacturer for Compassionate Use. Providers must contact QOL Medical 1-866-469-3773

Product Name:Sucraid	
Approval Length	N/A- Requests for drugs not covered by Medicaid must be obtained through manufacturer for Compassionate Use
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Prescribed by or in consultation with a gastroenterologist or rare disease specialist

AND

2 - Will be used with a sucrose-free, low starch diet

AND

3 - Provider attests that the patient has achieved a clinically meaningful response while on Sucraid therapy, defined as at least a 50 percent reduction in all of the following:

- Symptoms of abdominal pain, cramps, bloating, gas, vomiting
- Number of stools per day
- Watery, loose stool consistency
- Number of symptomatic days

AND

4 - Provider attests that the requested medication will be obtained under compassionate use*

Notes	*Approval Length: N/A- Requests for drugs not covered by Medicaid must be obtained through manufacturer for Compassionate Use. Providers must contact QOL Medical 1-866-469-3773

2 . Revision History

Date	Notes
1/30/2025	Updated PA to remove approval duration, added note directing provider to contact mfg for compassionate use.

Prior Authorization Guideline

Guideline ID	GL-269197
Guideline Name	Sunlenca (lenacapavir sodium)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Sunlenca	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Submission of medical records (e.g., chart notes) documenting all of the following:

1.1.1 Diagnosis of HIV-1 infection

AND

1.1.2 Both of the following:

1.1.2.1 Patient is heavily treatment-experienced with multidrug resistance as confirmed by a resistance assay

AND

1.1.2.2 Patient is failing their current antiretroviral regimen due to one of the following:

- Resistance
- Intolerance
- Safety considerations

AND

1.1.3 Patient is currently taking, or will be prescribed, an active and optimized background antiretroviral therapy regimen

AND

1.1.4 Prescribed by or in consultation with a clinician with HIV expertise

OR

1.2 For continuation of prior therapy

2 . Revision History

Date	Notes
5/29/2025	Added new GPI for Sunlenca tablet

Prior Authorization Guideline

Guideline ID	GL-206195
Guideline Name	Sunosi (solriamfetol)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/27/2025

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g. chart notes, lab values) documenting a diagnosis of narcolepsy with BOTH of the following:

1.1 The patient has daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least three months.

AND

1.2 A mean sleep latency of less than or equal to 8 minutes and two or more sleep onset rapid eye movement (REM) periods (SOREMPs) are found on a multiple sleep latency test (MSLT) performed according to standard techniques following a normal overnight polysomnogram. A SOREMP (within 15 minutes of sleep onset) on the preceding nocturnal polysomnogram may replace one of the SOREMPs on the MSLT.

AND

2 - Physician attestation to the following:

- Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

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

3.1 ONE of the following:

- Amphetamine based stimulant (e.g., amphetamine, dextroamphetamine)
- Methylphenidate based stimulant

AND

3.2 Armodafinil

AND

4 - Prescribed by one of the following:

- Neurologist

- Psychiatrist
- Sleep Medicine Specialist

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

Approval Criteria

1 - Reduction in symptoms of excessive daytime sleepiness associated with Sunosi therapy

Product Name:Sunosi	
Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g. chart notes, lab values) documenting a diagnosis of obstructive sleep apnea with ONE of the following:

1.1 Fifteen or more obstructive respiratory events per hour of sleep confirmed by a sleep study

OR

1.2 BOTH of the following:

1.2.1 Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study

AND

1.2.2 ONE or more of the following sign/symptoms are present:

- Daytime sleepiness
- Nonrestorative sleep
- Fatigue
- Insomnia
- Waking up with breath holding, gasping, or choking
- Habitual snoring noted by bed partner or other observer
- Observed apnea

AND

2 - BOTH of the following:

2.1 Standard treatments for the underlying airway obstruction (e.g., continuous positive airway pressure [CPAP], bi-level positive airway pressure [BiPAP]) have been used for one month or longer

AND

2.2 Patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction

AND

3 - History of failure, contraindication, or intolerance to armodafinil

AND

4 - Prescribed by one of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

Product Name:Sunosi	
Diagnosis	Obstructive Sleep Apnea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Reduction in symptoms of excessive daytime sleepiness associated with Sunosi therapy

AND

2 - Patient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g. continuous positive airway pressure [CPAP], bi-level positive airway pressure [BiPAP])

2 . Revision History

Date	Notes
2/27/2025	Narcolepsy initial auth: Corrected connector for 1.1 /1.2 to AND.

Prior Authorization Guideline

Guideline ID	GL-99767
Guideline Name	Sutent
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Sutent	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of gastrointestinal stromal tumor (GIST)	

AND

2 - History of failure, contraindication, or intolerance to Gleevec (imatinib)

Product Name:Sutent	
Diagnosis	Renal Cell Carcinoma (RCC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of renal cell carcinoma (RCC)

AND

2 - ONE of the following:

2.1 Disease has relapsed

OR

2.2 Diagnosis of Stage IV disease

OR

2.3 BOTH of the following:

2.3.1 Used in adjuvant setting

AND

2.3.2 Patient has a high risk of recurrence following nephrectomy

Product Name:Sutent	
Diagnosis	Islet Cell Tumor / Progressive Pancreatic Neuroendocrine Tumors (pNET)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of islet cell tumor / progressive pancreatic neuroendocrine tumors (pNET)

AND

2 - Disease is ONE of the following:

- Unresectable, locally advanced
- Metastatic

Product Name:Sutent	
Diagnosis	Soft Tissue Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Alveolar soft part sarcoma (ASPS)
- Angiosarcoma

- Solitary fibrous tumor / hemangiopericytoma

Product Name:Sutent	
Diagnosis	Thyroid Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following:

1.1.1 Diagnosis of ONE of the following:

- Follicular carcinoma
- Hürthle cell carcinoma
- Papillary carcinoma

AND

1.1.2 ONE of the following:

- Unresectable locoregional recurrent disease
- Persistent disease
- Metastatic disease

AND

1.1.3 ONE of the following:

- Patient has symptomatic disease
- Patient has progressive disease

AND

1.1.4 Disease is refractory to radioactive iodine treatment

OR

1.2 ALL of the following:

1.2.1 Diagnosis of medullary thyroid carcinoma

AND

1.2.2 ONE of the following:

- Patient has progressive disease
- Patient has symptomatic metastatic disease

AND

1.2.3 History of failure, contraindication, or intolerance to ONE of the following:

- Caprelsa (vandetanib)
- Cometriq (cabozantinib)

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

Approval Criteria

1 - Diagnosis of recurrent chordoma

Product Name:Sutent	
Diagnosis	Central Nervous System Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of surgically inaccessible meningiomas

AND

2 - ONE of the following:

- Disease is recurrent
- Disease is progressive

AND

3 - Further radiation is not possible

Product Name:Sutent	
Diagnosis	Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of thymic carcinoma

AND

2 - Used as second-line following a failure, contraindication, or intolerance to a first-line chemotherapy regimen (e.g., carboplatin/paclitaxel)

Product Name:Sutent	
Diagnosis	Gastrointestinal Stromal Tumor (GIST), Renal Cell Carcinoma (RCC), Islet Cell Tumor / Progressive Pancreatic Neuroendocrine Tumors (pNET), Soft Tissue Sarcoma, Thyroid Carcinoma, Chordoma, Central Nervous System Cancer, Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Sutent therapy

Product Name:Sutent	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Sutent will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Sutent	
Diagnosis	NCCN Recommended Regimens

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

Approval Criteria

1 - Documentation of positive clinical response to Sutent therapy

2 . Revision History

Date	Notes
6/2/2021	Arizona Medicaid 7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-124881
Guideline Name	Syfovre (pegcetacoplan)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2023

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of geographic atrophy (GA) secondary to age-related macular degeneration (AMD) as confirmed by one of the following:

- Fundus photography (e.g. fundus autofluorescence [FAF])

- Optical coherence tomography (OCT)
- Fluorescein angiography

AND

2 - GA is not secondary to any other conditions (e.g., Stargardt disease, cone rod dystrophy, toxic maculopathies)

AND

3 - Prescribed by or in consultation with an ophthalmologist experienced in the treatment of retinal diseases

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in growth rate of GA lesion)

2 . Revision History

Date	Notes
4/20/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-99649
Guideline Name	Symdeko
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Submission of laboratory result documenting ONE of the following:

2.1 The patient is homozygous for the F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

OR

2.2 The patient has at least ONE mutation in the CFTR gene that is responsive to Symdeko (See Table in Background Section)

AND

3 - The patient is greater than or equal to 6 years of age

AND

4 - Prescribed by or in consultation with a specialist affiliated with a CF care center

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

Approval Criteria

1 - Provider attests that the patient has achieved a clinically meaningful response while on Symdeko therapy to ONE of the following:

- Lung function as demonstrated by percent predicted expiratory volume in 1 second (ppFEV1)
- Body mass index (BMI)
- Pulmonary exacerbations
- Quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score

AND

2 - Prescribed by, or in consultation with, a specialist affiliated with a cystic fibrosis (CF) care center

2 . Background

Benefit/Coverage/Program Information

Table 1 CFTR Gene Mutations

A1067T	D1270N	F1052V	R1070W	S945L	3272-26A→G
A455E	D579G	F1074L	R117C	S977F	3849+10kbC→T
D110E	E193K	K1060T	R347H		711+3A→G
D110H	E56K	L206W	R352Q		2789+5G→A
D1152H	E831X	P67L	R74W		

3 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-99499
Guideline Name	Symlin
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Symlin	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient must have ONE of the following diagnoses:

- Type 1 diabetes
- Type 2 diabetes

AND **2** - Concurrent use of insulin therapy

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-117156
Guideline Name	Synagis
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/21/2022

Note:

PLEASE NOTE: PA IS NOT REQUIRED FOR CHILDREN UNDER 2 YEARS OF AGE

1 . Criteria

Product Name:Synagis*	
Diagnosis	Prematurity
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Patient is an infant born before 29 weeks, 0 days gestation

AND

1.2 Patient is less than 12 months of age at the start of RSV “season”

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV “season”***

AND

5 - The patient does not meet ONE of the following situations

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease

• Treatment of symptomatic RSV disease	
Notes	*NOTE: Approval for up to 5 doses per single RSV “season” ** Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports (http ://www.cdc.gov/surveillance/nrevss/rsv/index.html) • http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx ***NOTE: Infants in a neonatal intensive care unit who qualify for prop hylaxis may receive the first dose 48 to 72 hours before discharge to h ome or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in th e hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthl y doses may be needed.

Product Name:Synagis*	
Diagnosis	Chronic Lung Disease (CLD)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ALL of the following for patients age 0 to less than 12 months:

1.1.1 The patient is a preterm infant defined as gestational age less than 32 weeks, 0 days

AND

1.1.2 Patient has developed chronic lung disease (CLD) of prematurity

AND

1.1.3 There was a requirement for greater than 21% oxygen for at least the first 28 days after birth

OR

1.2 ALL of the following for patients age greater than or equal to 12 months to less than 24 months:

1.2.1 The patient was born at less than 32 weeks, 0 days gestation

AND

1.2.2 The patient required at least 28 days of oxygen after birth

AND

1.2.3 The patient continues to require supplemental oxygen, diuretics, or chronic systemic corticosteroid therapy within 6 months of the start of the second RSV “season”

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV “season”***

AND

5 - The patient does not meet ONE of the following situations

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease
- Treatment of symptomatic RSV disease

Notes	*NOTE: Approval for up to 5 doses per single RSV “season” ** Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports (http ://www.cdc.gov/surveillance/nrevss/rsv/index.html) • http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx ***NOTE: Infants in a neonatal intensive care unit who qualify for prop hylaxis may receive the first dose 48 to 72 hours before discharge to h ome or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in th e hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthl y doses may be needed.

Product Name:Synagis*	
Diagnosis	Congenital Heart Disease (CHD)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 ONE of the following for patients age 0 to less than 12 months:

1.1.1 Patient has hemodynamically significant congenital heart disease (CHD) including ONE of the following:

- Acyanotic heart disease and receiving medication to control congestive heart failure and will require cardiac surgical procedures
- Moderate to severe pulmonary hypertension
- Documentation that decisions regarding prophylaxis for infants with cyanotic heart defects were made in consultation with a pediatric cardiologist

OR

1.1.2 The patient is undergoing cardiac transplantation during the RSV “season”

OR

1.2 BOTH of the following:

1.2.1 The patient is greater than or equal to 12 months to less than 24 months of age:

AND

1.2.2 ONE of the following:

- After cardiac bypass
- At the conclusion of extracorporeal membrane oxygenation
- The patient is undergoing cardiac transplantation during the RSV “season”

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV “season”***

AND

5 - The patient does not meet ONE of the following situations

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease
- Treatment of symptomatic RSV disease

Notes	*NOTE: Approval for up to 5 doses per single RSV “season” ** Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports (http ://www.cdc.gov/surveillance/nrevss/rsv/index.html) • http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx ***NOTE: Infants in a neonatal intensive care unit who qualify for prop hylaxis may receive the first dose 48 to 72 hours before discharge to h ome or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in th e hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthl y doses may be needed.

Product Name:Synagis*	
Diagnosis	Congenital abnormalities of the airway or neuromuscular disease
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Patient is age 0 to less than 12 months

AND

1.2 Patient has ONE of the following:

- Neuromuscular disease
- A congenital anomaly that impairs the ability to clear secretions from the lower airway because of ineffective cough

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV “season”***

AND

5 - The patient does not meet ONE of the following situations

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy

• Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present] • Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present) • Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab • Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children • Synagis prophylaxis for prevention of nosocomial disease • Treatment of symptomatic RSV disease	
Notes	*NOTE: Approval for up to 5 doses per single RSV “season” ** Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports (http ://www.cdc.gov/surveillance/nrevss/rsv/index.html) • http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx ***NOTE: Infants in a neonatal intensive care unit who qualify for prop hylaxis may receive the first dose 48 to 72 hours before discharge to h ome or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in th e hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthl y doses may be needed.

Product Name:Synagis*	
Diagnosis	Immunocompromised children less than 24 months of age
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Patient is less than 24 months of age

AND

1.2 The patient is immunocompromised (e.g. receiving cancer chemotherapy, undergoing hematopoietic stem cell transplantation, or solid organ transplantation)

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV “season”***

AND

5 - The patient does not meet ONE of the following situations

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)
- Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab
- Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children
- Synagis prophylaxis for prevention of nosocomial disease
- Treatment of symptomatic RSV disease

Notes	*NOTE: Approval for up to 5 doses per single RSV “season” ** Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports (http

	://www.cdc.gov/surveillance/nrevss/rsv/index.html) • http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx ***NOTE: Infants in a neonatal intensive care unit who qualify for prop hylaxis may receive the first dose 48 to 72 hours before discharge to h ome or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in th e hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthl y doses may be needed.

Product Name:Synagis*	
Diagnosis	Cystic fibrosis (CF)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following for patients age 0 to less than 12 months:

1.1.1 Patient has cystic fibrosis

AND

1.1.2 Patient has clinical evidence of at least ONE of the following:

- Chronic lung disease (CLD)
- Nutritional compromise
- Failure to thrive defined as weight for length less than the 10th percentile on a pediatric growth chart

OR

1.2 BOTH of the following:

1.2.1 Patient is greater than or equal to 12 months to less than 24 months of age

AND

1.2.2 Patient has manifestations of severe lung disease including ONE of the following:

- Previous hospitalization for pulmonary exacerbation in the first year of life
- Abnormalities on chest radiography or chest computed tomography that persists when stable
- Weight for length less than the 10th percentile on a pediatric growth chart

AND

2 - Administered during RSV season**

AND

3 - Monthly dose of Synagis does not exceed 15 milligram per kilogram per dose

AND

4 - Monthly dose of Synagis does not exceed 5 doses per single RSV “season”***

AND

5 - The patient does not meet ONE of the following situations

- Infants and children with hemodynamically insignificant heart disease (e.g., secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, and patent ductus arteriosus)
- Infants with congenital heart disease and cardiac lesions adequately corrected by surgery, unless they continue to require medication for congestive heart failure
- Infants with cardiomyopathy sufficiently mild that they do not require pharmacotherapy
- Routine use of prophylaxis in children with Down syndrome [unless qualifying heart disease, CLD, airway clearance issues (the inability to clear secretions from the upper airway because of ineffective cough), or prematurity (less than 29 weeks, 0 days gestation) is present]
- Routine use of prophylaxis in children with cystic fibrosis (unless indications noted in proven indications above are present)

• Administration of monthly Synagis prophylaxis after an infant or child has experienced a breakthrough RSV hospitalization during the current season if child had met criteria for palivizumab • Prophylaxis for primary asthma prevention or to reduce subsequent episodes of wheezing in infants and children • Synagis prophylaxis for prevention of nosocomial disease • Treatment of symptomatic RSV disease	
Notes	*NOTE: Approval for up to 5 doses per single RSV “season” ** Information regarding RSV season may be found at: • Centers for Disease and Prevention (CDC) surveillance reports (http ://www.cdc.gov/surveillance/nrevss/rsv/index.html) • http://uhc-cs-10.uhc.com/sites/cspm/CSSP/Pages/Synagis.aspx ***NOTE: Infants in a neonatal intensive care unit who qualify for prop hylaxis may receive the first dose 48 to 72 hours before discharge to h ome or promptly after discharge. If the first dose is administered in the hospital, this dose will be considered the first dose of the maximum 5 dose series for the season. And any subsequent doses received in th e hospital setting, are also considered as part of the maximum 5 dose series. For infants born during the RSV “season,” fewer than 5 monthl y doses may be needed.

2 . Background

Benefit/Coverage/Program Information
Additional Information In most of North America, peak RSV activity typically occurs between November and March, usually beginning in November or December, peaking in January or February, and ending by the end of March or sometime in April. Communities in the southern United States, particularly some communities in the state of Florida, tend to experience the earliest onset of RSV. Data from the Centers for Disease Control and Prevention (CDC) have identified variations in the onset and offset of the RSV “season” in the state of Florida that could affect the timing of Synagis administration. [10] • Despite varied onsets, the RSV “season” is of the same duration (5 months) in the different regions of Florida. • On the basis of the epidemiology of RSV in Alaska, particularly in remote regions where the burden of RSV disease is significantly greater than the general US population, the selection of Alaska Native infants eligible for prophylaxis may differ from the remainder of the United States. Clinicians may wish to use RSV surveillance data generated by the state of Alaska to assist in determining onset and end of the RSV season for qualifying infants.

- Limited information is available concerning the burden of RSV disease among Native American populations. However, special consideration may be prudent for Navajo and White Mountain Apache infants in the first year of life.

For analysis of National Respiratory and Enteric Virus Surveillance System (NREVSS) reports in the CDC Morbidity and Mortality Weekly Report, season onset is defined as the first of 2 consecutive weeks during which the mean percentage of specimens testing positive for RSV antigen is ≥ 10% and RSV "season" offset is defined as the last of 2 consecutive weeks during which the mean percentage of positive specimens is ≥ 10%. Use of specimens to determine the start of the RSV "season" requires that the number of specimens tested be statistically significant.

3 . Revision History

Date	Notes
11/21/2022	Added note to guideline, PA not required for children under 2 yo

Prior Authorization Guideline

Guideline ID	GL-99534
Guideline Name	Systane, Refresh, Gonak, Genteal, Tears Naturale
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:brand Systane, brand Refresh, brand Gonak, brand Genteal, Tears Naturale	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - History of failure, contraindication, or intolerance to ALL of the following:

- Generic equivalents for drops, ointments and gel formulations for Systane, Refresh, Gonak, Genteal, Tears Naturale, and Generic equivalent to the requested brand product
- sodium chloride ophthalmic ointment

2 . Revision History

Date	Notes
5/20/2021	Arizona Medicaid 7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-164155
Guideline Name	Talicia and rifabutin
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2025

1 . Criteria

Product Name:generic rifabutin	
Diagnosis	Mycobacterium Avium Complex Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of Mycobacterium Avium Complex Prophylaxis	

AND

2 - Prescribed by or in consultation with an HIV or infectious disease specialist

AND

3 - Member has failed azithromycin or clarithromycin or is intolerant to the medication due to significant adverse effects or both are contraindicated

AND

4 - The requested dosage does not exceed 450 mg per day

Product Name:generic rifabutin	
Diagnosis	Mycobacterium Avium Complex Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Member is responding positively to therapy

Product Name:generic rifabutin	
Diagnosis	Mycobacterium Avium Complex Prophylaxis
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - For doses that exceed 450mg, the use of this drug is supported by information from ONE of the following appropriate compendia of current literature:

- Food and Drug Administration (FDA) approved indications and limits
- Published practice guidelines and treatment protocols
- Comparative data evaluating the efficacy, type and frequency of side effects and potential drug interactions among alternative products as well as the risks, benefits and potential member outcomes
- Drug Facts and Comparisons
- American Hospital Formulary Service Drug Information
- United States Pharmacopeia – Drug Information
- DRUGDEX Information System
- UpToDate
- MicroMedex
- Peer-reviewed medical literature, including randomized clinical trials, outcomes, research data and pharmacoeconomic studies
- Other drug reference resources

Product Name:generic rifabutin	
Diagnosis	Helicobacter pylori Infection (off-label)
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of H. pylori infection

AND

2 - Prescribed in combination with amoxicillin and a proton pump inhibitor

Product Name:Talicia	
Diagnosis	Helicobacter pylori Infection
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of H. pylori infection

AND

2 - The medication is prescribed by or in consultation with a gastroenterologist or infectious disease specialist

AND

3 - One of the following:

3.1 Both of the following:

3.1.1 Trial and failure, contraindication, or intolerance to Bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI])

AND

3.1.2 Trial and failure, contraindication, or intolerance to BOTH of the following suggested first line treatment regimens:

- Clarithromycin based therapy (e.g., clarithromycin based triple therapy, clarithromycin based concomitant therapy) or PCAB-clarithromycin triple therapy
- Rifabutin triple therapy

OR

3.2 Both of the following:

3.2.1 Culture and sensitivity report indicate resistance or lack of susceptibility of H. pylori to all first-line treatment regimens except Rifabutin triple therapy

AND

3.2.2 Member must have tried and failed rifabutin triple therapy

Product Name:generic rifabutin	
Diagnosis	Tuberculosis (off-label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of tuberculosis infection

AND

2 - Prescribed by or in consultation with an HIV or infectious disease specialist

AND

3 - Current treatment with protease inhibitors or non-nucleoside reverse transcriptase inhibitors (NNRTIs) for the treatment of HIV infection

Product Name:generic rifabutin	
Diagnosis	Tuberculosis (off-label)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Member is responding positively to therapy

2 . Revision History

Date	Notes
1/30/2025	Updated guideline targets, removed dosing chart

Prior Authorization Guideline

Guideline ID	GL-329256
Guideline Name	Taltz (ixekizumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Taltz	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of chronic moderate to severe plaque psoriasis (PsO)

AND

1.2 Greater than or equal to 3 percent body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.3 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.4 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.5 History of failure, contraindication, or intolerance to one of the following topical therapies:

- Vtama
- Zoryve 0.3% cream

AND

1.6 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Infliximab
- Otezla (apremilast)
- A preferred ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a dermatologist

Product Name:Taltz	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a dermatologist

Product Name:Taltz	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following preferred biologic products

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

AND

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

- Rheumatologist
- Dermatologist

Product Name:Taltz	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

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

- Rheumatologist
- Dermatologist

Product Name:Taltz	
Diagnosis	Ankylosing Spondylitis (AS), Non-radiographic axial spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 One of the following diagnoses:

- Active ankylosing spondylitis (AS)
- Active non-radiographic axial spondyloarthritis (nr-axSpA)

AND

1.2 History of failure to TWO nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen) at maximally indicated doses, each used for at least 4 weeks within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.3 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Taltz	
Diagnosis	Ankylosing Spondylitis (AS), Non-radiographic axial spondyloarthritis (nr-axSpA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

2 . Revision History

Date	Notes
7/16/2025	Updated preferred agents/embedded steps, updated criteria through out. PsA, added 'or verification of paid claims'

Prior Authorization Guideline

Guideline ID	GL-99779
Guideline Name	Tarceva
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Pancreatic Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of pancreatic cancer	

AND

2 - Disease is ONE of the following:

- Locally advanced
- Unresectable
- Metastatic

AND

3 - Used in combination with Gemzar (gemcitabine)

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Pancreatic Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tarceva therapy

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Metastatic
- Recurrent

AND

3 - ONE of the following:

- Tumors are positive for epidermal growth factor receptor (EGFR)exon 19 deletions
- Tumors are positive for exon 21 (L858R) substitution mutations
- Tumors are positive for a known sensitizing EGFR mutation (e.g. in-frame exon 20 insertions, exon 18 G719 mutation, exon 21 L861Q mutation)

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tarceva therapy

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chordoma

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Chordoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tarceva therapy

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

- Diagnosis of kidney cancer
- Disease is stage IV or relapsed

AND

2 - Disease is of non-clear cell histology

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Kidney Cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tarceva therapy

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of metastatic brain cancer from Non-Small Cell Lung Cancer (NSCLC)

AND

2 - ONE of the following:

- Tumors are positive for epidermal growth factor receptor (EGFR) exon 19 deletions
- Tumors are positive for exon 21 (L858R) substitution mutations
- Tumors are positive for a known sensitizing EGFR mutation (e.g., in-frame exon 20 insertions, exon 18 G719 mutation, exon 21 L861Q mutation)

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tarceva therapy

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Vulvar cancer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of vulvar cancer

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	Vulvar cancer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tarceva therapy

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Tarceva will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Brand Tarceva, generic erlotinib	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Tarceva therapy

2 . Revision History

Date	Notes
6/2/2021	Arizona Medicaid 7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-99771
Guideline Name	Targretin
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Targretin caps, generic bexarotene caps, Targretin gel	
Diagnosis	Cutaneous T-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cutaneous T-cell lymphoma (CTCL)	

AND

2 - History of failure, contraindication, or intolerance to at least one prior therapy (including skin-directed therapies [e.g., corticosteroids (clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate), phototherapy, or systemic therapies [e.g. Interferons])

Product Name:Brand Targretin caps, generic bexarotene caps, Targretin gel	
Diagnosis	Cutaneous T-Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has not had disease progression while on therapy

Product Name:Brand Targretin caps, generic bexarotene caps, Targretin gel	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Targretin will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Brand Targretin caps, generic bexarotene caps, Targretin gel	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Targretin therapy	

2 . Revision History

Date	Notes
6/2/2021	Arizona Medicaid 7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-113527
Guideline Name	Tarpeyo (budesonide)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/8/2022

1 . Criteria

Product Name:Tarpeyo	
Approval Length	9 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of primary immunoglobulin A nephropathy (IgAN) as confirmed by a kidney biopsy

AND

2 - Patient is at risk of rapid disease progression [e.g., generally a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool]

AND

3 - Used to reduce proteinuria

AND

4 - Estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m2

AND

5 - One of the following:

5.1 Patient has been on a minimum 90-day trial of a maximally tolerated dose and will continue to receive therapy with one of the following:

- An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

OR

5.2 Patient has a contraindication or intolerance to both ACE inhibitors and ARBs

AND

6 - Trial and failure, contraindication, or intolerance to another glucocorticoid (e.g., methylprednisolone, prednisone)

AND

7 - Prescribed by or in consultation with a nephrologist

2 . Revision History

Date	Notes
9/8/2022	Removed references, no clinical criteria changes.

Prior Authorization Guideline

Guideline ID	GL-99772
Guideline Name	Tasigna
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Tasigna	
Diagnosis	Chronic Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic myeloid leukemia

AND

2 - ONE of the following:

2.1 Patient is not a candidate for imatinib (Gleevec) as attested by physician

OR

2.2 Patient is currently on Tasigna therapy

Product Name:Tasigna	
Diagnosis	Chronic Myeloid Leukemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tasigna therapy

Product Name:Tasigna	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of progressive gastrointestinal stromal tumor (GIST)

AND

2 - History of failure, contraindication, or intolerance to ALL of the following:

- Gleevec (imatinib)
- Sutent (sunitinib)
- Stivarga (regorafenib)

Product Name:Tasigna	
Diagnosis	Gastrointestinal Stromal Tumor (GIST)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tasigna therapy

Product Name:Tasigna	
Diagnosis	Acute Lymphoblastic Leukemia (ALL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ALL)

Product Name:Tasigna	
Diagnosis	Acute Lymphoblastic Leukemia (ALL)

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

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Tasigna therapy

Product Name:Tasigna	
Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of myeloid/lymphoid neoplasms with eosinophilia and ABL1 (gene) rearrangement

AND

2 - Neoplasm is in blast or chronic phase

Product Name:Tasigna	
Diagnosis	Myeloid/Lymphoid Neoplasms with Eosinophilia and Tyrosine Kinase Fusion Genes
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient does not show evidence of progressive disease while on Tasigna therapy

Product Name:Tasigna	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Tasigna will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.	

Product Name:Tasigna	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Tasigna therapy	

2 . Revision History

Date	Notes
6/2/2021	Arizona Medicaid 7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-99652
Guideline Name	Tegsedi
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Tegsedi	
Diagnosis	Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - BOTH of the following:	

- Diagnosis of Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
- Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M)

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Documentation of ONE of the following:

- Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb
- Patient has a baseline familial amyloidotic polyneuropathy (FAP) Stage 1 or 2
- Patient has a baseline neuropathy impairment (NIS) score greater than or equal to 10 and less than or equal to 130

AND

4 - Patient has not had a liver transplant

AND

5 - Presence of clinical signs and symptoms of the disease (e.g., peripheral sensorimotor polyneuropathy, autonomic neuropathy, motor disability, etc.)

AND

6 - Patient is not receiving Tegsedi in combination with ONE of the following:

- Oligonucleotide agents [e.g., Onpattro (patisiran)]
- Tafamidis (e.g., Vyndaqel, Vyndamax)

Diagnosis	Hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has previously received treatment with Tegsedi

AND

2 - Prescribed by or in consultation with a neurologist

AND

3 - Documentation of ONE of the following:

- Patient continues to have a polyneuropathy disability (PND) score less than or equal to IIIb
- Patient continues to have a familial amyloidotic polyneuropathy (FAP) Stage 1 or 2
- Patient continues to have a neuropathy impairment (NIS) score greater than or equal to 10 and less than or equal to 130

AND

4 - Documentation that the patient has experienced a positive clinical response to Tegsedi therapy (e.g., improved neurologic impairment, motor function, quality of life, slowing of disease progression, etc.)

AND

5 - Patient is not receiving Tegsedi in combination with ONE of the following:

- Oligonucleotide agents [e.g., Onpattro (patisiran)]

- Tafamidis (e.g., Vyndaqel, Vyndamax)

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-127089
Guideline Name	Tepezza (teprotumumab-trbw)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2023

1 . Criteria

Product Name:Tepezza	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting diagnosis of thyroid eye disease (TED)

AND

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

- Endocrinologist
- Specialist with expertise in the treatment of TED
- Ophthalmologist

AND

3 - Treatment with Tepezza has not exceeded a total of 8 infusions

2 . Revision History

Date	Notes
6/26/2023	Removed criteria for TED severity due to expanded indication, added ophthalmologist as prescriber option.

Prior Authorization Guideline

Guideline ID	GL-457217
Guideline Name	Test Strips
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Non-preferred Test Strip Products	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - History of failure, contraindication, or intolerance to BOTH of the following*:

- True Metrix
- Accu-Chek

OR

2 - Patient is on an insulin pump

OR

3 - Patient is visually impaired

Notes	*See background section for plan specific preferred agents

Product Name:Preferred or non-preferred test strip products	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - ONE of the following:

1.1 For Insulin Dependent or Pregnant patients, the physician must confirm the patient requires a greater quantity because of more frequent blood glucose testing (e.g., patients on intravenous insulin infusions)

OR

1.2 For Non-Insulin Dependent Patients, ONE the following:

1.2.1 The patient is experiencing or is prone to hypoglycemia or hyperglycemia and requires additional testing to achieve glycemic control

OR

1.2.2 The patient's physician is adjusting medications and the patient requires additional blood glucose testing during this time

OR

1.2.3 The patient's physician is adjusting MNT (medical nutrition therapy) and the patient requires additional blood glucose testing during this time

OR

1.2.4 The patient requires additional testing due to fluctuations in blood glucose due to physical activity or exercise

OR

1.2.5 Other circumstances where prescribing physician confirms that the patient requires a greater quantity because of more frequent blood glucose testing (clinical review required by OptumRx reviewing pharmacist and/or medical director)

2 . Background

Benefit/Coverage/Program Information

Preferred Test Strips According to Plan

PLAN	PREFERRED TEST STRIPS
Arizona Complete Health	Accu-Chek Guide test strips
Care1st	OneTouch Ultra test strips OneTouch Verio test strips
MercyCare	True Metrix glucometers and strips

Banner University Family Care	Freestyle OneTouch Ultra test strips OneTouch Verio test strips
Health Choice	Accu-Check products
Molina	True Metrix
UHC/C&S AZ	Accu-Check test strips Contour test strips

3 . Revision History

Date	Notes
12/17/2025	Updated background table of preferred products.

Prior Authorization Guideline

Guideline ID	GL-731224
Guideline Name	Testosterone - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/14/2026

1 . Criteria

Product Name:PREFERRED: generic testosterone 1.62% gel (generic for Androgel), Depo-testosterone, testosterone cypionate, testosterone enanthate; NON-PREFERRED: Andrela, Andrenyx, generic testosterone 1% gel/pump, Brand Androgel, Brand Testim, generic testosterone TD gel (generic Testim), Brand Vogelxo gel/pump, generic testosterone 1.62% gel, generic testosterone TD gel/pump (generic Vogelxo), generic testosterone 2% TD gel (generic Fortesta), testosterone topical 30mg/act solution, Azmiro, Jatenzo, Kyzatrex, Natesto, Tlando, Undecatrex, Xyosted	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

1.1 TWO pre-treatment serum total testosterone levels less than 300 ng/dL (less than 10.4 nmol/L) or less than the reference range for the lab, taken at separate times (Document lab value and date for both levels)

OR

1.2 BOTH of the following:

1.2.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)

AND

1.2.2 ONE pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (less than 5 ng/dL or less than 0.17 nmol/L) or less than the reference range for the lab (This may require treatment to be temporarily held. Document lab value and date)

OR

1.3 Patient has a history of ONE of the following:

- Bilateral orchiectomy
- Panhypopituitarism
- A genetic disorder known to cause hypogonadism (e.g., congenital anorchia, Klinefelter's syndrome)

AND

2 - Patient is NOT taking ONE of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope

- Saizen

AND

3 - Patient is NOT taking with an Aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], or Aromasin [exemestane])

AND

4 - Patient was male at birth

AND

5 - Diagnosis of hypogonadism

AND

6 - ONE of the following:

- Significant reduction in weight (less than 90 percent ideal body weight) (e.g., AIDS wasting syndrome)
- Osteopenia
- Osteoporosis
- Decreased bone density
- Decreased libido
- Organic cause of testosterone deficiency (eg, injury, tumor, infection, or genetic defects)

AND

7 - If the request is for a NON-PREFERRED drug: Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic testosterone 1.62% gel (generic for Androgel by preferred manufacturers)

Product Name:PREFERRED: generic testosterone 1.62% gel (generic for Androgel), Depo-testosterone, testosterone cypionate, testosterone enanthate; NON-PREFERRED: Andrela, Andrenyx, generic testosterone 1% gel/pump, Brand Androgel, Brand Testim, generic

testosterone TD gel (generic Testim), Brand Vogelxo gel/pump, generic testosterone 1.62% gel, generic testosterone TD gel/pump (generic Vogelxo), generic testosterone 2% TD gel (generic Fortesta), testosterone topical 30mg/act solution, Azmiro, Jatenzo, Kyzatrex, Natesto, Tlando, Undecatrex, Xyosted	
Diagnosis	Gender Dysphoria in Patients less than 19 years old
Guideline Type	Prior Authorization
Approval Criteria **1** - Testosterone products used for gender dysphoria in patients less than 19 years of age are no longer covered under Medicaid and will be denied as a benefit exclusion. If requested testosterone product was started ON or BEFORE October 13, 2026, patient will be grandfathered for 6 months.	
Notes	Note: Testosterone products when used for gender dysphoria in patie nts less than 19 years of age are no longer covered under Medicaid a nd will be denied as benefit exclusion. If requested testosterone produ ct was started ON or BEFORE October 13, 2026, patients will be gran dfathered for 6 months.

Product Name:PREFERRED: generic testosterone 1.62% gel (generic for Androgel), Depo-testosterone, testosterone cypionate, testosterone enanthate; NON-PREFERRED: Andrela, Andrenyx, generic testosterone 1% gel/pump, Brand Androgel, Brand Testim, generic testosterone TD gel (generic Testim), Brand Vogelxo gel/pump, generic testosterone 1.62% gel, generic testosterone TD gel/pump (generic Vogelxo), generic testosterone 2% TD gel (generic Fortesta), testosterone topical 30mg/act solution, Azmiro, Jatenzo, Kyzatrex, Natesto, Tlando, Undecatrex, Xyosted	
Diagnosis	Gender Dysphoria in Adults age 19 and older
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is 19 years of age or older **AND**	

2 - Patient is using hormones to change physical characteristics

AND

3 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

AND

4 - Patient is NOT taking ONE of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

5 - Patient is NOT taking with an Aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])

AND

6 - If the request is for a NON-PREFERRED drug: Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic testosterone 1.62% gel (generic for Androgel by preferred manufacturers)

Product Name:PREFERRED: generic testosterone 1.62% gel (generic for Androgel), Depo-testosterone, testosterone cypionate, testosterone enanthate; NON-PREFERRED: Andrela, Andrenyx, generic testosterone 1% gel/pump, Brand Androgel, Brand Testim, generic testosterone TD gel (generic Testim), Brand Vogelxo gel/pump, generic testosterone 1.62% gel, generic testosterone TD gel/pump (generic Vogelxo), generic testosterone 2% TD gel (generic Fortesta), testosterone topical 30mg/act solution, Azmiro, Jatenzo, Kyzatrex, Natesto, Tlando, Undecatrex, Xyosted

Diagnosis	Hypogonadism, Gender Dysphoria in Adults 19 years and older
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Follow-up total serum testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document value and date)

OR

1.2 Follow-up total serum testosterone level drawn within the past 12 months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

OR

1.3 BOTH of the following:

1.3.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV disease, liver disorder, diabetes, obesity)

AND

1.3.2 ONE of the following:

1.3.2.1 Follow-up calculated free or bioavailable testosterone level drawn within the past 12 months is within or below the normal male limits of the reporting lab (document lab value and date)

OR

1.3.2.2 Follow-up calculated free or bioavailable testosterone level drawn within the past 12

months is outside of upper male limits of normal for the reporting lab and the dose is adjusted (document value and date)

AND

2 - Patient is NOT taking ONE of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

3 - Patient is NOT taking with an Aromatase inhibitor (e.g., Arimidex [anastrozole], Femara [letrozole], Aromasin [exemestane])

AND

4 - If the request is for a NON-PREFERRED drug: Submission of medical records (e.g., chart notes) or paid claims confirming a history of failure or intolerance to generic testosterone 1.62% gel (generic for Androgel by preferred manufacturers)

2 . Revision History

Date	Notes
9/23/2026	Gender dysphoria criteria updated, no longer covered for patients les s than 19yo under Medicaid.

Prior Authorization Guideline

Guideline ID	GL-642277
Guideline Name	Tezspire (tezepelumab-ekko)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Tezspire	
Diagnosis	Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of severe asthma

AND

2 - Patient is 12 years of age or older

AND

3 - One of the following:

- Patient has had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months
- Prior asthma-related hospitalization within the past 12 months

AND

4 - Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications:

4.1 Both of the following:

- High-dose inhaled corticosteroid (ICS) (i.e., greater than 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)

OR

4.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

AND

5 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to ALL of the following:

- Dupixent (dupilumab)
- Fasenra (benralizumab)
- Xolair (omalizumab)

AND

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

- Pulmonologist
- Allergist/Immunologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy as evidenced by one of the following:

- A reduction in asthma exacerbations
- Improvement in forced expiratory volume in 1 second (FEV1) from baseline

AND

2 - Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to ALL of the following:

- Dupixent (dupilumab)
- Fasenra (benralizumab)

- Xolair (omalizumab)

AND

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

- Pulmonologist
- Allergist/Immunologist

Product Name:Tezspire	
Diagnosis	Chronic rhinosinusitis with nasal polyps (CRSwNP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 12 years of age or older

AND

2 - Submission of documentation (e.g., chart notes) confirming ALL of the following

2.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by ALL of the following:

2.1.1 TWO or more of the following symptoms for greater than or equal to 12 weeks duration:

- Mucopurulent discharge
- Nasal obstruction and congestion
- Decreased or absent sense of smell
- Facial pressure or pain

AND

2.1.2 ONE of the following:

- Evidence of inflammation on paranasal sinus examination or computed tomography (CT)
- Evidence of purulence coming from paranasal sinuses or ostiomeatal complex

AND

2.1.3 The presence of nasal polyps

AND

2.2 ONE of the following:

- Patient has required prior sino-nasal surgery
- Patient has required systemic corticosteroids in the previous 2 years

AND

2.3 Patient has been unable to obtain symptom relief after trial of ALL of the following agents/classes of agents:

- Nasal saline irrigations
- Intranasal corticosteroids (e.g. fluticasone, mometasone, triamcinolone, etc.)
- Antileukotriene agents (e.g. montelukast, zafirlukast, zileuton)

AND

3 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Dupixent (dupilumab)
- Xolair (omalizumab)

AND

4 - Used in combination with another agent for CRSwNP (i.e., intranasal corticosteroids, nasal saline)

AND

5 - Patient is NOT receiving Tezspire in combination with another biologic medication [e.g., Nucala (mepolizumab), (Xolair (omalizumab), Dupixent (dupilumab)]

AND

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

- Otolaryngologist
- Allergist
- Pulmonologist

Product Name:Tezspire	
Diagnosis	Chronic rhinosinusitis with nasal polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming positive clinical response to therapy

AND

2 - Paid claims or submission of documentation (e.g., chart notes) demonstrating history of failure, contraindication, or intolerance to BOTH of the following:

- Dupixent (dupilumab)
- Xolair (omalizumab)

AND

3 - Used in combination with another agent for CRSwNP (i.e., intranasal corticosteroids, nasal saline)

AND

4 - Patient is NOT receiving Tezspire in combination with another biologic medication [e.g., Nucala (mepolizumab), (Xolair (omalizumab), Dupixent (dupilumab)]

AND

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

- Otolaryngologist
- Allergist
- Pulmonologist

2 . Revision History

Date	Notes
6/24/2026	Dupixent Preferred 10/1/26: updated steps for Asthma/CRSwNP

Prior Authorization Guideline

Guideline ID	GL-99780
Guideline Name	Thalomid
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Thalomid	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple myeloma

Product Name:Thalomid	
Diagnosis	Multiple Myeloma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Thalomid therapy

Product Name:Thalomid	
Diagnosis	Erythema Nodosum Leprosum (ENL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe erythema nodosum leprosum (ENL)

AND

2 - ONE of the following:

2.1 Used for acute treatment

OR

2.2 Used as maintenance therapy for prevention & suppression of cutaneous manifestations of ENL recurrence

Product Name:Thalomid

Diagnosis	Erythema Nodosum Leprosum (ENL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Thalomid therapy

Product Name:Thalomid	
Diagnosis	Aphthous Stomatitis or Ulcer
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe, recurrent aphthous stomatitis or ulcer

Product Name:Thalomid	
Diagnosis	Aphthous Stomatitis or Ulcer
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Thalomid therapy

Product Name:Thalomid

Diagnosis	Pyoderma Gangrenosum
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of pyoderma gangrenosum

AND

2 - Used as third line treatment

Product Name:Thalomid	
Diagnosis	Pyoderma Gangrenosum
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Thalomid therapy

Product Name:Thalomid	
Diagnosis	Cutaneous Manifestations Systemic Lupus Erythematosus (SLE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cutaneous manifestations of systemic lupus erythematosus (SLE)

Product Name:Thalomid	
Diagnosis	Cutaneous Manifestations Systemic Lupus Erythematosus (SLE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Thalomid therapy

Product Name:Thalomid	
Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Castleman's Disease (CD)

AND

2 - NOT used as first line therapy

Product Name:Thalomid	
Diagnosis	B-Cell Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Thalomid therapy

Product Name:Thalomid	
Diagnosis	Myelofibrosis-Associated Anemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary myelofibrosis

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 Serum erythropoietin levels less than 500 mU/mL

AND

2.1.2 History of failure, contraindication, or intolerance to erythropoietins [e.g., Procrit (epoetin alfa)]

OR

2.2 Serum erythropoietin levels greater than or equal to 500 mU/mL

Product Name:Thalomid	
Diagnosis	Myelofibrosis-Associated Anemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation that member has evidence of symptom improvement or reduction in spleen-liver volume while on Thalomid

Product Name:Thalomid	
Diagnosis	Acquired Immunodeficiency Syndrome (AIDS)- Related Kaposi Sarcoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Acquired Immunodeficiency Syndrome (AIDS)- Related Kaposi Sarcoma

AND

2 - Patient is currently being treated with antiretroviral therapy (ART)

AND

3 - Not used as first line therapy

Product Name:Thalomid	
Diagnosis	AIDS- Related Kaposi Sarcoma

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

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Thalomid therapy

Product Name:Thalomid	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Thalomid will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Thalomid	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Thalomid therapy

2 . Revision History

Date	Notes
6/3/2021	Arizona Medicaid 7.1 Implementation

Prior Authorization Guideline

Guideline ID	GL-525300
Guideline Name	Thrombopoiesis Stimulating Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Preferred: Nplate, generic eltrombopag tablet, Brand Promacta powder pack for suspension; Non-Preferred: Alvaiz, Doptelet, Doptelet Sprinkle, Brand Promacta tablet, generic eltrombopag powder pack for suspension, Tavalisse, Wayrilz	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic immune thrombocytopenia (ITP)	

AND

2 - History of failure, contraindication, or intolerance to ONE of the following:

- Corticosteroids
- Immunoglobulins
- Splenectomy

AND

3 - For Non-Preferred Drug requests: History of failure, contraindication, or intolerance to BOTH of the following preferred alternatives:

- generic eltrombopag tablet
- Nplate

Product Name:Preferred: Nplate, generic eltrombopag tablet, Brand Promacta powder pack for suspension; Non-Preferred: Alvaiz, Doptelet, Doptelet Sprinkle, Brand Promacta tablet, generic eltrombopag powder pack for suspension, Tavalisse, Wayrilz	
Diagnosis	Chronic Immune (idiopathic) thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - For Non-Preferred Drug requests: History of failure, contraindication, or intolerance to BOTH of the following preferred alternatives:

- generic eltrombopag tablet

- Nplate

Product Name:Preferred: generic eltrombopag tablet, Brand Promacta powder pack for suspension; Non-Preferred: Alvaiz, Brand Promacta tablet, generic eltrombopag powder pack for suspension	
Diagnosis	Severe Aplastic Anemia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe aplastic anemia

AND

2 - One of the following:

2.1 Used in combination with standard immunosuppressive therapy [e.g., Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine]

OR

2.2 History of failure, contraindication, or intolerance to at least one course of immunosuppressive therapy [e.g., Atgam (antithymocyte globulin equine), Thymoglobulin (antithymocyte globulin rabbit), cyclosporine]

AND

3 - For Non-Preferred Drug requests: History of failure, contraindication, or intolerance to generic eltrombopag tablet

Product Name:Preferred: generic eltrombopag tablet, Brand Promacta powder pack for suspension; Non-Preferred: Alvaiz, Brand Promacta tablet, generic eltrombopag powder pack for suspension	
Diagnosis	Severe Aplastic Anemia
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - For Non-Preferred Drug requests: History of failure, contraindication, or intolerance to generic eltrombopag tablet

Product Name:Preferred: generic eltrombopag tablet, Brand Promacta powder pack for suspension; Non-Preferred: Alvaiz, Brand Promacta tablet, generic eltrombopag powder pack for suspension	
Diagnosis	Chronic Hepatitis C-associated Thrombocytopenia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic Hepatitis C-associated thrombocytopenia

AND

2 - One of the following:

- Planning to initiate and maintain interferon-based treatment

- Currently receiving interferon-based treatment

AND

3 - For Non-Preferred Drug requests: History of failure, contraindication, or intolerance to generic eltrombopag tablet

Product Name:Preferred: generic eltrombopag tablet, Brand Promacta powder pack for suspension; Non-Preferred: Alvaiz, Brand Promacta tablet, generic eltrombopag powder pack for suspension	
Diagnosis	Chronic Hepatitis C-associated Thrombocytopenia
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Patient is currently on antiviral interferon therapy for treatment of chronic Hepatitis C

AND

3 - For Non-Preferred Drug requests: History of failure, contraindication, or intolerance to generic eltrombopag tablet

Product Name:Non-Preferred: Doptelet, Doptelet Sprinkle, Mulpleta	
Diagnosis	Thrombocytopenia
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of thrombocytopenia

AND

2 - Patient has chronic liver disease

AND

3 - Patient is scheduled to undergo a procedure

Product Name:Preferred: Nplate	
Diagnosis	Hematopoietic Syndrome of Acute Radiation Syndrome [HS-ARS]
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Hematopoietic Syndrome of Acute Radiation Syndrome [HS-ARS]

AND

2 - Patient is receiving myelosuppressive doses of radiation

2 . Revision History

Date	Notes
3/5/2026	January P&T changes: Brand Promacta tablet to NPD, generic eltro mbopag tablet to preferred (Nplate and Promacta susp still PDL), up

	dated preferred prerequisites. Removed embedded step for Thrombo cytopenia/CLD for Doptelet/Mulpleta.

Prior Authorization Guideline

Guideline ID	GL-99653
Guideline Name	Tobramycin Inhalation - ARIZONA
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Bethkis, Kitabis	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cystic fibrosis (CF)	

Product Name:Brand TOBI Nebulizer Solution, generic tobramycin solution for inhalation, TOBI Podhaler	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Lung infection with positive culture demonstrating Pseudomonas aeruginosa infection

AND

3 - History of failure, intolerance, or contraindication to BOTH of the following

- Brand Bethkis
- Kitabis

Product Name:Brand TOBI Nebulizer Solution, generic tobramycin solution for inhalation, TOBI Podhaler	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes

3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Prior Authorization Guideline

Guideline ID	GL-666358
Guideline Name	Tocilizumab
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Preferred: Tyenne SC/IV, Avtozma SC/IV, Tofidence IV	
Diagnosis	Rheumatoid Arthritis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of moderately to severely active Rheumatoid Arthritis (RA)

AND

1.2 History of failure to a 3 month trial of ONE non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Preferred: Tyenne SC/IV, Avtozma SC/IV, Tofidence IV	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis

AND

1.2 History of failure to a minimum duration of a 6-week trial, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:

- leflunomide
- methotrexate

AND

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

Product Name:Preferred: Tyenne SC/IV, Avtozma SC/IV, Tofidence IV	
Diagnosis	Systemic Juvenile Idiopathic Arthritis (SJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of active systemic juvenile idiopathic arthritis

AND

1.2 History of failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses:

- Minimum duration of a 3-month trial and failure of methotrexate
- Minimum duration of a 1-month trial of nonsteroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen
- Minimum duration of a 2-week trial of systemic glucocorticoid (e.g., prednisone)

AND

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

Product Name:Preferred: Tyenne SC/IV, Avtozma SC/IV, Tofidence IV	
Diagnosis	Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of giant cell arteritis (GCA)

AND

1.2 History of failure, contraindication, or intolerance to a glucocorticoid (e.g., prednisone)

AND

2 - Prescribed by or in consultation with a rheumatologist

Product Name:Preferred: Tyenne SC/IV, Avtozma SC/IV, Tofidence IV	
Diagnosis	Rheumatoid Arthritis, Polyarticular Juvenile Idiopathic Arthritis (PJIA), Systemic Juvenile Idiopathic Arthritis (SJIA), Giant Cell Arteritis (GCA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

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

Product Name:Preferred: Tyenne SC, Avtozma SC

Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of active systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by ALL of the following:

1.1 ONE of the following:

1.1.1 Skin thickening of the fingers of both hands extending proximal to the metacarpophalangeal joints

OR

1.1.2 TWO of the following:

- Skin thickening of the fingers (e.g., puffy fingers, sclerodactyly of the fingers)
- Fingertip lesions (e.g., digital tip ulcers, fingertip pitting scars)
- Telangiectasia
- Abnormal nailfold capillaries
- Pulmonary arterial hypertension
- Raynaud's phenomenon
- SSc-related autoantibodies (e.g., anticentromere, anti-topoisomerase I, anti-RNA polymerase III)

AND

1.2 Presence of interstitial lung disease as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10% of the lungs

AND

2 - Prescribed by, or in consultation with, a pulmonologist

Product Name:Preferred: Tyenne SC, Avtozma SC	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy

AND

2 - Prescribed by, or in consultation with, a pulmonologist

Product Name:Preferred: Tyenne IV, Avtozma IV, Tofidence IV	
Diagnosis	Coronavirus disease 2019 (COVID-19)
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 2 years of age or older

AND

2 - Submission of medical records (e.g., chart notes) confirming a diagnosis of COVID-19

AND

3 - Patient is hospitalized (tocilizumab is only FDA approved when used for COVID 19 patients in an inpatient setting)

AND

4 - Currently receiving systemic corticosteroids

AND

5 - Patient requires one of the following:

- Supplemental oxygen
- Non-invasive mechanical ventilation
- Invasive mechanical ventilation
- Extracorporeal membrane oxygenation (ECMO)

Notes	NOTE: Tocilizumab is only FDA approved when used for COVID-19 p atients in an inpatient setting

Product Name:Non-Preferred*: Actemra SC/IV and newly launched tocilizumab products	
Approval Length	Requests for Non-Preferred biosimilars are not approved at this time
Guideline Type	Prior Authorization

Approval Criteria

1 - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred products are Tyenne (tocilizumab-aazg), Avtozma (tocilizumab-anoh), and Tofidence (tocilizumab-bavi). **Please note: The drug(s) listed above may require additional review.

Notes	*Patients must use preferred tocilizumab biosimilar(s).

2 . Revision History

Date	Notes
7/28/2026	Updated preferred products to include Avtozma and Tofidence.

Prior Authorization Guideline

Guideline ID	GL-136966
Guideline Name	Topical Capsaicin Products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/1/2023

1 . Criteria

Product Name:Diclareal	
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of osteoarthritis of the knees

AND

2 - Submission of medical records (e.g., chart notes, paid claims history) documenting history of failure to ALL of the following:

- diclofenac 1% topical gel
- diclofenac 2% topical solution
- topical capsaicin cream/patch

Product Name:Trubrexa	
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming requested medication is being used for the treatment of acute and chronic pain in muscles and joints associated with muscle soreness, strains, sprains, arthritis, simple backache, muscle stiffness, etc

AND

2 - Submission of medical records (e.g., chart notes, paid claims history) documenting trial and failure, contraindication, or intolerance to ALL of the following:

- diclofenac 1% topical gel
- topical capsaicin cream/patch
- topical lidocaine patch

2 . Revision History

Date	Notes
12/1/2023	New program

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-99574
Guideline Name	Topical NSAIDs
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Flector Patch, generic diclofenac epolamine 1.3% patch	
Approval Length	2 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute pain due to minor strains, sprains, or contusions

AND

2 - ONE of the following:

2.1 The patient did not receive adequate pain relief when treated with at least three preferred non-steroidal anti-inflammatory drugs (NSAIDs) (An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy)

- Diclofenac DR (Generic Voltaren)
- Diclofenac ER (Generic Voltaren ER)
- Etodolac (Generic Lodine)
- Etodolac ER (Generic Lodine ER)
- Fenoprofen (Generic Nalfon)
- Flurbiprofen (Generic Ansaid)
- Ibuprofen
- Indomethacin (Generic Indocin)
- Ketorolac (Generic Toradol)
- Mefenamic (Generic Ponstel)
- Meloxicam (Generic Mobic)
- Nabumetone (Generic Relafen)
- Nabumetone DS (Generic Relafen DS)
- Naproxen (Generic Anaprox)
- Naproxen DR (Generic Anaprox DR)
- Naproxen EC (Generic Anaprox EC)
- Oxaprozin (Generic Daypro)
- Piroxicam (Generic Feldene)
- Sulindac (Generic Clinoril)

OR

2.2 The patient has one of the following risk factors for NSAID-induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI (gastrointestinal) bleeding
- Untreated or active H. Pylori gastritis
- Concurrent use of oral corticosteroids (e.g. prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g. warfarin, heparin)
- Concurrent use of antiplatelets (e.g. aspirin including low-dose, clopidogrel)

Product Name:Pennsaid 2%, diclofenac sodium soln 1.5%	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of pain due to osteoarthritis of the knee(s)

AND

2 - ONE of the following:

2.1 The patient did not receive adequate pain relief when treated with at least three preferred non-steroidal anti-inflammatory drugs (NSAIDs) (An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy)

- Diclofenac DR (Generic Voltaren)
- Diclofenac ER (Generic Voltaren ER)
- Etodolac (Generic Lodine)
- Etodolac ER (Generic Lodine ER)
- Fenoprofen (Generic Nalfon)
- Flurbiprofen (Generic Ansaid)
- Ibuprofen
- Indomethacin (Generic Indocin)
- Ketorolac (Generic Toradol)
- Mefenamic (Generic Ponstel)
- Meloxicam (Generic Mobic)
- Nabumetone (Generic Relafen)
- Nabumetone DS (Generic Relafen DS)
- Naproxen (Generic Anaprox)
- Naproxen DR (Generic Anaprox DR)
- Naproxen EC (Generic Anaprox EC)
- Oxaprozin (Generic Daypro)
- Piroxicam (Generic Feldene)
- Sulindac (Generic Clinoril)

OR

2.2 The patient has one of the following risk factors for NSAID-induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI bleeding
- Untreated or active H. Pylori gastritis

- Concurrent use of oral corticosteroids (e.g. prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g. warfarin, heparin)
- Concurrent use of antiplatelets (e.g. aspirin including low-dose, clopidogrel)

AND

3 - Patient has a history of failure, intolerance, or contraindication to diclofenac topical gel 1% (Rx formulation), or Voltaren OTC (over the counter)

Product Name:generic diclofenac topical gel 1% (Rx formulation), Voltaren OTC	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of pain due to osteoarthritis of joints amenable to topical treatment, including but not limited to the hands, knees, ankles, elbows, feet, and wrists

AND

2 - ONE of the following:

2.1 The patient did not receive adequate pain relief when treated with at least three preferred non-steroidal anti-inflammatory drugs (NSAIDs) (An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy)

- Diclofenac DR (Generic Voltaren)
- Diclofenac ER (Generic Voltaren ER)
- Etodolac (Generic Lodine)
- Etodolac ER (Generic Lodine ER)
- Fenoprofen (Generic Nalfon)
- Flurbiprofen (Generic Ansaid)
- Ibuprofen
- Indomethacin (Generic Indocin)
- Ketorolac (Generic Toradol)
- Mefenamic (Generic Ponstel)
- Meloxicam (Generic Mobic)
- Nabumetone (Generic Relafen)
- Nabumetone DS (Generic Relafen DS)

- Naproxen (Generic Anaprox)
- Naproxen DR (Generic Anaprox DR)
- Naproxen EC (Generic Anaprox EC)
- Oxaprozin (Generic Daypro)
- Piroxicam (Generic Feldene)
- Sulindac (Generic Clinoril)

OR

2.2 The patient has one of the following risk factors for NSAID-induced adverse GI (gastrointestinal) events:

- Patient is greater than or equal to 65 years of age
- Prior history of peptic, gastric, or duodenal ulcer
- History of NSAID-related ulcer
- History of clinically significant GI bleeding
- Untreated or active H. Pylori gastritis
- Concurrent use of oral corticosteroids (e.g. prednisone, prednisolone, dexamethasone)
- Concurrent use of anticoagulants (e.g. warfarin, heparin)
- Concurrent use of antiplatelets (e.g. aspirin including low-dose, clopidogrel)

Prior Authorization Guideline

Guideline ID	GL-325196
Guideline Name	Trastuzumab Products
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Preferred: Ogivri	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The drug is being used as indicated by National Comprehensive Cancer Network (NCCN) guidelines with a Category of Evidence and Consensus of 1, 2A, or 2B

Product Name:Non-Preferred*: Herceptin, Hercessi, Herzuma, Kanjinti, Ontruzant, Trazimera, and newly launched trastuzumab products

Approval Length	Requests for Non-Preferred biosimilars are not approved at this time
Guideline Type	Prior Authorization
Approval Criteria **1** - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred product is Ogivri (trastuzumab-dkst). **Please note: The drug(s) listed above may require additional review.	
Notes	*Patients must use preferred trastuzumab biosimilar(s).

2 . Revision History

Date	Notes
7/16/2025	New program, updated NP criteria verbiage.

Prior Authorization Guideline

Guideline ID	GL-500248
Guideline Name	Tremfya (guselkumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/21/2026

1 . Criteria

Product Name:Tremfya SC 100mg*	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of chronic moderate to severe plaque psoriasis (PsO)

AND

1.2 Both of the following:

- Patient is 6 years of age or older
- Patient weighs at least 40 kg

AND

1.3 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.4 History of failure to one of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

1.5 History of failure of a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.6 History of failure, contraindication, or intolerance to one of the following topical therapies

- Vtama
- Zoryve 0.3% cream

AND

1.7 History of failure, contraindication, or intolerance to ALL of the following preferred biologic products:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- Infliximab
- Otezla (apremilast)
- A preferred ustekinumab biosimilar

AND

2 - Prescribed by or in consultation with a dermatologist

Notes	*If patient meets criteria above, please approve at GPI-14

Product Name:Tremfya SC 100mg*	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a dermatologist

Notes	*If patient meets criteria above, please approve at GPI-14

Product Name:Tremfya SC 100mg*	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of active psoriatic arthritis (PsA)

AND

1.2 Both of the following:

- Patient is 6 years of age or older
- Patient weighs at least 40 kg

AND

1.3 History of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

1.4 History of failure, contraindication, or intolerance to ALL of the following preferred biologic products:

- A preferred adalimumab biosimilar or Enbrel (etanercept)
- infliximab
- Orencia (abatacept)
- Otezla (apremilast)
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

AND

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

- Rheumatologist
- Dermatologist

Notes	*If patient meets criteria above, please approve at GPI-14

Product Name:Tremfya SC 100mg*	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

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

- Rheumatologist
- Dermatologist

Notes	*If patient meets criteria above, please approve at GPI-14

Product Name:Tremfya IV	
Diagnosis	Crohn's Disease (CD)
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active Crohn's Disease (CD)

AND

2 - One of the following:

- Frequent diarrhea and abdominal pain
- At least 10% weight loss
- Complications such as obstruction, fever, abdominal mass
- Abnormal lab values (e.g., C-reactive protein [CRP])
- CD Activity Index (CDAI) greater than 220

AND

3 - Submission of medical records (e.g., chart notes) or verification of paid claims history documenting BOTH of the following:

3.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Methotrexate (Rheumatrex, Trexall)

AND

3.2 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- A preferred ustekinumab biosimilar

AND

4 - Prescribed by or in consultation with a gastroenterologist

AND

5 - Will be administered as an intravenous induction dose

Product Name:Tremfya SC	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active Crohn's Disease (CD)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - One of the following:

3.1 Will be used as a maintenance dose following the intravenous induction doses

OR

3.2 ALL of the following:

3.2.1 Will be used for induction dosing

AND

3.2.2 One of the following:

- Frequent diarrhea and abdominal pain
- At least 10% weight loss
- Complications such as obstruction, fever, abdominal mass

- Abnormal lab values (e.g., C-reactive protein [CRP])
- CD Activity Index (CDAI) greater than 220

AND

3.2.3 Submission of medical records (e.g., chart notes) or verification of paid claims history documenting BOTH of the following:

3.2.3.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Methotrexate (Rheumatrex, Trexall)

AND

3.2.3.2 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- A preferred ustekinumab biosimilar

Product Name:Tremfya IV	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - One of the following:

- Greater than 6 stools per day
- Frequent blood in the stools
- Frequent urgency
- Presence of ulcers
- Abnormal lab values (e.g., hemoglobin, erythrocyte sedimentation rate, C-reactive protein)
- Dependent on, or refractory to, corticosteroids

AND

3 - Submission of medical records (e.g., chart notes) or verification of paid claims history documenting BOTH of the following:

3.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
- Azathioprine
- Corticosteroids (e.g., prednisone)

AND

3.2 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- Xeljanz oral tablet (tofacitinib) (IR or XR)
- A preferred ustekinumab biosimilar

AND

4 - Prescribed by or in consultation with a gastroenterologist

AND

5 - Will be administered as an intravenous induction dose

Product Name:Tremfya SC	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - Prescribed by or in consultation with a gastroenterologist

AND

3 - One of the following:

3.1 Will be used as a maintenance dose following the intravenous induction doses

OR

3.2 ALL of the following:

3.2.1 Will be used for induction dosing

AND

3.2.2 One of the following:

- Greater than 6 stools per day
- Frequent blood in the stools
- Frequent urgency
- Presence of ulcers

- Abnormal lab values (e.g., hemoglobin, erythrocyte sedimentation rate, C-reactive protein)
- Dependent on, or refractory to, corticosteroids

AND

3.2.3 Submission of medical records (e.g., chart notes) or verification of paid claims history documenting BOTH of the following:

3.2.3.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
- Azathioprine
- Corticosteroids (e.g., prednisone)

AND

3.2.3.2 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- Xeljanz oral tablet (tofacitinib) (IR or XR)
- A preferred ustekinumab biosimilar

Product Name:Tremfya SC	
Diagnosis	Crohn's Disease (CD), Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

AND

2 - Prescribed by or in consultation with a gastroenterologist

2 . Revision History

Date	Notes
1/21/2026	CD initial auth section (IV and SC), removed older verbiage, no chan ge to clinical intent.

Prior Authorization Guideline

Guideline ID	GL-99513
Guideline Name	Tretinoin Capsules - ARIZONA
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021
P&T Approval Date:	
P&T Revision Date:	

1 . Criteria

Product Name:Tretinoin capsules	
Diagnosis	Acute Promyelocytic Leukemia (APL)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of acute promyelocytic leukemia	

Product Name:Tretinoin capsules	
Diagnosis	Acute Promyelocytic Leukemia (APL)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to tretinoin capsules

Product Name:Tretinoin capsules	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Tretinoin capsules will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Tretinoin capsules	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to tretinoin capsules

2 . Revision History

Date	Notes
4/8/2021	7/1 Implementation

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-413207
Guideline Name	Tretinoin Topical
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/7/2025

1 . Criteria

Product Name:generic tretinoin cream and gel*	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Patient is 26 years of age or less

OR

1.2 ALL of the following:

1.2.1 Patient is greater than 26 years of age

AND

1.2.2 Diagnosis of acne vulgaris

AND

1.2.3 The patient must have a history of therapeutic failure, contraindication, or intolerance to ALL of the following:

- benzoyl peroxide
- topical clindamycin
- topical erythromycin

Notes	*Only generic covered, PA not required for patients 26 years of age or less.

2 . Revision History

Date	Notes
10/7/2025	Updated product name heading, no change to clinical intent.

Prior Authorization Guideline

Guideline ID	GL-589213
Guideline Name	Trikafta (elexacaftor/tezacaftor/ivacaftor)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Trikafta	
Diagnosis	Cystic Fibrosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cystic fibrosis (CF)	

AND

2 - Submission of medical records (e.g., chart notes) or laboratory results confirming the presence of at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene

AND

3 - One of the following:

3.1 CFTR mutation is responsive based on clinical or in vitro data

OR

3.2 CFTR mutation results in the production of CFTR protein

AND

4 - One of the following:

- For granule packets, patient is at least 2 to less than 6 years of age
- For tablets, patient is 6 years of age or older

AND

5 - Prescribed by, or in consultation with, a specialist affiliated with a CF care center

Product Name:Trikafta	
Diagnosis	Cystic Fibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Provider attests that the patient has achieved a clinically meaningful response while on Trikafta therapy to ONE of the following:

- Lung function as demonstrated by percent predicted expiratory volume in 1 second (ppFEV1)
- Body mass index (BMI)
- Pulmonary exacerbations
- Quality of life as demonstrated by Cystic Fibrosis Questionnaire-Revised (CFQ-R) respiratory domain score

AND

2 - Prescribed by, or in consultation with, a specialist affiliated with a cystic fibrosis (CF) care center

2 . Revision History

Date	Notes
4/30/2026	Updated dx confirmation criterion due to expanded indication, combi ned initial auths for tablets/granules.

Prior Authorization Guideline

Guideline ID	GL-731216
Guideline Name	Triptans - AZM
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Brand Amerge, Brand Imitrex tablets, Brand Imitrex injection, generic sumatriptan 6mg PFS, generic almotriptan, brand Maxalt, brand Maxalt MLT, Onzetra Xsail, brand Relpax, Rizafilm, Symbravo, Brand Treximet, generic sumatriptan-naproxen, Zembrace, brand Zomig, brand Zomig ZMT, brand Frova, generic frovatriptan, Tosymra	
Diagnosis	Non-preferred products
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of migraine headaches with or without aura	

AND

2 - Patient has a history of failure, contraindication, or intolerance to a trial of at least three preferred products (document drugs, duration, and date of trials)*

- naratriptan (generic Amerge)
- rizatriptan (generic Maxalt)
- sumatriptan (Generic Imitrex)
- zolmitriptan (Generic Zomig)
- eletriptan (generic Relpax)

AND

3 - For Brand Treximet and generic sumatriptan-naproxen requests ONLY, BOTH of the following (applies to Brand/generic Treximet ONLY):

3.1 Trial, failure, contraindication or intolerance to BOTH of the following:

- naproxen
- sumatriptan

AND

3.2 Physician has provided rationale for needing to use fixed-dose combination therapy with requested medication instead of taking individual products in combination (i.e., naproxen and sumatriptan)

AND

4 - For Symbravo requests ONLY, BOTH of the following (applies to Symbravo ONLY):

4.1 Trial, failure, contraindication or intolerance to BOTH of the following:

- meloxicam
- rizatriptan

AND

4.2 Physician has provided rationale for needing to use fixed-dose combination therapy with requested medication instead of taking individual products in combination (i.e., meloxicam and rizatriptan)

AND

5 - For Rizafilm requests ONLY: history of failure to rizatriptan ODT (applies to Rizafilm ONLY)

Product Name:Brand Imitrex (inj, cartridge, auto-injector and PFS), generic sumatriptan (inj, cartridge, auto-injector and PFS)*	
Diagnosis	Migraine Headaches with or without Aura
Approval Length	12 month(s)
Guideline Type	Quantity Limits

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

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

- Neurologist
- Pain management specialist

AND

3 - Patient is currently receiving prophylactic therapy with at least ONE of the following:

3.1 Amitriptyline (Elavil)

OR

3.2 One of the following beta-blockers:

- atenolol
- metoprolol
- nadolol**
- propranolol
- timolol**

OR

3.3 Divalproex sodium (Depakote/Depakote ER)

OR

3.4 OnabotulinumtoxinA (Botox) ***

OR

3.5 Topiramate (Topamax)

OR

3.6 Venlafaxine (Effexor/Effexor XR)

OR

3.7 Calcitonin gene-related peptide (CGRP) receptor antagonists [e.g., Aimovig (erenumab), Emgality (galcanezumab)]

AND

4 - One of the following:

4.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

4.2 Higher dose or quantity is supported by one of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

OR

4.3 Physician provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the Food and Drug Administration (FDA) for the diagnosis indicated

AND

5 - Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	* See “Quantity Limits” table in background section for quantity limits ** Nadolol and timolol are non-preferred and should not be included in denial to provider *** OnabotulinumtoxinA (Botox) is a medical benefit, should not be inc luded in denial to provider

Product Name:Brand Imitrex (inj, cartridge, auto-injector and PFS), generic sumatriptan (inj, cartridge, auto-injector and PFS)*	
Diagnosis	Cluster Headaches
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - Diagnosis of cluster headaches

AND

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

- Neurologist
- Pain management specialist

AND

3 - Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months.

AND

4 - One of the following:

4.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

4.2 Higher dose or quantity is supported by one of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

OR

4.3 Physician provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the Food and Drug Administration (FDA) for the diagnosis indicated

AND

5 - Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	* See “Quantity Limits” table in background section for quantity limits

Product Name:Brand Amerge, generic naratriptan, Brand Frova, generic frovatriptan, Brand Imitrex tablets and nasal spray, generic sumatriptan tablets and nasal spray, generic almotriptan, Brand Maxalt and Maxalt MLT, generic rizatriptan and rizatriptan MLT, Onzetra Xsail, Brand Relpax, generic eletriptan, Rizafilm, Symbravo, Brand Treximet, generic sumatriptan-naproxen, Zembrace Sym Touch, Brand Zomig and Zomig ZMT, generic zolmitriptan and zolmitriptan ZMT, brand Zomig nasal, generic zolmitriptan nasal spray, Tosymra *	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - Diagnosis of migraine headaches with or without aura

AND

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

- Neurologist
- Pain management specialist

AND

3 - Patient is currently receiving prophylactic therapy with at least ONE of the following:

3.1 Amitriptyline (Elavil)

OR

3.2 One of the following beta-blockers:

- atenolol

- metoprolol
- nadolol**
- propranolol
- timolol**

OR

3.3 Divalproex sodium (Depakote/Depakote ER)

OR

3.4 OnabotulinumtoxinA (Botox) ***

OR

3.5 Topiramate (Topamax)

OR

3.6 Venlafaxine (Effexor/Effexor XR)

OR

3.7 Calcitonin gene-related peptide (CGRP) receptor antagonists [e.g., Aimovig (erenumab), Emgality (galcanezumab)]

AND

4 - One of the following:

4.1 Higher dose or quantity is supported in the dosage and administration section of the manufacturer's prescribing information

OR

4.2 Higher dose or quantity is supported by one of the following compendia:

- American Hospital Formulary Service Drug Information
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary (USP-NF)

OR

4.3 Physician provides evidence from published biomedical literature to support safety and additional efficacy at doses/quantities greater than those approved by the FDA (Food and Drug Administration) for the diagnosis indicated

AND

5 - Physician acknowledges that the potential benefit outweighs the risk associated with the higher dose or quantity

Notes	* See “Quantity Limits” table in background section for quantity limits ** Nadolol and timolol are non-preferred and should not be included in denial to provider *** OnabotulinumtoxinA (Botox) is a medical benefit, should not be inc luded in denial to provider

Product Name:Brand Zomig nasal spray, generic zolmitriptan nasal spray	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a history of failure, contraindication, or intolerance to sumatriptan nasal spray

2 . Background

Benefit/Coverage/Program Information

Quantity Limits

Drug Name	Strength	Quantity Limit
Brand Amerge generic naratriptan	1mg, 2.5mg	9 tabs/month
Brand Frova Generic frovatriptan	2.5mg	9 tabs/month
Brand Imitrex tablets generic sumatriptan tablets	25mg, 50mg, 100mg	9 tabs/month
Brand Maxalt Generic rizatriptan	5mg, 10mg	9 tabs/month
Brand Maxalt MLT Generic rizatriptan ODT Rizafilm	5mg, 10mg	9 tabs/month 9 films/month
Generic almotriptan	6.25mg, 12.5mg	6 tabs/month
Relpax Generic eletriptan	20mg, 40mg	6 tabs/month
Brand Zomig Generic zolmitriptan	2.5mg, 5mg	6 tabs/month
Brand Zomig ZMT Generic zolmitriptan ODT	2.5mg, 5mg	6 tabs/month
Brand Imitrex Nasal Spray Generic sumatriptan nasal spray	5mg, 20mg	6 spray devices/month
Zomig Nasal Spray	2.5mg, 5mg	6 spray devices/month
Treximet Generic sumatriptan/naproxen	85mg/500 mg	9 tabs/month

Symbravo (rizatriptan/meloxicam)	10mg/20mg	9 tabs/month
Onzetra Xsail	11mg	1 box (8 units)/month
Zembrace SymTouch	3mg	1 box (4 units)/month
Brand Imitrex Generic Sumatriptan Autoinjector/Cartridge Refills	4mg/0.5mL 6mg/0.5mL	8 autoinjectors or cartridge refills/month (4 boxes/month)
Brand Imitrex Generic Sumatriptan Vials	6mg/0.5mL	10 vials/month (2 boxes/month)
Generic Sumatriptan Pre-filled Syringe	6mg/0.5mL	8 prefilled syringes (4 boxes/month)
Tosymra nasal spray	10mg	6 units per month

3 . Revision History

Date	Notes
9/23/2026	Added Rizafilm as NPD target

Prior Authorization Guideline

Guideline ID	GL-707206
Guideline Name	Trutakna (atacicept-vymj)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN)

AND

2 - Patient is at risk for disease progression [e.g., proteinuria of at least 0.5 g/day, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool]

AND

3 - Used to reduce proteinuria

AND

4 - One of the following:

4.1 Patient has been on a minimum 90-day trial of a maximally tolerated dose and will continue to receive therapy with one of the following:

- An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

OR

4.2 Patient has a contraindication or intolerance to both ACE inhibitors and ARBs

AND

5 - Prescribed by or in consultation with a nephrologist

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

Approval Criteria

1 - Patient demonstrates a positive clinical response to therapy as demonstrated by a decrease in urine protein-to-creatinine ratio (UPCR) from baseline

2 . Revision History

Date	Notes
8/26/2026	New program

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-669267
Guideline Name	Tryngolza (olezarsen sodium)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Tryngolza 80 mg*	
Diagnosis	Familial chylomicronemia syndrome (FCS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting a diagnosis of familial chylomicronemia syndrome (FCS) (type 1 hyperlipoproteinemia)	

AND

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

2.1 Genetic confirmation of biallelic pathogenic variants in FCS-causing genes (i.e., LPL, GPIHBP1, APOA5, APOC2, or LMF1)

OR

2.2 A North American FCS (NAFCS) Score of greater than or equal to 45

AND

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

3.1 One of the following:

3.1.1 Patient has tried or will receive treatment with standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid and a fibrate)

OR

3.1.2 Patient has an intolerance to standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid and a fibrate)

AND

3.2 Baseline fasting triglyceride levels are greater than or equal to 880 mg/dL prior to treatment with requested drug

AND

4 - Requested drug will be used as adjunct to a low-fat diet

AND

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

- Cardiologist
- Endocrinologist
- Gastroenterologist
- Lipid specialist (lipidologist)

Notes	*Approve at GPI-14

Product Name:Tryngolza 80 mg*	
Diagnosis	Familial chylomicronemia syndrome (FCS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in triglyceride levels from baseline)

Notes	*Approve at GPI-14

Product Name:Tryngolza 50 mg*	
Diagnosis	Severe hypertriglyceridemia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of severe hypertriglyceridemia

AND

2 - Submission of medical records (e.g., chart notes) confirming one of the following baseline fasting triglyceride levels prior to treatment with requested drug:

- Greater than or equal to 500 mg/dL and at high risk for acute pancreatitis not related to alcohol use, biliary disease, or uncontrolled diabetes
- Greater than or equal to 1000 mg/dL

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming one of the following:

3.1 Both of the following:

3.1.1 Patient has tried at least a 90-day trial of one of the following standard of care triglyceride lowering therapy:

- Prescription omega-3 fatty acid [e.g., Lovaza, Vascepa]
- Fibrate [e.g., fenofibrate, gemfibrozil]

AND

3.1.2 Patient has been unable to achieve treatment goals (i.e., triglyceride levels less than 500 mg/dL)

OR

3.2 Patient has an intolerance to standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid [e.g. Lovaza, Vascepa] or a fibrate [e.g., fenofibrate, gemfibrozil])

AND

4 - Requested drug will be used as adjunct to a low-fat diet (e.g., less than 5% calories from added sugars, 20% to 25% calories from total fat)

AND

5 - One of the following:

- Patient is receiving other lipid lowering (e.g., statins, ezetimibe) at the maximally tolerated dose
- Patient has a documented inability to take other lipid-lowering therapy

AND

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

- Cardiologist
- Endocrinologist
- Gastroenterologist
- Lipid specialist (lipidologist)

Notes	*Approve at GPI-14

Product Name:Tryngolza 50 mg*	
Diagnosis	Severe hypertriglyceridemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in triglyceride levels from baseline)

AND

2 - One of the following:

- Patient is continuing to receive other lipid lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose
- Patient has a documented inability to take other lipid-lowering therapy

AND

3 - Requested drug will continue to be used as adjunct to a low-fat diet (e.g., less than 5% calories from added sugars, 20% to 25% calories from total fat)

Notes	*Approve at GPI-14

Product Name:Tryngolza 80 mg*	
Diagnosis	Severe hypertriglyceridemia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of severe hypertriglyceridemia

AND

2 - Submission of medical records (e.g., chart notes) confirming one of the following baseline fasting triglyceride levels prior to treatment with requested drug:

- Greater than or equal to 500 mg/dL and at high risk for acute pancreatitis not related to alcohol use, biliary disease, or uncontrolled diabetes
- Greater than or equal to 1000 mg/dL

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming one of the following:

3.1 Both of the following:

3.1.1 Patient has tried at least a 90-day trial of one of the following standard of care triglyceride lowering therapy:

- Prescription omega-3 fatty acid [e.g., Lovaza, Vascepa]
- Fibrate [e.g., fenofibrate, gemfibrozil]

AND

3.1.2 Patient has been unable to achieve treatment goals (i.e., triglyceride levels less than 500 mg/dL)

OR

3.2 Patient has an intolerance to standard of care triglyceride lowering therapy (i.e., prescription omega-3 fatty acid [e.g. Lovaza, Vascepa] or a fibrate [e.g., fenofibrate, gemfibrozil])

AND

4 - Requested drug will be used as adjunct to a low-fat diet (e.g., less than 5% calories from added sugars, 20% to 25% calories from total fat)

AND

5 - One of the following:

- Patient is receiving other lipid lowering (e.g., statins, ezetimibe) at the maximally tolerated dose
- Patient has a documented inability to take other lipid-lowering therapy

AND

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

- Cardiologist
- Endocrinologist
- Gastroenterologist
- Lipid specialist (lipidologist)

AND

7 - Submission of medical records (e.g., chart notes) or paid claims confirming patient has tried Tryngolza 50 mg for at least 3 consecutive months and has failed to achieve treatment goals

Notes	*Approve at GPI-14

Product Name:Tryngolza 80 mg*	
Diagnosis	Severe hypertriglyceridemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., reduction in triglyceride levels from baseline)

AND

2 - One of the following:

- Patient is continuing to receive other lipid lowering therapy (e.g., statins, ezetimibe) at the maximally tolerated dose
- Patient has a documented inability to take other lipid-lowering therapy

AND

3 - Requested drug will continue to be used as adjunct to a low-fat diet (e.g., less than 5% calories from added sugars, 20% to 25% calories from total fat)

AND **4** - Submission of medical records (e.g., chart notes) or paid claims confirming patient has tried Tryngolza 50 mg for at least 3 consecutive months and has failed to achieve treatment goals	
Notes	*Approve at GPI-14

2 . Revision History

Date	Notes
7/28/2026	Added GPI for 50mg strength, added criteria for new indication of sev ere hypertriglyceridemia.

Prior Authorization Guideline

Guideline ID	GL-155841
Guideline Name	Tryvio (aprocitentan)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Tryvio	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hypertension

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming patient has not achieved target blood pressure (e.g., systolic blood pressure [SBP] less than 130 mmHg) after treatment with ALL of the following antihypertensive medications from different classes for an adequate duration (minimum 4 weeks each) at a maximally tolerated dose:

2.1 One of the following:

- Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

AND

2.2 Diuretic (e.g., hydrochlorothiazide, chlorthalidone)

AND

2.3 Calcium channel blocker (e.g., amlodipine, nifedipine)

AND

2.4 Mineralocorticoid receptor antagonist (MRA) [e.g., eplerenone, spironolactone]

AND

3 - Provider attests other causes of hypertension have been excluded (e.g., secondary causes [e.g., primary hyperaldosteronism], white coat effect, medication nonadherence)

AND

4 - Used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program)

AND

5 - Requested drug will be used in combination with at least 3 antihypertensive medications from different classes

AND

6 - Prescribed by or in consultation with a specialist experienced in the treatment of resistant hypertension (e.g., cardiologist, nephrologist)

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., systolic blood pressure [SBP] less than 130 mmHg)

AND

2 - Patient continues to use Tryvio in combination with at least 3 antihypertensive medications from different classes and is adherent to therapy

AND

3 - Requested drug will continue to be used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community based program)

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming patient has been previously treated with ALL of the following antihypertensive medications from different classes for an adequate duration (minimum 4 weeks each) at a maximally tolerated dose:

4.1 One of the following:

- Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

AND

4.2 Diuretic (e.g., hydrochlorothiazide, chlorthalidone)

AND

4.3 Calcium channel blocker (e.g., amlodipine, nifedipine)

AND

4.4 Mineralocorticoid receptor antagonist (MRA) [e.g., eplerenone, spironolactone]

2 . Revision History

Date	Notes
9/26/2024	New program

Prior Authorization Guideline

Guideline ID	GL-107465
Guideline Name	Twyneo (tretinoin-benzoyl peroxide 0.1-3% cream)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2022

1 . Criteria

Product Name:Twyneo	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting both of the following:

1.1 Both of the following:

- Patient is 9 years of age or older

- Diagnosis of acne vulgaris

AND

1.2 The patient must have a history of therapeutic failure, contraindication, or intolerance to ALL of the following (verified via paid pharmacy claims or submission of medical records):

- benzoyl peroxide
- topical clindamycin
- topical erythromycin
- topical tretinoin (Brand Retin-A)

2 . Revision History

Date	Notes
5/24/2022	New program

Prior Authorization Guideline

Guideline ID	GL-417210
Guideline Name	Tysabri (natalizumab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Preferred: Tysabri	
Diagnosis	Multiple Sclerosis (MS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of multiple sclerosis (MS)	

Product Name:Preferred: Tysabri	
Diagnosis	Multiple Sclerosis (MS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)

Product Name:Preferred: Tysabri	
Diagnosis	Crohn's Disease (CD)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

AND

2 - Crohn's disease has evidence of inflammation (e.g., elevated C-reactive protein [CRP], elevated erythrocyte sedimentation rate, presence of fecal leukocytes)

AND

3 - Prescribed by or in consultation with a gastroenterologist

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting BOTH of the following:

4.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

- 6-mercaptopurine
- azathioprine
- Corticosteroids (e.g., prednisone)
- methotrexate

AND

4.2 History of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- A preferred ustekinumab biosimilar

Notes	Note: In CD, discontinue Tysabri in patients that have not experienced therapeutic benefit by 12 weeks of induction therapy, and in patients that cannot discontinue chronic concomitant steroids within six months of starting therapy.

Product Name:Preferred: Tysabri	
Diagnosis	Crohn's Disease (CD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline

- Reversal of high fecal output state

AND

2 - Prescribed by or in consultation with a gastroenterologist

Product Name:Non-Preferred*: Tyruko	
Approval Length	Requests for Non-Preferred biosimilars are not approved at this time
Guideline Type	Prior Authorization
Approval Criteria **1** - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred product is Tysabri (natalizumab). **Please note: The drug(s) listed above may require additional review.	
Notes	*Patients must use preferred natalizumab biosimilar(s).

2 . Revision History

Date	Notes
10/29/2025	Added new biosimilar Tyruko as NP

Prior Authorization Guideline

Guideline ID	GL-707209
Guideline Name	Tzield (teplizumab - mzwv)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Tzield	
Diagnosis	Stage 2 type 1 Diabetes Mellitus
Approval Length	1 authorization per lifetime
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of stage 2 type 1 diabetes mellitus

AND

2 - Submission of medical records (e.g., chart notes) confirming diagnosis by BOTH of the following:

2.1 Two or more of the following pancreatic islet autoantibodies

- Glutamic acid decarboxylase 65 (GAD) autoantibodies
- Insulin autoantibody (IAA)
- Insulinoma-associated antigen 2 autoantibody (IA-2A)
- Zinc transporter 8 autoantibody (ZnT8A)
- Islet cell autoantibody (ICA)

AND

2.2 Dysglycemia on oral glucose tolerance testing at baseline defined as one of the following:

- Fasting plasma glucose greater than or equal to 100mg/dL and less than 126mg/dL (5.6 - 6.9 mmol/L)
- 2-hour plasma glucose greater than or equal to 140mg/dL and less than or equal to 199mg/dL (7.8 -11.0 mmol/L)
- Hemoglobin A1C 5.7 to 6.4% (39-47mmol/mol) or greater than or equal to 10% increase in A1C

AND

3 - Patient is 1 year of age or older

AND

4 - Presence of type 2 diabetes mellitus or other forms of diabetes (e.g., genetic forms of diabetes, maturity-onset diabetes of the young (MODY), latent autoimmune diabetes in adults (LADA), or diabetes secondary to medications or surgery) has been ruled out

AND

5 - Provider attests that patient does not have laboratory or clinical evidence of active Epstein-

Barr virus (EBV) and cytomegalovirus (CMV) infection (e.g., undetectable viral load by PCR testing) prior to initiating treatment with Tzield

AND

6 - Submission of medical records (e.g., chart notes) AND absence of paid claims confirming patient has never received Tzield treatment in their lifetime

AND

7 - Treatment will not exceed the recommended 14 doses

AND

8 - Prescribed by or in consultation with an endocrinologist

Notes	*Per prescribing information, administer Tzield by intravenous infusion once daily for 14 consecutive days.

Product Name:Tzield	
Diagnosis	Stage 3 Type 1 Diabetes Mellitus
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of stage 3 type 1 diabetes mellitus

AND

2 - Submission of medical records (e.g., chart notes) confirming diagnosis by BOTH of the following:

2.1 One of the following:

- Fasting Plasma Glucose (FPG) ≥ 126 mg/dL (≥7.0 mmol/L)
- 2-Hour Plasma Glucose ≥ 200 mg/dL (≥11.1 mmol/L) during an oral glucose tolerance test
- Hemoglobin A1C ≥ 6.5% (≥ 48 mmol/mol)
- Random Plasma Glucose ≥ 200 mg/dL (≥11.1 mmol/L) in a patient with classic symptoms of hyperglycemia (e.g., polyuria, polydipsia, unexplained weight loss)

AND

2.2 Presence of at least one positive pancreatic islet cell autoantibody (e.g., antibodies against glutamic acid decarboxylase, zinc transporter 8, insulin, islet cells, or islet antigen)

AND

3 - Patient is between 8 and 17 years of age

AND

4 - Submission of medical records (e.g., chart notes) confirming evidence of residual beta-cell function as demonstrated by peak C-peptide ≥0.2 pmol/mL on a mixed-meal tolerance test (if a mixed meal tolerance test is not available, an alternative method for measuring peak C-peptide ≥0.2 pmol/mL may be appropriate)

AND

5 - Provider attests that patient does not have laboratory or clinical evidence of active Epstein-Barr virus (EBV) and cytomegalovirus (CMV) infection (e.g., undetectable viral load by PCR testing) prior to initiating treatment with Tzield

AND

6 - Submission of medical records (e.g., chart notes) AND absence of paid claims confirming patient has never received Tzield treatment in their lifetime

AND

7 - Provider attests to initiate Tzield treatment as soon as possible following stage 3 type 1 diabetes mellitus diagnosis but no later than 8 weeks from diagnosis

AND

8 - Treatment will not exceed two,12-day, treatment courses

AND

9 - Prescribed by or in consultation with an endocrinologist

2 . Revision History

Date	Notes
8/26/2026	Added criteria for Stage 3 type 1 DM, added submission of medical r ecords throughout

Prior Authorization Guideline

Guideline ID	GL-99501
Guideline Name	Uloric
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Uloric, generic febuxostat	
Approval Length	12 month(s)
Guideline Type	Step Therapy
Approval Criteria **1** - History of failure, contraindication or intolerance to allopurinol (generic Zyloprim)	

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-636310
Guideline Name	Ultomiris (ravulizumab-cwvz)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Ultomiris	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)

AND

2 - Patient is one month of age and older

AND

3 - Prescribed by or in consultation with a hematologist/oncologist

Product Name:Ultomiris	
Diagnosis	Paroxysmal Nocturnal Hemoglobinuria (PNH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions) to therapy

Product Name:Ultomiris	
Diagnosis	Atypical Hemolytic Uremic Syndrome (aHUS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of atypical hemolytic uremic syndrome (aHUS)

AND

2 - Patient is one month of age and older

AND

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

- Hematologist
- Nephrologist

Product Name:Ultomiris	
Diagnosis	Atypical Hemolytic Uremic Syndrome (aHUS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions) to therapy

Product Name:Ultomiris	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

- Diagnosis of generalized myasthenia gravis (gMG)
- Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

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

2.1 Trial and failure, contraindication, or intolerance to two preferred immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

OR

2.2 Both of the following:

2.2.1 Trial and failure, contraindication, or intolerance to one preferred immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

2.2.2 Trial and failure, contraindication, or intolerance to one of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG)

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Requested medication is not being used in combination with any one of the following:

- Neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo, Vyvgart, Vyvgart Hytrulo)
- Another complement inhibitor (e.g., eculizumab, Zilbrysq)
- Immune globulin (e.g., IVIG)
- B-cell depletion therapy (e.g., Uplizna)

Product Name:Ultomiris	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Requested medication is not being used in combination with any one of the following:

- Neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo, Vyvgart, Vyvgart Hytrulo)
- Another complement inhibitor (e.g., eculizumab, Zilbrysq)
- Immune globulin (e.g., IVIG)
- B-cell depletion therapy (e.g., Uplizna)

Product Name:Ultomiris	
Diagnosis	Neuromyelitis Optica Spectrum Disorder (NMOSD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

- Diagnosis of neuromyelitis optica spectrum disorder (NMOSD)
- Patient is anti-aquaporin-4 (AQP4) antibody positive

AND

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

- Neurologist
- Ophthalmologist

Product Name:Ultomiris	
Diagnosis	Neuromyelitis Optica Spectrum Disorder (NMOSD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
6/25/2026	gMG: Added combination therapy criteria to initial and reauth

Prior Authorization Guideline

Guideline ID	GL-636312
Guideline Name	Uplizna (inebilizumab-cdon)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Uplizna	
Diagnosis	Neuromyelitis Optica Spectrum Disorder (NMOSD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of neuromyelitis optica spectrum disorder (NMOSD)

AND

2 - Submission of medical records (e.g., chart notes) confirming patient is anti-aquaporin-4 (AQP4) antibody positive

AND

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

- Neurologist
- Ophthalmologist

AND

4 - One of the following:

4.1 Submission of medical records (e.g., chart notes) or paid claims confirming history of failure, contraindication, or intolerance to one of the following preferred rituximab products:

- Ruxience
- Truxima

OR

4.2 For continuation of prior therapy

Product Name:Uplizna	
Diagnosis	Immunoglobulin G4-Related Disease (IgG4-RD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of Immunoglobulin G4-Related Disease (IgG4-RD)

AND

2 - Presence of disease involving two or more organ systems or sites (e.g., Pancreas, Submandibular gland, Lymph node(s), Kidneys, Bile Duct, Lungs or Lacrimal glands)

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming ONE of the following:

3.1 Patient is currently being treated with a glucocorticoid (e.g., prednisone, methylprednisolone)

OR

3.2 Trial and failure, contraindication or intolerance to a glucocorticoid (e.g., prednisone, methylprednisolone)

Product Name:Uplizna	
Diagnosis	Neuromyelitis Optica Spectrum Disorder (NMOSD), Immunoglobulin G4-Related Disease (IgG4-RD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

Product Name:Uplizna	
Diagnosis	Generalized Myasthenia Gravis (gMG)

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of generalized myasthenia gravis (gMG)

AND

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

2.1 Both of the following:

2.1.1 Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

2.1.2 Both of the following:

2.1.2.1 Trial and failure, contraindication, or intolerance to two immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) (May be verified via paid pharmacy claims)

AND

2.1.2.2 Trial and failure, contraindication, or intolerance to one of the following: (May be verified via paid pharmacy claims)

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG) or immunoglobulin (IG) therapy

OR

2.2 Both of the following:

2.2.1 Patient is anti-muscle-specific tyrosine kinase (MuSK) antibody positive

AND

2.2.2 Both of the following:

2.2.2.1 Trial and failure, contraindication, or intolerance to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus) (May be verified via paid pharmacy claims)

AND

2.2.2.2 Trial and failure, contraindication, or intolerance to one of the following: (May be verified via paid pharmacy claims)

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG) or immunoglobulin (IG) therapy
- Rituximab

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Requested medication is not being used in combination with any one of the following:

- Neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo, Vyvgart, Vyvgart Hytrulo)
- Complement inhibitor (e.g., eculizumab, Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)

Product Name:Uplizna	
Diagnosis	Generalized Myasthenia Gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - Requested medication is not being used in combination with any one of the following:

- Neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo, Vyvgart, Vyvgart Hytrulo)
- Complement inhibitor (e.g., eculizumab, Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)

2 . Revision History

Date	Notes
6/25/2026	gMG: Updated combination therapy criteria verbiage, no change to cl inical intent.

Prior Authorization Guideline

Guideline ID	GL-450243
Guideline Name	Urea Cycle Disorder Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Buphenyl, generic sodium phenylbutyrate, Pheburane	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Diagnosis of urea cycle disorder (UCD)

AND

1.2 One of the following deficiencies:

- carbamylphosphate synthetase (CPS)
- ornithine transcarbamylase (OTC)
- argininosuccinic acid synthetase (AS)

AND

2 - Molecular genetic testing confirms mutations in the CPS1, OTC, or ASS1 gene [2]

AND

3 - Trial and failure, or intolerance to generic sodium phenylbutyrate (applies to Brand Buphenyl and Pheburane only)

AND

4 - Used as an adjunct with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

AND

5 - Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders

Product Name:Olpruva, Brand Ravicti, generic glycerol phenylbutyrate	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Diagnosis of urea cycle disorder (UCD)

AND

1.2 One of the following deficiencies:

- carbamylphosphate synthetase (CPS)
- ornithine transcarbamylase (OTC)
- argininosuccinic acid synthetase (AS)

AND

2 - Molecular genetic testing confirms mutations in the CPS1, OTC, or ASS1 gene

AND

3 - Inadequate response to one of the following:

- Dietary protein restriction
- Amino acid supplementation

AND

4 - Trial and failure, contraindication, or intolerance to generic sodium phenylbutyrate

AND

5 - For generic glycerol phenylbutyrate requests, history of failure or intolerance to Brand Ravicti

AND

6 - Used as an adjunct with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

AND

7 - Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders

Product Name:Brand Buphenyl, generic sodium phenylbutyrate, Olpruva, Pheburane, Brand Ravicti, generic glycerol phenylbutyrate	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., plasma ammonia and amino acid levels within normal limits)

AND

2 - Used as an adjunct with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

2 . Revision History

Date	Notes
12/17/2025	Added generic Ravicti

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Prior Authorization Guideline

Guideline ID	GL-731217
Guideline Name	Ustekinumab
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Preferred: Starjemza SC	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values, prescription claims history) documenting ALL of the following:

1.1 Diagnosis of chronic moderate to severe plaque psoriasis (PsO)

AND

1.2 Greater than or equal to 3% body surface area involvement, palmoplantar, facial, or genital involvement, or severe scalp psoriasis

AND

1.3 History of failure to ONE of the following topical therapies, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., betamethasone, clobetasol, desonide)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
- Vtama
- Zoryve 0.3% cream

AND

1.4 Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

2 - Patient is 6 years of age or older

AND

3 - Prescribed by or in consultation with a dermatologist

Product Name:Preferred: Starjemza SC	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a dermatologist

Product Name:Preferred: Starjemza SC	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active psoriatic arthritis (PsA)

AND

2 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

3 - Patient is 6 years of age or older

AND

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

- Rheumatologist
- Dermatologist

Product Name:Preferred: Starjemza SC	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

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

- Rheumatologist
- Dermatologist

Product Name:Preferred: Starjemza SC/IV	
Diagnosis	Crohn’s Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active Crohn’s disease (CD)

AND

2 - Patient is 2 years of age or older

AND

3 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- Azathioprine (Imuran)
- 6-mercaptopurine (Purinethol)
- Methotrexate (Rheumatrex, Trexall)

AND

4 - Prescribed by or in consultation with a gastroenterologist

Product Name:Preferred: Starjemza SC/IV	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - Patient is 2 years of age or older

AND

3 - Paid claims or submission of medical records (e.g., chart notes) documenting history of failure to ONE of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced:

- Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)
- 6-mercaptopurine (Purinethol)
- Azathioprine (Imuran)
- Aminosalicylates (e.g., mesalamine, sulfasalazine)

AND

4 - Prescribed by or in consultation with a gastroenterologist

Product Name:Preferred: Starjemza SC/IV	
Diagnosis	Crohn's Disease (CD), Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a gastroenterologist

Product Name:Non-Preferred*: Ustekinumab SC/IV, Ustekinumab-aauz SC/IV, Ustekinumab-aekn SC/IV, Ustekinumab-ttwe SC/IV, Imuldosa SC/IV, Otulfi SC/IV, Pyzchiva SC/IV, Selarsdi SC/IV, Stelara SC/IV, Steqeyma SC/IV, Wezlana SC/IV, Yesintek SC/IV, and newly launched ustekinumab products	
Approval Length	Requests for Non-Preferred biosimilars are not approved at this time

Guideline Type	Prior Authorization
Approval Criteria **1** - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred product is Starjemza (ustekinumab-hmny). **Please note: The drug(s) listed above may require additional review.	
Notes	*Patients must use preferred ustekinumab biosimilar(s).

2 . Revision History

Date	Notes
9/23/2026	Added age criterion for UC indication due to expanded approval, corr ect typo in NPD target (product details) section (ustekinumab-aauz)

Prior Authorization Guideline

Guideline ID	GL-155844
Guideline Name	Vafseo (vadadustat)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Vafseo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or paid claims confirming ALL of the following:

1.1 Diagnosis of chronic kidney disease (CKD)

AND

1.2 Patient has been on dialysis for at least 3 months

AND

1.3 Adequate iron stores confirmed by both of the following:

- Patient's ferritin level is greater than 100mcg/L
- Patient's transferrin saturation (TSAT) is greater than 20%

AND

1.4 Hemoglobin level less than 11 g/dL

AND

1.5 Trial and failure, contraindication or intolerance to one of the following preferred erythropoietin stimulating agents (ESA):

- Epogen (epoetin alfa)
- Retacrit (epoetin alfa-epbx)

AND

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

- hematologist
- nephrologist

AND

3 - Patient is not on concurrent treatment with an erythropoeitin stimulating agent [ESA] (e.g., Aranesp, Epogen, Procrit)

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) or paid claims confirming ALL of the following:

1.1 Patient demonstrates positive clinical response to therapy (e.g., increase in hemoglobin)

AND

1.2 Hemoglobin level does not exceed 11g/dL

AND

1.3 Adequate iron stores confirmed by both of the following:

- Patient's ferritin level is greater than 100mcg/L
- Patient's transferrin saturation (TSAT) is greater than 20%

AND

1.4 Trial and failure, contraindication or intolerance to one of the following:

- Epogen (epoetin alfa)
- Retacrit (epoetin alfa-epbx)

AND

2 - Patient is not on concurrent treatment with an erythropoeitin stimulating agent [ESA] (e.g., Aranesp, Epogen, Procrit)

2 . Revision History

Date	Notes
9/26/2024	New program

Prior Authorization Guideline

Guideline ID	GL-99693
Guideline Name	Valchlor
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021
P&T Approval Date:	
P&T Revision Date:	

1 . Criteria

Product Name:Valchlor	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Chronic or smoldering T-cell leukemia-lymphoma
- Primary cutaneous marginal zone or follicle center B-cell lymphoma
- Lymphomatoid papulosis (LyP) with extensive lesions
- Mycosis fungoides (MF)-Sezary syndrome (SS)

Product Name:Valchlor	
Diagnosis	Primary Cutaneous Lymphomas
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Valchlor

Product Name:Valchlor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Valchlor will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Valchlor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Valchlor therapy	

2 . Revision History

Date	Notes
4/8/2021	7/1 Implementation

Prior Authorization Guideline

Guideline ID	GL-114467
Guideline Name	Valsartan oral solution
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Valsartan oral solution	
Diagnosis	Patients 7 years of age or older
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 7 years of age or older

AND

2 - Patient cannot take solid dosage form due to swallowing issues

2 . Revision History

Date	Notes
9/26/2022	New program

Prior Authorization Guideline

Guideline ID	GL-364197
Guideline Name	Vanrafia (atrasentan)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2025

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting diagnosis of primary immunoglobulin A nephropathy (IgAN)

AND

2 - Diagnosis has been confirmed by ALL of the following:

- Kidney biopsy
- Proteinuria of greater than or equal to 1 g/day
- Estimated glomerular filtration rate (eGFR) of greater than or equal to 30 mL/min/1.73 m2

AND

3 - Patient is at risk for disease progression [e.g., generally a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool]

AND

4 - Used to reduce proteinuria

AND

5 - Submission of medical records (e.g., chart notes) demonstrating patient has been on a minimum 90-day trial of a maximally tolerated dose of one of the following (paid pharmacy claims may be used to confirm appropriate trial):

- An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

AND

6 - Prescribed by or in consultation with a nephrologist

Product Name:Vanrafia	
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting a positive clinical response to therapy as demonstrated by a decrease in urine protein-to-creatinine ratio (UPCR) from baseline	

2 . Revision History

Date	Notes
8/28/2025	New program

Prior Authorization Guideline

Guideline ID	GL-99655
Guideline Name	Vecamyl
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - Diagnosis of moderately severe to severe essential hypertension

OR

2 - Diagnosis of uncomplicated malignant hypertension

Product Name:Vecamyl	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of a positive clinical response to Vecamyl therapy	

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

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Prior Authorization Guideline

Guideline ID	GL-589204
Guideline Name	Velphoro (sucroferric oxyhydroxide), Auryxia (ferric citrate)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Velphoro, Brand Auryxia, generic ferric citrate tablet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following

- Diagnosis of hyperphosphatemia
- Diagnosis of End Stage Renal Disease

AND **2** - One of the following: • For Velphoro requests: Patient is 9 years of age or older • For Brand Auryxia/ferric citrate requests: Patient is 18 years of age or older **AND** **3** - Adherence to and trial and failure to one of the following at maximum dosages (MUST be verified via paid pharmacy claims or submission of medical records) • Sevelamer Carbonate at the maximum dosage – 800mg/15 per day • Sevelamer Powder Packets at maximum dosage – 2.4gm packet 4 per day **AND** **4** - For Ferric citrate tablet (generic for Auryxia) requests ONLY: history of failure or intolerance to Brand Auryxia	
Notes	1. Approval will not be granted for requests based on potential side effects, i.e., constipation 2. Approval will not be granted for submitted prior authorizations based on pill burden. Velphoro and Sevelamer are both taken 3 times a day. PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

2 . Revision History

Date	Notes
4/30/2026	Update naming convention for Ferric Citrate tab. Added B over G note for PA team.

Prior Authorization Guideline

Guideline ID	GL-300304
Guideline Name	Velsipity (etrasimod)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2025

1 . Criteria

Product Name:Velsipity	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - One of the following:

- Greater than 6 stools per day
- Frequent blood in the stools
- Frequent urgency
- Presence of ulcers
- Abnormal lab values (e.g., hemoglobin, ESR, CRP)
- Dependent on, or refractory to, corticosteroids

AND

3 - Paid claims or submission of medical records (e.g., chart notes) confirming a trial and failure, contraindication, or intolerance to one of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)
- Azathioprine
- Corticosteroids (e.g., prednisone)

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming history of failure, contraindication, or intolerance to ALL of the following:

- A preferred adalimumab biosimilar
- infliximab
- Xeljanz (tofacitinib) oral tablet (IR or XR)
- A preferred ustekinumab biosimilar

AND

5 - Prescribed by or in consultation with a gastroenterologist

Product Name:Velsipity	
Diagnosis	Ulcerative Colitis (UC)

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following:

- Improvement in intestinal inflammation (e.g., mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline
- Reversal of high fecal output state

AND

2 - Prescribed by or in consultation with a gastroenterologist

2 . Revision History

Date	Notes
7/3/2025	Updated preferred agents/embedded steps, updated criteria.

Prior Authorization Guideline

Guideline ID	GL-136978
Guideline Name	Veltassa
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/1/2023

1 . Criteria

Product Name:Veltassa	
Diagnosis	Non-Life Threatening Hyperkalemia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-life threatening hyperkalemia

AND

2 - Patient is 12 years of age or older

AND

3 - Where clinically appropriate, medications known to cause hyperkalemia (e.g. angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, aldosterone antagonist, non-steroidal anti-inflammatory drugs [NSAIDs]) have been discontinued or reduced to the lowest effective dose

AND

4 - Where clinically appropriate, loop or thiazide diuretic therapy for potassium removal has failed

AND

5 - Patient follows a low potassium diet (less than or equal to 3 grams per day)

AND

6 - History of failure, intolerance, or contraindication to Lokelma

Product Name:Veltassa	
Diagnosis	Non-Life Threatening Hyperkalemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a positive clinical response to Veltassa therapy

AND

2 - Patient continues to require treatment for hyperkalemia

AND

3 - Where clinically appropriate, medications known to cause hyperkalemia (e.g. angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker, aldosterone antagonist, non-steroidal anti-inflammatory drugs [NSAIDs])) have been discontinued or reduced to the lowest effective dose

2 . Revision History

Date	Notes
9/26/2024	Added new GPI, added age criterion due to expanded approval

Prior Authorization Guideline

Guideline ID	GL-146005
Guideline Name	Vemlidy
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2024

1 . Criteria

Product Name:Vemlidy	
Diagnosis	Treatment-Naïve Chronic Hepatitis B Infection
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a contraindication to entecavir therapy

AND

2 - Both of the following:

- Patient is 6 years of age or older
- Patient weighs at least 25 kg

Product Name:Vemlidy	
Diagnosis	Treatment-Experienced Chronic Hepatitis B Infection
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 ALL of the following:

1.1.1 Patient is currently on Viread therapy

AND

1.1.2 ONE of the following:

- Patient has a creatinine clearance less than 60 mL per minute
- Patient has a diagnosis of osteoporosis

AND

1.1.3 Both of the following:

- Patient is 6 years of age or older
- Patient weighs at least 25 kg

OR

1.2 Patient is currently on Vemlidy therapy

2 . Revision History

Date	Notes
4/22/2024	Updated age/weight criterion due to expanded indication

Prior Authorization Guideline

Guideline ID	GL-135321
Guideline Name	Veopoz (pozelimab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2023

1 . Criteria

Product Name:Veopoz	
Diagnosis	CD55-deficient protein-losing enteropathy (PLE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of active CD55-deficient protein-losing enteropathy (PLE), also known as CHAPLE disease

AND

1.2 Patient has a confirmed genotype of biallelic CD55 loss-of-function mutation

AND

1.3 Patient is 1 year of age or older

AND

1.4 Patient has hypoalbuminemia (serum albumin concentration of ≤ 3.2 g/dL)

AND

1.5 Patient has at least one of the following signs or symptoms within the last six months:

- abdominal pain
- diarrhea
- peripheral edema
- facial edema

AND

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

- Immunologist
- Geneticist
- Hematologist

Product Name:Veopoz	
Diagnosis	CD55-deficient protein-losing enteropathy (PLE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g. decrease in albumin transfusions and hospitalizations, normalization of serum IgG concentrations, etc.)	

2 . Revision History

Date	Notes
10/23/2023	New program

Prior Authorization Guideline

Guideline ID	GL-107454
Guideline Name	Verkazia (cyclosporine ophthalmic emulsion 0.1%)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2022

1 . Criteria

Product Name:Verkazia	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting all of the following:

1.1 Diagnosis of moderate to severe vernal keratoconjunctivitis confirmed by the presence of

clinical signs and symptoms (e.g., itching, photophobia, giant papillae at the upper tarsal conjunctiva or at the limbus, thick mucus discharge, conjunctival hyperaemia)

AND

1.2 Trial and failure, contraindication, or intolerance to one of the following (verified via pharmacy paid claims or submission of medical records):

- Topical ophthalmic “dual-acting” mast cell stabilizer and antihistamine (e.g., olopatadine, azelastine)
- Topical ophthalmic mast cell stabilizers (e.g., cromolyn)

AND

1.3 Trial and failure, contraindication, or intolerance, for short term use (up to 2 to 3 weeks), of topical ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluorometholone) ((verified via pharmacy paid claims or submission of medical records)

AND

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

- Ophthalmologist
- Optometrist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy as evidenced by an improvement in clinical signs and symptoms (e.g., itching, photophobia, papillary hypertrophy, mucus discharge, conjunctival hyperaemia)

2 . Revision History

Date	Notes
5/24/2022	New program

Prior Authorization Guideline

Guideline ID	GL-148802
Guideline Name	Vijoice (alpelisib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2024

1 . Criteria

Product Name:Vijoice tablets, Vijoice granules	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS)

AND

2 - Submission of documentation of mutation in the PIK3CA gene

AND

3 - Patient is 2 years of age or older

AND

4 - Submission of documentation of severe clinical manifestations (e.g., Congenital Lipomatous Overgrowth, Vascular malformations, Epidermal nevi, Scoliosis/skeletal and spinal [CLOVES], Facial Infiltrating Lipomatosis [FIL], Klippel-Trenaunay Syndrome [KTS], Megalencephaly-Capillary Malformation Polymicrogyria [MCAP])

AND

5 - Prescribed by or in consultation with a physician who specializes in the treatment of PROS

Product Name:Vijoice tablets, Vijoice granules	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation of positive clinical response to therapy (e.g., radiological response defined as a ≥ 20% reduction from baseline in the sum of target lesion volume)

AND

2 - Prescribed by or in consultation with a physician who specializes in the treatment of PROS

2 . Revision History

Date	Notes
6/27/2024	Added new granule formulation

Prior Authorization Guideline

Guideline ID	GL-530192
Guideline Name	Viltepso (viltolarsen)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Viltepso	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of Duchenne muscular dystrophy (DMD)

AND

1.2 Presence of a mutation of the dystrophin gene amenable to exon 53 skipping

AND

2 - Patient is 4 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Dose will not exceed 80 milligrams per kilogram of body weight infused once weekly

AND

5 - Submission of medical records including results of baseline North Star Ambulatory Assessment (NSAA) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) as evidenced by NSAA scoring

AND

6 - Patient will not receive Viltepso in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Exondys 51 (eteplirsen), Vyondys 53 (golodirsen)]

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

Approval Criteria

1 - Patient is tolerating therapy

AND

2 - Dose will not exceed 80 milligrams per kilogram of body weight infused once weekly

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Submission of medical records including results of recent North Star Ambulatory Assessment (NSAA) confirming patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) as evidenced by NSAA scoring

AND

5 - Patient will not receive Viltepso in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Exondys 51 (eteplirsen), Vyondys 53 (golodirsen)]

2 . Revision History

Date	Notes
2/26/2026	Added submission of NSAA testing for confirmation of ambulatory sta tus.

Prior Authorization Guideline

Guideline ID	GL-550187
Guideline Name	Vitamin B-12
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) including lab values documenting a Vitamin B-12 deficiency

Product Name:Vitamin B-12

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) including lab values documenting improvement in Vitamin B-12 deficiency (e.g., Vitamin B-12 levels within normal range)

2 . Revision History

Date	Notes
3/24/2026	Updated submission of records verbiage, added reauth criteria

Prior Authorization Guideline

Guideline ID	GL-547233
Guideline Name	Vitamin C
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) including lab values documenting a Vitamin C deficiency

Product Name:Vitamin C

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) including lab values documenting improvement in Vitamin C deficiency (e.g., Vitamin C levels within normal range)

2 . Revision History

Date	Notes
3/24/2026	Updated submission of records verbiage, added reauth criteria

Prior Authorization Guideline

Guideline ID	GL-547232
Guideline Name	Vitamin D
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) including lab values documenting a Vitamin D deficiency

Product Name:Vitamin D

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) including lab values documenting improvement in Vitamin D deficiency (e.g., Vitamin D levels within normal range)

2 . Revision History

Date	Notes
3/24/2026	Updated submission of records verbiage, added reauth criteria

Prior Authorization Guideline

Guideline ID	GL-228335
Guideline Name	Vivjoa (oteseconazole)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Vivjoa	
Approval Length	4 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of recurrent vulvovaginal candidiasis (RVVC)

AND

2 - Patient is NOT of reproductive potential

AND

3 - Diagnosis of RVVC confirmed by one of the following:

- Positive potassium hydroxide (KOH) preparation
- Vaginal fungal culture

AND

4 - Patient has experienced 3 or more symptomatic episodes of vulvovaginal candidiasis (VVC) within the past 12 months

AND

5 - Trial and failure, contraindication, or intolerance to one intravaginal product (e.g., clotrimazole, miconazole, tioconazole, terconazole, boric acid)

AND

6 - One of the following:

- Failure of a maintenance course of oral fluconazole defined as 100-mg, 150-mg, or 200-mg taken weekly for 6 months or Inadequate response (defined as greater than or equal to 24 weeks of therapy)
- Recurrence of infection while on maintenance therapy, adverse reaction or contraindication to oral fluconazole

AND

7 - Trial and failure, contraindication or intolerance to Brexafemme (ibrexafungerp)

2 . Revision History

Date	Notes

4/24/2025	Updated oral fluconazole step, added step through Brexafemme

Prior Authorization Guideline

Guideline ID	GL-107466
Guideline Name	Vonjo (pacritinib)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2022

1 . Criteria

Product Name:Vonjo	
Diagnosis	Myelofibrosis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of ONE of the following:

- Primary myelofibrosis
- Post-polycythemia vera myelofibrosis
- Post-essential thrombocythemia myelofibrosis

AND

1.2 Disease is intermediate or high risk

AND

1.3 Pre-treatment platelet count below 50 x 10^9 L

AND

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

- Hematologist
- Oncologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., symptom improvement, spleen volume reduction)

Product Name:Vonjo	
Diagnosis	NCCN Recommended Regimens

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - This drug will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

2 . Revision History

Date	Notes
5/24/2022	New Program

Prior Authorization Guideline

Guideline ID	GL-155420
Guideline Name	Vonoprazan Containing Agents
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2024

1 . Criteria

Product Name:Voquezna Dual Pak, Voquezna Triple Pak	
Diagnosis	Helicobacter pylori (H. pylori) Infection
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Helicobacter pylori infection

AND

2 - Trial and failure, contraindication, or intolerance to BOTH of the following first line treatment regimens:

- Clarithromycin based therapy (e.g., clarithromycin based triple therapy, clarithromycin based concomitant therapy) [D]
- Bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI])

Product Name:Voquezna 20mg tablet	
Diagnosis	Helicobacter pylori (H. pylori) Infection
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Helicobacter pylori infection

AND

2 - One of the following:

- Used in combination with amoxicillin and clarithromycin for the treatment of H. pylori infection
- Used in combination with amoxicillin for the treatment of H. pylori infection

AND

3 - Trial and failure, contraindication, or intolerance to BOTH of the following first line treatment regimens:

- Clarithromycin based therapy (e.g., clarithromycin based triple therapy, clarithromycin based concomitant therapy) [D]
- Bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI])

Product Name:Voquezna 20mg tablet	
Diagnosis	Healing and Relief of Heartburn associated with Erosive Esophagitis
Approval Length	8 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of erosive esophagitis

AND

2 - Used for healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis

AND

3 - Trial (of a minimum 8-week supply) and inadequate response (within the last 365 days), contraindication, or intolerance to TWO of the following generic proton pump inhibitors (PPI's):

- omeprazole
- esomeprazole
- pantoprazole
- lansoprazole
- rabeprazole
- dexlansoprazole

Product Name:Voquezna 10mg tablet	
Diagnosis	Maintenance of Healing and Relief of Heartburn associated with Erosive Esophagitis
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Used to maintain healing and relief of heartburn associated with erosive esophagitis

AND

2 - Trial (of a minimum 8-week supply) and inadequate response (within the last 365 days), contraindication, or intolerance to TWO of the following generic proton pump inhibitors (PPI's):

- omeprazole
- esomeprazole
- pantoprazole
- lansoprazole
- rabeprazole
- dexlansoprazole

Product Name:Voquezna 10mg tablet*	
Diagnosis	Relief of Heartburn associated with Non-Erosive Gastroesophageal Reflux Disease
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-erosive Gastroesophageal Reflux Disease

AND

2 - Both of the following:

- Patient has history of heartburn for at least 6 months
- Heartburn symptoms are present for at least 4 days during any consecutive 7-day period

AND

3 - Trial (of a minimum 8-week supply) and inadequate response (within the last 365 days), contraindication, or intolerance to TWO of the following generic proton pump inhibitors (PPI's): • omeprazole • esomeprazole • pantoprazole • lansoprazole • rabeprazole • dexlansoprazole	
Notes	*Voquezna 20 mg tablets are not FDA approved for non-erosive gastr oesophageal reflux disease.

2 . Revision History

Date	Notes
9/26/2024	Added criteria for new indication

Prior Authorization Guideline

Guideline ID	GL-137865
Guideline Name	Voxzogo (vosoritide)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/15/2023

1 . Criteria

Product Name:Voxzogo	
Diagnosis	Achondroplasia
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient has open epiphyses	

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of achondroplasia as confirmed by one of the following: [2, 3]

2.1 Both of the following:

2.1.1 Patient has clinical manifestations characteristic of achondroplasia (e.g., macrocephaly, frontal bossing, midface retrusion, disproportionate short stature with rhizomelic shortening of the arms and the legs, brachydactyly, trident configuration of the hands, thoracolumbar kyphosis, and accentuated lumbar lordosis)

AND

2.1.2 Patient has radiographic findings characteristic of achondroplasia (e.g., large calvaria and narrowing of the foramen magnum region, undertubulated, shortened long bones with metaphyseal abnormalities, narrowing of the interpedicular distance of the caudal spine, square ilia and horizontal acetabula, small sacrosciatic notches, proximal scooping of the femoral metaphyses, and short and narrow chest)

OR

2.2 Molecular genetic testing confirmed c.1138G>A or c.1138G>C variant (i.e., p.Gly380Arg mutation) in the fibroblast growth factor receptor-3 (FGFR3) gene

AND

3 - Patient did not have limb-lengthening surgery in the previous 18 months and does not plan on having limb-lengthening surgery while on Voxzogo therapy

AND

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

- Clinical geneticist
- Endocrinologist
- A physician who has specialized expertise in the management of achondroplasia

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

Approval Criteria

1 - Patient continues to have open epiphyses

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy as evidenced by one of the following:

- Improvement in annualized growth velocity (AGV) compared to baseline
- Improvement in height Z-score compared to baseline

AND

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

- Clinical geneticist
- Endocrinologist
- A physician who has specialized expertise in the management of achondroplasia

Product Name:Voxzogo	
Diagnosis	Idiopathic Short Stature (ISS)
Approval Length	N/A - Requests for non-approvable diagnoses should not be approved
Guideline Type	Prior Authorization

Approval Criteria **1** - Requests for coverage for diagnosis of Idiopathic Short Stature (ISS) are not authorized and will not be approved	
Notes	Approval Length: N/A - Requests for Idiopathic Short Stature (ISS) sh ould not be approved. Deny as a benefit exclusion.

2 . Revision History

Date	Notes
12/15/2023	Updated effective date

Prior Authorization Guideline

Guideline ID	GL-401288
Guideline Name	Voydeya (danicopan)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

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

Approval Criteria

1 - Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)

AND

2 - Will be used as add-on therapy to Ultomiris (ravulizumab) or Soliris (eculizumab)

AND

3 - Hemoglobin levels less than or equal to 9.5 g/dL

AND

4 - Absolute reticulocyte count greater than or equal to 120 × 10^9 /L

AND

5 - Prescribed by or in consultation with a hematologist/oncologist

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., hemoglobin stabilization, decrease in the number of red blood cell transfusions)

AND

2 - Will be used as add-on therapy to Ultomiris (ravulizumab) or Soliris (eculizumab)

2 . Revision History

Date	Notes

9/25/2025	New program

Prior Authorization Guideline

Guideline ID	GL-525288
Guideline Name	Voyxact (sibeprenlimab-szsi)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of primary immunoglobulin A nephropathy (IgAN)

AND

2 - Patient is at risk for disease progression (e.g., proteinuria of at least 0.5 g/day, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool)

AND

3 - Used to reduce proteinuria

AND

4 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting one of the following:

4.1 Patient has been on a minimum 90-day trial of a maximally tolerated dose and will continue to receive therapy with one of the following:

- An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril)
- An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan)

OR

4.2 Patient has a contraindication or intolerance to both ACE inhibitors and ARBs

AND

5 - Prescribed by or in consultation with a nephrologist

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

Approval Criteria

1 - Patient demonstrates a positive clinical response to therapy as demonstrated by a decrease in urine protein-to-creatinine ratio (UPCR) from baseline

2 . Revision History

Date	Notes
2/26/2026	New Program

Prior Authorization Guideline

Guideline ID	GL-369200
Guideline Name	Vtama (tapinarof)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2025

1 . Criteria

Product Name:Vtama	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging, paid claims history) documenting a diagnosis of plaque psoriasis

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging, paid claims history) documenting a minimum duration of a 4 week trial and failure, contraindication, or intolerance to ONE of the following topical therapies:

- Corticosteroids (e.g., betamethasone, clobetasol)
- Vitamin D analogs (e.g., calcitriol, calcipotriene)
- Tazarotene
- Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

3 - Prescribed by or in consultation with a dermatologist

Product Name:Vtama	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging, paid claims history) documenting positive clinical response to therapy as evidenced by one of the following:

- Reduction in the body surface area (BSA) involvement from baseline
- Improvement in symptoms (e.g., pruritus, inflammation) from baseline

Product Name:Vtama	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of atopic dermatitis

AND

2 - Patient is 2 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting confirming a trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to TWO of the following:

- Medium or higher potency topical corticosteroid
- Elidel (pimecrolimus) cream
- Tacrolimus ointment
- Eucrisa (crisaborole) ointment

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Vtama	
Diagnosis	Atopic Dermatitis (AD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging, paid claims history) documenting positive clinical response to therapy as evidenced by one of the following:

- Reduction in the body surface area (BSA) involvement from baseline
- Reduction in pruritus severity from baseline
- Improvement in quality of life from baseline

2 . Background

Clinical Practice Guidelines

Table 1: Relative potencies of topical corticosteroids

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
High Potency	Amcinonide	Cream, lotion, ointment	0.1
	Augmented betamethasone dipropionate	Cream	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
	Betamethasone valerate	Cream, foam, lotion, ointment	0.1

Medium potency	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream	0.1
	Triamcinolone acetonide	Cream, ointment	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes
9/25/2025	Update steps AD/PsO, now preferred.

Prior Authorization Guideline

Guideline ID	GL-641221
Guideline Name	Vyjuvek (beremagene geperpavec-svdt)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Vyjuvek	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of dystrophic epidermolysis bullosa (DEB)

AND

2 - Submission of medical records (e.g., chart notes) confirming patient has mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene

AND

3 - Medication is being used for the treatment of wounds

AND

4 - Medication will be applied by a healthcare professional

AND

5 - Submission of medical records (e.g., chart notes) confirming wound(s) being treated meet all of the following criteria:

- Adequate granulation tissue
- Excellent vascularization
- No evidence of active wound infection in the wound being treated
- No evidence or history of squamous cell carcinoma in the wound being treated

AND

6 - Prescribed by or in consultation with a dermatologist

AND

7 - Medication is not being used concurrently with other FDA approved therapies (e.g., Filsuvez) for the treatment of epidermolysis bullosa

Product Name:Vyjuvek	
Approval Length	6 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response (e.g., decrease in wound size, increase in granulation tissue, complete wound closure)

AND

2 - Wound(s) being treated meet all of the following criteria:

- Adequate granulation tissue
- Excellent vascularization
- No evidence of active wound infection in the wound being treated
- No evidence or history of squamous cell carcinoma in the wound being treated

AND

3 - Medication is not being used concurrently with other FDA approved therapies (e.g., Filsuvez) for the treatment of epidermolysis bullosa

2 . Revision History

Date	Notes
6/25/2026	Updated concurrent use criterion verbiage for initial and reauth.

Prior Authorization Guideline

Guideline ID	GL-624208
Guideline Name	Vykat XR (diazoxide choline)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Vykat XR	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of Prader-Willi syndrome (PWS)

AND

2 - Medication is being used for hyperphagia due to PWS

AND

3 - Submission of medical records (e.g., chart notes) documenting disease is confirmed by the presence of a mutation in chromosome 15 as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

4 - Patient is 4 years of age or older

AND

5 - Patient does not have hepatic impairment or renal impairment

AND

6 - All of the following:

- Baseline body weight or BMI has been obtained
- Fasting plasma glucose and HbA1c have been evaluated prior to initiating treatment
- For patients with hyperglycemia, prescriber confirms blood glucose has been optimized prior to initiating treatment
- Patient's blood glucose and HbA1c will be monitored periodically during treatment

AND

7 - Patient is able to successfully swallow the number of tablets necessary to achieve the target maintenance dose

AND

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

- Endocrinologist
- Geneticist
- Specialist knowledgeable in the treatment of Prader-Willi syndrome

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) demonstrating positive clinical response to therapy (e.g., decreased hunger or thoughts about food, decreased weight or BMI)

2 . Revision History

Date	Notes
5/27/2026	Updated criteria with additional monitoring parameters

Prior Authorization Guideline

Guideline ID	GL-99867
Guideline Name	Vyndaqel and Vyndamax
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Vyndaqel, Vyndamax	
Diagnosis	Transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)	

AND

2 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting ONE of the following:

2.1 Documentation that the patient has a pathogenic transthyretin (TTR) mutation (e.g., V30M)

OR

2.2 Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of ATTR amyloid deposits

OR

2.3 Submission of medical records (e.g., chart notes, lab work, imaging) documenting ALL of the following

2.3.1 Echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis

AND

2.3.2 Radionuclide imaging (99mTc-DPD, 99mTc-PYP, or 99m Tc-HMDP) showing grade 2 or 3 cardiac uptake*

AND

2.3.3 Absence of monoclonal protein identified in serum, urine immunofixation (IFE), serum free light chain (sFLC) assay

AND

3 - Prescribed by, or in consultation, with a cardiologist

AND

4 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting presence of clinical signs and symptoms of cardiomyopathy (e.g., heart failure, dyspnea, edema, hepatomegaly, ascites, angina, etc.)

AND

5 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting BOTH of the following:

5.1 ONE of the following:

5.1.1 Patient has New York Heart Association (NYHA) Functional Class I or II heart failure

OR

5.1.2 BOTH of the following:

5.1.2.1 Patient has New York Heart Association (NYHA) Functional Class III heart failure

AND

5.1.2.2 Patient's cardiopulmonary functional status allows patient to ambulate 100 meters or greater in six minutes or less

AND

5.2 Patient has an N-terminal pro-B-type naturetic peptide (NT-proBNP) level greater than or equal to 600 picograms/milliliter

AND

6 - One of the following:

6.1 Paid claims or submission of medical records (e.g., chart notes) verifying patient is not receiving Vyndaqel or Vyndamax in combination with either of the following:

- Onpattro (patisiran)
- Tegsedi (inotersen)

OR

6.2 If the patient is receiving Vyndaqel/Vyndamax in combination with Onpattro (patisiran) or Tegsedi (inotersen), the physician attests that he/she will coordinate care with other specialist(s) involved in the patient's amyloidosis treatment plan to determine optimal long term monotherapy** treatment regimen

Notes	NOTE: *May require prior authorization and notification ** Referring to monotherapy with Vyndaqel/Vyndamax, Onpattro, or T egsedi

Product Name:Vyndaqel, Vyndamax	
Diagnosis	Transthyretin (ATTR)-mediated amyloidosis with cardiomyopathy (ATTR-CM)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that the patient has experienced a positive clinical response to Vyndaqel or Vyndamax (e.g., improved symptoms, quality of life, slowing of disease progression, decreased hospitalizations, etc.)

AND

2 - Prescribed by or in consultation with a cardiologist

AND

3 - Submission of medical records (e.g., chart notes) documenting that patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

4 - Paid claims or submission of medical records (e.g., chart notes) verifying patient is not receiving Vyndaqel or Vyndamax in combination with either of the following:

- Onpattro (patisiran)
- Tegsedi (inotersen)

2 . Revision History

Date	Notes
12/9/2021	Added submission of records/paid claims where applicable.

Prior Authorization Guideline

Guideline ID	GL-530193
Guideline Name	Vyondys 53 (golodirsen)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	3/1/2026

1 . Criteria

Product Name:Vyondys 53	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of Duchenne muscular dystrophy (DMD)

AND

1.2 Confirmed mutation of the dystrophin gene amenable to exon 53 skipping

AND

2 - Patient is 6 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

5 - Submission of medical records including results of baseline North Star Ambulatory Assessment (NSAA) confirming the patient is ambulatory without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) as evidenced by NSAA scoring

AND

6 - Patient will not receive Vyondys 53 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen)]

Product Name:Vyondys 53	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is tolerating therapy

AND

2 - Dose will not exceed 30 milligrams per kilogram of body weight infused once weekly

AND

3 - Prescribed by or in consultation with a neurologist with expertise in the treatment of DMD

AND

4 - Submission of medical records including results of recent North Star Ambulatory Assessment (NSAA) confirming patient is maintaining ambulatory status without needing an assistive device (e.g., without side-by-side assist, cane, walker, wheelchair, etc.) as evidenced by NSAA scoring

AND

5 - Patient will not receive Vyondys 53 in combination with Duvyzat (givinostat) or other exon-skipping therapies for DMD [e.g., Amondys 45 (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen)]

2 . Revision History

Date	Notes
2/26/2026	Added submission of NSAA testing for confirmation of ambulatory sta tus.

Prior Authorization Guideline

Guideline ID	GL-636313
Guideline Name	Vyvgart (efgartigimod alfa-fcab)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Vyvgart, Vyvgart Hytrulo	
Diagnosis	Generalized myasthenia gravis (gMG)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting diagnosis of generalized myasthenia gravis (gMG)

AND

2 - Submission of medical records (e.g., chart notes) or paid claims confirming BOTH of the following:

2.1 Trial and failure, contraindication, or intolerance to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

2.2 Trial and failure, contraindication, or intolerance to one of the following:

- Chronic plasmapheresis or plasma exchange (PE)
- Intravenous immunoglobulin (IVIG) or immunoglobulin (IG) therapy

AND

3 - Prescribed by or in consultation with a neurologist

AND

4 - Requested medication is not being used in combination with any one of the following:

- Another neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo)
- Complement inhibitor (e.g., eculizumab, Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)
- B-cell depletion therapy (e.g., Uplizna)

Product Name:Vyvgart, Vyvgart Hytrulo	
Diagnosis	Generalized myasthenia gravis (gMG)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy

AND

2 - Requested medication is not being used in combination with any one of the following:

- Another neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo)
- Complement inhibitor (e.g., eculizumab, Ultomiris, Zilbrysq)
- Immune globulin (e.g., IVIG)
- B-cell depletion therapy (e.g., Uplizna)

Product Name:Vyvgart Hytrulo	
Diagnosis	Chronic inflammatory demyelinating polyneuropathy (CIDP)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP) as confirmed by ALL of the following:

1.1.1 Progressive symptoms present for at least 2 months

AND

1.1.2 Symptomatic polyradiculoneuropathy as indicated by ONE of the following:

- Progressive or relapsing motor impairment of more than one limb
- Progressive or relapsing sensory impairment of more than one limb

AND

1.1.3 Electrophysiologic findings when THREE of the following four criteria are present:

- Partial conduction block of 1 or more motor nerve
- Reduced conduction velocity of 2 or more motor nerves
- Prolonged distal latency of 2 or more motor nerves
- Prolonged F-wave latencies of 2 or more motor nerves or the absence of F waves

AND

1.2 Trial and failure, contraindication, or intolerance to ONE of the following standard of care treatments:

- Corticosteroids (minimum 3 month trial duration)
- Immunoglobulin
- Plasma exchange

AND

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

- Immunologist
- Neurologist
- Hematologist

AND

3 - Requested medication is not being used in combination with any one of the following:

- another neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo)
- complement inhibitor (e.g., Soliris, Ultomiris, Zilbrysq)
- immune globulin (e.g., IVIG)

Product Name:Vyvgart Hytrulo	
Diagnosis	Chronic inflammatory demyelinating polyneuropathy (CIDP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes, lab work, imaging) documenting positive clinical response to therapy (e.g., Improvement in INCAT or aINCAT score)

AND

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

- Immunologist
- Neurologist
- Hematologist

AND

3 - Requested medication is not being used in combination with any one of the following:

- another neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo)
- complement inhibitor (e.g., Soliris, Ultomiris, Zilbrysq)
- immune globulin (e.g., IVIG)

2 . Revision History

Date	Notes
6/25/2026	gMG: Removal of criteria for patients to be AChR positive due to new expanded indication for Vyvgart/Vyvgart Hytrulo. Previously only indi cated for patients who were AChR positive, new expanded indication for all serotypes. Updated combination therapy criterion verbiage.

Prior Authorization Guideline

Guideline ID	GL-620205
Guideline Name	Wainua (eplontersen)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) with polyneuropathy

AND

2 - Submission of medical records (e.g., chart notes) confirming patient has a transthyretin (TTR) mutation (e.g., V30M)

AND

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

- Patient has a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2
- Patient has a baseline neuropathy impairment score (NIS) greater than or equal to 10 and less than or equal to 130
- Patient has a baseline Karnofsky Performance Status score greater than 50%

AND

4 - Presence of clinical signs and symptoms of the disease (e.g., neuropathy, quality of life)

AND

5 - Patient has not had a liver transplant

AND

6 - Prescribed by or in consultation with a neurologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart note) documenting a positive clinical response to therapy as evidenced by an improvement in clinical signs and symptoms from baseline (e.g., neuropathy, quality of life, lower serum TTR level)

AND

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

- Patient continues to have a familial amyloidotic polyneuropathy (FAP) stage of 1 or 2
- Patient continues to have a neuropathy impairment score (NIS) greater than or equal to 10 and less than or equal to 130
- Patient continues to have a Karnofsky Performance Status score greater than 50%

AND

3 - Patient has not had a liver transplant

2 . Revision History

Date	Notes
5/27/2026	Added new GPI

Prior Authorization Guideline

Guideline ID	GL-540207
Guideline Name	Wakix (pitolisant)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Wakix	
Diagnosis	Narcolepsy with Cataplexy (i.e., Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)

AND

1.2 Symptoms of cataplexy are present

AND

1.3 Symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep) are present

AND

2 - Physician attestation to the following: Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - Patient is 6 years of age or older

AND

4 - Prescribed by one of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

Product Name:Wakix	
Diagnosis	Narcolepsy without cataplexy (Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)

AND

1.2 Symptoms of cataplexy are absent

AND

1.3 Symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep) are present

AND

2 - Physician attestation to the following: Other causes of sleepiness have been ruled out or treated (including but not limited to obstructive sleep apnea, insufficient sleep syndrome, shift work, the effects of substances or medications or their withdrawal, sleep phase disorder, or other sleep disorders)

AND

3 - Patient is 6 years of age or older

AND

4 - Paid claims or submission of medical records (e.g., chart notes) confirming BOTH of the following:

4.1 Trial and failure, contraindication (e.g., age), or intolerance to BOTH of the following:

- armodafinil or modafinil

- Sunosi (solriamfetol)

AND

4.2 Trial and failure, contraindication, or intolerance to an amphetamine (e.g., amphetamine, dextroamphetamine) or methylphenidate based stimulant UNLESS patient is not a candidate

AND

5 - Prescribed by one of the following:

- Neurologist
- Psychiatrist
- Sleep Medicine Specialist

Product Name:Wakix	
Diagnosis	All Indications Listed Above
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a reduction in symptoms of excessive daytime sleepiness associated with therapy

2 . Revision History

Date	Notes
3/24/2026	Age criterion add/update for narcolepsy w cataplexy

Prior Authorization Guideline

Guideline ID	GL-509188
Guideline Name	Wegovy (semaglutide)
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Wegovy injection, Wegovy tablets	
Diagnosis	Weight Loss
Guideline Type	Prior Authorization
Approval Criteria **1** - Wegovy when used for the treatment of weight loss is excluded and is to be denied as a benefit exclusion	

Product Name:Wegovy injection, Wegovy tablets	
Diagnosis	Reduction of risk of major adverse cardiovascular events

Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Treatment is being requested to reduce the risk of major adverse cardiovascular events

AND

2 - Patient is 45 years of age or older

AND

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

3.1 BMI (body mass index) greater than or equal to 30 kg/m2 (kilograms per square meter)

AND

3.2 Established cardiovascular disease as evidenced by one of the following:

3.2.1 Prior myocardial infarction (MI)

OR

3.2.2 One of the following diagnoses/diagnosis codes:

- I25.2 Old myocardial infarction
- I46.2 Cardiac arrest due to underlying cardiac condition
- I46.8 Cardiac arrest due to other underlying condition
- I46.9 Cardiac arrest, cause unspecified
- Z95.0 Presence of cardiac pacemaker
- Z95.1 Presence of aortocoronary bypass graft
- Z95.2 Presence of prosthetic heart valve
- Z95.3 Presence of xenogenic heart valve
- Z95.4 Presence of other heart-valve replacement

- Z95.5 Presence of coronary angioplasty implant and graft

AND

4 - Used in combination with a reduced calorie diet and increased physical activity

AND

5 - For patients with a history of myocardial infarction, submission of medical records (e.g., chart notes) or paid claims documenting one of the following:

5.1 Patient is on therapy from each of the following classes (as confirmed by claims history or submission of medical records):

- Cholesterol lowering medication (e.g., statin, PCSK9i)
- Beta blocker (i.e., carvedilol, metoprolol, or bisoprolol)
- Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)
- Antiplatelet (e.g., aspirin, clopidogrel)

OR

5.2 Patient has a history of intolerance or contraindication to all of the following therapeutic classes (please specify intolerance or contraindication):

- Cholesterol lowering medication (e.g., statin, PCSK9i)
- Beta blocker (i.e., carvedilol, metoprolol, or bisoprolol)
- Angiotensin-converting enzyme inhibitor (ACE-I)/angiotensin II receptor blocker (ARB)/angiotensin II receptor blocker neprilysin inhibitor (ARNI)
- Antiplatelet (e.g., aspirin, clopidogrel)

AND

6 - Patient does NOT have diagnosis of diabetes or HgA1c greater than or equal to 6.5%

AND

7 - Patient does NOT have New York Heart Association class IV heart failure

AND

8 - Patient does NOT have end-stage renal disease

Product Name:Wegovy injection, Wegovy tablets	
Diagnosis	Reduction of risk of major adverse cardiovascular events
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BMI (body mass index) greater than or equal to 30 kg/m2 (kilograms per square meter)

AND

2 - Used in combination with a reduced calorie diet and increased physical activity

AND

3 - Patient does NOT have diagnosis of diabetes or HgA1c greater than or equal to 6.5%

AND

4 - Patient does NOT have New York Heart Association class IV heart failure

AND

5 - Patient does NOT have end-stage renal disease

Product Name:Wegovy injection	
Diagnosis	Metabolic dysfunction-associated steatohepatitis (MASH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH)

AND

2 - Patient does not have cirrhosis (e.g., decompensated cirrhosis)

AND

3 - Disease is fibrosis stage F2 or F3 as confirmed by one of the following:

- Enhanced liver fibrosis (ELF) test
- Liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE) (e.g., FibroScan)
- FibroScan aspartate aminotransferase (FAST)
- MRI aspartate aminotransferase (MAST)
- Magnetic Resonance Elastography combined with fibrosis-4 index (MEFIB)
- Liver biopsy within the past 12 months

AND

4 - Patient is 18 years of age or older

AND

5 - Used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)

AND

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

- Gastroenterologist
- Hepatologist
- Endocrinologist

AND

7 - Medication is not being co-administered with another GLP-1 receptor agonist (e.g., Saxenda, Trulicity, Victoza)

AND

8 - Medication will not be used in combination with Rezdiffra (resmetirom) for the treatment of MASH

Product Name:Wegovy injection	
Diagnosis	Metabolic dysfunction-associated steatohepatitis (MASH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive response to therapy (e.g., improvement in liver function tests (LFTs), fibrosis stage improvement, improvement from baseline on MASH-specific imaging [VCTE >/= 25%, MRE >/= 20%, etc.], etc.)

AND

2 - Patient has not progressed to cirrhosis

AND

3 - Used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)

AND

4 - Medication is not being co-administered with another GLP-1 receptor agonist (e.g., Saxenda, Trulicity, Victoza)

AND

5 - Medication will not be used in combination with Rezdiffra (resmetirom) for the treatment of MASH

2 . Revision History

Date	Notes
1/28/2026	Added criteria for MASH indication. Added GPIs for tablet formulation .

Prior Authorization Guideline

Guideline ID	GL-99695
Guideline Name	Xalkori
Formulary	• Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021
P&T Approval Date:	
P&T Revision Date:	

1 . Criteria

Product Name:Xalkori	
Diagnosis	Inflammatory Myofibroblastic Tumor (IMT)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - Diagnosis of inflammatory myofibroblastic tumor (IMT) with anaplastic lymphoma kinase (ALK) translocation

Product Name:Xalkori	
Diagnosis	Non-Small Cell Lung Cancer (NSCLC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of non-small cell lung cancer (NSCLC)

AND

2 - Disease is ONE of the following:

- Metastatic
- Recurrent
- Advanced

AND

3 - ONE of the following:

- Tumor is anaplastic lymphoma kinase (ALK)-positive
- Tumor is ROS1-positive
- Tumor is positive for mesenchymal-epithelial transition (MET) amplification
- Tumor is positive for MET exon 14 skipping mutation

Product Name:Xalkori	
Diagnosis	Central Nervous System (CNS) Cancers
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of metastatic brain cancer from non-small cell lung cancer (NSCLC)

AND

2 - ONE of the following:

- Tumor is anaplastic lymphoma kinase (ALK)-positive
- Tumor is ROS1-positive

Product Name:Xalkori	
Diagnosis	Anaplastic Large Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of anaplastic large cell lymphoma

AND

2 - Tumor is anaplastic lymphoma kinase (ALK)-positive

AND

3 - Disease is relapsed or refractory

Product Name:Xalkori	
Diagnosis	Inflammatory Myofibroblastic Tumor (IMT), Non-Small Cell Lung Cancer (NSCLC), Central Nervous System (CNS) Cancers, Anaplastic Large Cell Lymphoma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient does not show evidence of progressive disease while on Xalkori therapy

Product Name:Xalkori	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Xalkori will be approved for uses supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B.

Product Name:Xalkori	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Xalkori therapy

2 . Revision History

Date	Notes
4/8/2021	7/1 Implementation

Prior Authorization Guideline

Guideline ID	GL-285207
Guideline Name	Xdemvy (lotilaner)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2025

1 . Criteria

Product Name:Xdemvy	
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of Demodex blepharitis

AND

1.2 Patient exhibits one of the following signs of Demodex infestation

Collarettes

Eyelid margin erythema

Eyelash anomalies (e.g., eyelash misdirection)

AND

1.3 Patient is experiencing symptoms or architectural changes associated with Demodex infestation (e.g., burning, tearing, itching, foreign body sensation, eyelashes missing, eyelashes growing inward)

AND

1.4 Inadequate response to at least a 12-week trial of BOTH of the following:

tea tree-oil

eyelid scrub

AND

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

Ophthalmologist

Optometrist

2 . Revision History

Date	Notes
5/30/2025	Updated embedded step

Prior Authorization Guideline

Guideline ID	GL-660309
Guideline Name	Xeljanz, Xeljanz XR (tofacitinib)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:PREFERRED: Brand Xeljanz tablets, Brand Xeljanz XR tablets	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of moderately to severely active rheumatoid arthritis (RA)	

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:PREFERRED: Brand Xeljanz tablets, Brand Xeljanz XR tablets	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:PREFERRED: Brand Xeljanz tablets, Brand Xeljanz XR tablets, Brand Xeljanz oral solution	
Diagnosis	Psoriatic Arthritis (PsA)

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

Approval Criteria

1 - Diagnosis of active psoriatic arthritis

AND

2 - Patient is 2 years of age or older (Applies to Xeljanz IR tablets and oral solution only)

AND

3 - Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to a 3 month trial of methotrexate at the maximally indicated dose within the last 6 months, unless contraindicated or clinically significant adverse effects are experienced

AND

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

Rheumatologist

Dermatologist

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:PREFERRED: Brand Xeljanz tablets, Brand Xeljanz XR tablets, Brand Xeljanz oral solution	
Diagnosis	Psoriatic Arthritis (PsA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

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

Rheumatologist

Dermatologist

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:PREFERRED: Brand Xeljanz tablets, Brand Xeljanz XR tablets	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting history of failure to one of the following conventional therapies at maximally indicated doses within the last 3 months, unless contraindicated or clinically significant adverse effects are experienced:

Corticosteroids (e.g., prednisone, methylprednisolone, budesonide)

6-mercaptopurine (Purinethol)

Azathioprine (Imuran)

Aminosalicylates (e.g., mesalamine, sulfasalazine)

AND

3 - Prescribed by or in consultation with a gastroenterologist

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:PREFERRED: Brand Xeljanz tablets, Brand Xeljanz XR tablets	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a gastroenterologist

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:PREFERRED: Brand Xeljanz tablets, Brand Xeljanz XR tablets	
Diagnosis	Ankylosing Spondylitis (AS)

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

Approval Criteria

1 - Diagnosis of active ankylosing spondylitis

AND

2 - Trial and failure, contraindication, or intolerance to TWO nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen)

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:PREFERRED: Brand Xeljanz tablets, Brand Xeljanz XR tablets	
Diagnosis	Ankylosing Spondylitis (AS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - Prescribed by or in consultation with a rheumatologist	
Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:PREFERRED: Brand Xeljanz tablets, Brand Xeljanz oral solution	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active polyarticular course juvenile idiopathic arthritis

AND

2 - Submission of medical records (e.g., chart notes) or paid claims documenting trial and failure, contraindication, or intolerance to one of the following nonbiologic DMARDs:

leflunomide

methotrexate

AND

3 - Prescribed by or in consultation with a rheumatologist

Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:PREFERRED: Brand Xeljanz tablets, Brand Xeljanz oral solution	
Diagnosis	Polyarticular Juvenile Idiopathic Arthritis (PJIA)
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy **AND** **2** - Prescribed by or in consultation with a rheumatologist	
Notes	PA Team Note: To approve products designated "Only Brand Covered" or "Brand Over Generic - Not Covered"; flip Brand/Generic Flag to "Y", approve at MSC "O".

Product Name:NON-PREFERRED: generic tofacitinib tablets, generic tofacitinib ER tablets, generic tofacitinib oral solution	
Approval Length	N/A - Requests for generic tofacitinib should not be approved
Guideline Type	Prior Authorization
Approval Criteria **1** - Requests for generic tofacitinib are not authorized and will not be approved	
Notes	Approval Length: N/A - Requests for generic tofacitinib should not be approved. Patients need to use Brand Xeljanz or other preferred alternatives.

2 . Revision History

Date	Notes
7/28/2026	Brand Xeljanz is Brand over Generic; Moved generic tofacitinib to separate NPD section with denial criteria, removed step verbiage throughout.

Prior Authorization Guideline

Guideline ID	GL-716192
Guideline Name	Xenazine (tetrabenazine)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Preferred: generic tetrabenazine; Non-Preferred: Brand Xenazine	
Diagnosis	Chorea associated with Huntington's Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chorea in patients with Huntington's disease

AND

2 - For Brand Xenazine requests ONLY: History of failure or intolerance to generic tetrabenazine

Product Name:Preferred: generic tetrabenazine; Non-Preferred: Brand Xenazine	
Diagnosis	Tardive Dyskinesia (Off Label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of tardive dyskinesia

AND

2 - One of the following:

2.1 Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication

OR

2.2 Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication

AND

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

Neurologist

Psychiatrist

AND

4 - For Brand Xenazine requests ONLY: History of failure or intolerance to generic tetrabenazine

Product Name:Preferred: generic tetrabenazine; Non-Preferred: Brand Xenazine	
Diagnosis	Tardive Dyskinesia (Off Label)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - For Brand Xenazine requests ONLY: History of failure or intolerance to generic tetrabenazine

Product Name:Preferred: generic tetrabenazine; Non-Preferred: Brand Xenazine	
Diagnosis	Tourette's syndrome (off-label)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has tics associated with Tourette's syndrome

AND

2 - History of failure, contraindication, or intolerance to Haldol (haloperidol)

AND

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

Neurologist

Psychiatrist

AND

4 - For Brand Xenazine requests ONLY: History of failure or intolerance to generic tetrabenazine

Product Name:Preferred: generic tetrabenazine; Non-Preferred: Brand Xenazine	
Diagnosis	Tourette's syndrome (off-label)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - For Brand Xenazine requests ONLY: History of failure or intolerance to generic tetrabenazine

2 . Revision History

Date	Notes
9/11/2026	Tetrabenazine to PDL, added step through generic tetrabenazine for Brand Xenazine requests

Prior Authorization Guideline

Guideline ID	GL-99529
Guideline Name	Xenleta
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Xenleta	
Diagnosis	Community-acquired bacterial pneumonia
Approval Length	7 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 All of the following:

1.3.1 Diagnosis of community-acquired bacterial pneumonia (CABP)

AND

1.3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Xenleta

AND

1.3.3 History of failure, contraindication, or intolerance to three of the following antibiotics:

Amoxicillin

A macrolide

Doxycycline

A fluoroquinolone

Combination therapy with amoxicillin/clavulanate or cephalosporin AND a macrolide or doxycycline

Product Name:Xenleta*	
Diagnosis	Off-Label Uses
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 For continuation of therapy upon hospital discharge

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 The medication is being prescribed by or in consultation with an infectious disease specialist

Notes	*Approval Duration: Based on provider recommended treatment durations, not to exceed 6 months

2 . Revision History

Date	Notes
5/18/2021	7/1 Implementation

Prior Authorization Guideline

Guideline ID	GL-131958
Guideline Name	Xenpozyme (olipudase alfa)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2023

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of acid sphingomyelinase deficiency (ASMD)*

AND

2 - Disease confirmed by ONE of the following: [2]

2.1 Molecular genetic testing confirms biallelic pathogenic variants in the SMPD1 (sphingomyelin phophodiesterase-1) gene

OR

2.2 Residual acid sphingomyelinase activity that is less than 10% of controls (in peripheral blood lymphocytes or cultured skin fibroblasts)

AND

3 - Submission of medical records (e.g., chart notes) documenting patient has non-central nervous system manifestations of ASMD

AND

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

Metabolic disease specialist

Geneticist

Notes	*Acid Sphingomyelinase Deficiency is also known as Niemann-Pick Disease types A, A/B, and B [1]

Product Name:Xenpozyme	
Approval Length	24 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., decrease in spleen size, decrease in liver size, increase in platelet count, improved lung function)

2 . Revision History

Date	Notes
8/29/2023	Added new GPI for 4 mg strength

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-709189
Guideline Name	Xeomin (incobotulinumtoxinA)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Xeomin	
Diagnosis	Cervical Dystonia (also known as spasmodic torticollis)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cervical dystonia (also known as spasmodic torticollis)

Product Name:Xeomin	
Diagnosis	Cervical Dystonia (also known as spasmodic torticollis)
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - At least 3 months have elapsed or will have elapsed since the last treatment

Product Name:Xeomin	
Diagnosis	Blepharospasm
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of blepharospasm

Product Name:Xeomin	
Diagnosis	Blepharospasm
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - At least 3 months have elapsed or will have elapsed since the last treatment

Product Name:Xeomin	
Diagnosis	Upper Limb Spasticity
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of upper limb spasticity

AND

2 - Patient is 2 years of age or older

Product Name:Xeomin	
Diagnosis	Upper Limb Spasticity
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - At least 3 months have elapsed or will have elapsed since the last treatment

Product Name:Xeomin	
Diagnosis	Chronic Sialorrhea
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic sialorrhea

AND

2 - Patient is 2 years of age or older

Product Name:Xeomin	
Diagnosis	Chronic Sialorrhea
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - At least 4 months have elapsed or will have elapsed since the last treatment

Product Name:Xeomin	
Diagnosis	Cosmetic Use
Approval Length	N/A - requests for cosmetic use are excluded and will not be approved
Guideline Type	Prior Authorization
Approval Criteria **1** - Requests for coverage of any Xeomin product for treating the appearance of facial lines are not authorized and will not be approved. These uses are considered cosmetic only and are excluded from coverage.	
Notes	Requests for coverage of any Xeomin product for treating the appearance of facial lines are not authorized and will not be approved. These uses are considered cosmetic only and are excluded from coverage.

2 . Revision History

Date	Notes
8/26/2026	New program

Prior Authorization Guideline

Guideline ID	GL-99658
Guideline Name	Xermelo
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Xermelo	
Diagnosis	Carcinoid Syndrome Diarrhea
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of carcinoid syndrome diarrhea

AND

2 - Diarrhea is inadequately controlled with somatostatin analog therapy (e.g., octreotide, Sandostatin LAR, Somatuline Depot)

AND

3 - Used in combination with somatostatin analog therapy (e.g., octreotide, Sandostatin LAR, Somatuline Depot)

Product Name:Xermelo	
Diagnosis	Carcinoid Syndrome Diarrhea
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Xermelo

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-642192
Guideline Name	Xgeva and Denosumab 120mg products
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

Product Name:Xgeva, Aukelso, Bilprevda, Bomyntra, Osenvelt, Wyost, Xtrenbo, Jubereq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The drug is being used as indicated by National Comprehensive Cancer Network (NCCN) guidelines with a Category of Evidence and Consensus of 1, 2A, or 2B	

2 . Revision History

Date	Notes
6/25/2026	Added Jubereq as target

Prior Authorization Guideline

Guideline ID	GL-147691
Guideline Name	Xhance (fluticasone nasal spray)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2024

1 . Criteria

Product Name:Xhance	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

Chronic rhinosinusitis with nasal polyps (CRSwNP)

Chronic rhinosinusitis without nasal polyps (CRSsNP)

AND **2** - History of failure to generic fluticasone nasal spray

2 . Revision History

Date	Notes
5/23/2024	New program

Prior Authorization Guideline

Guideline ID	GL-660364
Guideline Name	Xocova (ensitrelvir)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Xocova	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming requested drug is used for post-exposure prophylaxis of coronavirus disease 2019 (COVID-19)

AND

2 - Treatment is initiated within 72 hours following contact with an individual who has COVID-19

AND

3 - Submission of medical records (e.g., chart notes) confirming a negative COVID-19 test prior to initiation

AND

4 - Patient is 12 years of age or older

AND

5 - Provider has confirmed (via pregnancy test) that the patient is not pregnant prior to receiving treatment

AND

6 - Females of reproductive potential will use effective contraception during treatment and for 2 weeks after the final dose

AND

7 - Patient is high-risk due to co-morbidities (e.g., cancer, cerebrovascular disease, CKD, chronic lung or liver disease, heart disease)

2 . Revision History

Date	Notes
7/28/2026	New Program

Prior Authorization Guideline

Guideline ID	GL-700350
Guideline Name	Xolair and Omalizumab products
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Preferred: Xolair	
Diagnosis	Allergic Asthma
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming diagnosis of moderate to severe persistent allergic asthma

AND

2 - Submission of documentation (e.g., chart notes, lab values) confirming a positive skin test or in vitro reactivity to a perennial aeroallergen

AND

3 - One of the following:

3.1 Both of the following:

Patient is 12 years of age or older

Submission of documentation (e.g., chart notes, lab values) confirming pre-treatment serum immunoglobulin (Ig)E level between 30 to 700 IU/mL

OR

3.2 Both of the following:

Patient is 6 years to less than 12 years of age

Submission of documentation (e.g. chart notes, lab values) confirming pre-treatment serum immunoglobulin (Ig)E level between 30 to 1300 IU/mL

AND

4 - Paid claims or submission of documentation (e.g., chart notes) confirming patient is currently being treated with ONE of the following, unless there is a contraindication or intolerance to these medications:

4.1 Both of the following:

High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day)

Additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium)

OR

4.2 One maximally-dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Symbicort [budesonide/formoterol], Breo Ellipta [fluticasone/vilanterol])

AND

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

Pulmonologist

Allergist/immunologist

Product Name:Preferred: Xolair	
Diagnosis	Allergic Asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming a positive clinical response to therapy (e.g., reduction in exacerbations, improvement in forced expiratory volume in 1 second [FEV1], decreased use of rescue medications)

AND

2 - Paid claims or submission of documentation (e.g., chart notes) confirming patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], tiotropium) unless there is a contraindication or intolerance to these medications

AND

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

Pulmonologist

Allergist/immunologist

Product Name:Preferred: Xolair	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming diagnosis of chronic spontaneous urticaria

AND

2 - Persistent symptoms (itching and hives) for at least 4 consecutive weeks despite titrating to an optimal dose with a second generation H1 antihistamine (e.g., cetirizine, fexofenadine), unless there is a contraindication or intolerance to H1 antihistamines

AND

3 - Paid claims or submission of documentation (e.g., chart notes) confirming concurrent use with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines

AND

4 - Paid claims or submission of documentation (e.g., chart notes) confirming patient has tried and had an inadequate response or intolerance to at least TWO of the following additional therapies:

Doxepin

H1 antihistamine

H2 antagonist (e.g., famotidine, cimetidine)

Hydroxyzine

Leukotriene receptor antagonist (e.g., montelukast)

AND

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

Allergist/immunologist

Dermatologist

Product Name:Preferred: Xolair	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment

AND

2 - Submission of documentation (e.g., chart notes) confirming patient has experienced at least one of the following:

Reduction in itching severity from baseline

Reduction in the number of hives from baseline

Product Name:Preferred: Xolair	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years of age or older

AND

2 - Submission of documentation (e.g., chart notes) confirming ONE of the following:

2.1 ALL of the following:

2.1.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) defined by ALL of the following:

2.1.1.1 TWO or more of the following symptoms for greater than or equal to 12 weeks duration:

Mucopurulent discharge

Nasal obstruction and congestion

Decreased or absent sense of smell

Facial pressure or pain

AND

2.1.1.2 ONE of the following:

Evidence of inflammation on paranasal sinus examination or computed tomography (CT)

Evidence of purulence coming from paranasal sinuses or ostiomeatal complex

AND

2.1.1.3 The presence of nasal polyps

AND

2.1.2 ONE of the following:

Patient has required prior sino-nasal surgery

Patient has required systemic corticosteroids in the previous 2 years

AND

2.1.3 Patient has been unable to obtain symptom relief after trial of ALL of the following agents/classes of agents:

Nasal saline irrigations

Intranasal corticosteroids (e.g. fluticasone, mometasone, triamcinolone, etc.)

Antileukotriene agents (e.g. montelukast, zafirlukast, zileuton)

OR

2.2 ALL of the following:

2.2.1 Diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP)

AND

2.2.2 Patient is currently on Xolair therapy

AND

3 - Patient will receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids

AND

4 - Patient is NOT receiving Xolair in combination with another biologic medication [e.g., Dupixent (dupilumab), Nucala (mepolizumab)]

AND

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

Otolaryngologist

Allergist

Pulmonologist

Product Name:Preferred: Xolair	
Diagnosis	Chronic Rhinosinusitis with Nasal Polyps (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes, lab values) confirming a positive clinical response to Xolair therapy

AND

2 - Patient will continue to receive Xolair as add-on maintenance therapy in combination with intranasal corticosteroids

AND

3 - Patient is NOT receiving Xolair in combination with another biologic medication [e.g., Dupixent (dupilumab), Nucala (mepolizumab)]

AND

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

Otolaryngologist

Allergist

Pulmonologist

Product Name:Preferred: Xolair	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	20 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Submission of documentation (e.g., chart notes, lab values) confirming both of the following:

1.1.1 Diagnosis of IgE Mediated Food Allergy as evidenced by one of the following:

Positive skin prick test (defined as greater than or equal to 4 mm wheal greater than saline control) to food

Positive food specific IgE (greater than or equal to 6 kUA/L)

Positive oral food challenge, defined as experiencing dose-limiting symptoms at a single dose of less than or equal to 300 mg of food protein

AND

1.1.2 Clinical history of IgE Mediated Food Allergy

OR

1.2 Submission of documentation (e.g., chart notes, lab values) confirming patient has a history of severe allergic response, including anaphylaxis, following exposure to one or more foods

AND

2 - Patient is 1 year of age or older

AND

3 - Used in conjunction with food allergen avoidance

AND

4 - Submission of documentation (e.g., chart notes, lab values) confirming both of the following:

Baseline (pre-Xolair treatment) serum total IgE level is greater than or equal to 30 IU/mL and less than or equal to 1850 IU/mL

Dosing is according to serum total IgE levels and body weight

AND

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

Allergist

Immunologist

Product Name:Preferred: Xolair	
Diagnosis	IgE-Mediated Food Allergy
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes, lab values) confirming a positive clinical response to therapy e.g., reduction of type 1 allergic reactions, including anaphylaxis, following accidental exposure to one or more foods)

AND

2 - Used in conjunction with food allergen avoidance

AND

3 - Submission of documentation (e.g., chart notes, lab values) confirming that dosing will continue to be based on body weight and pretreatment total IgE serum levels (Note: Dose should only be adjusted during therapy due to significant changes in patient body weight)

AND

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

Allergist

Immunologist

Product Name:Non-Preferred: Omlyclo and newly launched omalizumab products	
Approval Length	Requests for Non-Preferred biosimilar products are not approved at this time
Guideline Type	Prior Authorization
Approval Criteria **1** - Per your health plan's criteria, the non-preferred drug is not approved for coverage because the plan's preferred product is Xolair (omalizumab).	
Notes	Approval Length: N/A - Requests for non-preferred omalizumab products should not be approved. Patients need to use Xolair or other preferred alternatives.

2 . Background

Clinical Practice Guidelines

The Global Initiative for Asthma Global Strategy for Asthma Management and Prevention: Table 1. Low, medium and high daily doses of inhaled corticosteroids in adolescents and adults 12 years and older [3]

Inhaled corticosteroid	Total Daily ICS Dose (mcg)		
	Low	Medium	High

Beclometasone dipropionate (pMDI, standard particle, HFA)	200-500	> 500-1000	> 1000
Beclometasone dipropionate (DPI or pMDI, extrafine particle*, HFA)	100-200	> 200-400	> 400
Budesonide (DPI, or pMDI, standard particle, HFA)	200-400	> 400-800	> 800
Ciclesonide (pMDI, extrafine particle*, HFA)	80-160	> 160-320	> 320
Fluticasone furoate (DPI)	100		200
Fluticasone propionate (DPI)	100-250	> 250-500	> 500
Fluticasone propionate (pMDI, standard particle, HFA)	100-250	> 250-500	> 500
Mometasone furoate (DPI)	Depends on DPI device – see product information		
Mometasone furoate (pMDI, standard particle, HFA)	200-400		> 400

DPI: dry powder inhaler; HFA: hydrofluoroalkane propellant; ICS: inhaled corticosteroid; N/A: not applicable; pMDI: pressurized metered dose inhaler (non-chlorofluorocarbon formulations); ICS by pMDI should be preferably used with a spacer *See product information.

***This is not a table of equivalence**,* but instead, suggested total daily doses for the 'low', 'medium' and 'high' dose ICS options for adults/adolescents, based on available studies and product information. Data on comparative potency are not readily available and therefore this table does NOT imply potency equivalence. Doses may be country -specific depending on local availability, regulatory labelling and clinical guidelines.

For new preparations, including generic ICS, the manufacturer's information should be reviewed carefully; products containing the same molecule may not be clinically equivalent.

3 . Revision History

Date	Notes

8/26/2026	Added Omlyclo as NPD target

Prior Authorization Guideline

Guideline ID	GL-150126
Guideline Name	Xolremdi (mavorixafor)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2024

1 . Criteria

Product Name:Xolremdi	
Diagnosis	WHIM syndrome
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of WHIM (warts, hypogammaglobulinemia, infections and myelokathexis) syndrome

AND

1.2 Patient has genotype confirmed variant of CXCR4 as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

1.3 Patient has an absolute neutrophil count (ANC) less than or equal to 500 cells /µL

AND

2 - Patient is 12 years of age or older

AND

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

Immunologist

Hematologist

Geneticist

Allergist

Product Name:Xolremdi	
Diagnosis	WHIM syndrome
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy (e.g., improvement in ANC, reduction in infections)

2 . Revision History

Date	Notes
7/23/2024	New program

Prior Authorization Guideline

Guideline ID	GL-99502
Guideline Name	Xopenex Respules
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Brand Xopenex inhalation soln, generic levalbuterol inhalation soln	
Approval Length	12 month(s)
Guideline Type	Step Therapy

Approval Criteria

1 - The patient has a history of failure, contraindication, or intolerance to treatment with albuterol inhalation solution

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-139344
Guideline Name	Xphozah (tenapanor)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2024

1 . Criteria

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

Approval Criteria

1 - Diagnosis of hyperphosphatemia in chronic kidney disease

AND

2 - Patient is on dialysis

AND

3 - Submission of medical records (e.g., chart notes) or paid claims confirming trial and inadequate response (minimum 30-day supply), contraindication or intolerance to ALL of the following:

calcium carbonate

calcium acetate

sevelamer carbonate

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - Trial and inadequate response (minimum 30-day supply), contraindication or intolerance to ALL of the following::

calcium carbonate

calcium acetate

sevelamer carbonate

2 . Revision History

Date	Notes
1/23/2024	New program

Prior Authorization Guideline

Guideline ID	GL-241268
Guideline Name	Xromi (hydroxyurea)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

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

Approval Criteria

1 - Diagnosis of sickle cell anemia

AND

2 - Patient has moderate to severe painful crises

AND

3 - Patient is 6 months of age or older

AND

4 - One of the following:

4.1 Patient is unable to swallow solid oral dosage forms (e.g., oral tablet, capsule) due to one of the following:

Age

Physical impairment (e.g., difficulties with motor or oral coordination)

Dysphagia

Patient is using a feeding tube or nasal gastric tube

OR

4.2 Dosage requirements cannot be met with a solid dosage form

Notes	Note: PA is required for patients greater than 10 years of age

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

Notes	Note: PA is required for patients greater than 10 years of age

2 . Revision History

Date	Notes
4/24/2025	New program

Prior Authorization Guideline

Guideline ID	GL-626189
Guideline Name	Xtoro (finafloxacin) otic suspension
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	6/1/2026

1 . Criteria

Product Name:Xtoro	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Diagnosis of acute otitis externa (AOE)

AND

1.2 Infection is caused by susceptible strains of Pseudomonas aeruginosa and Staphylococcus aureus

AND

2 - Trial and failure, contraindication, or intolerance to all of the following:

ofloxacin

ciprofloxacin

2 . Revision History

Date	Notes
5/27/2026	New program

Prior Authorization Guideline

Guideline ID	GL-99660
Guideline Name	Xuriden
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

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

Approval Criteria

1 - Diagnosis of a hereditary orotic aciduria

Product Name:Xuriden

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

Approval Criteria

1 - Documentation of positive clinical response to Xuriden therapy

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Medicaid SP to Medicaid Arizona SP for 7/1

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Prior Authorization Guideline

Guideline ID	GL-700339
Guideline Name	Yartemlea (narsoplimab-wuug)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	9/1/2026

1 . Criteria

Product Name:Yartemlea	
Approval Length	16 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of hematopoietic stem cell transplant-associated thrombotic microangiopathy (TA-TMA)

AND

2 - Submission of medical records (e.g., chart notes) including lab records collected within the past 30 days confirming ALL of the following:

Platelet count less than 150 x 109//L

Evidence of microangiopathic hemolysis (e.g., presence of schistocytes, serum lactate dehydrogenase (LDH) greater than or equal to two times the upper limit of normal, or haptoglobin less than the lower limit of normal)

Renal dysfunction (i.e., doubling of serum creatinine from pretransplant)

AND

3 - Patient is 2 years of age or older

AND

4 - Prescriber attests that patient will not be using Yartemlea (narsoplimab-wuug) in combination with another complement inhibitor

AND

5 - Prescribed by, or in consultation with, a hematologist, oncologist, or stem cell transplant specialist

AND

6 - One of the following:

If the patient weighs less than 50 kg: Dose does not exceed 4 mg/kg twice weekly

If the patient weighs greater than or equal to 50 kg: Dose does not exceed 370 mg twice weekly

Notes	Note: Requests for patients under 2 years of age will be reviewed by AHCCCS FFS or MCO plan

2 . Revision History

Date	Notes
8/26/2026	Added additional criteria; baseline labs, concomitant use, and dosage criteria. Updated specialist requirement verbiage

Prior Authorization Guideline

Guideline ID	GL-553401
Guideline Name	Yeztugo (lenacapavir)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	4/1/2026

1 . Criteria

Product Name:Yeztugo	
Diagnosis	HIV-1 Pre-Exposure Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Requested drug is being used for pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired HIV-1 infection

AND

2 - Patient's weight is greater than or equal to 35 kg

AND

3 - Both of the following:

3.1 Provider attests that the patient has a negative HIV-1 test prior to the initiation of Yeztugo

AND

3.2 Provider attests that the patient has been informed about the need for the required testing, adherence, and every 6-month injection dosing schedule with Yeztugo

AND

4 - One of the following:

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

emtricitabine-tenofovir (generic Truvada)

Descovy

OR

4.2 Submission of medical records (e.g., chart notes) from provider documenting BOTH of the following:

Patient would benefit from long-acting injectable therapy over standard oral regimens

Patient would be adherent to testing and dosing schedule

Diagnosis	HIV-1 Pre-Exposure Prophylaxis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Provider attests that patient is adherent to the testing appointments and scheduled injections of Yeztugo

AND

2 - Both of the following:

2.1 Patient has a negative HIV-1 test

AND

2.2 Provider confirms that the patient will be tested for HIV-1 infection with each subsequent injection

2 . Revision History

Date	Notes
3/24/2026	Updated HIV testing requirement in both initial and reauth.

Prior Authorization Guideline

Guideline ID	GL-161661
Guideline Name	Yorvipath (palopegteriparatide)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	1/1/2025

1 . Criteria

Product Name:Yorvipath	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of hypoparathyroidism

AND

1.2 Requested drug is not being used in the setting of acute post-surgical hypoparathyroidism

AND

1.3 Patient has achieved albumin-corrected serum calcium of at least 7.8 mg/dL using calcium and active vitamin D (e.g., calcitriol) treatment

AND

2 - Prescribed by or in consultation with an endocrinologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting that patient demonstrates positive clinical response to therapy as evidenced by maintenance of normalized calcium levels compared to baseline

2 . Revision History

Date	Notes
12/4/2024	New program

Prior Authorization Guideline

Guideline ID	GL-749231
Guideline Name	Yuviwel (navepegritide)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of achondroplasia as confirmed by one of the following:

1.1 Both of the following:

1.1.1 Patient has clinical manifestations characteristic of achondroplasia (e.g., macrocephaly, frontal bossing, midface retrusion, disproportionate short stature with rhizomelic shortening of the arms and the legs, brachydactyly, trident configuration of the hands, thoracolumbar kyphosis, and accentuated lumbar lordosis)

AND

1.1.2 Patient has radiographic findings characteristic of achondroplasia (e.g., large calvaria and narrowing of the foramen magnum region, undertubulated, shortened long bones with metaphyseal abnormalities, narrowing of the interpedicular distance of the caudal spine, square ilia and horizontal acetabula, small sacrosciatic notches, proximal scooping of the femoral metaphyses, and short and narrow chest)

OR

1.2 Disease is confirmed by the presence of c.1138G>A or c.1138G>C variant (i.e., p.Gly380Arg mutation) in the fibroblast growth factor receptor-3 (FGFR3) gene as detected by a FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

2 - Submission of medical records (e.g., chart notes) confirming patient has open epiphyses

AND

3 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming history of failure to Voxzogo (vosoritide)

AND

4 - Patient is 2 years of age or older

AND

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

Clinical geneticist

Endocrinologist

A physician who has specialized expertise in the management of achondroplasia

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming patient continues to have open epiphyses

AND

2 - Submission of medical records (e.g., chart notes) documenting patient demonstrates positive clinical response to therapy as evidenced by one of the following:

Improvement in annualized growth velocity (AGV) compared to baseline

Improvement in height Z-score compared to baseline

AND

3 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming history of failure to Voxzogo (vosoritide)

AND

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

Clinical geneticist

Endocrinologist

A physician who has specialized expertise in the management of achondroplasia

2 . Revision History

Date	Notes
10/28/2026	Added step through Voxzogo to initial and reauth sections

Prior Authorization Guideline

Guideline ID	GL-715191
Guideline Name	Zeposia (ozanimod)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Zeposia	
Diagnosis	Multiple Sclerosis (MS)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of multiple sclerosis (MS)

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims confirming a history of failure, contraindication, or intolerance to a trial of at least TWO of the preferred alternatives:

Avonex

Briumvi

generic glatiramer or Glatopa

generic dalfampridine

generic dimethyl fumarate

generic fingolimod

Kesimpta

Rebif

generic teriflunomide

Tysabri

Product Name:Zeposia	
Diagnosis	Multiple Sclerosis (MS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression)

Product Name:Zeposia	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderately to severely active ulcerative colitis (UC)

AND

2 - Submission of medical records (e.g., chart notes) or verification of paid claims documenting BOTH of the following:

2.1 Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies:

6-mercaptopurine

Aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine)

Azathioprine

Corticosteroids (e.g., prednisone)

AND

2.2 History of failure, contraindication, or intolerance to ALL of the following:

A preferred adalimumab biosimilar

infliximab

Xeljanz (tofacitinib) oral tablet (IR or XR)

A preferred ustekinumab biosimilar

AND **3** - Prescribed by or in consultation with a gastroenterologist

Product Name:Zeposia	
Diagnosis	Ulcerative Colitis (UC)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to therapy **AND** **2** - Prescribed by or in consultation with a gastroenterologist	

2 . Revision History

Date	Notes
9/11/2026	10/1 changes: MS: Updated preferred prerequisites (Brand Copaxone, Ocrevus/Zunovo to NPD)

Prior Authorization Guideline

Guideline ID	GL-427211
Guideline Name	Zevaskyn (prademagene zamikeracel)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2025

1 . Criteria

Product Name:Zevaskyn	
Diagnosis	Recessive Dystrophic Epidermolysis Bullosa (RDEB)
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming a diagnosis of Recessive Dystrophic Epidermolysis Bullosa (RDEB)

AND

2 - Maximum of twelve sheets are supplied for potential use

AND

3 - Zevaskyn will be applied in a surgical health care setting in a qualified wound center by a provider with expertise in wound care in Recessive Dystrophic Epidermolysis Bullosa (RDEB)

2 . Revision History

Date	Notes
10/29/2025	New program

Prior Authorization Guideline

Guideline ID	GL-636308
Guideline Name	Zilbrysq (zilucoplan injection)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	7/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of generalized myasthenia gravis (gMG)

AND

2 - Patient is anti-acetylcholine receptor (AChR) antibody positive

AND

3 - One of the following:

3.1 Trial and failure, contraindication, or intolerance to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

OR

3.2 Both of the following:

3.2.1 Trial and failure, contraindication, or intolerance to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus)

AND

3.2.2 Trial and failure, contraindication, or intolerance to one of the following:

Chronic plasmapheresis or plasma exchange (PE)

Intravenous immunoglobulin (IVIG)

AND

4 - Both of the following:

4.1 Trial and failure, contraindication, or intolerance to Epysqli (eculizumab-aagh)

AND

4.2 Trial and failure, contraindication, or intolerance to one of the following:

Rystiggo

Ultomiris

Vyvgart

Vyvgart Hytrulo

AND

5 - Prescribed by or in consultation with a neurologist

AND

6 - Requested medication is not being used in combination with any one of the following:

Neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo, Vyvgart, Vyvgart Hytrulo)

Another complement inhibitor (e.g., eculizumab, Ultomiris)

Immune globulin (e.g., IVIG)

B-cell depletion therapy (e.g., Uplizna)

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - Both of the following:

2.1 Trial and failure, contraindication, or intolerance to Epysqli (eculizumab-aagh)

AND

2.2 Trial and failure, contraindication, or intolerance to one of the following:

Rystiggo

Ultomiris

Vyvgart

Vyvgart Hytrulo

AND

3 - Requested medication is not being used in combination with any one of the following:

Neonatal Fc Receptor (FcRn) blocker (e.g., Imaavy, Rystiggo, Vyvgart, Vyvgart Hytrulo)

Another complement inhibitor (e.g., eculizumab, Ultomiris)

Immune globulin (e.g., IVIG)

B-cell depletion therapy (e.g., Uplizna)

2 . Revision History

Date	Notes
6/25/2026	Added combination therapy criteria to initial and reauth

Prior Authorization Guideline

Guideline ID	GL-114472
Guideline Name	Zimhi (naloxone)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Zimhi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - History of failure, or intolerance to preferred naloxone products (e.g., Brand Narcan nasal spray, Kloxxado, preferred naloxone injections)

2 . Revision History

Date	Notes
9/26/2022	New program

Prior Authorization Guideline

Guideline ID	GL-133807
Guideline Name	Zinplava (bezlotoxumab)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2023

1 . Criteria

Product Name:Zinplava	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Used for the reduction of the recurrence of Clostridium difficile infection (CDI)

AND

1.2 Patient is 1 year of age or older

AND

1.3 Used in combination with antibacterial drug treatment for CDI [e.g., oral Vancocin (vancomycin), Flagyl (metronidazole), or Dificid (fidaxomicin)]

AND

1.4 Patient has one or more of the following risk factors associated with CDI recurrence:

One or more prior episodes of CDI in the previous 6 months

Immunocompromised

Chronic dialysis

Inflammatory bowel disease

Continued use of non-CDI antimicrobials after diagnosis of CDI and/or after CDI treatment

AND

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

Infectious disease specialist

Gastroenterologist

2 . Revision History

Date	Notes
9/26/2023	New Program

Prior Authorization Guideline

Guideline ID	GL-500252
Guideline Name	Zolgensma (onasemnogene abeparvovec-xioi), Itvisma (onasemnogene abeparvovec-brve)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Zolgensma	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming the mutation or deletion of genes in chromosome 5q resulting in one of the following:

1.1 Homozygous gene deletion or mutation of SMN1 gene (e.g., homozygous deletion of exon 7 at locus 5q13)

OR

1.2 Compound heterozygous mutation of SMN1 gene (e.g., deletion of Survival of Motor Neuron 1 [SMN1] exon 7 [allele 1] and mutation of SMN1 [allele 2])

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 Diagnosis of symptomatic spinal muscular atrophy (SMA) confirmed by a neurologist with expertise in the diagnosis and treatment of SMA

AND

2.1.2 Patient is less than 2 years of age

OR

2.2 All of the following:

2.2.1 Diagnosis of SMA based on the results of SMA newborn screening

AND

2.2.2 Patient has 4 copies or less of Survival of Motor Neuron 2 (SMN 2)

AND

2.2.3 Patient is less than or equal to 6 months of age

AND

3 - Patient is not dependent on invasive ventilation

AND

4 - Patient is not dependent on the use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

5 - Submission of medical records (e.g., chart notes) documenting patient's anti-AAV9 antibody titers are less than or equal to 1:50

AND

6 - Both of the following:

6.1 Provider attests that the patient has never received onasemnogene abeparvovec treatment in their lifetime

AND

6.2 Provider attests that the patient is not receiving concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g. Spinraza, Evrysdi)

AND

7 - Prescribed by a neurologist with expertise in the diagnosis of SMA

Product Name:Itvisma	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization

Approval Criteria

1 - Both of the following:

1.1 Submission of medical records (e.g., chart notes) confirming diagnosis of spinal muscular atrophy (SMA)

AND

1.2 Submission of medical records (e.g., chart notes) confirming the presence of a SMN1 gene mutation

AND

2 - Patient is 2 years of age or older and under 17 years old

AND

3 - Both of the following:

3.1 Provider attests that the patient has never received onasemnogene abeparvovec (e.g., Zolgensma) treatment in their lifetime

AND

3.2 Provider attests that the patient is not receiving concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g. Spinraza, Evrysdi)

AND

4 - Patient will commence systemic corticosteroids equivalent to oral prednisolone at 1mg per kg of body weight per day (mg/kg/day), starting one day prior to Itvisma therapy and planned for a total of 30 days

AND

5 - Submission of medical records (e.g., chart notes) confirming the absence of hepatic dysfunction [e.g., alanine aminotransferase (ALT), total bilirubin, gamma-glutamyl transferase

(GGT) or glutamate dehydrogenase (GLDH) less than or equal to the upper limit of normal (ULN)]

AND

6 - Provider attests that patient has not had clinical signs or symptoms of infection within 30 days prior to treatment

AND

7 - Both of the following:

7.1 Patient can sit independently

AND

7.2 Patient has never had the ability to walk independently

AND

8 - Submission of medical records (e.g., chart notes) confirming anti-AAV9 antibody titers are less than or equal to 1:50

AND

9 - Patient's clinical signs and symptoms onset occurred at greater than or equal to 6 months of age

AND

10 - Patient is not dependent on any of the following:

Invasive ventilation

Awake noninvasive ventilation for greater than 6 hours during a 24-hour period

Noninvasive ventilation for greater than 12 hours during a 24-hour period

AND

11 - Both of the following:

11.1 Patient has not received surgery for scoliosis or hip fixation in the 12 months prior to approval

AND

11.2 Patient has no planned surgery for scoliosis or hip fixation within the next 64 weeks following therapy

AND

12 - Prescribed by a neurologist with expertise in the diagnosis of SMA

2 . Revision History

Date	Notes
1/28/2026	Added criteria for Itvisma, updated guideline name. Updated Zolgensma criteria.

Prior Authorization Guideline

Guideline ID	GL-99503
Guideline Name	Zontivity
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Zontivity	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

History of myocardial infarction (MI)

Peripheral arterial disease (PAD)

AND

2 - Patient does not have a history of ONE of the following:

Stroke

Transient ischemic attack (TIA)

Intracranial hemorrhage (ICH)

AND

3 - Patient does not have active pathological bleeding

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-99504
Guideline Name	Zortress - ARIZONA
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	12/9/2021

1 . Criteria

Product Name:Zortress	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Kidney transplant rejection prophylaxis in patients at low-moderate immunologic risk

OR

2 - Liver transplant rejection prophylaxis

2 . Revision History

Date	Notes
3/11/2021	Bulk Copy C&S Arizona Standard to Medicaid Arizona Standard for 7 /1 go live

Prior Authorization Guideline

Guideline ID	GL-669257
Guideline Name	Zoryve (roflumilast)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	8/1/2026

1 . Criteria

Product Name:Zoryve 0.3% cream, Zoryve foam	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of plaque psoriasis

AND

2 - One of the following:

For Zoryve 0.3% cream: Patient is 2 years of age or older

For Zoryve foam: Patient is 12 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid claims history documenting a minimum duration of a 4 week trial and failure, contraindication, or intolerance to ONE of the following topical therapies:

Corticosteroids (e.g., betamethasone, clobetasol)

Vitamin D analogs (e.g., calcitriol, calcipotriene)

Tazarotene

Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

4 - Prescribed by or in consultation with a dermatologist

Product Name:Zoryve 0.3% cream, Zoryve foam	
Diagnosis	Plaque Psoriasis (PsO)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by one of the following:

Reduction in the body surface area (BSA) involvement from baseline

Improvement in symptoms (e.g., pruritus, inflammation) from baseline

Product Name:Zoryve 0.05% cream, Zoryve 0.15% cream	
Diagnosis	Atopic Dermatitis
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of mild to moderate atopic dermatitis

AND

2 - One of the following:

For Zoryve 0.05% cream: Patient is between 2 and 5 years of age

For Zoryve 0.15% cream: Patient is 6 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid claims history documenting trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to TWO of the following:

Medium or higher potency topical corticosteroid

Elidel (pimecrolimus) cream

Tacrolimus ointment

Eucrisa (crisaborole) ointment

AND

4 - Prescribed by or in consultation with a dermatologist

Product Name:Zoryve foam	
Diagnosis	Seborrheic Dermatitis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting a diagnosis of seborrheic dermatitis

AND

2 - Patient is 9 years of age or older

AND

3 - Submission of medical records (e.g., chart notes) or paid claims history documenting a minimum duration of a 4 week trial and failure, contraindication, or intolerance to TWO of the following topical therapies (trial must be from two different classes):

Corticosteroids (e.g., betamethasone, clobetasol)

Antifungals (e.g., ciclopirox, ketoconazole)

Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)

AND

4 - Prescribed by or in consultation with a dermatologist

Product Name:Zoryve foam	
Diagnosis	Seborrheic Dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) documenting positive clinical response to therapy as evidenced by improvement from baseline for one of the following:

Scaling

Erythema

Pruritis

Body surface area (BSA) involvement

2 . Background

Clinical Practice Guidelines

Relative potencies of topical corticosteroids

Class	Drug	Dosage Form	Strength (%)
Very high potency	Augmented betamethasone dipropionate	Ointment	0.05
	Clobetasol propionate	Cream, foam, ointment	0.05
	Diflorasone diacetate	Ointment	0.05
	Halobetasol propionate	Cream, ointment	0.05
	Amcinonide	Cream, lotion, ointment	0.1

High Potency	Augmented betamethasone dipropionate	Cream	0.05
	Betamethasone dipropionate	Cream, foam, ointment, solution	0.05
	Desoximetasone	Cream, ointment	0.25
	Desoximetasone	Gel	0.05
	Diflorasone diacetate	Cream	0.05
	Fluocinonide	Cream, gel, ointment, solution	0.05
	Halcinonide	Cream, ointment	0.1
	Mometasone furoate	Ointment	0.1
	Triamcinolone acetonide	Cream, ointment	0.5
Medium potency	Betamethasone valerate	Cream, foam, lotion, ointment	0.1
	Clocortolone pivalate	Cream	0.1
	Desoximetasone	Cream	0.05
	Fluocinolone acetonide	Cream, ointment	0.025
	Flurandrenolide	Cream, ointment	0.05
	Fluticasone propionate	Cream	0.05
	Fluticasone propionate	Ointment	0.005
	Mometasone furoate	Cream	0.1
	Triamcinolone acetonide	Cream, ointment	0.1
Lower-medium potency	Hydrocortisone butyrate	Cream, ointment, solution	0.1
	Hydrocortisone probutate	Cream	0.1
	Hydrocortisone valerate	Cream, ointment	0.2
	Prednicarbate	Cream	0.1
Low potency	Alclometasone dipropionate	Cream, ointment	0.05
	Desonide	Cream, gel, foam, ointment	0.05
	Fluocinolone acetonide	Cream, solution	0.01
Lowest potency	Dexamethasone	Cream	0.1
	Hydrocortisone	Cream, lotion, ointment, solution	0.25, 0.5, 1
	Hydrocortisone acetate	Cream, ointment	0.5-1

3 . Revision History

Date	Notes

7/28/2026	Added age criterion for PsO indication, updated age criterion for AD i ndication.

Prior Authorization Guideline

Guideline ID	GL-114155
Guideline Name	Ztalmy (ganaxolone)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2022

1 . Criteria

Product Name:Ztalmy	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of documentation (e.g., chart notes) confirming diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD)

AND

2 - Patient has a mutation in the CDKL5 gene

AND

3 - Patient is 2 years of age or older

AND

4 - Patient is experiencing motor seizures (e.g., bilateral tonic, generalized tonic-clonic, bilateral clonic, atonic, focal, or bilateral tonic-clonic)

AND

5 - One of the following:

5.1 Trial and failure, contraindication, or intolerance to two preferred anticonvulsants (e.g., valproic acid, levetiracetam, lamotrigine)

OR

5.2 For continuation of prior therapy

AND

6 - Prescribed by or in consultation with a neurologist

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

Approval Criteria

1 - Documentation of positive clinical response to therapy as evidenced by a reduction in the frequency of seizures from baseline

2 . Revision History

Date	Notes
9/20/2022	New Program

Prior Authorization Guideline

Guideline ID	GL-241267
Guideline Name	Zunveyl (benzgalantamine)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2025

1 . Criteria

Product Name:Zunveyl	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of mild to moderate dementia of the Alzheimer's type

AND

2 - Patient is 18 years of age or older

AND

3 - Trial and failure (of a minimum 30-day supply), contraindication, or intolerance to ALL of the following:

generic galantamine

generic rivastigmine

generic donepezil

2 . Revision History

Date	Notes
4/24/2025	New program

Prior Authorization Guideline

Guideline ID	GL-139356
Guideline Name	Zurzuvae (zuranolone)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	2/1/2024

1 . Criteria

Product Name:Zurzuvae	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Diagnosis of severe postpartum depression (PPD)

OR

1.2 Both of the following:

1.2.1 Diagnosis of mild to moderate postpartum depression (PPD)

AND

1.2.2 Trial and failure, contraindication or intolerance to at least one oral SSRI or SNRI (e.g., escitalopram, duloxetine)

AND

2 - Patient is 18 years of age or older

AND

3 - Onset of symptoms in the third trimester or within 4 weeks of delivery

AND

4 - Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence or the degree of driving impairment caused by Zurzuvae

2 . Revision History

Date	Notes
1/23/2024	New program

Prior Authorization Guideline

Guideline ID	GL-589221
Guideline Name	Zycubo (copper histidinate)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	5/1/2026

1 . Criteria

Product Name:Zycubo	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 Diagnosis of Menkes disease

AND

1.2 Molecular genetic testing confirms pathogenic variants of the ATP7A gene (copper-transporting ATPase) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA)

AND

2 - Provider attests that the patient will be closely monitored for copper accumulation and related toxicity throughout therapy

AND

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

Pediatrician

Neurologist

Geneticist

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

Approval Criteria

1 - Patient demonstrates positive clinical response to therapy

AND

2 - Provider attests that the patient will continue to be monitored for copper accumulation and related toxicity throughout therapy

AND

3 - Patient has not exceeded 3 years duration of treatment with Zycubo

AND

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

Pediatrician

Neurologist

Geneticist

2 . Revision History

Date	Notes
4/30/2026	New program

Prior Authorization Guideline

Guideline ID	GL-116186
Guideline Name	Zynteglo (betibeglogene autotemcel)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	11/1/2022

1 . Criteria

Product Name:Zynteglo	
Approval Length	1 Time Authorization in Lifetime
Guideline Type	Prior Authorization

Approval Criteria

1 - Submission of medical records (e.g., chart notes) confirming diagnosis of transfusion-dependent beta-thalassemia as confirmed by the presence of a mutation at both alleles of the β-globin gene (i.e., β0/β0, β0/β+, β+/β+, β0/βE)

AND

2 - One of the following:

Patient has a history of transfusions of at least 100 mL/kg/year of packed red blood cells (pRBCs)

Patient requires 8 or more red blood cell (RBC) transfusions per year

AND

3 - Patient is 4 years of age or older [A]

AND

4 - Patient is ineligible for an allogeneic hematopoietic stem cell transplant with an HLA-identical sibling donor [B]

AND

5 - Provider attests that patient is clinically stable and eligible to undergo hematopoietic stem cell transplant (HSCT) and has not received any prior gene therapy or HSCT

AND

6 - Patient has obtained a negative test result for all of the following prior to cell collection:

Hepatitis B virus (HBV)

Hepatitis C virus (HCV)

Human T-lymphotrophic virus 1 & 2 (HTLV-1/HTLV-2)

Human immunodeficiency virus (HIV)

AND

7 - Patient is able to provide an adequate number of cells to meet the minimum recommended dose of 5 x 10^6 CD34+ cells/kg

AND

8 - Patient does not have any of the following [1-4]:

Severely elevated iron in the heart (e.g., patients with cardiac T2* less than 10 msec by MRI)

Advanced liver disease

MRI results of the liver demonstrating liver iron content greater than or equal to 15 mg/g (unless biopsy confirms absence of advanced disease)

AND

9 - Both of the following:

Iron chelation therapy (e.g., deferoxamine, deferasirox) will be discontinued for at least 7 days prior to initiating myeloablative conditioning therapy

Prophylactic HIV anti-retroviral medications (e.g., Truvada, Descovy) or hydroxyurea will be discontinued for at least one month prior to mobilization (or for the expected duration for elimination of those medications)

AND

10 - Prescribed by a stem cell transplant specialist

AND

11 - Patient has never received Zynteglo treatment in their lifetime

2 . Endnotes

The safety and efficacy of Zynteglo in children less than 4 years of age have not been established. [1]

Per consultant feedback, Zynteglo should be reserved for patients who do not have an HLA-identical sibling for an allogeneic hematopoietic stem cell transplant. [5]

3 . Revision History

Date	Notes
10/28/2022	New Program

Prior Authorization Guideline

Guideline ID	GL-731212
Guideline Name	Zyvox (linezolid)
Formulary	Medicaid - Arizona (AZM, AZMREF, AZMDDD)

Guideline Note:

Effective Date:	10/1/2026

1 . Criteria

Product Name:Brand Zyvox tablets*, Brand Zyvox oral suspension*, generic linezolid oral suspension*	
Diagnosis	Labeled Uses
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following: **1.1** For continuation of therapy upon hospital discharge	

OR

1.2 As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

1.3 BOTH of the following:

1.3.1 ONE of the following diagnoses:

Nosocomial pneumonia

Community-acquired pneumonia

Skin and skin structure infections (complicated and uncomplicated)

AND

1.3.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Zyvox

OR

1.4 Invasive infection caused by or likely to be caused by vancomycin-resistant Enterococcus faecium (VRE)

Notes	*Approval Duration: For vancomycin-resistant Enterococcus faecium, authorization will be issued for 28 days. For osteomyelitis, authorization will be issued for the requested duration, not to exceed 6 weeks. All other approvals will be issued for 14 days. Note: generic linezolid tablets are preferred without PA required

Product Name:Brand Zyvox tablets*, Brand Zyvox oral suspension*, generic linezolid oral suspension*	
Diagnosis	Off label Uses
Guideline Type	Prior Authorization

Approval Criteria

1 - For continuation of therapy upon hospital discharge

OR

2 - As continuation of therapy when transitioning from intravenous antibiotics that are shown to be sensitive to the cultured organism for the requested indication

OR

3 - The medication is being prescribed by or in consultation with an Infectious Disease specialist

Notes	*Approval Duration: Based on provider recommended treatment durations, not to exceed 6 months. Note: generic linezolid tablets are preferred without PA required

2 . Revision History

Date	Notes
9/23/2026	Removed generic linezolid tablets as targets, no longer requires PA.