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Acitretin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-434337
Guideline Name	Acitretin
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of severe psoriasis

AND

2 - Prescribed by or in consultation with a dermatologist

AND

3 - ONE of the following:

3.1 Failure to a 3-month trial of methotrexate at the maximally indicated dose, as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to methotrexate (please specify intolerance or contraindication)

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

Approval Criteria **1** - Documentation of positive clinical response to the requested therapy

2 . Revision History

Date	Notes
11/4/2025	Added NV Formulary.

ADHD Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-397266
Guideline Name	ADHD Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Adderall, generic amphetamine/dextroamphetamine, Brand Adderall XR, generic amphetamine/dextroamphetamine ER, Brand Mydayis, generic amphetamine/dextroamphetamine 3-Bead ER capsules, Adzenys XR ODT, Amphetamine ER ODT, Dyanavel XR, Brand Evekeo, generic amphetamine, Cotempla XR ODT, Brand Daytrana, generic methylphenidate patch, Quillivant, Quillichew, Brand Metadate CD, generic methylphenidate cap ER (CD), Brand Ritalin, generic methylphenidate tablets, methylphenidate chew, Brand Methylin, generic methylphenidate solution, methylphenidate ER tab, Brand Concerta, Brand Relexxii, generic methylphenidate ER (OSM), Methylphenidate ER (OSM), Brand Ritalin LA, generic methylphenidate ER (LA), Aptensio XR, generic methylphenidate ER capsules (XR), Jornay PM, Azstarys, methamphetamine, Xelstrym, Brand Zenzedi, generic dextroamphetamine tablets, Brand Procentra, generic dextroamphetamine solution, Brand Dexedrine, dextroamphetamine ER, Brand Focalin, generic dexmethylphenidate, Brand Focalin XR, generic dexmethylphenidate ER, Qelbree, Brand Vyvanse, generic lisdexamfetamine, atomoxetine, Brand Intuniv, generic guanfacine ER, clonidine ER 0.1 mg, Onyda XR	
Diagnosis	Patients over 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:

- Patient has a diagnosis of ADD/ADHD (Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder)
- Other treatable causes of ADD/ADHD have been ruled out

OR

1.2 Patient has another Food and Drug Administration (FDA) approved diagnosis

AND

2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Brand Adderall, generic amphetamine/dextroamphetamine, Brand Adderall XR, generic amphetamine/dextroamphetamine ER, Brand Mydayis, generic amphetamine/dextroamphetamine 3-Bead ER capsules, Adzenys XR ODT, Amphetamine ER ODT, Dyanavel XR, Brand Evekeo, generic amphetamine, Cotempla XR ODT, Brand Daytrana, generic methylphenidate patch, Quillivant, Quillichew, Brand Metadate CD, generic methylphenidate cap ER (CD), Brand Ritalin, generic methylphenidate tablets, methylphenidate chew, Brand Methylin, generic methylphenidate solution, methylphenidate ER tab, Brand Concerta, Brand Relexxii, generic methylphenidate ER (OSM), Methylphenidate ER (OSM), Brand Ritalin LA, generic methylphenidate ER (LA), Aptensio XR, generic methylphenidate ER capsules (XR), Jornay PM, Azstarys, methamphetamine, Xelstrym, Brand Zenzedi, generic dextroamphetamine tablets, Brand Procentra, generic dextroamphetamine solution, Brand Dexedrine, dextroamphetamine ER, Brand Focalin, generic dexmethylphenidate, Brand Focalin XR, generic dexmethylphenidate ER, Qelbree, Brand Vyvanse, generic lisdexamfetamine, atomoxetine, Brand Intuniv, generic guanfacine ER, clonidine ER 0.1 mg, Onyda XR	
Diagnosis	Patients less than or equal to 18 years of age

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

- The request is for a short-acting stimulant and the patient is at least 3 years of age
- For any other request, the patient is at least 6 years of age

AND

2 - The patient has an International Classification of Diseases (ICD) code for ADD (Attention Deficit Disorder) with or without hyperactivity

AND

3 - The medication is prescribed by a psychiatrist

AND

4 - An initial evaluation or regular examination has been done within the past 12 months with the treating prescriber

AND

5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes

9/25/2025	New guideline

Alzheimer's Disease Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-504217
Guideline Name	Alzheimer's Disease Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Aduhelm	
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 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 ALL 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
- Repeatable Battery for the Assessment of Neuropsychological (RBANS) score 85 or less
- Mini-Mental State Examination score of 24-30
- Montreal Cognitive Assessment (MoCA) of 17 or above

AND

2 - Documentation of beta-amyloid protein disposition, 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 testing documents abnormalities suggestive of beta-amyloid accumulation (e.g., AB42 level, AB42:AB40 ratio)

AND

3 - ALL 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
- Patient had no history of relevant brain hemorrhage, bleeding disorder, and cerebrovascular abnormalities in last six months

AND

4 - A baseline brain MRI has been completed within 12 months prior to initiating treatment to rule out other causes (e.g., stroke, small vessel disease, tumor)

AND

5 - Counseling has been provided on the risk of amyloid-related imaging abnormalities (ARIA) (ARIA with edema [ARIA-E] and ARIA with hemosiderin deposition [ARIA-H]) and recipient and/or caregiver are aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting

AND

6 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist, or other expert in the disease state

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory values) documenting benefit 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 ALL 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
- Repeatable Battery for the Assessment of Neuropsychological (RBANS) score 85 or less
- Mini-Mental State Examination score of 24-30

AND

2 - Patient has a follow-up brain MRI that has been completed after the initiation of therapy 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 - Prescribed by a neurologist, geriatrician, or geriatric psychiatrist

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

Approval Criteria

1 - Diagnosis of ONE of the following:

- Mild cognitive impairment due to Alzheimer's disease (AD)
- Mild dementia due to AD

AND

2 - ALL of the following:

- Clinical Dementia Rating-Global (CDR-G) score of 0.5 to 1
- Memory Box score at least 0.5
- Mini-Mental State Examination (MMSE) score of 22-30
- Objective evidence of cognitive impairment at screening
- PET scan or CSF assessment of amyloid beta (1-42) is positive for amyloid beta plaque

AND

3 - Prescriber attests that other conditions causing similar symptoms have been ruled out (e.g., vascular dementia, dementia with Lewy bodies, frontotemporal dementia, normal pressure hydrocephalus)

AND

4 - Prescribed by a neurologist, geriatrician, geriatric psychiatrist, or other expert in the treatment of AD

AND

5 - Patient does not have risk factors for intracerebral hemorrhage (e.g., prior cerebral hemorrhage > 1 cm in greatest diameter, more than 4 microhemorrhages, superficial siderosis, evidence of vasogenic edema, evidence of cerebral contusion, aneurysm, vascular malformation, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory, severe small vessel, or white matter disease)

AND

6 - Patient has NOT had a stroke, TIA, or seizure in the last 12 months

AND

7 - Patient has NOT demonstrated clinically significant and unstable psychiatric illness in the last six months

AND

8 - Patient does NOT have a history of alcohol or substance abuse within the last 12 months

AND

9 - Patient is NOT currently taking an anticoagulant or antiplatelet agent (with the exception of aspirin 325 mg/day or less)

AND

10 - Brain MRI has been obtained within 12 months prior to treatment initiation

AND

11 - Baseline disease severity has been assessed using an objective measure/tool (e.g., MMSE, AD Assessment Scale-Cognitive Subscale [ADAS-Cog-13], AD Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI], Clinical Dementia Rating Sum of Boxes [CDR-SB])

Product Name:Leqembi, Leqembi IQLIK	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient continues to meet initial authorization criteria

AND

2 - Scoring on an objective measure/tool demonstrates improvement, stability, or slowing in cognitive and/or functional impairment (e.g., AD Assessment Scale-Cognitive Subscale [ADAS-Cog-13], AD Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI], Mini-Mental State Examination [MMSE], Clinical Dementia Rating Sum of Boxes [CDR-SB])

AND

3 - Patient has not progressed to moderate or severe Alzheimer's disease (AD)

AND

4 - Patient has not experienced any treatment-restricting adverse effects (e.g., severe hypersensitivity reactions)

AND

5 - Patient has undergone MRI prior to the 5th, 7th, and 14th infusions to monitor for ARIA-E or ARIA-H

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

Approval Criteria

1 - Patient has a diagnosis of mild cognitive impairment (MCI) due to Alzheimer's disease (AD) or mild Alzheimer's dementia as evidenced by BOTH of the following:

- MMSE (Mini-Mental State Examination) score 20 to 28
- PET scan or CSF assessment of amyloid beta (1-42) is positive for amyloid beta plaque

AND

2 - Prescriber has assessed baseline disease severity utilizing an objective measure/tool (e.g., MMSE, Alzheimer's Disease Assessment Scale-Cognitive Subscale [ADAS-Cog-13], Alzheimer's Disease Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI], Clinical Dementia Rating-Sum of Boxes [CDR-SB])

AND

3 - Other conditions mimicking, but of non-Alzheimer's dementia etiology, have been ruled out (e.g., vascular dementia, dementia with Lewy bodies [DLB], frontotemporal dementia [FTD], normal pressure hydrocephalus)

AND

4 - A baseline MRI has been obtained prior to initiating treatment with Kisunla

AND

5 - Prescriber attests that MRI will be repeated prior to the 2nd, 3rd, 4th, and 7th infusions

AND

6 - Patient does not have history of alcohol or substance abuse within the past 2 years

AND

7 - Medication will NOT be used concurrently with other anti-amyloid immunotherapies (e.g., Leqembi)

AND

8 - Prescribed by a neurologist, geriatrician, geriatric psychiatrist, or other specialist with advanced knowledge in treating AD

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

Approval Criteria

1 - Patient has a diagnosis of mild cognitive impairment (MCI) due to Alzheimer's disease (AD) or mild Alzheimer's dementia as evidenced by BOTH of the following:

- MMSE (Mini-Mental State Examination) score 20 to 28
- PET scan or CSF assessment of amyloid beta (1-42) is positive for amyloid beta plaque

AND

2 - Prescriber has assessed baseline disease severity utilizing an objective measure/tool (e.g., MMSE, Alzheimer's Disease Assessment Scale-Cognitive Subscale [ADAS-Cog-13], Alzheimer's Disease Cooperative Study-Activities of Daily Living Inventory-Mild Cognitive Impairment version [ADCS-ADL-MCI], Clinical Dementia Rating-Sum of Boxes [CDR-SB])

AND

3 - Other conditions mimicking, but of non-Alzheimer's dementia etiology, have been ruled out (e.g., vascular dementia, dementia with Lewy bodies [DLB], frontotemporal dementia [FTD], normal pressure hydrocephalus)

AND

4 - Prescriber attests that MRI will be repeated prior to the 2nd, 3rd, 4th, and 7th infusions

AND

5 - Patient does not have history of alcohol or substance abuse within the past 2 years

AND

6 - Medication will NOT be used concurrently with other anti-amyloid immunotherapies (e.g., Leqembi)

AND

7 - Prescribed by a neurologist, geriatrician, geriatric psychiatrist, or other specialist with advanced knowledge in treating AD

AND

8 - Scoring on an objective measure/tool (e.g., ADAS-Cog 13; ADCS-ADL-MCI; MMSE; CDR-SB) demonstrates improvement, stability, or slowing in cognitive and/or functional impairment

AND

9 - Patient has NOT progressed to moderate or severe AD

AND

10 - Patient has NOT experienced any treatment-restricting adverse effects (e.g., severe hypersensitivity reactions)

AND

11 - Prescriber attests that stopping of Kisunla dosing will be considered when amyloid plaques are reduced to minimal levels on amyloid PET imaging

2 . Revision History

Date	Notes
1/20/2026	Added Kisunla

Amvuttra

Prior Authorization Guideline

Guideline ID	GL-423407
Guideline Name	Amvuttra
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Amvuttra	
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 - Patient will receive supplementation with vitamin A as the recommended daily allowance during Amvuttra therapy

AND

3 - Amvuttra will NOT be used in combination with other transthyretin (TTR) reducing agents (e.g., inotersen [Tegsedi], tafamidis [Vyndamax, Vyndaqel], patisiran [Onpattro])

AND

4 - Both of the following:

4.1 Patient has a definitive diagnosis of hereditary transthyretin-mediated (hATTR) amyloidosis (formerly known as familial amyloid polyneuropathy (FAP))

AND

4.2 Diagnosis is confirmed by amyloid deposition on tissue biopsy and identification of a pathogenic TTR variant using molecular genetic testing

AND

5 - Polyneuropathy is demonstrated by AT LEAST 2 of the following:

- Subjective patient symptoms are suggestive of neuropathy
- Abnormal nerve conduction studies are consistent with polyneuropathy
- Abnormal neurological examination is suggestive of neuropathy

AND

6 - Both of the following:

- Patient's peripheral neuropathy is attributed to hATTR
- Other causes of neuropathy have been excluded

AND

7 - Baseline strength and weakness has been documented using an objective clinical measuring tool (e.g., Medical Research Council [MRC] muscle strength)

AND

8 - Patient has not had an orthotopic liver transplant (OLT)

AND

9 - Quantity does not exceed one syringe every three months

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

Approval Criteria

1 - Patient continues to meet the initial criteria

AND

2 - Absence of unacceptable toxicity from the drug (e.g. ocular symptoms related to hypovitaminosis A, etc.)

AND

3 - Patient has experienced disease response compared to pre-treatment baseline as evidenced by ONE of the following:

- Stabilization or improvement in signs and symptoms of neuropathy
- Stabilization or improvement in Medical Research Council (MRC) Scale for muscle strength

2 . Revision History

Date	Notes
10/23/2025	New

Andembry

Prior Authorization Guideline

Guideline ID	GL-504190
Guideline Name	Andembry
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as 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 variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, and heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - Prescribed for the prophylaxis of HAE attacks

AND

3 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Dawnzera, Haegarda, Orladeyo, Takhzyro)

AND

4 - Prescriber attests that patient has experienced attacks of a severity and/or frequency such that they would clinically benefit from prophylactic therapy with Andembry

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

AND

6 - ONE of the following:

6.1 Failure to Haegarda confirmed by claims history or submitted medical records

OR

6.2 History of contraindication or intolerance to Haegarda (please specify intolerance or contraindication)

OR

6.3 Patient is currently on Andembry therapy confirmed by claims history or submitted medical records

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

Approval Criteria

1 - Documentation of positive clinical response to Andembry therapy

AND

3 - Reduction in the utilization of on-demand therapies used for acute attacks (e.g., Berinert, Firazyr, Ruconest) as determined by claims information, while on Andembry therapy

AND

2 - Prescribed for the prophylaxis of HAE attacks

AND

4 - Not used in combination with other products indicated for prophylaxis against HAE attacks (e.g., Cinryze, Dawnzera, Haegarda, Orladeyo, Takhzyro)

AND

5 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
1/15/2026	New Program.

Anthelmintics

Prior Authorization Guideline

Guideline ID	GL-434339
Guideline Name	Anthelmintics
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Generic albendazole	
Approval Length	*Approve for 1 month, **Approve for 6 months, ***Approve for 12 months
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following*:

- Enterobius vermicularis (pinworm)
- Ascariasis (roundworm)
- Toxocariasis (roundworm)
- Trichinellosis
- Trichuriasis (whipworm)
- Capillariasis
- Baylisascaris
- Clonorchiasis (liver flukes)
- Gnathostomiasis
- Strongyloidiasis
- Loiasis
- Opisthorchiasis
- Anisakiasis

OR

2 - Diagnosis of ONE of the following**:

- Taeniasis or Cysticercosis/Neurocysticercosis
- Hydatid Disease [Echinococcosis (Tapeworm)]
- Ancylostoma/Necatoriasis (Hookworm)

OR

3 - Diagnosis of microsporidiosis not caused by Enterocytozoon bieneusi or Vittaforma corneae***

Product Name:Emverm	
Approval Length	*Approve for 1 month, **Approve for 6 months
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following*:

- Enterobius vermicularis (pinworm)
- Ancylostoma/Necatoriasis (Hookworm)
- Ascariasis (roundworm)
- Toxocariasis (roundworm)
- Trichinellosis
- Trichuriasis (whipworm)
- Capillariasis
- Baylisascaris

OR

2 - Diagnosis of hydatid Disease [Echinococcosis (Tapeworm)]**

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary - LKC

Anti-Fungal Agents

Prior Authorization Guideline

Guideline ID	GL-458407
Guideline Name	Anti-Fungal Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Vivjoa	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of recurrent vulvovaginal candidiasis (VVC) with greater than or equal to 3 episodes of VVC in a 12-month period

AND

2 - Patient is a biological female who is postmenopausal or has another reason for permanent infertility (e.g., tubal ligation, hysterectomy, salpingo-oophorectomy)

AND

3 - Patient does NOT have hypersensitivity to any component of the product

AND

4 - Patient is NOT pregnant

AND

5 - Patient is NOT lactating

AND

6 - Patient has tried and failed or has contraindication or intolerance to maintenance antifungal therapy with oral fluconazole for six months

2 . Revision History

Date	Notes
12/8/2025	Removed all criteria except for Vivjoa.

Anti-Hepatitis Agents

Prior Authorization Guideline

Guideline ID	GL-423190
Guideline Name	Anti-Hepatitis Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Epclusa, Sofosbuvir/velpatasvir	
Approval Length	Reference criteria section for approval length: approval length is 12 weeks if * notated; approval length is 24 weeks if ** notated
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV (Hepatitis C Virus) **AND**	

2 - The patient is not receiving the requested medication in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]

AND

3 - The requested medication is prescribed by, or in consultation with, one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist (certified through the American Academy of HIV Medicine)

AND

4 - The patient meets one of the following:

4.1 If genotype 1, 2, 3, 4, 5, or 6 and without decompensated liver disease, both of the following:*

- The requested medication is being used alone
- The request is FDA (Food and Drug Administration) approved for patient weight and age

OR

4.2 If genotype 1, 2, 3, 4, 5, or 6 and with decompensated liver disease, both of the following:**

- The requested medication is being used in combination with ribavirin
- The request is FDA approved for patient weight and age

OR

4.3 If genotype 1, 2, 3, 4, 5, or 6 and with ribavirin intolerance/ineligible or prior Sovaldi (sofosbuvir) or NS5A-based treatment failure, both of the following:**

4.3.1 The patient has decompensated liver disease

AND

4.3.2 One of the following:

4.3.2.1 The patient is ribavirin intolerant or ineligible

OR

4.3.2.2 Both of the following:

- The patient has had prior failure (defined as viral relapse, breakthrough while on therapy, or is a non-responder to therapy) to Sovaldi or NS5A-based treatment
- The requested medication is being used in combination with ribavirin

Product Name:Harvoni, Ledipasvir/sofosbuvir	
Approval Length	Reference criteria section for approval length: approval length is 8 weeks if * notated; approval length is 12 weeks if ** notated; approval length is 24 weeks if *** notated
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is not receiving the requested medication in combination with another HCV (Hepatitis C Virus) direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]

AND

2 - The requested medication is prescribed by, or in consultation with, one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist (certified through the American Academy of HIV Medicine)

AND

3 - The patient meets one of the following:

3.1 If genotype 1, and treatment naïve, without cirrhosis and pre-treatment HCV ribonucleic acid (RNA) is less than 6 million IU/mL (international units per milliliter), both of the following:*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- Submission of medical records confirming pre-treatment HCV RNA less than 6 million IU/mL

OR

3.2 If genotype 1, and treatment naïve, without cirrhosis and pre-treatment HCV RNA is greater than or equal to 6 million IU/mL, both of the following:**

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- Submission of medical records confirming pre-treatment HCV RNA greater than or equal to 6 million IU/mL

OR

3.3 If genotype 1, and treatment naïve, with compensated cirrhosis, all of the following:**

3.3.1 Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1

AND

3.3.2 Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has cirrhosis

AND

3.3.3 The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

OR

3.4 If genotype 1, and treatment experienced, without cirrhosis, both of the following:**

3.4.1 Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1

AND

3.4.2 One of the following:

3.4.2.1 The patient has experienced treatment failure with a previous treatment regimen that included peginterferon plus ribavirin or an HCV protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] plus peginterferon plus ribavirin

OR

3.4.2.2 Both of the following:

- The patient has experienced treatment failure with a previous treatment regimen that included Sovaldi (sofosbuvir) except in combination with Olysio (simeprevir)
- The medication is used in combination with ribavirin

OR

3.5 If genotype 1, and ribavirin eligible, treatment experienced, with compensated cirrhosis, all of the following:**

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has cirrhosis
- The patient has experienced treatment failure with a previous treatment regimen that included peginterferon plus ribavirin or an HCV protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] plus peginterferon plus ribavirin
- The requested medication is used in combination with ribavirin
- The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

OR

3.6 If genotype 1, and ribavirin ineligible, treatment experienced, with compensated cirrhosis, all of the following:***

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has cirrhosis
- The patient has experienced treatment failure with a previous treatment regimen that included peginterferon plus ribavirin or an HCV protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] plus peginterferon plus ribavirin
- The patient is ribavirin ineligible
- The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

OR

3.7 If genotype 1, 4, 5 or 6 and with decompensated cirrhosis or post-liver transplant, all of the following:**

3.7.1 Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1, 4, 5 or 6

AND

3.7.2 One of the following:

3.7.2.1 Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has decompensated cirrhosis (e.g., Child-Pugh class B or C)

OR

3.7.2.2 Both of the following:

- The patient is a liver transplant recipient
- The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

AND

3.7.3 The medication is used in combination with ribavirin

OR

3.8 If genotype 1,4, 5, or 6 and with decompensated cirrhosis, ribavirin ineligible or prior failure of Sovaldi or NS5A based regimen, all of the following:***

3.8.1 Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1, 4, 5 or 6

AND

3.8.2 Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has decompensated cirrhosis (e.g., Child-Pugh class B or C)

AND

3.8.3 One of the following:

3.8.3.1 The patient is ribavirin ineligible

OR

3.8.3.2 Both of the following:

- The patient has experienced treatment failure with a previous treatment regimen that included Sovaldi (sofosbuvir) or an NS5A inhibitor [e.g., Daklinza (daclatasvir)]
- The medication is used in combination with ribavirin

OR

3.9 If genotype 4, and treatment naïve or treatment experienced (peginterferon plus ribavirin), both of the following:**

3.9.1 Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 4

AND

3.9.2 One of the following:

3.9.2.1 The patient is treatment naïve

OR

3.9.2.2 One of the following:

3.9.2.2.1 The patient has experienced failure with a previous treatment regimen that included peginterferon plus ribavirin and is without cirrhosis

OR

3.9.2.2.2 Both of the following:

- The patient has experienced failure with a previous treatment regimen that included peginterferon plus ribavirin and has compensated cirrhosis (Child-Pugh class A)
- The medication is used in combination with ribavirin

OR

3.10 If genotype 5 or 6, and treatment naïve or treatment experienced (peginterferon plus ribavirin), both of the following:**

3.10.1 Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 5 or 6

AND

3.10.2 One of the following:

- The patient is treatment naïve
- The patient has experienced failure with a previous treatment regimen that included peginterferon plus ribavirin

Product Name:Mavyret	
Approval Length	Reference criteria section for approval length: approval length is 8 weeks if * notated; approval length is 12 weeks if ** notated; approval length is 16 weeks if *** notated
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is not receiving the requested medication in combination with another hepatitis C virus (HCV) direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

AND

2 - The requested medication is prescribed by, or in consultation with, one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist (certified through the American Academy of HIV Medicine)

AND

3 - The patient meets one of the following:

3.1 If genotype 1, 2, 3, 4, 5, or 6, and treatment naïve without cirrhosis, both of the following:**

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV
- The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

OR

3.2 If genotype 1, 2, 3, 4, 5, or 6, and treatment naïve, with compensated cirrhosis, both of the following:*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV

- The patient has compensated cirrhosis (Child-Pugh class A)

OR

3.3 If genotype 1, and treatment experienced (prior failure to an NS3/4A protease inhibitor), without decompensated cirrhosis, all of the following:**

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- The patient has experienced failure with a previous treatment regimen that included an HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)]
- The patient has had no previous treatment experience with a treatment regimen that included an NS5A inhibitor [e.g., Daklinza (daclatasvir)]
- The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

OR

3.4 If genotype 1, and treatment experienced (prior failure to an NS5A inhibitor), without decompensated cirrhosis, all of the following:***

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1
- The patient has experienced failure with a previous treatment regimen that included an NS5A inhibitor [e.g., Daklinza (daclatasvir)]
- The patient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)]
- The patient is without decompensated cirrhosis (Child-Pugh class B or C)

OR

3.5 If genotype 3, and treatment experienced (interferon or Sovaldi based regimen), without decompensated cirrhosis, all of the following:***

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 3
- The patient has experienced failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)
- The patient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor [e.g., Daklinza (daclatasvir)]

- The patient is without decompensated cirrhosis (Child-Pugh class B or C)

OR

3.6 If genotype 1, 2, 4, 5, or 6, and treatment experienced (interferon or Sovaldi based regimen), without cirrhosis, all of the following:*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1, 2, 4, 5 or 6
- The patient has experienced failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)
- The patient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor [e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor [e.g., Daklinza (daclatasvir)]

OR

3.7 If genotype 1, 2, 4, 5, or 6, and treatment experienced (interferon or Sovaldi based regimen), with compensated cirrhosis, all of the following:**

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1, 2, 4, 5 or 6
- The patient has experienced failure with a previous treatment regimen that included interferon, peginterferon, ribavirin, and/or Sovaldi (sofosbuvir)
- The patient has had no previous treatment experience with a treatment regimen that included an HCV NS3/4A protease inhibitor (e.g., Incivek (telaprevir), Olysio (simeprevir), Victrelis (boceprevir)] or an NS5A inhibitor (e.g., Daklinza (daclatasvir)]
- The patient has compensated cirrhosis (e.g., Child-Pugh class A)

Product Name:Sovaldi	
Approval Length	Reference criteria section for approval length: approval length is 12 weeks if * notated; approval length is 24 weeks if ** notated
Guideline Type	Prior Authorization

Approval Criteria

1 - The requested medication is prescribed by, or in consultation with, one of the following:

- Hepatologist

- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist (certified through the American Academy of HIV Medicine)

AND

2 - The patient meets one of the following:

2.1 If genotype 1 or 4 and without decompensated liver disease, all of the following:*

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV (Hepatitis C Virus) genotype 1 or 4
- The requested medication is used in combination with peginterferon alfa and ribavirin
- The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)
- The patient has not experienced failure with a previous treatment regimen that includes Sovaldi

OR

2.2 If genotype 3, and without decompensated liver disease, all of the following:**

2.2.1 Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV (Hepatitis C Virus) genotype 3

AND

2.2.2 One of the following:

- Patient is 12 years of age or older
- If patient is less than 12 years of age, the patient weighs at least 35 kg (kilograms)

AND

2.2.3 The requested medication is used in combination with ribavirin

AND

2.2.4 The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

AND

2.2.5 The patient has not experienced failure with a previous treatment regimen that includes Sovaldi

OR

2.3 If genotype 2, and without decompensated cirrhosis, all of the following:*

2.3.1 Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV (Hepatitis C Virus) genotype 2

AND

2.3.2 One of the following:

- Patient is 12 years of age or older
- If patient is less than 12 years of age, the patient weighs at least 35 kg (kilograms)

AND

2.3.3 The medication is used in combination with ribavirin

AND

2.3.4 The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

AND

2.3.5 The patient has not experienced failure with a previous treatment regimen that includes Sovaldi

Product Name:Vosevi	
Approval Length	12 Week(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is without decompensated liver disease (e.g., Child-Pugh class B or C)

AND

2 - The patient is not receiving the requested medication in combination with another hepatitis C virus (HCV) direct acting antiviral agent [e.g., Harvoni (ledipasvir/sofosbuvir), Zepatier (elbasvir/grazoprevir)]

AND

3 - The requested medication is prescribed by, or in consultation with, one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist (certified through the American Academy of HIV Medicine)

AND

4 - The patient meets one of the following:

4.1 If genotype 1, 2, 3, 4, 5, or 6, and without decompensated cirrhosis, prior relapse to NS5A based regimen, all of the following:

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV
- The patient is a previous relapse to an NS5A based regimen [(e.g., Daklinza (daclatasvir), Epclusa (ledipasvir/sofosbuvir), Mavyret (glecaprevir/pibrentasvir), Technivie (ombitasvir/paritaprevir/ritonavir), Viekira (ombitasvir/paritaprevir/ ritonavir/dasabuvir), Zepatier (elbasvir/grazoprevir)]
- Submission of medical records (e.g., chart notes or laboratory values) confirming normal hepatic function and mild fibrosis (e.g., METAVIR fibrosis score less than or equal to F2)

OR

4.2 If genotype 1a, without decompensated cirrhosis, prior relapse to sofosbuvir based regimen without an NS5A inhibitor, both of the following:

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1a
- The patient is a previous relapser to a sofosbuvir based regimen without an NS5A inhibitor

OR

4.3 If genotype 3 and without decompensated cirrhosis, prior relapse to sofosbuvir based regimen without an NS5A inhibitor, both of the following:

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 3
- The patient is a previous relapser to a sofosbuvir based regimen without an NS5A inhibitor

Product Name:Zepatier	
Approval Length	Reference criteria section for approval length: approval length is 12 weeks if * notated; approval length is 16 weeks if ** notated
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient does not have moderate to severe hepatic impairment (e.g., Child-Pugh class B or C)

AND

2 - The patient is not receiving the requested medication in combination with another hepatitis C virus (HCV) direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)]

AND

3 - The requested medication is prescribed by, or in consultation with, one of the following:

- Hepatologist
- Gastroenterologist
- Infectious Disease Specialist
- HIV Specialist (certified through the American Academy of HIV Medicine)

AND

4 - The patient meets one of the following:

4.1 If genotype 1a, and treatment naïve, or Peg-IFN/RBV experienced, or Peg-IFN/RBV/protease inhibitor experienced, without NS5A polymorphism, all of the following:**

4.1.1 Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1a

AND

4.1.2 One of the following:

- The patient is treatment naïve
- The patient has had prior failure to peginterferon alfa plus ribavirin treatment
- The patient has had prior failure to treatment with peginterferon alfa plus ribavirin plus an HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir, or telaprevir)

AND

4.1.3 Both of the following:

- The patient has been tested for the presence of NS5A resistance associated polymorphisms
- The patient has baseline NS5A resistance associated polymorphisms (e.g., polymorphisms at amino acid positions 28, 30, 31, or 93)

AND

4.1.4 The requested medication is used in combination with ribavirin

OR

4.2 If genotype 1b, and treatment naïve, or Peg-IFN/RBV experienced, or Peg-IFN/RBV/protease inhibitor experience, both of the following:*

4.2.1 Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 1b

AND

4.2.2 One of the following:

4.2.2.1 The patient is treatment naïve

OR

4.2.2.2 The patient has had prior failure to peginterferon alfa plus ribavirin treatment

OR

4.2.2.3 Both of the following:

- The patient has had prior failure to treatment with peginterferon alfa plus ribavirin plus an HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir or telaprevir)
- The requested medication is used in combination with ribavirin

OR

4.3 If Genotype 4, and treatment naïve, submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 4*

OR

4.4 If genotype 4, and Peg-IFN/RBV experienced, all of the following:**

- Submission of medical records (e.g., chart notes, laboratory values) confirming the patient has a diagnosis of chronic HCV genotype 4
- The patient has had prior failure to peginterferon alfa plus ribavirin
- The requested medication is used in combination with ribavirin

2 . Revision History

Date	Notes
10/23/2025	New guideline

Anti-lipidemic Agents - PCSK9 Inhibitors

Prior Authorization Guideline

Guideline ID	GL-504220
Guideline Name	Anti-lipidemic Agents - PCSK9 Inhibitors
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient has an FDA (Food and Drug Administration)-approved diagnosis and meets labeled age requirement

AND

2 - The requested medication was prescribed by, or in consultation with, a cardiologist or lipid specialist

AND

3 - The requested medication will be used as an adjunct to a low-fat diet and exercise

AND

4 - One of the following:

4.1 Both of the following:

4.1.1 The patient has had an inadequate response to high intensity statin therapy defined as all of the following:

- The patient has received therapy with at least 40 mg (milligram) of atorvastatin or at least 20 mg of rosuvastatin for at least the past three months
- The patient has received add-on therapy with ezetimibe to the maximum tolerable dose of statin for at least the past two weeks or the patient has a contraindication to ezetimibe therapy
- The low-density lipoprotein cholesterol (LDL-C) after therapy for at least the past three months was either greater than or equal to 100 mg/dL (milligrams/deciliter) for familial hypercholesterolemia or greater than or equal to 70 mg/dL for clinical atherosclerotic cardiovascular disease

AND

4.1.2 The statin therapy will be continued with the requested therapy

OR

4.2 Both of the following:

4.2.1 The patient has had an inadequate response to moderate intensity statin therapy defined as all of the following:

4.2.1.1 The patient has an intolerance or contraindication to high intensity statin therapy

AND

4.2.1.2 The patient has received therapy with one of the following for at least the past 3 months:

- atorvastatin 10 to 20 mg
- rosuvastatin 5 to 10 mg
- simvastatin greater than 20 mg
- pravastatin greater than 40 mg
- lovastatin 40 mg
- fluvastatin XL 80 mg
- fluvastatin 40 mg twice daily
- pitavastatin greater than 2 mg

AND

4.2.1.3 The patient has received add-on therapy with ezetimibe to the maximum tolerable dose of statin for at least the past two weeks or the patient has a contraindication to ezetimibe therapy

AND

4.2.1.4 The LDL-C after therapy for at least the past three months was either greater than or equal to 100 mg/dL for familial hypercholesterolemia or greater than or equal to 70 mg/dL for clinical atherosclerotic cardiovascular disease

AND

4.2.2 The statin therapy will be continued with the requested therapy

OR

4.3 Documentation that the patient experienced an adverse reaction to at least two statins (please document adverse reaction)

OR

4.4 Documentation that the patient has a labeled contraindication to all statins (please document contraindication)

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

Approval Criteria

1 - The patient has been adherent with the requested therapy

AND

2 - The patient has been adherent with statin therapy, has experienced an adverse reaction to at least two statins or the patient has a labeled contraindication to statin therapy

AND

3 - The patient is continuing a low-fat diet and exercise regimen

AND

4 - The patient has achieved a reduction in LDL-C (low-density lipoprotein cholesterol) level

2 . Revision History

Date	Notes

1/20/2026	Updated LDL requirements and consolidated criteria. Added free text box prompts for adverse reaction and contraindication in initial auth.

Anti-Migraine Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-504218
Guideline Name	Anti-Migraine Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Brand Frova, generic frovatriptan, brand Relpax, generic eletriptan, brand Maxalt, brand Maxalt- MLT, generic rizatriptan, generic rizatriptan ODT, brand Imitrex tab/inj, generic sumatriptan tab/nasal/inj, brand Treximet, generic sumatriptan/naproxen, almotriptan, naratriptan, Zembrace, brand Zomig tab/nasal, generic zolmitriptan tab/nasal/ODT, Tosymra, Onzetra Xsail, Reyvow	
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - One of the following:

1.1 The patient's current medication history documents the use of prophylactic medications

for migraine headache (e.g. beta-blockers, tricyclic antidepressants, anticonvulsants, selective serotonin reuptake Inhibitors (SSRIs) and/or calcium channel blockers)

OR

1.2 Prescriber agrees to initiating prophylactic medications for migraine headache (e.g. beta-blockers, tricyclic antidepressants, anticonvulsants, selective serotonin reuptake Inhibitors (SSRIs) and/or calcium channel blockers)

OR

1.3 Prescriber is aware of and understands the implications of daily use and/or overuse of triptans and agrees to counsel the patient on this issue in an effort to taper the quantity of triptan medication required

AND

2 - Patient does NOT have ischemic heart disease

AND

3 - If the request is for a sumatriptan, rizatriptan, or a zolmitriptan product, the patient's current medication history does not have monoamine oxidase (MAO) inhibitors

AND

4 - If the request is for Maxalt (rizatriptan) 10mg or Maxalt-MLT (rizatriptan ODT) 10mg, the patient's current medication history does not indicate the use of propranolol

AND

5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Aimovig, Ajovy, Emgality 120mg, Qulipta, Vyepti

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 a diagnosis of episodic migraines

AND

1.1.2 Patient has 4 to 14 migraine days per month, but not more than 14 headache days per month

AND

1.1.3 ONE of the following:

- Patient is 18 years of age or older
- If the request is for Ajovy, the patient is six years of age or older and weighs 45 kg or more

OR

1.2 ALL of the following:

1.2.1 Patient has a diagnosis of chronic migraines

AND

1.2.2 Patient has at least 15 headache days per month, of which at least eight must be migraine days for at least three months

AND

1.2.3 Patient has been considered for medication overuse headache (MOH) and potentially offending medication(s) have been discontinued

AND

1.2.4 Patient is 18 years of age or older

AND

2 - Patient has a documented history of failure (after at least a two-month trial) or an intolerance/contraindication to at least one medication from TWO of the following categories:

- Elavil (amitriptyline) or Effexor (venlafaxine)
- Depakote/Depakote ER (divalproex) or Topamax (topiramate)
- One of the following beta blockers: atenolol, propranolol, nadolol, timolol, or metoprolol

AND

3 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Aimovig, Ajovy, Emgality 120mg, Qulipta, Vyepti	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a documented positive response to the CGRP (calcitonin gene-related peptide) therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

2 - Patient has had a decrease in use of acute migraine medications (e.g., NSAIDs, triptans) since the start of CGRP therapy

AND

3 - If the patient is using the requested medication for prevention of chronic migraine, the patient continues to be monitored for medication overuse headache

Product Name:Nurtec ODT	
Diagnosis	Episodic Migraine
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 - Patient has a diagnosis of episodic migraines, having 4 to 14 migraine days per month but not more than 18 headache days per month

AND

3 - TWO of the following:

3.1 One of the following:

- Patient has a documented 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:

- Patient has a documented history of failure (after at least a two-month trial) or intolerance to Depakote/Depakote ER (divalproex) or Topamax (topiramate)
- Patient has a contraindication to both Depakote/Depakote ER (divalproex) or Topamax (topiramate)

OR

3.3 Patient has a history of failure (after at least a two-month trial) or intolerance to one of the following beta blockers:

- Atenolol
- Propranolol
- Nadolol
- Timolol
- Metoprolol

AND

4 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Nurtec ODT	
Diagnosis	Episodic Migraine
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a documented positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

2 - Patient has had a decrease in use of acute migraine medications (e.g., NSAIDs, triptans) since the start of therapy

Product Name:Nurtec ODT, Ubrelvy, Zavzpret	
Diagnosis	Acute Migraines
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of acute migraine with or without aura

AND

2 - Patient is 18 years of age or older

AND

3 - ONE of the following:

- For Zavzpret requests, the prescribed dose will not exceed one spray in 24 hours
- For all other requests, the prescribed dose will not exceed two doses per migraine

AND

4 - Requested medication is treating no more than eight migraine episodes per 30 days

AND

5 - Patient has had at least one trial and failure of a triptan agent

AND

6 - The medication is prescribed by or in consultation with a neurologist or a pain specialist

AND

7 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Nurtec ODT, Ubrelvy, Zavzpret	
Diagnosis	Acute Migraines
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a documented positive response to the CGRP (calcitonin gene-related peptide) therapy

AND

2 - The medication is prescribed by or in consultation with a neurologist or a pain specialist

Product Name:Emgality 100mg	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of episodic cluster headache

AND

2 - Patient has experienced at least two cluster periods lasting from seven 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 - The medication is prescribed by or in consultation with a neurologist or a pain specialist

AND

5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Emgality 100mg	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has documented positive response to Emgality therapy, demonstrated by a reduction in headache frequency and/or intensity

AND

2 - The medication is prescribed by or in consultation with a neurologist or a pain specialist

Product Name:Dihydroergotamine nasal spray/inj, Trudhesa	
Diagnosis	Acute treatment of migraine
Approval Length	3 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 headaches with or without aura

AND

3 - The medication will be used for the acute treatment of migraine

AND

4 - One of the following:

4.1 Patient has tried and failed or has intolerance to TWO triptans (e.g., eletriptan, rizatriptan, sumatriptan)

OR

4.2 Patient has contraindication to all triptans

AND

5 - The medication is prescribed by or in consultation with a neurologist, pain specialist, or a headache specialist

OR

6 - If the patient has more than four headaches days per month, ONE of the following:

6.1 Patient is currently being treated with Elavil (amitriptyline) or Effexor (venlafaxine) unless there is a contraindication or intolerance to these medications

OR

6.2 Patient is currently being treated with Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate) unless there is a contraindication or intolerance to these medications

OR

6.3 Patient is 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

7 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Dihydroergotamine nasal spray/inj, Trudhesa	
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 - The medication is prescribed by or in consultation with a neurologist, pain specialist, or a headache specialist

Product Name:Dihydroergotamine injection	
Diagnosis	Acute treatment of cluster headache episodes
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of cluster headache

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has had a trial and failure, contraindication, or intolerance to sumatriptan injection

AND

4 - The medication is prescribed by or in consultation with a neurologist, pain specialist, or a headache specialist

AND

5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Dihydroergotamine injection	
Diagnosis	Acute treatment of cluster headache episodes
Approval Length	3 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 - The medication is prescribed by or in consultation with a neurologist, pain specialist, or a headache specialist

2 . Revision History

Date	Notes
1/20/2026	Updated GPIs. Added Zavzpret, Tosymra, Onzetra Xsail, Reyvow. Up dated auth duration for triptans. Updated Ajovy age criteria. Updated Nurtec criteria for episodic migraine

Anti-Parkinson's Agents

Prior Authorization Guideline

Guideline ID	GL-422522
Guideline Name	Anti-Parkinson's Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Xadago	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Parkinson's disease (PD)

AND

2 - Patient is 5 years of age or older

AND

3 - Documentation that patient will continue levodopa and/or other dopaminergic treatments

AND

4 - Patient reports more than 1.5 hours per day “off” episodes (“off” episodes refer to “end-of-dose wearing off” and unpredictable “on/off” episodes)

AND

5 - Patient will NOT concurrently be taking any of the following drugs: other MAO inhibitors (MAOIs) or other drugs that are potent inhibitors of MAOI (e.g., linezolid), opioid drugs (e.g., tramadol, meperidine, and related derivatives), SNRIs, tri- or tetra-cyclic or triazolopyridine antidepressants (TCAs), cyclobenzaprine, methylphenidate, amphetamine and their derivatives, St. John’s wort or dextromethorphan

AND

6 - Patient does not have severe hepatic impairment (e.g., Child-Pugh C)

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

Approval Criteria

1 - Documentation of positive clinical response to Xadago therapy

AND **2** - Documentation that patient will continue levodopa and/or other dopaminergic treatments

Product Name:Duopa, Inbrija, brand Lodosyn, generic carbidopa tabs, Rytary, Crexont, Dhivy, Sinemet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - If the request is for a non-preferred medication, trial of ONE preferred agent	
Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
10/21/2025	New

Antibiotics

Prior Authorization Guideline

Guideline ID	GL-422556
Guideline Name	Antibiotics
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:cefixime, cefdinir, cefpodoxime	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Provider attestation that a third-generation cephalosporin is clinically indicated due to contraindications(s) to first-line therapy, treatment failure with first-line therapy, lack of alternative therapies, and/or proven resistance to other alternative treatment options

OR

2 - Prescribed by an infectious disease specialist or by an emergency department provider

OR

3 - If the request is for cefixime, medication is prescribed for gonococcal infection where ceftriaxone is unavailable

OR

4 - A third-generation cephalosporin is being prescribed in the setting of severe penicillin allergy

OR

5 - The patient resides in ONE of the following:

- Acute Care
- Long-term Acute Care (LTAC)
- Skilled Nursing Facility (SNF)

Product Name:Brand Cipro, generic ciprofloxacin, levofloxacin, Baxdela, moxifloxacin, ofloxacin	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Culture and sensitivity-proven susceptibilities and resistance to other agents suggest the requested drug is necessary

OR

2 - Prescribed by an infectious disease specialist or by an emergency department provider

OR

3 - The patient resides in ONE of the following:

- Acute Care
- Long-term Acute Care (LTAC)
- Skilled Nursing Facility (SNF)

Product Name:Sivextro	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of Acute Bacterial Skin and Skin Structure Infection

AND

1.2 Infection is caused by methicillin-resistant Staphylococcus aureus (MRSA)

AND

1.3 ONE of the following:

- Patient had a trial of or has a contraindication to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns [e.g., trimethoprim/sulfamethoxazole (TMP/SMX), doxycycline, vancomycin, daptomycin, telavancin, clindamycin])
- Patient started treatment with IV antibiotic(s) in the hospital and requires continued outpatient therapy

OR

2 - Prescribed by an infectious disease specialist or by an emergency department provider

OR

3 - The patient resides in ONE of the following:

- Acute Care
- Long-term Acute Care (LTAC)
- Skilled Nursing Facility (SNF)

Product Name:Brand Zyvox, generic linezolid	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of vancomycin-resistant enterococcus (VRE) faecium infection or diagnosis of MRSA infection

AND

1.2 ONE of the following:

- Patient had a trial of or has a contraindication to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns [e.g., TMP/SMX, doxycycline, vancomycin, tetracycline, clindamycin])
- Patient started treatment with IV antibiotic(s) in the hospital and requires continued outpatient therapy

OR

2 - Prescribed by an infectious disease specialist or by an emergency department provider

OR

3 - The patient resides in ONE of the following:

- Acute Care
- Long-term Acute Care (LTAC)
- Skilled Nursing Facility (SNF)

2 . Revision History

Date	Notes
10/22/2025	New program

Anticonvulsants

Prior Authorization Guideline

Guideline ID	GL-485274
Guideline Name	Anticonvulsants
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/2/2026

1 . Criteria

Product Name:Epidiolex	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Lennox-Gastaut syndrome (LGS), Dravet Syndrome (DS) or Tuberous Sclerosis Complex (TSC)

AND

2 - The patient is 1 year of age or older

AND

3 - A recent serum transaminase (ALT and AST) and total bilirubin level has been obtained and is within normal limits

AND

4 - The requested medication is prescribed by or in consultation with a neurologist

AND

5 - The requested medication will be used as adjunctive therapy in recipients with uncontrolled seizure management (the patient has taken one or more antiepileptic drugs and has chart notes confirming persistent seizure events after titration of current anti-seizure regiment to highest tolerated doses)

AND

6 - The total dose does NOT exceed one of the following:

- LGS/DS: 20 milligrams/kilogram/day (mg/kg/day) (10 mg/kg twice daily)
- TSC: 25 mg/kg/day (12.5 mg/kg twice daily)

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

Approval Criteria

1 - Documentation of a positive clinical response to the requested medication

AND

2 - Serum transaminase (ALT and AST) and total bilirubin level has been re-checked per package insert

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

Approval Criteria

1 - The patient has a diagnosis of acute intermittent seizures

AND

2 - The patient is at least 12 years of age

AND

3 - The requested medication is prescribed by or in consultation with a neurologist

AND

4 - The dose must not exceed two sprays per seizure cluster, no more than one episode every three days and treat no more than five episodes per month

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

Approval Criteria

1 - The patient has a diagnosis of epilepsy

AND

2 - The patient is at least 6 years of age

AND

3 - The requested medication is prescribed for the acute treatment of intermittent, stereotypic episodes of frequent seizure activity that are distinct from a patient's usual seizure pattern

AND

4 - The requested medication is prescribed by or in consultation with a neurologist

AND

5 - The quantity requested does not exceed treatment for more than five episodes per month

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

Approval Criteria

1 - The patient has a diagnosis of seizures associated with Dravet Syndrome

AND

2 - The patient is 2 years of age or older

AND

3 - The requested medication is prescribed by or in consultation with a neurologist

Product Name:Nayzilam, Valtoco, Fintepla	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response to the requested medication

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

Approval Criteria

1 - The patient is at least 2 years of age

AND

2 - The patient has a diagnosis of seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD) confirmed with genetic testing

AND

3 - The patient has tried and/or is concomitantly receiving at least 2 other anticonvulsant medications

AND

4 - The requested medication is prescribed by or in consultation with a neurologist

AND

5 - The daily dose does not exceed 1,800 milligrams

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

Approval Criteria

1 - The patient continues to meet initial authorization criteria

AND

2 - The prescriber attests to stabilization of disease or reduction in seizure frequency from baseline

AND

3 - The patient has not experienced any treatment-restricting adverse effects (e.g., somnolence, pyrexia, suicidal thoughts, or behavior)

Product Name:Brand Aptiom, generic eslicarbazepine, Brand Banzel, generic rufinamide, Briviact (IV included), Brand Carbatrol, Brand Tegretol, Brand Tegretol XR, generic carbamazepine, generic carbamazepine ER, Brand Celontin, generic methsuximide, Brand Depakote, generic divalproex, Brand Depakote ER, generic divalproex ER, Diacomit, Brand Eprontia, Brand Topamax, generic topiramate, Brand Trokendi, generic topiramate ER, Spritam, Levetiracetam, Brand Keppra, generic levetiracetam, Brand Lamictal, Subvenite, generic lamotrigine, Brand Lamictal ODT, generic lamotrigine ODT, Brand Lamictal XR, generic lamotrigine ER, Brand Zarontin, generic ethosuximide, Brand Felbatol, generic felbamate, Brand Fycompa, generic perampanel, generic tiagabine, Brand Trileptal, generic oxcarbazepine, Brand Oxtellar XR, generic oxcarbazepine ER, Brand Sabril, Brand Vigadrone, generic vigabatrin, generic valproic acid, Brand Vimpat, generic lacosamide, Xcopri, Brand Zonegran, generic zonisamide, Brand Mysoline, generic primidone, generic phenobarbital, Brand Onfi, generic clobazam, Sympazan, Brand Klonopin, generic clonazepam, generic clonazepam ODT, generic clorazepate, Brand Valium, generic diazepam, Brand Cerebyx, generic fosphenytoin, Brand Dilantin, generic phenytoin, Phenytek, , generic phenytoin ER

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the patient is less than 18 years of age, one of the following:

1.1 The requested medication is being used for the treatment of a seizure disorder

OR

1.2 The prescribing provider has a specialty in neurology or pediatric neurology

OR

1.3 If the requested medication is being used for a behavioral health indication, one of the following:

1.3.1 Patient has been discharged from an institutional facility within the past 6 months* (please document name of discharge institution and date of discharge)

OR

1.3.2 Patient has been started on the requested medication within the past 6 months and is stabilized* (please document start date of medication)

OR

1.3.3 All of the following:

1.3.3.1 The requested medication is prescribed by or in consultation with a child psychiatrist

AND

1.3.3.2 The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

AND

1.3.3.3 Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

1.3.3.3.1 For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

OR

1.3.3.3.2 For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

AND

1.3.3.4 If the patient is less than 6 years of age, the requested medication is being utilized

for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

AND

2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Brand Lyrica IR, generic pregabalin IR, Brand Neurontin, generic gabapentin (generic Neurontin)	
Approval Length	*Approval length if used for a behavioral health condition and patient has been discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the patient is less than 18 years of age, one of the following:

1.1 The requested medication is being used for a non-behavioral health indication

OR

1.2 The requested medication is being used for a behavioral health indication and patient meets one of the following:

1.2.1 Patient has been discharged from an institutional facility within the past 6 months* (please document name of discharge institution and date of discharge)

OR

1.2.2 Patient has been started on the requested medication within the past 6 months and is stabilized* (please document start date of medication)

OR

1.2.3 All of the following:

1.2.3.1 The requested medication is prescribed by or in consultation with a child psychiatrist

AND

1.2.3.2 The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

AND

1.2.3.3 Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

1.2.3.3.1 For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

OR

1.2.3.3.2 For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

AND

1.2.3.4 If the patient is less than 6 years of age, the requested medication is being utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

AND

2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

2 . Revision History

Date	Notes
1/2/2026	Unchecked admin box in guideline details. No other changes to guid eline.

Antidepressants

Prior Authorization Guideline

Guideline ID	GL-387231
Guideline Name	Antidepressants
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Wellbutrin SR/XL, generic bupropion IR/SR/ER/XL, Forfivo XL, Bupropion XL, Aplenzin, Auvelity, Desvenlafaxine ER, Brand Pristiq, generic desvenlafaxine ER, Brand Effexor XR, generic venlafaxine IR/ER, Venlafaxine besylate ER, Fetzima, Brand Remeron, generic mirtazapine, generic trazodone, Trintellix, Brand Viibryd, generic vilazodone, Zurzuvae, Brand Celexa, generic citalopram, Citalopram, generic fluvoxamine, generic fluvoxamine ER, Brand Lexapro, generic escitalopram, Brand Paxil, generic paroxetine, Brand Paxil CR, generic paroxetine ER, Brand Prozac, generic fluoxetine, Brand Zoloft, generic sertraline	
Approval Length	*Approval length for patients discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the patient is less than 18 years of age, one of the following:

1.1 Patient has been discharged from an institutional facility within the past 6 months* (please document name of discharge institution and date of discharge)

OR

1.2 Patient has been started on the requested medication within the past 6 months and is stabilized* (please document start date of medication)

OR

1.3 All of the following:

1.3.1 The requested medication is prescribed by or in consultation with a child psychiatrist

AND

1.3.2 The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

AND

1.3.3 Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

1.3.3.1 For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

OR

1.3.3.2 For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

AND

1.3.4 If the patient is less than 6 years of age, the requested medication is being utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

AND

2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:generic duloxetine	
Approval Length	*Approval length if used for a behavioral health condition and patient has been discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the patient is less than 18 years of age, one of the following:

1.1 The requested medication is being used for a non-behavioral health indication

OR

1.2 The requested medication is being used for a behavioral health indication and patient meets one of the following:

1.2.1 Patient has been discharged from an institutional facility within the past 6 months* (please document name of discharge institution and date of discharge)

OR

1.2.2 Patient has been started on the requested medication within the past 6 months and is stabilized* (please document start date of medication)

OR

1.2.3 All of the following:

1.2.3.1 The requested medication is prescribed by or in consultation with a child psychiatrist

AND

1.2.3.2 The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

AND

1.2.3.3 Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

1.2.3.3.1 For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

OR

1.2.3.3.2 For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

AND

1.2.3.4 If the patient is less than 6 years of age, the requested medication is being utilized

for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature **AND** **2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	
Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
9/25/2025	New guideline

Antiemetics

Prior Authorization Guideline

Guideline ID	GL-404253
Guideline Name	Antiemetics
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:generic granisetron, generic ondansetron, Anzemet	
Approval Length	6 month(s)*
Guideline Type	Quantity Limit

Approval Criteria

1 - One of the following:

1.1 The patient has failed on chemotherapy-related antiemetic therapy at lower doses

OR

1.2 The patient is receiving chemotherapy treatments more often than once a week

OR

1.3 The patient has a diagnosis of Acquired Immune Deficiency Syndrome (AIDS), associated nausea and vomiting

OR

1.4 Both of the following:

- The patient has a diagnosis of hyperemesis gravidarum
- The patient has failed at least one other antiemetic therapy or all other available therapies are medically contraindicated

Notes	*Allow for a 30-day fill

Product Name:generic granisetron, generic ondansetron, Anzemet	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Brand Marinol, generic dronabinol, Syndros	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 The patient has a diagnosis of chemotherapy-induced nausea and/or vomiting and all of the following:

1.1.1 The patient has experienced an inadequate response, adverse event or has a contraindication to at least one serotonin receptor antagonist

AND

1.1.2 The patient has experienced an inadequate response, adverse event or has a contraindication to at least one other antiemetic agent

AND

1.1.3 The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the patient

OR

1.2 The patient has been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) and has anorexia associated with weight loss and meets both of the following:

1.2.1 The patient has experienced an inadequate response, adverse event or has a contraindication to megestrol (Megace)

AND

1.2.2 The prescriber is aware of the potential for mental status changes associated with the use of this agent and will closely monitor the patient

2 . Revision History

Date	Notes
10/2/2025	Added NP check for generic granisetron, generic ondansetron, Anze met

Antihemophilic Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-423187
Guideline Name	Antihemophilic Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Hemofil M, Koate, Koate-DVI, Recombinate, Kogenate FS, Nuwiq, Advate, Kovaltry, Xyntha, Xyntha Solofuse, Eloctate, Altuviiio, Novoeight, Esperoct, Adynovate, Jivi, Obizur, Afstyla, Humate-P, Alphanate, Wilate, Feiba, Novoseven RT, Sevenfact, Alphanine SD, Rixubis, Ixinity, Benefix, Idelvion, Alprolix, Rebinyn, Profilnine, Coagadex, Tretten, Corifact, Kcentra, Vonvendi, Qfitlia, Alhemo, Hemlibra, Hympavzi, Ryplazim	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - One of the following:	

1.1 The requested medication is being prescribed for an FDA (Food and Drug Administration) approved indication

OR

1.2 The patient's diagnosis is supported as a use of American Hospital Formulary Service Drug Information (AHFS DI)

OR

1.3 One of the following:

1.3.1 The patient's diagnosis is supported in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of IIb or better (see DRUGDEX Strength of Recommendation table)

OR

1.3.2 Both of the following:

- The patient's diagnosis is listed in the FDA Uses/Non-FDA Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of III or Class Indeterminant (see DRUGDEX Strength of Recommendation table)
- Efficacy is rated as “effective” or “evidence favors efficacy” (see DRUGDEX Efficacy Rating and PA Approval Status table)

OR

1.3.3 The patient's diagnosis is supported in any other section of DRUGDEX

OR

1.4 The use is supported by clinical research in two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal and one of the following:

1.4.1 The dosage quantity/duration of the medication is reasonably safe and effective based

on information contained in the FDA approved labeling, peer-reviewed medical literature, or accepted standards of medical practice

OR

1.4.2 The dosage/quantity/duration of the medication is reasonably safe and effective based on one of the following compendia:

- AHFS Compendium
- Thomson Reuters (Healthcare) Micromedex/ DRUGDEX (not Drug Points) Compendium
- Elsevier Gold Standard's Clinical Pharmacology Compendium
- National Comprehensive Cancer Network Drugs and Biologics Compendium

AND

2 - The dispensing provider will monitor the amount of product the patient has left to avoid over-stock

AND

3 - The prescriber is a specialist in treating hemophilia

2 . Revision History

Date	Notes
10/16/2025	New guideline

Antipsychotics

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-485276
Guideline Name	Antipsychotics
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/2/2026

1 . Criteria

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

Approval Criteria

1 - Patient has Parkinson's related psychosis

AND

2 - Patient is 18 years of age or older

Product Name:Brand Abilify, generic aripiprazole, Abilify Mycite, Brand Clozaril, generic clozapine, Fanapt, Brand Latuda, generic lurasidone, Secuado, Brand Saphris, generic asenapine, Caplyta, Brand Geodon, generic ziprasidone, Brand Invega tablets, generic paliperidone ER tablets, Lybalvi, Brand Risperdal, generic risperidone, Brand Seroquel, generic quetiapine, Brand Seroquel XR, generic quetiapine ER, Brand Zyprexa, generic olanzapine, Rexulti, Vraylar, lithium, Brand Lithobid, generic lithium ER	
Approval Length	*Approval length for patients discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the patient is less than 18 years of age, one of the following:

1.1 Patient has been discharged from an institutional facility within the past 6 months* (please document name of discharge institution and date of discharge)

OR

1.2 Patient has been started on the requested medication within the past 6 months and is stabilized* (please document start date of medication)

OR

1.3 All of the following:

1.3.1 The requested medication is prescribed by or in consultation with a child psychiatrist

AND

1.3.2 The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

AND

1.3.3 Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

1.3.3.1 For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

OR

1.3.3.2 For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

AND

1.3.4 If the patient is less than 6 years of age, the requested medication is being utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

AND

2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
1/2/2026	Unchecked admin box in guideline details. No other changes to guid eline.

Anxiolytics, Sedatives and Hypnotics

Prior Authorization Guideline

Guideline ID	GL-480227
Guideline Name	Anxiolytics, Sedatives and Hypnotics
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Ambien, generic zolpidem, Zolpidem, Brand Ambien CR, generic zolpidem ER, generic zolpidem SL, Edluar, Belsomra, generic estazolam, generic quazepam, generic flurazepam, Brand Lunesta, generic eszopiclone, Brand Rozerem, generic ramelteon, Brand Restoril, generic temazepam, Brand Silenor, generic doxepin tabs, Brand Halcion, generic triazolam, generic zaleplon	
Approval Length	*Approval length for patients discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient has a diagnosis of insomnia	

AND

2 - If the patient is less than 18 years of age, one of the following:

2.1 Patient has been discharged from an institutional facility within the past 6 months* (please document name of discharge institution and date of discharge)

OR

2.2 Patient has been started on the requested medication within the past 6 months and is stabilized* (please document start date of medication)

OR

2.3 All of the following:

2.3.1 The requested medication is prescribed by or in consultation with a child psychiatrist

AND

2.3.2 The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

AND

2.3.3 Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

2.3.3.1 For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

OR

2.3.3.2 For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months **AND** **2.3.4** If the patient is less than 6 years of age, the requested medication is being utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature **AND** **3** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
12/17/2025	Updated guideline type to Prior Authorization

Arikayce

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-434341
Guideline Name	Arikayce
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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) documenting respiratory cultures positive for MAC within the previous 6 months

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) or prescription 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:

- 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

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 a 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 prescription claims history documenting that the patient continues to receive a multidrug background regimen containing at least TWO of the following agents:

- 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

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary. LKC

Arikayce

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-434341
Guideline Name	Arikayce
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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) documenting respiratory cultures positive for MAC within the previous 6 months

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) or prescription 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:

- 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

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 a 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 prescription claims history documenting that the patient continues to receive a multidrug background regimen containing at least TWO of the following agents:

- 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

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary. LKC

Attruby

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-434340
Guideline Name	Attruby
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Attruby	
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 - One of the following:

2.1 Documentation that the patient has a pathogenic TTR mutation (e.g., V30M)

OR

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

OR

2.3 All of the following:

- Echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis
- Radionuclide imaging (99mTc-DPD, 99mTc-PYP, or 99m Tc-HMDP) showing grade 2 or 3 cardiac uptake*
- Absence of light chain amyloidosis

AND

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

AND

4 - Physician attests that the patient has an N-terminal pro-B-type naturetic peptide (NT-proBNP) level that, when combined with signs and symptoms, is considered definitive for a diagnosis of ATTR-CM

AND

5 - One of the following:

- History of heart failure, with at least one prior hospitalization for heart failure
- Presence of signs and symptoms of heart failure (e.g., dyspnea, edema)

AND

6 - Prescribed by or in consultation with a cardiologist

AND

7 - Patient is not receiving Attruby in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), Vyndaqel/Vyndamax (tafamadis), or Wainua (eplontersen)]

Notes	*May require prior authorization and notification

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

Approval Criteria

1 - Documentation that the patient has experienced a positive clinical response to Attruby (e.g., improved symptoms, quality of life, slowing of disease progression, decreased hospitalizations, etc.)

AND

2 - Documentation that patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure

AND

3 - Prescribed by or in consultation with a cardiologist

AND

4 - Patient is not receiving Attruby in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), Vyndaqel/Vyndamax (tafamadis), or Wainua (eplontersen)]

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary - LKC

Auvi-Q (epinephrine injection device)

Prior Authorization Guideline

Guideline ID	GL-421298
Guideline Name	Auvi-Q (epinephrine injection device)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Auvi-Q	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The patient or caregiver is unable to read or comprehend written directions	

2 . Revision History

Date	Notes
10/15/2025	New program

Azole Antifungals

Prior Authorization Guideline

Guideline ID	GL-434342
Guideline Name	Azole Antifungals
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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 - Diagnosis of ONE of the following:

- Blastomycosis
- Histoplasmosis
- Aspergillosis

OR

2 - BOTH of the following:

2.1 Diagnosis of coccidioidomycosis

AND

2.2 ONE of the following:

2.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

2.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

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

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

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

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

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 - 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

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

Approval Criteria

1 - Diagnosis of invasive aspergillosis

OR

2 - ALL of the following:

2.1 Diagnosis of candidemia

AND

2.2 Patient is non-neutropenic

AND

2.3 ONE of the following:

2.3.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

2.3.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

3 - BOTH of the following:

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

3.2 ONE of the following:

3.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

3.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

OR

4 - Diagnosis of Scedosporium apiospermum infection (asexual form of Pseudallescheria boydii)

OR

5 - Diagnosis of Fusarium spp. infection including Fusarium solani

OR

6 - Diagnosis of Exserohilum species infection

Product Name:Brand Vfend susp, generic voriconazole susp	
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:

1.2.1 Diagnosis of Candidemia

AND

1.2.2 Patient is non-neutropenic

AND

1.2.3 ONE of the following:

1.2.3.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

1.2.3.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

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 ONE of the following:

1.3.2.1 Failure to fluconazole (generic Diflucan) as confirmed by claims history or submission of medical records

OR

1.3.2.2 History of contraindication, intolerance, or resistance to fluconazole (generic Diflucan) (please specify intolerance, contraindication, or resistance)

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

AND

2 - Physician has provided rationale for the patient needing to use voriconazole oral suspension instead of voriconazole tablets

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

Approval Criteria

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

- Aspergillus
- Candida

AND

2 - ONE of the following conditions:

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

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

OR

2.1.2 Hematologic malignancies with prolonged neutropenia from chemotherapy [e.g., acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

2.2 Patient has a prior fungal infection requiring secondary prophylaxis

Product Name:Brand Noxafil tablets, generic posaconazole tablets	
Diagnosis	Treatment of Invasive Aspergillosis
Approval Length	84 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of invasive aspergillosis

AND

2 - ONE of the following:

2.1 Failure to voriconazole (generic Vfend) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication, intolerance, or resistance to voriconazole (generic Vfend) (please specify intolerance, contraindication, or resistance)

Product Name:Brand Noxafil suspension, generic posaconazole suspension, Noxafil delayed release suspension packets	
Diagnosis	Prophylaxis of Aspergillus or Candida Infections
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

- Aspergillus
- Candida

AND

2 - ONE of the following conditions:

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

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

OR

2.1.2 Hematologic malignancies with prolonged neutropenia from chemotherapy [e.g., acute myeloid leukemia (AML), myelodysplastic syndromes (MDS)]

OR

2.2 Patient has a prior fungal infection requiring secondary prophylaxis

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

Approval Criteria

1 - Diagnosis of oropharyngeal candidiasis (OPC)

AND

2 - ONE of the following:

2.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Fluconazole (generic Diflucan)
- Itraconazole (generic Sporanox)

OR

2.2 History of contraindication, intolerance, or resistance to BOTH of the following (please specify intolerance, contraindication, or resistance):

- Fluconazole (generic Diflucan)
- Itraconazole (generic Sporanox)

Product Name:Cresemba	
Approval Length	3 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Diagnosis of invasive aspergillosis

AND

1.2 ONE of the following:

1.2.1 Failure to voriconazole (generic Vfend) as confirmed by claims history or submission of medical records

OR

1.2.2 History of contraindication, intolerance, or resistance to voriconazole (generic Vfend) (please specify intolerance, contraindication, or resistance)

OR

2 - Diagnosis of invasive mucormycosis

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

Approval Criteria

1 - Diagnosis of ONE of the following fungal infections:

- Blastomycosis
- Histoplasmosis

- Aspergillosis

AND

2 - ONE of the following:

2.1 Failure to itraconazole capsules (generic Sporanox) as confirmed by claims history or submission of medical records

OR

2.2 History of contraindication or intolerance to itraconazole capsules (generic Sporanox) (please specify intolerance or contraindication)

Product Name:Brand Sporanox capsules, generic itraconazole capsules, Brand Sporanox oral solution, generic itraconazole oral solution, Brand Vfend tablets, generic voriconazole tablets, Brand Vfend suspension, generic voriconazole suspension, Brand Noxafil tablets, generic posaconazole tablets, Brand Noxafil oral suspension, generic posaconazole oral suspension, Noxafil delayed release suspension packets, Cresemba, Tolsura	
Diagnosis	Infectious Diseases Society of America (IDSA) Recommended Regimens
Approval Length	Based on provider and IDSA recommended treatment durations, up to 12 months
Guideline Type	Prior Authorization

Approval Criteria

1 - Use is recognized for treatment of the diagnosis by the Infectious Diseases Society of America (IDSA)

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Benefit Determination Mifeprex

Prior Authorization Guideline

Guideline ID	GL-434343
Guideline Name	Benefit Determination Mifeprex
Formulary	• Medicaid - Community & State Arizona (ACUAZ, ACUAZEC) • Medicaid - Community & State Florida MMA (CSFL, CSFLD) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Kansas (ACUKS, ACUKSC, ACUKSEC) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Texas (ACUTX, ACUTXC, ACUTXEC, ACUTXSK) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Mifeprex, generic mifepristone	
Approval Length	1 month(s)
Guideline Type	Benefit Determination

Approval Criteria **1** - Provider attests patient requires treatment for purposes identified in the Hyde amendment and any applicable state laws and regulations **AND** **2** - Submission of all necessary state form(s) and/or certification document(s)

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Benlysta

Prior Authorization Guideline

Guideline ID	GL-380424
Guideline Name	Benlysta
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Benlysta	
Diagnosis	Systemic Lupus Erythematosus (SLE)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active Systemic Lupus Erythematosus (SLE)

AND

2 - Patient meets the age requirement for the requested formulation:

- Benlysta IV & autoinjector: 5 years of age or older
- Benlysta prefilled syringe: 18 years of age or older

AND

3 - Documentation confirms that the patient is autoantibody positive (i.e., anti-nuclear antibody [ANA] and/or anti-double-stranded deoxyribonucleic acid [anti-dsDNA])

AND

4 - The patient is currently receiving at least one standard of care treatment for active SLE that includes one or more of the following agents (unless all agents are contraindicated):

- Antimalarials (e.g., Plaquenil (hydroxychloroquine))
- Corticosteroids (e.g., prednisone)
- Glucocorticoids
- Immunosuppressants (e.g., methotrexate, Imuran (azathioprine), mycophenolate)

AND

5 - Medication is prescribed by or in consultation with a rheumatologist

AND

6 - Patient does NOT have active central nervous system (CNS) lupus

AND

7 - Patient is currently NOT receiving treatment for a chronic infection

AND

8 - Patient does NOT have evidence of severe renal disease

Product Name:Benlysta	
Diagnosis	Lupus Nephritis
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of active lupus nephritis

AND

2 - Patient meets the age requirement for the requested formulation:

- Benlysta IV: 5 years of age or older
- Benlysta prefilled syringe & autoinjector: 18 years of age or older

AND

3 - The patient is currently receiving at least one standard of care treatment that includes one or more of the following agents (unless all agents are contraindicated):

- Antimalarials (e.g., Plaquenil (hydroxychloroquine))
- Corticosteroids (e.g., prednisone)
- Glucocorticoids
- Immunosuppressants (e.g., methotrexate, Imuran (azathioprine), mycophenolate)

AND

4 - Medication is prescribed by or in consultation with a rheumatologist or nephrologist

AND

5 - Patient does NOT have active central nervous system (CNS) lupus

AND

6 - Patient is currently NOT receiving treatment for a chronic infection

Product Name:Benlysta	
Diagnosis	Systemic Lupus Erythematosus (SLE), Lupus Nephritis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Benlysta therapy

2 . Revision History

Date	Notes
9/4/2025	New

Besremi

Prior Authorization Guideline

Guideline ID	GL-435256
Guideline Name	Besremi
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Arizona (ACUAZ, ACUAZEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Besremi

Diagnosis	Polycythemia Vera
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of polycythemia vera

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

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name:Besremi	
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 Besremi therapy

2 . Revision History

Date	Notes
11/4/2025	Combined formularies - added AZ, NV, VA, WA, IN, NM. No clinical c hanges.

Bile Acid Agents

Prior Authorization Guideline

Guideline ID	GL-458420
Guideline Name	Bile Acid Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Patient has a diagnosis of cerebrotendinous xanthomatosis (CTX) genetically confirmed by a mutation in the CYP27A1 gene

AND

2 - Patient is at least 18 years of age

AND

3 - The requested medication is prescribed by, or in consultation with, a geneticist, neurologist, endocrinologist, or other specialist with advanced knowledge in treating CTX

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - The requested medication is prescribed by, or in consultation with, a geneticist, neurologist, endocrinologist, or other specialist with advanced knowledge in treating CTX

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

Approval Criteria

1 - The requested medication is being prescribed for one of the following:

1.1 Treatment of Bile Acid Synthesis Disorder due to Single Enzyme Defects (SEDs)

OR

1.2 Adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestations of liver disease, steatorrhea or complications from decreased fat-soluble vitamin absorption

AND

2 - Diagnosis confirmed by one of the following:

- Abnormal urinary bile acid by Fast Atom Bombardment ionization-Mass Spectrometry (FAB-MS) analysis
- Genetic testing consistent with diagnosis

AND

3 - The requested medication is prescribed by, or in consultation with, a gastroenterologist or hepatologist

Product Name:Cholbam	
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 without any treatment-restricting adverse events (including complete biliary obstruction)

AND

3 - The requested medication is prescribed by, or in consultation with, a gastroenterologist or hepatologist

2 . Revision History

Date	Notes
12/8/2025	New guideline

Biltricide

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-434344
Guideline Name	Biltricide
Formulary	• Medicaid - Community & State Arizona (ACUAZ, ACUAZEC) • Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Biltricide, generic praziquantel

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 Infections due to schistosoma

OR

1.2 Infections due to the liver trematodes (flukes), Clonorchis sinensis/Opisthorchis viverrini (i.e., clonorchiasis or opisthorchiasis)

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Botulinum Toxin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-422549
Guideline Name	Botulinum Toxin
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Dysport, Botox, Myobloc, Xeomin	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The provider attests they are familiar with and experienced in the use of botulinum toxin products and utilize FDA-approved product labeling, compendia, and peer-reviewed scientific literature to select the appropriate drug and dose regimen for each patient condition

AND

2 - The provider attests the requested medication is being used for a covered condition found within the "Provider Type 20, 24, and 77 Billing Guide" applicable to botulinum toxins

AND

3 - Submission of medical records documenting patient has been unresponsive to conventional methods of treatment (e.g., medication, physical therapy and other appropriate methods used to control and/or treat spastic conditions)

AND

4 - Provider attests that if maximum dose is reached and positive clinical response is not established, treatment will be discontinued

AND

5 - ONE of the following:

- Treatment is NOT more frequent than every 90 days
- Documentation of medical necessity is required for treatment more frequent than every 90 days (document rationale)

AND

6 - Request is for treatment of one injection per site (a site is defined as including muscles of a single contiguous body part, such as a single limb, eyelid, face, or neck)

AND

7 - Requested medication is NOT being used for cosmetic or investigational purposes

Product Name:Dysport, Botox, Myobloc, Xeomin

Approval Length	6 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
10/22/2025	New program

Brineura (cerliponase alfa)

Prior Authorization Guideline

Guideline ID	GL-390193
Guideline Name	Brineura (cerliponase alfa)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brineura	
Approval Length	4 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of symptomatic late infantile neuronal ceroid lipofuscinosis Type 2 (CLN2), also known as tripeptidyl peptidase 1 (TPP1) deficiency

AND

2 - Diagnosis confirmed by TPP1 enzyme detected by a dried blood spot test and CLN2 genotype analysis

AND

3 - Patient is 3 years of age or older

AND

4 - Prescribed by or in consultation with a neurologist with expertise in the diagnosis of CLN2

AND

5 - Administered by, or under the direction of, a physician knowledgeable in intraventricular administration

AND

6 - Patient does NOT have acute intraventricular access-related complications (e.g., leakage, device failure or device-related infections)

AND

7 - Patient does NOT have a ventriculoperitoneal shunt

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

Approval Criteria

1 - Patient does NOT have acute intraventricular access-related complications (e.g., leakage, device failure or device-related infections)

AND

2 - Patient does NOT have a ventriculoperitoneal shunt

AND

3 - Documentation of positive clinical response to Brineura (e.g., improvement in walking or crawling, or no evidence of disease progression)

2 . Revision History

Date	Notes
9/8/2025	New program.

Brinsupri

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-501247
Guideline Name	Brinsupri
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Brinsupri

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

Approval Criteria

1 - Patient has a diagnosis of non-cystic fibrosis bronchiectasis

AND

2 - Patient has ALL of the following signs and symptoms associated with bronchiectasis:

- Cough most days of the week lasting greater than 3 months
- Production of mucopurulent sputum most days of the week lasting greater than 3 months
- Recurrent respiratory tract infections

AND

3 - Chest computed tomography (CT) is positive for bronchiectasis

AND

4 - Cystic fibrosis has been ruled out by one of the following:

- Sweat chloride test is negative
- Mutation analysis of the cystic fibrosis transmembrane conductance regulator (CFTR) gene is negative for cystic fibrosis

AND

5 - ONE of the following:

5.1 If the patient is 12 to 17 years of age, patient has experienced one or more pulmonary exacerbation(s) requiring systemic antimicrobial therapy in the previous 12 months

OR

5.2 If the patient is 18 years of age or older, patient has experienced two or more pulmonary exacerbations requiring systemic antimicrobial therapy in the previous 12 months

AND

6 - ONE of the following:

6.1 Patient does not have co-existing COPD or asthma

OR

6.2 Patient has co-existing COPD, AND patient is currently being treated with one of the following therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Dual therapy with a long-acting muscarinic antagonist (LAMA) (e.g., tiotropium, umeclidinium) AND a long-acting beta agonist (LABA) (e.g., salmeterol, arformoterol, formoterol)
- Triple therapy [LAMA plus LABA combined with an inhaled corticosteroid (ICS) (e.g., budesonide, fluticasone propionate)]

OR

6.3 Patient has co-existing asthma, AND the patient is currently being treated with one of the following therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Inhaled corticosteroid (ICS) (e.g., fluticasone propionate)
- Dual therapy with a LABA (e.g., salmeterol, arformoterol, formoterol) AND ICS (e.g., budesonide, fluticasone propionate)
- Triple therapy with a LAMA (e.g., tiotropium, umeclidinium) plus LABA (e.g., salmeterol, arformoterol, formoterol) combined with an ICS (e.g., budesonide, fluticasone propionate)]

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 - Documentation of a positive clinical response (e.g, the patient has not had an increase in the number of annual pulmonary exacerbations requiring treatment with systemic antibiotics, patient has not initiated therapy with long-term maintenance systemic or inhaled antibiotics since starting Brinsupri)

AND

2 - ONE of the following:

2.1 Patient does not have co-existing COPD or asthma

OR

2.2 Patient has co-existing COPD, AND continues to be treated with one of the following therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Dual therapy with a long-acting muscarinic antagonist (LAMA) (e.g., tiotropium, umeclidinium) AND a long-acting beta agonist (LABA) (e.g., salmeterol, arformoterol, formoterol)
- Triple therapy [LAMA plus LABA combined with an inhaled corticosteroid (ICS) (e.g., budesonide, fluticasone propionate)]

OR

2.3 Patient has co-existing asthma, AND continues to be treated with one of the following

therapies at maximally tolerated doses unless there is a contraindication or intolerance to these medications:

- Inhaled corticosteroid (ICS) (e.g., fluticasone propionate)
- Dual therapy with a LABA (e.g., salmeterol, arformoterol, formoterol) AND ICS (e.g., budesonide, fluticasone propionate)
- Triple therapy with a LAMA (e.g., tiotropium, umeclidinium) plus LABA (e.g., salmeterol, arformoterol, formoterol) combined with an ICS (e.g., budesonide, fluticasone propionate)]

AND

3 - Prescribed by or in consultation with a pulmonologist

2 . Revision History

Date	Notes
1/16/2026	New

Bronchitol

Prior Authorization Guideline

Guideline ID	GL-434346
Guideline Name	Bronchitol
Formulary	• Medicaid - Community & State Arizona (ACUAZ, ACUAZEC) • Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Bronchitol	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Used in conjunction with standard CF therapies [e.g., chest physiotherapy, bronchodilators, antibiotics, anti-inflammatory therapy (e.g., ibuprofen, oral/inhaled corticosteroids)]

AND

3 - Patient has passed the Bronchitol Tolerance Test

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

Approval Criteria

1 - Documentation of positive clinical response to Bronchitol therapy

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary, - LKC

Buphenyl

Prior Authorization Guideline

Guideline ID	GL-434347
Guideline Name	Buphenyl
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Buphenyl oral powder, generic sodium phenylbutyrate oral powder	
Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of urea cycle disorders (UCDs)

Product Name:Brand Buphenyl tablets, generic sodium phenylbutyrate tablets	
Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of urea cycle disorders (UCDs)

AND

2 - Prescriber provides a reason or special circumstance the patient cannot use sodium phenylbutyrate (generic Buphenyl) powder for oral solution

Product Name:Brand Buphenyl tablets, generic sodium phenylbutyrate tablets	
Diagnosis	Urea Cycle Disorders (UCDs)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Buphenyl (sodium phenylbutyrate) tablets

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

C&S Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Clinical Review

Prior Authorization Guideline

Guideline ID	GL-510255
Guideline Name	C&S Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Clinical Review
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Florida MMA (CSFL, CSFLD) • Medicaid - Community & State Louisiana (ACULA, ACULAC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC)

Guideline Note:

Effective Date:	2/15/2026

Note:

EPSDT does not apply to drugs listed in Table 1.

1 . Criteria

Diagnosis	Exception to Policy Limitations for Medicaid Patients Less Than 21 Years of Age^
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 The use of the requested medication is for an indicated diagnosis that is supported by the Food and Drug Administration (FDA)

OR

1.2 The use of the requested medication 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

AND

2 - The use of the requested medication is NOT for experimental or investigational purposes

AND

3 - Prescriber attests that the requested medication is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition (health problem)

AND

4 - Prescriber attests the requested medication is an accepted method for treatment (medical practice)

AND

5 - Prescriber attests the requested medication is the least costly treatment of equally effective choices

AND

6 - Prescriber attests the requested medication is safe and effective

AND

7 - Submission of medical records (e.g. chart notes, assessments, treatment plans, monitoring plans, etc.) confirming previous and current treatments used to treat diagnosis (Must include regimen, duration, treatment goals, and response to treatment)

AND

8 - The requested medication is prescribed within the dosing guidelines from ONE of the following:

8.1 The manufacturer's published dosing guidelines

OR

8.2 ONE of the following compendia:

- American Hospital Formulary Service Drug Information
- National Comprehensive Cancer Network Drugs and Biologics Compendium
- Thomson Micromedex DrugDex
- Clinical pharmacology
- United States Pharmacopoeia-National Formulary

Notes	^ This criteria does not apply to CSFLD and ACUFLEC. Note: ACUFLEC does not have Rx benefits. ^ This criteria does NOT apply to ACUNE/ ACUNEEL1

2 . Background

Benefit/Coverage/Program Information
Table 1: EPSDT does not apply to the following drugs
Abecma
Acthar
Acthar gel
Agamree
Beqvez
Casgevy
Cortrophin
Crenessity
Egrifta SV
Egrifta WR
Elevidys
Encelto
Epclusa
Evrysdi
Genotropin
Genotropin Miniquick
Hemgenix
Humatrope

Humira
Increlex
Kebilidi
Ledipasvir/sofosbuvir
Lenmeldy
Leqembi
Luxturna
Lyfgenia
Mavyret
Ngenla
Norditropin Flexpro
Nutropin AQ Nuspin 10
Nutropin AQ Nuspin 20
Nutropin AQ Nuspin 5
Omnitrope
Onpattro
Papzimeos
Ribavirin
Roctavian
Saizen
Serostim
Skysona
Skytrofa
Sofosbuvir/velpatasvir
Sogroya

Solvadi
Spinraza
Stelara
Strensiq
Synagis
Tabloid
Tecelra
Vosevi
Voxzogo
Vyjuvek
Yescarta
Zepatier
Zolgensma
Zomacton
Zorbtive
Zynteglo

3 . Revision History

Date	Notes
1/30/2026	Minor update to criteria wording. Added exclusion list.

Cabenuva and Vocabria

Prior Authorization Guideline

Guideline ID	GL-422494
Guideline Name	Cabenuva and Vocabria
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Cabenuva, Vocabria	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 The requested medication is being used for continuation of prior therapy

OR

1.2 All of the following:

1.2.1 Patient has a diagnosis of HIV (Human immunodeficiency virus)-1 infection

AND

1.2.2 Patient is currently virologically suppressed [HIV-1 RNA (Ribonucleic Acid) less than 50 copies/mL (milliliter)] on a stable, uninterrupted antiretroviral regimen for at least six months

AND

1.2.3 Patient has no history of treatment failure or known/suspected resistance to either cabotegravir or rilpivirine

AND

1.2.4 Prescribed by, or in consultation with, a clinician with HIV expertise

AND

1.2.5 Will not be used concurrently with other ART (Antiretroviral therapy) medications

2 . Revision History

Date	Notes
10/20/2025	New guideline

Cablivi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-434348
Guideline Name	Cablivi
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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 - Diagnosis of acquired thrombotic thrombocytopenic purpura (aTTP)

AND

2 - Cablivi was initiated as a bolus intravenous injection administered by a healthcare provider in combination with plasma exchange therapy

AND

3 - Cablivi will be used in combination with immunosuppressive therapy (e.g., corticosteroids)

AND

4 - 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)

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Camzyos

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-434349
Guideline Name	Camzyos
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of obstructive hypertrophic cardiomyopathy (HCM)

AND

2 - Heart failure is classified as ONE of the following:

- New York Heart Association (NYHA) class II heart failure
- NYHA class III heart failure

AND

3 - Patient has a left ventricular ejection fraction of greater than or equal to 55%

AND

4 - Patient has a Valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation

AND

5 - ONE of the following:

5.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol)
- Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil)

OR

5.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Non-vasodilating beta blocker (e.g., atenolol, bisoprolol, metoprolol, propranolol)
- Nondihydropyridine calcium channel blocker (i.e., diltiazem, verapamil)

AND

6 - Camzyos is 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., reduction in NYHA class, no worsening in NYHA class)

AND

2 - Patient has a left ventricular ejection fraction of greater than or equal to 50%

AND

3 - Camzyos is prescribed by, or in consultation with, a cardiologist

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Carbaglu

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-434813
Guideline Name	Carbaglu
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Carbaglu, generic carglumic acid	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hyperammonemia due to ONE of the following:

- N-acetylglutamate synthase (NAGS) deficiency
- Propionic acidemia (PA)
- Methylmalonic acidemia (MMA)

Product Name:Brand Carbaglu, generic carglumic acid	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

2 . Revision History

Date	Notes
11/4/2025	Added Nevada Formulary

Cayston (aztreonam)

Prior Authorization Guideline

Guideline ID	GL-395197
Guideline Name	Cayston (aztreonam)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is greater than or equal to 7 years of age

AND

2 - Submission of medical records, chart notes, labs, etc., documenting a diagnosis of Cystic Fibrosis (CF) with positive sputum culture confirming pseudomonas aeruginosa of the airway

AND

3 - The patient has FEV1 between 25% and 75% predicted

AND

4 - The prescriber attests that the patient is not colonized with Burkholderia cepacian

AND

5 - One of the following:

- Trial and failure, contraindication, or intolerance to inhaled tobramycin
- Antibiotic susceptibility testing indicates aztreonam to be more effective than tobramycin

AND

6 - Cayston will be dosed per FDA label (75 mg every eight hours administered with 28 days on/28 days off cycle) and the patient was counseled to use bronchodilator before taking a dose of Cayston)

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

Approval Criteria

1 - Positive response to therapy as demonstrated by improvement in CF respiratory symptoms

AND **2** - The patient has not experienced any treatment-restricting adverse effects (e.g., bronchospasms, allergic reactions)

2 . Revision History

Date	Notes
9/10/2025	1/1/2026 Implementation

Cerdelga and Zavesca

Prior Authorization Guideline

Guideline ID	GL-435249
Guideline Name	Cerdelga and Zavesca
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Gaucher disease type 1

AND

2 - Patient is ONE of the following as detected by an FDA-cleared test:

- CYP2D6 extensive metabolizer
- CYP2D6 intermediate metabolizer
- CYP2D6 poor metabolizer

Product Name:Brand Zavesca, generic miglustat, Yargesa	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of mild to moderate type 1 Gaucher disease

AND

1.2 Patient is unable to receive enzyme replacement therapy due to ONE of the following conditions:

- Allergy or hypersensitivity to enzyme replacement therapy
- Poor venous access
- Unavailability of enzyme replacement therapy (e.g., Cerezyme, VPRIV)

OR

2 - ALL of the following:

- Diagnosis of Niemann-Pick disease type C (NPC)
- Diagnosis has been genetically confirmed by mutation analysis of NPC1 and NPC2 genes
- Provider attests patient presents with neurological manifestations of NPC

Product Name:Cerdelga, Brand Zavesca, generic miglustat, Yargesa	
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
11/4/2025	Added NV formulary. No clinical updates.

Chantix

Prior Authorization Guideline

Guideline ID	GL-439188
Guideline Name	Chantix
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Chantix, varenicline, apo-varenicline	
Approval Length	6 Month(s)*
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient has not exceeded 180 days of therapy in the last 12 months	

AND

2 - Treatment is being requested for tobacco cessation

AND

3 - ONE of the following:

3.1 Failure to ONE of the following as confirmed by claims history or submission of medical records:

- Nicotine replacement patches OTC (over the counter) (e.g., Nicoderm CQ-OTC)
- Nicotine gum OTC (e.g., Nicorette gum-OTC)
- Nicotine lozenge OTC (e.g., Nicorette lozenge-OTC)

OR

3.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance)

- Nicotine replacement patches OTC (over the counter) (e.g., Nicoderm CQ-OTC)
- Nicotine gum OTC (e.g., Nicorette gum-OTC)
- Nicotine lozenge OTC (e.g., Nicorette lozenge-OTC)

AND

4 - ONE of the following:

4.1 Failure to bupropion as confirmed by claims history or submission of medical records

OR

4.2 History of contraindication or intolerance to bupropion (please specify contraindication or intolerance)

Notes	*Authorization will be issued for 6 months, not to exceed 180 days of t herapy per 12 months.

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Colchicine

Prior Authorization Guideline

Guideline ID	GL-461274
Guideline Name	Colchicine
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:colchicine tablets	
Diagnosis	Familial Mediterranean Fever (FMF)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Familial Mediterranean Fever (FMF)

AND

2 - The patient is 4 years of age or older

Product Name:colchicine tablets	
Diagnosis	Familial Mediterranean Fever (FMF)
Approval Length	12 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - The patient has a diagnosis of Familial Mediterranean Fever (FMF)

AND

2 - The patient is 12 years of age or older

AND

3 - The patient's dose is less than or equal to 2.4 mg (milligrams) daily (120 tablets/30 days)

AND

4 - Documentation that the patient had an inadequate response to 1.8 mg daily (90 tablets/30 days)

Product Name:colchicine tablets	
Diagnosis	Acute Gout
Approval Length	2 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of acute gout (does not require prophylaxis)

AND

2 - The patient is 16 years of age or older

AND

3 - The patient has had an inadequate response, adverse reaction or contraindication to an NSAID (indomethacin, naproxen, ibuprofen, sulindac, or ketoprofen)

AND

4 - The patient has had an inadequate response, adverse reaction or contraindication to a corticosteroid (oral or intra-articular)

Product Name:colchicine tablets, Brand Mitigare, generic colchicine capsules	
Diagnosis	Prophylaxis of Chronic Gout
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The requested medication is being used for prophylaxis of chronic gout

AND

2 - One of the following:

- For tablets, the patient is 16 years of age or older
- For capsules, the patient is 18 years of age or older

AND

3 - One of the following:

3.1 Documentation that the patient will be treated with colchicine in combination with allopurinol, Uloric (febuxostat), or probenecid

OR

3.2 Documentation that the patient will be treated with colchicine monotherapy and both of the following:

- The patient has had an inadequate response to allopurinol at a dose of 600 mg/day (milligrams per day) for at least two weeks or had an adverse reaction or contraindication to allopurinol
- The patient has had an inadequate response to Uloric (febuxostat) at a dose of 80 mg/day for at least two weeks or has had an adverse reaction or contraindication to Uloric (febuxostat)

AND

4 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
12/1/2025	Removed Mitigare and colchicine capsules from "colchicine tablets" QL section.

Colony Stimulating Factors

Prior Authorization Guideline

Guideline ID	GL-421297
Guideline Name	Colony Stimulating Factors
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Granix, Nyvepria, Neupogen, Fulphila, Leukine, Neulasta, Nivestym, Releuko, Udenyca, Zarxio, Ziextenzo	
Approval Length	1 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Used for an FDA-approved indication **AND**	

2 - If used for a diagnosis of nonmyeloid malignancy, ONE of the following:

- The patient is receiving myelosuppressive anticancer drugs that are associated with a febrile neutropenia risk of at least 20%
- The patient is at high risk for complications from neutropenia (e.g., sepsis syndrome, current infection, age > 65 years, absolute neutrophil count (ANC) < 100 cells/microliter or the expected duration of neutropenia is > 10 days)
- The patient has experienced a prior episode of febrile neutropenia, and the requested drug will be used as secondary prophylaxis

AND

3 - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
10/15/2025	New program

Compounded Medications

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-423188
Guideline Name	Compounded Medications
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Compounded Medications	
Approval Length	6 months, unless the provider requests for a shorter length of therapy
Guideline Type	Administrative

Approval Criteria

1 - Each active ingredient in the compounded medication is FDA (Food and Drug Administration)-approved or national compendia supported for the condition being treated

AND

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

AND

3 - If any prescription ingredients require PA (prior authorization) and/or step therapy, all drug specific criteria have been met

AND

4 - The compounded medication is NOT being used for cosmetic purpose

AND

5 - The compounded medication does NOT include any ingredient that has been withdrawn or removed from the market due to safety reasons (drugs withdrawn from the market due to safety or effectiveness)

AND

6 - One of the following:

6.1 The patient has tried and failed therapy or had an intolerance to at least two FDA-approved, commercially available prescription therapeutic alternatives, one of which is the same route of administration as the requested compound

OR

6.2 One of the following:

- The patient has a contraindication to commercially available products
- One or no other therapeutic alternatives are commercially available
- Compound medication is prepared in a different dosage form for a recipient who is unable to take the commercially available formulation (mixing or reconstituting commercially available products based on the manufacturer's instructions or the product's approved labeling does not meet this criteria)

- The patient has an allergy or sensitivity to inactive ingredients (e.g., dyes, preservatives, sugars, etc.) that are found in commercially available products

2 . Revision History

Date	Notes
10/16/2025	New guideline

Corlanor (ivabradine)

Prior Authorization Guideline

Guideline ID	GL-422507
Guideline Name	Corlanor (ivabradine)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Corlanor, generic ivabradine	
Approval Length	Approval length will be based on the appropriate use for the individual agents, not to exceed 12 months
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient has a diagnosis of chronic heart failure **AND**	

2 - Patient has a left ventricular ejection fraction (LVEF) less than or equal to 35%

AND

3 - Patient has a resting heart rate greater than or equal to 70 bpm (beats per minute)

AND

4 - The patient is greater than or equal to 18 years of age

AND

5 - The prescriber is a cardiologist or there is documentation that a cardiologist has been consulted regarding the diagnosis and treatment recommendations

AND

6 - The patient is in a normal sinus rhythm

AND

7 - The patient is on a maximally tolerated dose of a beta-blocker or the recipient has a contraindication to beta-blocker use

2 . Revision History

Date	Notes
10/21/2025	New guideline

Crenessity

Prior Authorization Guideline

Guideline ID	GL-439190
Guideline Name	Crenessity
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Crenessity

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

Approval Criteria

1 - Diagnosis of classic congenital adrenal hyperplasia (CAH) due to 21-hydroxylase deficiency

AND

2 - Diagnosis confirmed by one of the following:

- Pretreatment serum 17-hydroxyprogesterone (17-OHP) level > 3,000 ng/dL
- Cosyntropin stimulation 17OHP level > 10,000 ng/dL
- Genetic variant in CYP21A2 gene

AND

3 - Patient is 4 years of age or older

AND

4 - Chronic treatment with a supraphysiologic glucocorticoid (GC) regimen (e.g., dexamethasone, hydrocortisone, methylprednisolone, prednisone, prednisolone) defined as ONE of the following:

4.1 BOTH of the following:

- Patient is 4 to 17 years old
- Daily glucocorticoid dose > 12 mg/m2 in hydrocortisone dose equivalents

OR

4.2 BOTH of the following:

- Patient is at least 18 years old

- Daily glucocorticoid dose > 13 mg/m2/day in hydrocortisone dose equivalents

AND

5 - Prescribed by an endocrinologist

AND

6 - If the request is for Crenessity oral solution, ONE of the following:

6.1 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- Oral-motor difficulties
- Dysphagia

OR

6.2 Patient utilizes a feeding tube for medication administration

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

Approval Criteria

1 - Documentation of positive clinical response to Crenessity therapy (e.g., reduction in total glucocorticoid daily dose, decreased androstenedione levels)

AND

2 - Patient will continue to receive concomitant glucocorticoid replacement (e.g., dexamethasone, hydrocortisone, methylprednisolone, prednisone, prednisolone)

AND

3 - Prescribed by an endocrinologist

AND

4 - If the request is for Crenessity oral solution, ONE of the following:

4.1 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- Oral-motor difficulties
- Dysphagia

OR

4.2 Patient utilizes a feeding tube for medication administration

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Cuvrior

Prior Authorization Guideline

Guideline ID	GL-423398
Guideline Name	Cuvrior
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Cuvrior	
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 Wilson's Disease (defined by a prior or current Leipzig score of greater than or equal to 4)

AND

3 - Both of the following:

3.1 Patient is being treated with penicillamine for at least 1 year at a stable dose and regimen for at least 4 months

AND

3.2 Patient is tolerating penicillamine and adequately controlled (e.g., serum non-ceruloplasmin copper [NCC] level greater than or equal to 25 and less than or equal to 150 mcg/L or 24-hour urinary copper excretion [UCE] of levels greater than or equal to100 and less than or equal to 900 mcg/24 hours);

AND

4 - Penicillamine will be discontinued before initiating Cuvrior

AND

5 - Patient will not concurrently use another formulation of trientine (e.g., Syprine, generic trientine)

AND

6 - Prescribed by or in consultation with a hepatologist or neurologist

AND

7 - Daily dose does not exceed 3,000 mg

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

Approval Criteria

1 - Patient continues to meet the initial criteria

AND

2 - Evidence of effectiveness of therapy (e.g., as assessed by serum NCC level greater than or equal to 25 and less than or equal to150 mcg/L or 24-hour UCE levels greater than or equal to100 and less than or equal to 900 mcg/24 hours)

AND

3 - Patient does not exhibit clinical manifestations of advancement of Wilson's Disease from baseline (e.g., jaundice, edema, ascites, esophageal varices, liver failure, CNS symptoms)

AND

4 - Patient has not experienced any treatment-restricting adverse effects (e.g., hypersensitivity reactions, copper deficiency, iron deficiency)

2 . Revision History

Date	Notes
10/22/2025	New

Cystaran, Cystadrops

Prior Authorization Guideline

Guideline ID	GL-439195
Guideline Name	Cystaran, Cystadrops
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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
11/5/2025	Added Nevada Formulary

Cystic Fibrosis Agents

Prior Authorization Guideline

Guideline ID	GL-398299
Guideline Name	Cystic Fibrosis Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Patient is age appropriate according to the FDA-approved package labeling

AND

3 - Documentation that the patient has had an FDA-approved CF mutation test confirming the presence of one of the gene mutations listed in the FDA-approved package insert

AND

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

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

Approval Criteria

1 - Documentation of a positive clinical response to therapy

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

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Patient is age appropriate according to the FDA-approved package labeling

AND

3 - The patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene

AND

4 - If the request is for Orkambi tablets, ONE of the following:

- The requested dose is two tablets every 12 hours
- The requested dose is one tablet every 12 hours in the presence of severe hepatic impairment

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 - Patient is age appropriate according to the FDA-approved package labeling

AND

3 - Prescribed by or in consultation with either a pulmonologist or a specialist associated with a CF care center

AND

4 - ONE of the following:

- The patient is homozygous for the F508del mutation as detected by an FDA cleared CF mutation test or Clinical Laboratory Improvement Amendments (CLIA) approved facility
- The patient has one of the FDA approved package insert listed mutations on at least one allele in the CF transmembrane conductance regulator (CFTR) gene as detected by FDA cleared CF mutation test or CLIA approved facility

Product Name:Symdeko	
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., improvement in lung function or decreased number of pulmonary exacerbations)

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

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Patient is age appropriate according to the FDA-approved package labeling

AND

3 - The patient has at least one F508del mutation in the CF transmembrane conductance regulator (CFTR) gene or a mutation in the CFTR gene that is responsive based on in vitro data as detected by an FDA cleared CF mutation test, or a test performed at a Clinical Laboratory Improvement Amendments (CLIA) approved facility

AND

4 - Prescribed by or in consultation with either a pulmonologist or a specialist affiliated with a CF care center

Product Name:Trikafta	
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. improvement in lung function [percent predicted FEV1 {PPFEV1}] or decreased number of pulmonary exacerbations)

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

Approval Criteria

1 - Diagnosis of cystic fibrosis (CF)

AND

2 - Patient is age appropriate according to the FDA-approved package labeling

AND

3 - The patient has at least one F508del mutation or another responsive mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by FDA-cleared CF mutation test or Clinical Laboratory Improvement Amendments (CLIA)-approved facility

AND

4 - The patient does NOT have moderate or severe hepatic impairment (Child-Pugh class B or C)

AND

5 - Prescriber attests that liver function tests are being monitored per FDA package-insert (i.e., prior to initiating therapy, every month for the first six months, every three months for next 12 months, then at least annually)

AND

6 - Prescribed by, or in consultation with, a pulmonologist or a specialist affiliated with a CF care center

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

Approval Criteria

1 - Documentation of positive response to therapy **AND** **2** - Prescribed by, or in consultation with, a pulmonologist or a specialist affiliated with a CF care center

2 . Revision History

Date	Notes
9/22/2025	New program

Daliresp (roflumilast) and Ohtuvayre (ensifentrine)

Prior Authorization Guideline

Guideline ID	GL-398208
Guideline Name	Daliresp (roflumilast) and Ohtuvayre (ensifentrine)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Daliresp, generic roflumilast	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2 - History of COPD exacerbations

AND

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

- Long-acting anticholinergic agent
- Long-acting beta agonist
- Inhaled corticosteroid

AND

4 - Patient does NOT have moderate (Child-Pugh B) or severe (Child-Pugh C) hepatic impairment

AND

5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

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

Approval Criteria

1 - Diagnosis of chronic obstructive pulmonary disease (COPD)

AND

2 - History of COPD exacerbations

AND

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

- Long-acting anticholinergic agent
- Long-acting beta agonist
- Inhaled corticosteroid

AND

4 - If the patient has hepatic impairment, the prescriber attests that Ohtuvayre will be used with caution

AND

5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

2 . Revision History

Date	Notes
9/16/2025	New program

Daraprim

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439197
Guideline Name	Daraprim
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Daraprim, generic pyrimethamine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Submission of medical records (e.g., chart notes) documenting 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:

- Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate
- 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 count less than or equal to 100 cells per mm^3 if initiating prophylaxis, or CD4 count 100-200 cells per mm^3 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:

- Patient has been re-challenged with trimethoprim-sulfamethoxazole (TMP-SMX) using a desensitization protocol and is still unable to tolerate
- 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 count greater than 200 cells/mm^3 for greater than 3 months after institution of com bination antiretroviral therapy.

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Daybue (trofinetide)

Prior Authorization Guideline

Guideline ID	GL-422505
Guideline Name	Daybue (trofinetide)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is two years of age or older

AND

2 - The patient has a diagnosis of typical Rett Syndrome, and a documented MECP2 gene mutation confirmed by genetic testing

AND

3 - Prescribed by or in consultation with neurologist, geneticist, or developmental pediatrician

AND

4 - Prescriber has assessed baseline disease severity of behavior and/or functionality using an objective measure or tool (e.g., Clinical Global Impression-Improvement [CGI-I] score, Motor-Behavior Assessment [MBA], Interval History Form, Clinical Severity Scale, Rett Syndrome Gross Motor Scale)

AND

5 - The patient does not have progressive weight loss prior to initiation of therapy

AND

6 - The patient does not have moderate or severe renal impairment (e.g., estimated glomerular filtration rate (eGFR) less than 45 mL/min/1.73m2)

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

Approval Criteria

1 - The patient continues to meet the initial authorization criteria

AND

2 - The patient must have response to therapy from pre-treatment baseline with disease stability or improvement in core symptoms as evidenced on objective measure or tool (e.g., Rett Syndrome Behavior Questionnaire [RSBQ], CGI-I, MBA, Interval History Form, Clinical Severity Scale, Rett Syndrome Gross Motor scale)

AND

3 - The patient has not experienced any treatment-restricting adverse effects (e.g., severe diarrhea or dehydration, significant weight loss)

2 . Revision History

Date	Notes
10/21/2025	1/1/2026 Implementation

DEKAs Plus

Prior Authorization Guideline

Guideline ID	GL-435253
Guideline Name	DEKAs Plus
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:DEKAs Plus Ocean, DEKAs Plus	
Diagnosis	Cystic Fibrosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of cystic fibrosis

2 . Revision History

Date	Notes
11/4/2025	Combined formularies - added NV, VA, NM. No clinical changes.

Diabetic Supply Program

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-457209
Guideline Name	Diabetic Supply Program
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Insulin pumps and patches (all brands)	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a documented diagnosis of DM1 (diabetes mellitus type I) or Gestational Diabetes

AND

2 - The requested product must be prescribed by, or in consultation with, an endocrinologist

AND

3 - The patient meets all age restrictions stated in the manufacturer's label

AND

4 - The patient must have been compliant on their current antidiabetic regimen for at least the last six months and the requested regimen must include multiple day injections of insulin (requiring at least three injections per day)

AND

5 - One of the following

5.1 Documented history of recurring hypoglycemia

OR

5.2 Wide fluctuations in pre-meal blood glucose, history of severe glycemic excursions or experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200 mg/dL (milligrams per deciliter)

OR

5.3 Prior use of an insulin pump with documented frequency of glucose self-testing of at least four times per day in the month immediately prior to the request

AND

6 - If the request is non-preferred*, one of the following:

6.1 The patient must have one of the following reasons/special circumstances:

- The patient has had an allergic reaction to a preferred product or related supply
- The patient has a visual impairment which requires the use of a non-preferred product
- The patient has medical necessity justification (e.g., mental or physical limitation) which requires them to stay on their current product

OR

6.2 Both of the following:

- The patient must have been trained to use the non-preferred product
- The patient must have benefited from use of the non-preferred product

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Insulin pumps and patches (all brands)	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has documented positive clinical response to the product, including current HbA1C (hemoglobin A1C) (please document date of last HbA1C and value)

Product Name:Continuous Glucose Monitors, sensors, and transmitters (all brands)	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a documented diagnosis of DM1 (diabetes mellitus type I), DM2 (diabetes mellitus type 2) or Gestational Diabetes

AND

2 - The patient meets all age restrictions stated in the manufacturer's label

AND

3 - The patient must have been compliant on their current antidiabetic regimen for at least the last six months and the requested regimen must include multiple day injections of insulin (requiring at least three injections per day)

AND

4 - One of the following

4.1 Documented history of recurring hypoglycemia

OR

4.2 Wide fluctuations in pre-meal blood glucose, history of severe glycemic excursions or experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200 mg/dL (milligrams per deciliter)

OR

4.3 The patient is currently using insulin pump therapy while continuing to need frequent dosage adjustments or experiencing recurring episodes of severe hypoglycemia [50 mg/dL (milligrams per deciliter)]

AND

5 - If the request is non-preferred*, one of the following:

5.1 The patient must have one of the following reasons/special circumstances:

• The patient has had an allergic reaction to a preferred product or related supply • The patient has a visual impairment which requires the use of a non-preferred product • The patient has medical necessity justification (e.g., mental or physical limitation) which requires them to stay on their current product **OR** **5.2** Both of the following: • The patient must have been trained to use the non-preferred product • The patient must have benefited from use of the non-preferred product	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
11/25/2025	New guideline

Dojolvi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439199
Guideline Name	Dojolvi
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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 confirming the diagnosis of long-chain fatty acid oxidation disorders (LC-FAOD) with at least two of the following diagnostic criteria:

- Disease specific elevation of acyl-carnitines on a newborn blood spot or in plasma
- Low enzyme activity in cultured fibroblasts
- Genetic testing demonstrating one or more pathogenic mutations in a gene associated with long-chain fatty acid oxidation disorders (e.g., CPT2, ACADVL, HADHA, or HADHB)

AND

2 - Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) products

AND

3 - Prescribed by a board-certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD)

AND

4 - Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI)

AND

5 - Patient is receiving disease related dietary management

AND

6 - If not diagnosed by newborn screening, patient has a history of clinical manifestations of long-chain fatty acid oxidation disorders LC-FAOD (e.g., rhabdomyolysis)

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

Approval Criteria

1 - Documentation of positive clinical response to Dojolvi therapy (e.g., increased cardiac efficiency, decreased left ventricular wall mass, decreased incidence of rhabdomyolysis, etc.)

AND

2 - Patient is not receiving Dojolvi in combination with any other medium-chain triglyceride (MCT) product

AND

3 - Prescribed by a board-certified medical geneticist experienced in the treatment of long-chain fatty acid oxidation disorders (LC-FAOD)

AND

4 - Target recommended daily dosage does not exceed 35% of the patient's total prescribed daily caloric intake (DCI)

AND

5 - Patient is receiving disease related dietary management

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Doptelet

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439201
Guideline Name	Doptelet
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Doptelet	
Diagnosis	Thrombocytopenia in patients with chronic liver disease who are scheduled to undergo a procedure
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

AND

4 - ONE of the following:

- Failure to Mulpleta (lusutrombopag) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to Mulpleta (lusutrombopag) (please specify contraindication or intolerance)

Product Name:Doptelet	
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 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to at least ONE of the following as confirmed by claims history or submission of medical records:

- Corticosteroids
- Immunoglobulins

OR

2.1.1.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Corticosteroids
- Immunoglobulins

AND

2.1.2 ONE of the following:

- Failure to eltrombopag olamine (generic Promacta) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to eltrombopag olamine (generic Promacta) (please specify contraindication or intolerance)

OR

2.2 Patient is currently on Doptelet therapy

Product Name:Doptelet	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)

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

Approval Criteria

1 - Documentation of positive clinical response to Doptelet therapy

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Doxepin Topical

Prior Authorization Guideline

Guideline ID	GL-416248
Guideline Name	Doxepin Topical
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Prudoxin, Brand Zonalon, generic doxepin cream	
Approval Length	8 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of pruritus with atopic dermatitis or lichen simplex chronicus

AND

2 - The patient is 18 years of age or older

AND **3** - Treatment will not exceed 8 days

2 . Revision History

Date	Notes
10/7/2025	New guideline

Duchenne Muscular Dystrophy (DMD) Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-504221
Guideline Name	Duchenne Muscular Dystrophy (DMD) Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Exondys 51	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)

AND

2 - There is documentation of a confirmed mutation of the dystrophin gene amenable to exon 51 skipping

AND

3 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

AND

4 - The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight once weekly

Product Name:Exondys 51	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has experienced a benefit from therapy (e.g., disease amelioration compared to untreated patients)

AND

2 - The patient is tolerating therapy

AND

3 - The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight once weekly

AND

4 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

Product Name:Brand Emflaza, generic deflazacort, Jaythari, Pyquvi, Kymbee	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)

AND

2 - The patient is 5 years of age or older

AND

3 - The patient has received genetic testing for a mutation of the dystrophin gene, and one of the following:

- Documentation of a confirmed mutation of the dystrophin gene
- Muscle biopsy confirming an absence of dystrophin protein

AND

4 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

AND

5 - The patient has had at least a three-month trial and failure of prednisone (prednisolone or equivalent dose) or a documented intolerance to prednisone (prednisolone or equivalent dose) given at a dose of 0.75 mg/kg/day (milligrams per kilogram per day) or 10 mg/kg/week

AND

6 - The prescribed dose does not exceed 0.9 mg per kg of body weight once daily

Product Name:Brand Emflaza, generic deflazacort, Jaythari, Pyquvi, Kymbee	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy (e.g., improvement or preservation of muscle strength)

AND

2 - The prescribed dose does not exceed 0.9 mg per kg of body weight once daily

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, laboratory values) confirming the following:

1.1 The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)

AND

1.2 Mutation of the dystrophin gene amenable to exon 53 skipping

AND

2 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

AND

3 - The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight infused once weekly

Product Name:Vyondys 53	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 If the patient has been on therapy for less than 12 months, all of the following:

- The patient is tolerating therapy
- The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight infused once weekly
- The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

OR

1.2 If the patient has been on therapy for 12 months or more, all of the following:

- The patient experienced a benefit from therapy (e.g. disease amelioration compared to untreated patients)
- The patient is tolerating therapy
- The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight infused once weekly
- The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

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, laboratory values) confirming the following:

1.1 The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)

AND

1.2 Mutation of the dystrophin gene amenable to exon 53 skipping

AND

2 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

AND

3 - The prescribed dose does not exceed 80 mg (milligrams) per kg (kilogram) of body weight infused once weekly

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

Approval Criteria

1 - One of the following:

1.1 If the patient has been on therapy for less than 12 months, all of the following:

- The patient is tolerating therapy
- The prescribed dose does not exceed 80 mg (milligrams) per kg (kilogram) of body weight infused once weekly
- The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

OR

1.2 If the patient has been on therapy for 12 months or more, all of the following:

- The patient experienced a benefit from therapy (e.g. disease amelioration compared to untreated patients)
- The patient is tolerating therapy
- The prescribed dose does not exceed 80 mg (milligrams) per kg (kilogram) of body weight infused once weekly
- The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

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, laboratory values) confirming the following:

1.1 The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)

AND

1.2 Mutation of the dystrophin gene amenable to exon 45 skipping

AND

2 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

AND

3 - The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight infused once weekly

Product Name:Amondys 45	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is tolerating therapy

AND

2 - The prescribed dose does not exceed 30 mg (milligrams) per kg (kilogram) of body weight infused once weekly

AND

3 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

Product Name:Elevidys	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

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

1.1 The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy)

AND

1.2 The patient has mutation of the DMD gene

AND

1.3 The patient does not have any deletion in exon 8 and/or exon 9 in the DMD gene

AND

1.4 The patient has a baseline anti-AAVrh74 total binding antibody titer of less than 1,400 as measured by enzyme-linked immunosorbent assay (ELISA)

AND

2 - The patient is 4 years of age or older

AND

3 - The requested medication is prescribed by, or in consultation with, a pediatric neuromuscular specialist with advanced knowledge in treating DMD

AND

4 - The patient is NOT on concomitant therapy with DMD-directed antisense oligonucleotides (e.g., golodirsen, casimersen, viltolarsen, eteplirsen)

AND

5 - The patient does NOT have an active infection, including clinically important localized infections

AND

6 - The patient has been on a stable dose of corticosteroid, unless contraindicated or intolerance, prior to start of therapy and will be used concomitantly with a corticosteroid regimen pre- and post-infusion

AND

7 - The patient's troponin-I levels will be monitored at baseline and subsequently as clinically indicated

AND

8 - The patient will have liver function assessed prior to and following therapy for at least three months as indicated

AND

9 - The patient is receiving physical and/or occupational therapy

AND

10 - The patient has never previously received Elevidys treatment in their lifetime

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

Approval Criteria

1 - Patient is 2 years of age or older

AND

2 - Diagnosis of DMD (Duchenne Muscular Dystrophy) confirmed by genetic analysis (e.g., dystrophin deletion, duplication mutation) or muscle biopsy documenting absent dystrophin

AND

3 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

AND

4 - The patient has had at least one of the following:

4.1 At least six month trial and failure of prednisone (prednisolone or equivalent dose) at dose of 0.75 mg/kg/day (milligrams per kilogram per day)

OR

4.2 Documented history of intolerable adverse events, hypersensitivity, or contraindication to prednisone (prednisolone or equivalent dose)

AND

5 - The requested medication is dosed per FDA (Food and Drug Administration)-label based on patient weight [up to a maximum daily dosage of 300 mg (milligrams) for patients weighing more than 50 kg (kilogram)]

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

Approval Criteria

1 - Patient is 2 years of age or older

AND

2 - Diagnosis of DMD (Duchenne Muscular Dystrophy) confirmed by genetic analysis (e.g., dystrophin deletion, duplication mutation) or muscle biopsy documenting absent dystrophin

AND

3 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

AND

4 - The requested medication is dosed per FDA (Food and Drug Administration)-label based on patient weight [up to a maximum daily dosage of 300 mg (milligrams) for patients weighing more than 50 kg (kilogram)]

AND

5 - Documentation of positive clinical response to therapy

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

Approval Criteria

1 - The patient is 6 years of age or older

AND

2 - The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy) confirmed by genetic analysis (e.g., dystrophin deletion, duplication mutation) or muscle biopsy documenting absent dystrophin

AND

3 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

AND

4 - The requested medication will be used in combination with a corticosteroid (i.e., prednisone) unless contraindicated or not tolerated

AND

5 - Platelets are greater than or equal to 150 x 10^9/liter prior to initiation

AND

6 - The requested medication will be dosed per FDA (Food and Drug Administration)-label based on patient body weight [maximum dose of 53.2 mg (milligrams) twice daily]

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

Approval Criteria

1 - The patient is 6 years of age or older

AND

2 - The patient has a diagnosis of DMD (Duchenne Muscular Dystrophy) confirmed by genetic analysis (e.g., dystrophin deletion, duplication mutation) or muscle biopsy documenting absent dystrophin

AND

3 - The requested medication is prescribed by, or in consultation with, a neurologist who has experience treating children

AND

4 - The requested medication will be used in combination with a corticosteroid (i.e., prednisone) unless contraindicated or not tolerated

AND

5 - The requested medication will be dosed per FDA (Food and Drug Administration)-label based on patient body weight [maximum dose of 53.2 mg (milligrams) twice daily]

AND

6 - Patient has NOT experienced any treatment-restricting adverse effects (e.g., hematological changes such as thrombocytopenia or other signs of myelosuppression, hypertriglyceridemia, severe-gastrointestinal disturbances, and/or QTc prolongation)

AND

7 - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
1/21/2026	Updated GPIs. Added Kymbee

Egrifta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-438202
Guideline Name	Egrifta
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Egrifta SV, Egrfita WR	
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
11/5/2025	Added Egrifta WR. Added NV formulary.

Ekterly

Prior Authorization Guideline

Guideline ID	GL-461195
Guideline Name	Ekterly
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of hereditary angioedema (HAE) as 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 variant(s) in the gene(s) for factor XII, angiopoietin-1, plasminogen-1, kininogen-1, myoferlin, or heparan sulfate-glucosamine 3-O-sulfotransferase 6
- Recurring angioedema attacks that are refractory to high-dose antihistamines with confirmed family history of angioedema
- Recurring angioedema attacks that are refractory to high-dose antihistamines with unknown background de-novo mutation(s) (i.e., no family history) (HAE-unknown)

AND

2 - Prescribed for the acute treatment of HAE attacks

AND

3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr, icatibant, Kalbitor, Ruconest, Sajazir)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

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

Approval Criteria

1 - Documentation of positive clinical response to Ekterly therapy

AND

2 - Prescribed for the acute treatment of HAE (hereditary angioedema) attacks

AND

3 - Not used in combination with other products indicated for the acute treatment of HAE attacks (e.g., Berinert, Firazyr, icatibant, Kalbitor, Ruconest, Sajazir)

AND

4 - Prescribed by ONE of the following:

- Immunologist
- Allergist

2 . Revision History

Date	Notes
12/8/2025	No changes to criteria. Inactivated GL-439202 for 1/1/26, due to formulary changes. Removed VA and MI. Added IN. GL-461195 for 1/1/26 with correct formularies.

Elfabrio

Prior Authorization Guideline

Guideline ID	GL-422498
Guideline Name	Elfabrio
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is 18 years of age or older

AND

2 - The patient has a documented diagnosis of Fabry disease (α -galactosidase A [α-Gal A] deficiency) with biochemical/genetic confirmation by one of the following:

- α-Gal-A activity in plasma, isolated leukocytes, and/or cultured cells (males only)
- Detection of pathogenic mutations in the galactosidase alpha (GLA) gene by molecular genetic testing

AND

3 - Prescribed by or in consultation with a neurologist, geneticist, or other specialist with advanced knowledge in treating Fabry disease

AND

4 - The patient must have a baseline value for plasma GL-3 and/or GL-3 inclusions, plasma or urinary globotriaosylceramide (Gb3/GL-3); or plasma globotriaosylsphingosine (lyso- Gb3)

AND

5 - Patient must not be taking migalastat (Galafold) or agalsidase beta (Fabrazyme) during pegunigalsidase alfa-iwxj (Elfabrio) therapy

AND

6 - Medication is dosed per FDA labeling of 1 mg/kg (based on actual body weight) administered by IV infusion every two weeks

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

Approval Criteria

1 - The patient continues to meet the initial authorization criteria

AND

2 - Patient must have experienced a disease response with treatment as defined by a reduction or stabilization in greater than or equal to 1 of the following, as compared to pre-treatment baseline:

- plasma GL-3 and/or GL-3 inclusions
- plasma or urinary Gb3/GL-3
- plasma lyso-Gb3

AND

3 - The patient must have experienced a disease response with treatment as defined by an improvement or stabilization in the rate of decline of the eGFR

AND

4 - The patient has not experienced unacceptable toxicity from the drug (e.g., anaphylaxis and severe hypersensitivity reactions, severe infusion-associated reactions, glomerulonephritis).

2 . Revision History

Date	Notes
10/21/2025	1/1/2026 Implementation

Elmiron

Prior Authorization Guideline

Guideline ID	GL-435262
Guideline Name	Elmiron
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Elmiron	
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
11/4/2025	Combined formularies - added NV, VA, NE, NM, PA CAID. No clinical changes.

Empaveli

Prior Authorization Guideline

Guideline ID	GL-443192
Guideline Name	Empaveli
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA)

Guideline Note:

Effective Date:	1/1/2026

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 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by BOTH of the following:

1.1 Flow cytometry analysis confirming presence of PNH clones

AND

1.2 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

2 - ONE of the following:

2.1 Patient will not be prescribed Empaveli in combination with another complement inhibitor used for the treatment of PNH (e.g., Bkemv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)

OR

2.2 Patient is currently receiving another complement inhibitor (e.g., Bkemv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris) which will be discontinued and Empaveli will be initiated in accordance with the United States Food and Drug Administration approved labeling

AND

3 - 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 - Documentation of positive clinical response to Empaveli therapy [e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH (lactate dehydrogenase), increased reticulocyte count, etc.]

AND

2 - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of paroxysmal nocturnal hemoglobinuria (PNH) (e.g., Bkemv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)

AND

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

- Hematologist
- Oncologist

Product Name:Empaveli	
Diagnosis	C3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)
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 immune complex/monoclonal immunoglobulin-mediated Membranoproliferative glomerulonephritis (IC-MPGN)

AND

1.1.2 Confirmation of diagnosis is based on immunofluorescence microscopy on kidney biopsy

AND

1.1.3 All of the following secondary causes of IC-MPGN have been ruled out:

- Infections (e.g., Hepatitis B and hepatitis C virus, chronic bacterial infections, parasitic infections)
- Autoimmune diseases [e.g., systemic lupus erythematosus (SLE), Sjogren's syndrome, rheumatoid arthritis, systemic sclerosis]
- Monoclonal gammopathy

AND

1.1.4 Patient has NOT had a kidney transplant

OR

1.2 All of the following:

1.2.1 Diagnosis of complement 3 glomerulopathy (C3G)

AND

1.2.2 Confirmation of diagnosis is based on immunofluorescence microscopy on kidney biopsy

AND

1.2.3 One of the following:

1.2.3.1 Serum complement 3 (C3) protein less than 77 milligrams per deciliter (alternatively, less than 0.85 x lower limit of the central laboratory normal range)

OR

1.2.3.2 Other complement abnormalities are present [e.g., soluble membrane attack complex (sC5b-9), serum factor H, serum factor B, factor I, membrane cofactor protein (MCP, CD46), C3/C4/C5 nephritic factor (NeF)] which are suggestive of a C3 glomerulopathy

AND

1.2.4 Presence of monoclonal gammopathy of undetermined significance (MGUS) has been excluded by measurement of serum free light chains or other investigative means based on standards of care

AND

2 - Glomerulonephritis has persisted ≥ 3 months in duration

AND

3 - Disease is considered to be moderate to severe based on proteinuria greater than or equal to 1.5 grams per day and/or abnormal kidney function

AND

4 - Used to reduce proteinuria

AND

5 - One of the following:

- Failure to a glucocorticoid (e.g., methylprednisolone, prednisone) as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to a glucocorticoid (e.g., methylprednisolone, prednisone) (please specify contraindication or intolerance)

AND

6 - One of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with one of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

6.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication or intolerance)

AND

7 - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of C3G or IC-MPGN (e.g., Bkemv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)

AND

8 - Prescribed by or in consultation with a nephrologist

Product Name:Empaveli	
Diagnosis	C3 Glomerulopathy (C3G) or Primary Immune-Complex Membranoproliferative Glomerulonephritis (IC-MPGN)

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

Approval Criteria

1 - Documentation of positive clinical response to Empaveli therapy demonstrated by a reduction in proteinuria

AND

2 - Patient is not receiving Empaveli in combination with another complement inhibitor used for the treatment of C3G or IC-MPGN (e.g., Bkemv, Epysqli, Fabhalta, PiaSky, Soliris, Ultomiris)

AND

3 - Prescribed by, or in consultation with, a nephrologist

2 . Revision History

Date	Notes
11/6/2025	Added Epysqli to examples of other complement inhibitors. Added cri teria for new FDA-approved indications C3G and IC-MPGN. Added N V formulary.

Entresto (sacubitril-valsartan)

Prior Authorization Guideline

Guideline ID	GL-422540
Guideline Name	Entresto (sacubitril-valsartan)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Entresto, generic sacubitril/valsartan	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of chronic heart failure New York Heart Association (NYHA) Class II to IV

AND

2 - The patient has reduced LVEF (left ventricular ejection fraction)

AND

3 - The patient is one year of age or older

AND

4 - The prescriber is a cardiologist or there is documentation that a cardiologist has been consulted

AND

5 - The patient has had a trial of an angiotensin converting enzyme (ACE) or an angiotensin receptor blocker (ARB) for at least four weeks prior to the initiation of therapy

AND

6 - The patient will NOT concurrently receive an ACE inhibitor

AND

7 - The patient is on an individualized dose of a beta blocker, or the patient has a contraindication to beta blocker use

AND

8 - The requested dose will not exceed 97/103 mg twice daily

AND

9 - If the request is for sprinkle capsules, there is documentation of a clinical reason why the patient cannot safely take tablets (e.g., difficulty swallowing) (please document reasoning)

2 . Revision History

Date	Notes
10/22/2025	New guideline

Esbriet, Ofev

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439204
Guideline Name	Esbriet, Ofev
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Esbriet, generic pirfenidone, Ofev	
Diagnosis	Idiopathic Pulmonary Fibrosis
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:

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 an ICD-10 Code of J84.112 (idiopathic pulmonary fibrosis)

AND

1.2 ONE of the following:

1.2.1 If the patient was 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 If the patient was subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern reveal IPF or probable IPF

AND

2 - ONE of the following:

2.1 If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev

OR

2.2 If the request is for Ofev, it is not being used in combination with Esbriet (pirfenidone)

AND

3 - The prescriber is a pulmonologist

Product Name:Brand Esbriet, generic pirfenidone, Ofev	
Diagnosis	Idiopathic Pulmonary Fibrosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

AND

2 - ONE of the following:

2.1 If the request is for Esbriet (pirfenidone), it is not being used in combination with Ofev

OR

2.2 If the request is for Ofev, it is not being used in combination with Esbriet (pirfenidone)

Product Name:Ofev	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of 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 At least 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 (ribonucleic acid) 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% of the lungs

AND

2 - Ofev is not being used in combination with Esbriet (pirfenidone)

AND

3 - The prescriber is a pulmonologist

Product Name:Ofev	
Diagnosis	Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic fibrosing interstitial lung disease (ILD) with a progressive phenotype as documented by BOTH of the following:

1.1 Presence of fibrotic ILD as determined by finding evidence of pulmonary fibrosis on HRCT (high-resolution computed tomography), involving at least 10% of the lungs

AND

1.2 Patient is presenting with clinical signs of progression as defined by ONE of the following in the previous 24 months:

1.2.1 Forced vital capacity (FVC) decline of greater than 10%

OR

1.2.2 TWO of the following:

- FVC decline of greater than or equal to 5%, but less than 10%
- Patient is experiencing worsening respiratory symptoms
- Patient is exhibiting increasing extent of fibrotic changes on chest imaging

AND

2 - Ofev is not being used in combination with Esbriet (pirfenidone)

AND

3 - The prescriber is a pulmonologist

Product Name:Ofev	
Diagnosis	Systemic Sclerosis-Associated Interstitial Lung Disease, Chronic Fibrosing Interstitial Lung Disease with a Progressive Phenotype
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Ofev therapy

AND

2 - Ofev is not being used in combination with Esbriet (pirfenidone)

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Evkeeza (evinacumab-dgnb)

Prior Authorization Guideline

Guideline ID	GL-422545
Guideline Name	Evkeeza (evinacumab-dgnb)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Evkeeza	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is at least 5 years of age

AND

2 - Prescribed by or in consultation with a specialist in cardiology, lipidology, or endocrinology

AND

3 - The patient has a confirmed diagnosis of homozygous familial hypercholesterolemia (HoFH) by ONE of the following:

3.1 Documented DNA test for functional mutation(s) in low density lipoprotein (LDL) receptor alleles or alleles known to affect LDL receptor functionality

OR

3.2 ALL of the following:

- Untreated LDL cholesterol (LDL-C) levels greater than 500 mg/dL or treated LDL-C greater than or equal to 300 mg/dL
- Cutaneous or tendon xanthoma before 10 years of age
- Untreated LDL-C levels in both parents consistent with heterozygous familial hypercholesterolemia (HeFH)

AND

4 - The patient does not have HeFH

AND

5 - Submission of baseline LDL-C, total cholesterol (TC), apolipoprotein B (apo B), and non-high density lipoprotein cholesterol (non-HDL-C) labs prior to initiating treatment

AND

6 - The patient has been receiving stable background lipid lowering therapy for greater than or equal to 4 weeks

AND

7 - Therapy will be used in conjunction with diet and other LDL-lowering therapies (e.g., statins, ezetimibe, PCSK9 inhibitors, lomitapide, LDL apheresis)

AND

8 - The patient has tried and failed at least a three-month trial of adherent therapy with ezetimibe used in combination with the highest available or maximally tolerated dose of atorvastatin or rosuvastatin, unless contraindication to statin or ezetimibe

AND

9 - The patient has tried and failed at least a three-month trial of adherent therapy with combination therapy consisting of the highest available or maximally tolerated dose of atorvastatin or rosuvastatin, ezetimibe, and a PCSK9 inhibitor indicated for HoFH (i.e., evolocumab), unless contraindicated

AND

10 - Despite pharmacological treatment with a PCSK9 inhibitor, statin, and ezetimibe, the patient's LDL-C is greater than or equal to 100 mg/dL or greater than or equal to 70 mg/dL for recipients with clinical atherosclerotic cardiovascular disease

AND

11 - If the patient is female, must have a negative pregnancy test and have been counseled to use effective contraception during treatment

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

Approval Criteria

1 - Prescribed by or in consultation with a specialist in cardiology, lipidology, or endocrinology

AND

2 - The patient has had a documented reduction in LDL-C when compared to the initial baseline labs

AND

3 - The patient continues to adhere to diet and background lipid lowering therapy (e.g., statin, ezetimibe, PCSK9 inhibitor)

2 . Revision History

Date	Notes
10/22/2025	1/1/2026 Implementation

Fabhalta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439205
Guideline Name	Fabhalta
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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 - Submission of medical records (e.g., chart notes, laboratory values, etc.) documenting the diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) as confirmed by BOTH of the following:

1.1 Flow cytometry analysis confirming presence of PNH clones

AND

1.2 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

2 - ONE of the following:

2.1 Patient will not be prescribed Fabhalta in combination with another complement inhibitor used for the treatment of PNH (e.g., Empaveli, PiaSky, eculizumab, Ultomiris)

OR

2.2 Patient is currently receiving another complement inhibitor (e.g., Empaveli, PiaSky, eculizumab, Ultomiris) which will be discontinued and Fabhalta will be initiated in accordance with the United States Food and Drug Administration approved labeling

AND

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

- 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 - Documentation of positive clinical response to Fabhalta therapy (e.g., increased or stabilization of hemoglobin levels, reduction in transfusions, improvement in hemolysis, decrease in LDH, increased reticulocyte count, etc.)

AND

2 - Patient is not receiving Fabhalta in combination with another complement inhibitor used for the treatment of PNH (e.g., Empaveli, PiaSky, eculizumab, Ultomiris)

AND

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

- Hematologist
- Oncologist

Product Name:Fabhalta	
Diagnosis	Primary 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) confirmed by renal 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 30 mL/min/1.73 m2

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

AND

6 - ONE of the following:

6.1 Patient is on a stabilized dose and receiving concomitant therapy with a maximally

tolerated sodium-glucose cotransporter-2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin)] as confirmed by claims history or submission of medical records

OR

6.2 Patient has an allergy, contraindication, or intolerance to SGLT2 inhibitors (please specify allergy, contraindication, or intolerance)

AND

7 - ONE of the following:

7.1 Failure to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) as confirmed by claims history or submission of medical records

OR

7.2 History of intolerance or contraindication to a glucocorticoid (please specify intolerance or contraindication)

AND

8 - Prescribed by or in consultation with a nephrologist

Product Name:Fabhalta	
Diagnosis	Complement 3 glomerulopathy (C3G)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of complement 3 glomerulopathy (C3G) confirmed by all of the following:

1.1 Documentation of a kidney biopsy demonstrating characteristic findings of C3G

AND

1.2 Glomerulonephritis has persisted at least 3 months in duration

AND

1.3 ONE of the following:

- Serum complement 3 (C3) protein less than 77 mg/dL (alternatively, less than 0.85 x lower limit of the central laboratory normal range)
- Other complement abnormalities are present [e.g., soluble membrane attack complex (sC5b-9), serum factor H, serum factor B, factor I, membrane cofactor protein (MCP, CD46), C3/C4/C5 nephritic factor (NeF)] which are suggestive of a C3 glomerulopathy

AND

1.4 Presence of monoclonal gammopathy of undetermined significance (MGUS) has been excluded by measurement of serum free light chains or other investigative means based on standards of care

AND

2 - Disease is considered to be moderate to severe based on proteinuria greater than or equal to 1.5 g/day and/or abnormal kidney function

AND

3 - Used to reduce proteinuria

AND

4 - ONE of the following:

- Failure to a glucocorticoid (e.g., methylprednisolone, prednisone) as confirmed by claims history or submission of medical records

- History of intolerance or contraindication to a glucocorticoid (please specify intolerance or contraindication)

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

AND

6 - Patient has NOT undergone a solid-organ or cell transplant, including kidney transplant

AND

7 - Prescribed by or in consultation with a nephrologist

Product Name:Fabhalta	
Diagnosis	Primary immunoglobulin A nephropathy (IgAN), Complement 3 glomerulopathy (C3G)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Documentation of positive clinical response to Fabhalta therapy demonstrated by a reduction in proteinuria

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Filsuvez (birch triterpenes)

Prior Authorization Guideline

Guideline ID	GL-391201
Guideline Name	Filsuvez (birch triterpenes)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Filsuvez	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is greater than or equal to 6 months old

AND

2 - Diagnosis of dystrophic epidermolysis bullosa (DEB) or junctional epidermolysis bullosa (JEB) confirmed by genetic testing

AND

3 - Presence of open partial-thickness wounds associated with DEB or JEB for greater than or equal to 21 days

AND

4 - The requested medication will be applied every one to four days with dressing changes

AND

5 - The patient does not have current evidence or history of squamous cell carcinoma (SCC) in the area that will undergo treatment

AND

6 - The patient does not have active infection in the area that will undergo treatment

AND

7 - Will not be used concurrently with Vyjuvek

AND

8 - Prescribed by, or in consultation with, a dermatologist or geneticist

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

Approval Criteria

1 - The patient continues to meet initial authorization criteria

AND

2 - Documentation of positive response to therapy

Firdapse

Prior Authorization Guideline

Guideline ID	GL-500236
Guideline Name	Firdapse
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Firdapse	
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 - Diagnosis confirmed by ONE of the following:

2.1 Increased compound muscle action potential (CMAP) amplitude after exercise or with high-frequency repetitive nerve stimulation (RNS)

OR

2.2 A high titer P/Q-type voltage-gated calcium channels (VGCC) antibody

AND

3 - Prescribed by or in consultation with a specialist in the treatment of LEMS (e.g., neurologist or oncologist)

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

Approval Criteria

1 - Documentation of positive clinical response to Firdapse therapy (e.g., improved muscle strength, improved mobility)

2 . Revision History

Date	Notes
1/20/2026	Removed IN and PACAID. Updated initial authorization to include co nfirmation of diagnosis. Removed requirement for no concomitant us e with similar potassium channel blockers. Added examples of positiv e clinical response under reauth criteria.

Functional Gastrointestinal Disorder Agents

Prior Authorization Guideline

Guideline ID	GL-397228
Guideline Name	Functional Gastrointestinal Disorder Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Linzess	
Diagnosis	Chronic idiopathic constipation (CIC), Function Constipation (FC)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of one of the following:

- Chronic idiopathic constipation (CIC)
- Function Constipation (FC) in pediatric recipients

AND

2 - The requested medication must be FDA (Food and Drug Administration)-approved for the patient's age

AND

3 - The patient has trial and failure, contraindication or intolerance to either lactulose or polyethylene glycol (Miralax)

AND

4 - The patient has trial and failure, contraindication or intolerance to at least one stimulant laxative, such as sennosides (Ex-Lax, Senokot), bisacodyl (Dulcolax) or cascara sagrada

AND

5 - The requested dose does not exceed the following:

5.1 For CIC: 145 mcg (micrograms), once daily

OR

5.2 For FC: 72 mcg, once daily

Product Name:Brand Amitiza, generic lubiprostone, Brand Motegrity, generic prucalopride, Trulance	
Diagnosis	Chronic idiopathic constipation (CIC)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of chronic idiopathic constipation (CIC)

AND

2 - The requested medication must be FDA (Food and Drug Administration)-approved for the patient's age

AND

3 - The patient has trial and failure, contraindication or intolerance to either lactulose or polyethylene glycol (Miralax)

AND

4 - The patient has trial and failure, contraindication or intolerance to at least one stimulant laxative, such as sennosides (Ex-Lax, Senokot), bisacodyl (Dulcolax) or cascara sagrada

AND

5 - The requested dose does not exceed the following:

5.1 For Amitiza (lubiprostone): 24 mcg (micrograms), twice daily

OR

5.2 For Motegrity (prucalopride): 2 mg (milligrams), once daily

OR

5.3 For Trulance: 2 mg once daily

AND

6 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Ibsrela, Linzess, Brand Amitiza, generic lubiprostone, Trulance	
Diagnosis	Irritable Bowel Syndrome with constipation
Approval Length	Approval Duration is to be determined based on the requested medication and diagnosis, not to exceed one year
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Irritable Bowel Syndrome with Constipation (IBS-C)

AND

2 - The patient is 18 years of age or older

AND

3 - The requested dose is appropriate based on FDA (Food and Drug Administration) approved indication and age

AND

4 - If the request is for Amitiza, the patient is female

AND

5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Brand Lotronex, generic alosetron, Viberzi

Diagnosis	Irritable Bowel Syndrome with diarrhea
Approval Length	Approval Duration is to be determined based on the requested medication and diagnosis, not to exceed one year
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Irritable Bowel Syndrome with Diarrhea (IBS-D)

AND

2 - The patient is 18 years of age or older

AND

3 - The requested dose is appropriate based on FDA (Food and Drug Administration) approved indication and age

AND

4 - The requested medication is being prescribed by or in consultation with a gastroenterologist

AND

5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Linzess, Brand Amitiza, generic lubiprostone, Ibsrela, Motegrity, generic prucalopride, Movantik, Relistor, Symproic, Trulance	
Diagnosis	Opioid-Induced Constipation
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Opioid-Induced Constipation

AND

2 - The patient is 18 years of age or older

AND

3 - The requested medication is being used for an FDA (Food and Drug Administration) approved indication

AND

4 - Documentation of an inadequate response, adverse reaction, or contraindication to one agent from three of the following four traditional laxative drug classes:

- Bulk forming laxatives
- Osmotic laxatives
- Saline laxatives
- Stimulant laxatives

AND

5 - If the request is for Relistor injection, all of the following:

5.1 The dose does not exceed 0.15 mg/kg (milligrams per kilogram)

AND

5.2 The patient's current weight is greater than 114 kg

AND

5.3 The patient is not enrolled in The Division of Health Care Financing and Policy's (DHCFP's) hospice program

AND

6 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

2 . Revision History

Date	Notes
10/1/2025	New guideline

Furoscix

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439207
Guideline Name	Furoscix
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Furoscix	
Approval Length	1 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Chronic heart failure
- Chronic kidney disease (CKD)

AND

2 - Submission of medical records confirming that the patient is established on background loop diuretic therapy (e.g., bumetanide, furosemide, torsemide) for the treatment of edema

AND

3 - BOTH of the following:

- Patient does NOT require ongoing emergency care or hospitalization
- Patient is currently a candidate for parenteral diuresis outside of the hospital

AND

4 - Furoscix is prescribed by or in consultation with ONE of the following:

- Cardiologist
- Nephrologist

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Galafold

Prior Authorization Guideline

Guideline ID	GL-435261
Guideline Name	Galafold
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA)

Guideline Note:

Effective Date:	1/1/2026

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) or Elfabrio (pegunigalsidase alfa-iwxj)

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) or Elfabrio (pegunigalsidase alfa-iwxj)

2 . Revision History

Date	Notes
11/4/2025	Combined formularies - added NV, VA, NE, NM, PA CAID. No clinical changes.

Gattex

Prior Authorization Guideline

Guideline ID	GL-439208
Guideline Name	Gattex
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Gattex	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Short Bowel Syndrome (SBS)

AND

2 - Dependent on parenteral support

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

Approval Criteria

1 - Documentation of positive clinical response to Gattex therapy

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Gimoti (metoclopramide)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-413210
Guideline Name	Gimoti (metoclopramide)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Gimoti	
Approval Length	2 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of acute diabetic gastroparesis

AND

2 - Patient is 18 years of age or older

AND

3 - Patient does not have any of the following:

- History of signs or symptoms of tardive dyskinesia (TD)
- History of a dystonic reaction to metoclopramide
- Known or suspected circumstances where stimulation of gastrointestinal (GI) motility could be dangerous (e.g., GI hemorrhage, mechanical obstruction, or perforation)
- Known or suspected pheochromocytoma or other catecholamine-releasing paraganglioma
- Diagnosis of epilepsy or any other seizure disorder
- Hypersensitivity to metoclopramide (e.g., angioedema, bronchospasm)
- Moderate or severe renal impairment (CrCL < 60 mL/minute)
- Moderate or severe hepatic impairment (Child-Pugh B or C)

AND

4 - ONE of the following:

- The patient has had an adequate (e.g., 2-4 week) trial and failure of oral (e.g., tablet, solution, orally disintegrating tablet) or injectable (e.g., IM) metoclopramide
- The patient is not a candidate for oral metoclopramide (e.g., demonstrated or documented erratic absorption of oral medications)

Product Name:Gimoti	
Approval Length	2 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient meets initial authorization criteria

AND

2 - At least two weeks have passed (i.e., drug holiday) since completion of a previous course or metoclopramide treatment of any dosage form

AND

3 - Patient demonstrated improvement in signs and symptoms of diabetic gastroparesis (e.g., nausea, vomiting, early satiety, postprandial fullness, bloating, upper abdominal pain)

AND

4 - Prescriber attests that the patient is being monitored for extrapyramidal symptoms (e.g., tardive dyskinesia, dystonia) or other serious adverse events (e.g., suicidal ideation, fluid retention)

2 . Revision History

Date	Notes
10/7/2025	New program

GnRH Analogs

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-422483
Guideline Name	GnRH Analogs
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Eligard, Vabrinty, Fensolvi, Synarel, Triptodur, Camcevi, Trelstar, Supprelin LA	
Diagnosis	Central precocious puberty (CPP)
Approval Length	12 months, or until the member reaches the age of 11 years if female or 12 years if male
Guideline Type	Prior Authorization
Approval Criteria **1** - The patient has a diagnosis of idiopathic or neurogenic central precocious puberty (CPP)	

AND

2 - The medication is being prescribed by, or in consultation with, a pediatric endocrinologist

AND

3 - There is an onset of secondary sex characteristics before age eight years for females or before nine years for males

AND

4 - The patient is currently less 11 years of age if female, or less than 12 years of age if male

AND

5 - The requested dose and frequency are based on FDA (Food and Drug Administration)-approved guidelines

AND

6 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Eligard, Vabrinty, Fensolvi, Synarel, Triptodur, Camcevi, Trelstar, Supprelin LA	
Diagnosis	Gender Dysphoria, formerly known as gender identity disorder
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of gender dysphoria, formerly known as gender identity disorder

AND

2 - The patient is less than 18 years of age

AND

3 - The medication is being prescribed for suppression of puberty

AND

4 - The provider indicates a demonstrable knowledge what gonadotropins medically can and cannot do and their social benefits and risks

AND

5 - One of the following:

5.1 A documented real-life experience (living as the other gender) for at least three months prior to the administration of gonadotropin

OR

5.2 A period of psychotherapy for at least three months by a mental health professional after the initial evaluation

AND

6 - The patient meets all of the following to define gender dysphoria:

- A strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex)

- Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex
- The disturbance is not concurrent with a physical intersex condition
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning
- The transsexual identity has been present persistently for at least two years
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality

AND

7 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Eligard, Vabrinty, Fensolvi, Synarel, Triptodur, Camcevi, Trelstar, Supprelin LA	
Diagnosis	Endometriosis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Endometriosis

AND

2 - The patient has had an inadequate response, adverse reaction, or contraindication to an NSAID (non-steroidal anti-inflammatory drug)

AND

3 - The patient has had an inadequate response, adverse reaction, or contraindication to a hormonal contraceptive

AND

4 - The requested dose and frequency are based on FDA (Food and Drug Administration)-approved guidelines

AND

5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Eligard, Vabrinty, Fensolvi, Synarel, Triptodur, Camcevi, Trelstar, Supprelin LA	
Diagnosis	Uterine leiomyomata (fibroids)
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of uterine leiomyomata (fibroids)

AND

2 - The patient is symptomatic

AND

3 - One of the following:

- Submission of medical records (e.g., chart notes) confirming the anticipated surgery date (or notation that surgery is planned once the fibroids shrink)

- Clinical rational why surgical intervention is not required (Please document reasoning)

AND

4 - The requested dose and frequency are based on FDA (Food and Drug Administration)-approved guidelines

AND

5 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Lupron Depot, Lupron Depot-Ped, leuprolide acetate inj kit 5 mg/mL, Eligard, Vabrinty, Fensolvi, Synarel, Triptodur, Camcevi, Trelstar, Supprelin LA	
Diagnosis	Prostate Cancer
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of prostate cancer

AND

2 - The requested dose and frequency are based on FDA (Food and Drug Administration)-approved guidelines

AND

3 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
10/29/2025	New guideline

Gonadotropin Releasing Hormone Receptor (GnRH) Antagonist and Combinations

Prior Authorization Guideline

Guideline ID	GL-421254
Guideline Name	Gonadotropin Releasing Hormone Receptor (GnRH) Antagonist and Combinations
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Orilissa 200mg	
Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe pain associated with endometriosis

AND

2 - ONE of the following:

2.1 History of inadequate pain control response following a minimum 3-month trial, or intolerance or contraindication, with ONE of the following:

- Danazol
- Combination (estrogen/progesterone) oral contraceptive
- Progestins

OR

2.2 The patient had surgical ablation to prevent occurrence

AND

3 - Treatment has not exceeded 6 months

Product Name:Orilissa 150mg, Myfembree	
Diagnosis	Endometriosis
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 - ONE of the following:

2.1 History of inadequate pain control response following a minimum 3-month trial, or intolerance or contraindication, with ONE of the following:

- Danazol
- Combination (estrogen/progesterone) oral contraceptive

- Progestins

OR

2.2 The patient had surgical ablation to prevent occurrence

Product Name:Orilissa 150mg, Myfembree	
Diagnosis	Endometriosis
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documented improvement in pain associated with endometriosis (improvement in dysmenorrhea and non-menstrual pelvic pain)

AND

2 - Treatment duration will not exceed a total of 24 months

Product Name:Oriahnn, Myfembree	
Diagnosis	Uterine leiomyomas (fibroids)
Approval Length	6 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 - ONE of the following:

2.1 History of inadequate pain control response following a minimum 3-month trial, or intolerance or contraindication, with ONE of the following:

- Danazol
- Combination (estrogen/progesterone) oral contraceptive
- Progestins

OR

2.2 The patient had surgical ablation to prevent occurrence

Product Name:Oriahnn, Myfembree	
Diagnosis	Uterine leiomyomas (fibroids)
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documented improvement in menstrual bleeding

AND

2 - Treatment duration will not exceed a total of 24 months

2 . Revision History

Date	Notes

10/14/2025	New program

Growth Hormones

Prior Authorization Guideline

Guideline ID	GL-461205
Guideline Name	Growth Hormones
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Genotropin, Genotropin Miniquick, Norditropin FlexPro, Nutropin AQ, Humatrope, Ngenla, Omnitrope, Sogroya, Zomacton	
Diagnosis	Patients less than 18 years of age
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - The request is for a patient with open epiphyses and with remaining growth potential	

AND

2 - The patient has had an evaluation by a pediatric endocrinologist or pediatric nephrologist with a recommendation for growth hormone therapy

AND

3 - The patient has had an evaluation ruling out all other causes for short stature

AND

4 - The patient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids, or gonadotropic hormones

AND

5 - One of the following:

5.1 The patient has a diagnosis of Noonan Syndrome and both of the following:

- Patient's height is at least two standard deviations below the mean or below the fifth percentile for the patient's age and gender
- Bone age is less 16 years for male patients or less than 14 years for female patients

OR

5.2 Patient has a diagnosis of Turner Syndrome and one of the following:

5.2.1 Patient is female and has a bone age of less than 14 years

OR

5.2.2 Patient is male and both of the following:

- Patient's height is at least two standard deviations below the mean or below the fifth percentile for the patient's age and gender

- Bone age is less than 16 years

OR

5.3 Patient has a diagnosis of Prader-Willi Syndrome

OR

5.4 The patient has a diagnosis of chronic renal insufficiency [less than 75 mL/min (milliliters/minute)], and their height is at least two standard deviations below the mean or below the third percentile for the patient's age and gender

OR

5.5 All of the following:

- The patient has a diagnosis of being small for gestational age
- The patient is two years of age or older
- The height is at least two standard deviations below the mean or below the third percentile for the patient's age and gender

OR

5.6 The patient is a newborn infant with evidence of hypoglycemia, and has low growth hormone level [less than 20 ng/mL (nanograms/milliliter)], low for age insulin like growth factor (IGF)-1 or IGF binding protein (BP) 3

OR

5.7 The patient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease (e.g., hypopituitarism due to structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation) and all of the following:

5.7.1 Height is at least two standard deviations below the mean or below the third percentile for the patient's age and gender

AND

5.7.2 Bone age is less than 16 years for male or less than 14 years for female

AND

5.7.3 One of the following:

- The patient has failed two growth hormone stimulation tests (less than 10 ng/mL)
- The patient has failed one growth hormone stimulation test (less than 10 ng/mL) and one IGF-1 or IGFBP-3 test
- The patient has failed one growth hormone stimulation test (less than 10 ng/mL) or IGF-1 or IGFBP-3 test and they have deficiencies in three or more pituitary axes [e.g., thyroid stimulating hormone (TSH), luteinizing hormone (LH), follicle stimulating hormone (FSH), adrenocorticotropic hormone (ACTH) or antidiuretic hormone (ADH)]

AND

6 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Genotropin, Genotropin Miniquick, Norditropin FlexPro, Nutropin AQ, Humatrope, Ngenla, Omnitrope, Sogroya, Zomacton	
Diagnosis	Patients greater than or equal to 18 years of age
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The request is for a patient with closed epiphyses and no remaining growth potential

AND

2 - The patient is being evaluated by an endocrinologist

AND

3 - The patient is receiving adequate replacement therapy for any other pituitary hormone deficiencies, such as thyroid, glucocorticoids, or gonadotropic hormones

AND

4 - The patient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease (e.g., hypopituitarism due to structure lesions/trauma to the pituitary including pituitary tumor, pituitary surgical damage, trauma, or cranial irradiation)

AND

5 - One of the following:

5.1 The patient has failed two growth hormone stimulation tests [less than 5 ng/mL (nanograms/mL)]

OR

5.2 The patient has failed one growth hormone stimulation test (less than 5 ng/mL) and one insulin like growth factor (IGF)-1 or IGF binding protein (BP) 3 test

OR

5.3 The patient has failed one growth hormone stimulation test (less than 5 ng/mL) or IGFBP-3 test and has deficiencies in three or more pituitary axes [i.e., thyroid stimulating hormone (TSH), luteinizing hormone (LH), follicle stimulating hormone (FSH), adrenocorticotropic hormone (ACTH) or antidiuretic hormone (ADH)] and has severe clinical manifestations of growth hormone deficiency as evident by alterations in body composition (e.g., decreased lean body mass, increased body fat), cardiovascular function (e.g., reduced cardiac output, lipid abnormalities) or bone mineral density

AND

6 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	
Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Genotropin, Genotropin Miniquick, Norditropin FlexPro, Nutropin AQ, Humatrope, Ngenla, Omnitrope, Sogroya, Zomacton	
Diagnosis	All above indications
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is less than 21 years of age, then all of the following:

1.1 The request is for a patient with open epiphyses and with remaining growth potential

AND

1.2 One of the following diagnoses:

- Chronic renal insufficiency
- Growth hormone deficiency
- Hypothalamic pituitary disease
- Newborn infant with evidence of hypoglycemia
- Noonan Syndrome
- Prader-Willi Syndrome
- Small for gestational age
- Turner Syndrome

AND

1.3 The patient’s growth rate on treatment is at least 2.5 cm/year (centimeters/year)

AND

1.4 The patient does NOT have evidence of an expanding lesion or tumor formation

AND

1.5 The patient has NOT undergone a renal transplant

OR

2 - Patient is greater than or equal to 21 years of age, then all of the following:

2.1 The request is for a patient with closed epiphyses and no remaining growth potential

AND

2.2 The patient has a diagnosis of growth hormone deficiency or hypothalamic pituitary disease

AND

2.3 There is documentation of improvement in clinical manifestations associated with growth hormone deficiency

Product Name:Serostim	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Human Immune Deficiency Virus (HIV) with wasting or cachexia

AND

2 - The requested medication is indicated to increase lean body mass, body weight and physical endurance

AND

3 - The patient is receiving and is compliant with antiretroviral therapy (ART)

AND

4 - The patient has experienced an involuntary weight loss of greater than 10% pre-illness baseline or they have a body mass index of less than 20 kilograms (kg)/meter(m)^2

AND

5 - The patient has experienced an adverse event, allergy, or inadequate response to megestrol acetate, or the patient has a contraindication to treatment with megestrol acetate

AND

6 - The patient has experienced an adverse event, allergy, or inadequate response to an anabolic steroid (e.g., testosterone, oxandrolone, nandrolone) or the patient has a contraindication to treatment with anabolic steroids

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

Approval Criteria

1 - The patient has a diagnosis of acromegaly

AND

2 - The patient is 18 years age or older

AND

3 - One of the following:

3.1 The patient has an inadequate response to one of the following:

- Surgery
- Radiation therapy
- Dopamine agonist (e.g. bromocriptine, cabergoline) therapy

OR

3.2 The patient is not a candidate for all the following

- Surgery
- Radiation therapy
- Dopamine agonist (e.g. bromocriptine, cabergoline) therapy

AND

4 - The patient has tried and failed, or has a contraindication or intolerance to, generic octreotide (a somatostatin analogue)

AND

5 - The requested medication is prescribed by, or in consultation with, an endocrinologist

Product Name:Somavert	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a documented positive clinical response to the requested therapy (e.g., biochemical control; decrease or normalization of IGF-1 levels)

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

Approval Criteria

1 - Patient is one year or age or older

AND

2 - Patient's weight is greater than 11.5 kg (kilograms)

AND

3 - Patient has growth failure secondary to growth hormone deficiency (GHD)

AND

4 - Patient has short stature as defined by height that is greater than or equal to 2 standard deviations below the mean for chronological age and one of the following:

4.1 Patient has hypothalamic-pituitary defects (e.g., major congenital malformation, tumor, or irradiation) and a deficiency of greater than or equal to 1 additional pituitary hormone

OR

4.2 Patient had an inadequate response to growth hormone (GH) provocation tests on two separate stimulation tests as defined as a serum peak GH concentration less than 10 ng/mL (nanograms per milliliter)

AND

5 - Other causes of growth failure must be ruled out (e.g., malnutrition, hypothyroidism, hypercortisolism)

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

Approval Criteria

1 - Patient continues to meet the initial authorization criteria

AND

2 - Patient has shown a beneficial response compared to pre-treatment baseline [with lonapegsomatropin-tcgd or somatropin (if used as switch maintenance)] as evidenced by one of the following:

- Improvement in height
- Improvement in growth velocity

2 . Revision History

Date	Notes

11/24/2025	Combined Genotropin, Genotropin Miniquick, Norditropin FlexPro, N utropin AQ, Humatrope, Ngenla, Omnitrope, Sogroya, Zomacton Rea uth to one box for all Initial Auth indications.

H1 Blockers - Non-Sedating

Prior Authorization Guideline

Guideline ID	GL-421257
Guideline Name	H1 Blockers - Non-Sedating
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Allegra OTC, generic fexofenadine Rx/OTC, fexofenadine D OTC, cetirizine D OTC, cetirizine oral soln 5mg/5mL OTC, Brand Clarinex, generic desloratadine, Clarinex-D, Claritin, Claritin D, Xyzal	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The patient has had a two-week trial of ONE preferred medication*	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
10/14/2025	1/1/2026 Implementation

Harliku

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-501246
Guideline Name	Harliku
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of alkaptonuria

AND

2 - Patient is 18 years of age or older

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) confirming ONE of the following:

- Urinary homogentisic acid (HGA) excretion greater than 0.4g per 24 hours
- Biallelic mutation in homogentisate 1,2-dioxygenase (HGD) gene confirmed by genetic testing

AND

4 - Harliku will not be used in combination with any of the following:

- Generic nitisinone
- Nityr
- Orfadin

AND

5 - Prescribed by or in consultation with a geneticist, metabolic disease specialist, or rheumatologist

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Harliku therapy (e.g., reduced urinary HGA levels, improvement in joint symptoms)

AND

2 - Harliku will not be used in combination with any of the following:

- Generic nitisinone
- Nityr
- Orfadin

AND

3 - Prescribed by or in consultation with a geneticist, metabolic disease specialist, or rheumatologist

2 . Revision History

Date	Notes
1/16/2026	New

HCG

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-509215
Guideline Name	HCG
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Novarel, Chorionic Gonadotropin, Ovidrel, Pregnyl	
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
1/26/2026	Combined formularies. Removed GPI for Novarel 10000 Unit (obsolete). No changes to clinical criteria.

Hematopoietic, Hematinic Agents

Prior Authorization Guideline

Guideline ID	GL-504222
Guideline Name	Hematopoietic, Hematinic Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Epogen, Procrit, Retacrit	
Approval Length	1 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has been evaluated for adequate iron stores

AND

2 - Serum hemoglobin (Hb) results within seven days of PA (prior authorization) request (please document date and value)

AND

3 - Patient will achieve and maintain hemoglobin levels in ONE of the following conditions:

- Treatment of anemia secondary to myelosuppressive anticancer chemotherapy: Hb levels should not exceed 10 g/dL
- Treatment of anemia related to zidovudine therapy in HIV-infected patients: Hb levels should not exceed 12 g/dL
- Treatment of anemia secondary to CKD (Dialysis patient): Hb levels should not exceed 11 g/dL
- Treatment of anemia secondary to CKD (Non-Dialysis patient): 10 g/dL for adults; 12 g/dL for pediatrics
- To reduce the need for allogenic transfusions in surgery recipients when a significant blood loss is anticipated and ESA being prescribed to achieve and maintain hemoglobin levels within the range of 10 to 13 g/dL
- Treatment of anemia secondary to myelodysplastic syndrome (MDS) : Hb levels should not exceed 12 g/dL
- Treatment of anemia secondary to myeloproliferative neoplasms (MPN): Hb levels should not exceed 10 g/dL

AND

4 - NOT used for the following:

- Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (AML, CML) or erythroid cancers
- Anemia of cancer not related to cancer treatment
- Any anemia associated only with radiotherapy
- Prophylactic use to prevent chemotherapy-induced anemia
- Prophylactic use to reduce tumor hypoxia
- Patients with erythropoietin-type resistance due to neutralizing antibodies
- Anemia due to cancer treatment if patients have uncontrolled hypertension

AND

5 - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

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

Approval Criteria

1 - The patient has been evaluated for adequate iron stores

AND

2 - Serum hemoglobin (Hb) results within seven days of PA (prior authorization) request (please document date and value)

AND

3 - Patient will achieve and maintain hemoglobin levels in ONE of the following conditions:

- Treatment of anemia secondary to myelosuppressive anticancer chemotherapy: Hb levels should not exceed 10 g/dL
- Treatment of anemia secondary to CKD (Dialysis patient): Hb levels should not exceed 11 g/dL
- Treatment of anemia secondary to CKD (Non-Dialysis patient): 10 g/dL for adults; 12 g/dL for pediatrics
- Treatment of anemia secondary to myelodysplastic syndrome (MDS) : Hb levels should not exceed 12 g/dL
- Treatment of anemia secondary to myeloproliferative neoplasms (MPN): Hb levels should not exceed 10 g/dL

AND

4 - NOT used for the following:

- Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis

- Anemia associated with the treatment of acute and chronic myelogenous leukemias (AML, CML) or erythroid cancers
- Anemia of cancer not related to cancer treatment
- Any anemia associated only with radiotherapy
- Prophylactic use to prevent chemotherapy-induced anemia
- Prophylactic use to reduce tumor hypoxia
- Patients with erythropoietin-type resistance due to neutralizing antibodies
- Anemia due to cancer treatment if patients have uncontrolled hypertension

AND

5 - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

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

Approval Criteria

1 - The patient has been evaluated for adequate iron stores

AND

2 - Serum hemoglobin (Hb) results within seven days of PA (prior authorization) request (please document date and value)

AND

3 - Patient will achieve and maintain hemoglobin levels in ONE of the following conditions:

- Treatment of anemia secondary to CKD (Dialysis patient): Hb levels should not exceed 11 g/dL

- Treatment of anemia secondary to CKD (Non-Dialysis patient): 10 g/dL for adults; 12 g/dL for pediatrics

AND

4 - NOT used for the following:

- Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (AML, CML) or erythroid cancers
- Anemia of cancer not related to cancer treatment
- Any anemia associated only with radiotherapy
- Prophylactic use to prevent chemotherapy-induced anemia
- Prophylactic use to reduce tumor hypoxia
- Patients with erythropoietin-type resistance due to neutralizing antibodies
- Anemia due to cancer treatment if patients have uncontrolled hypertension

AND

5 - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

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

Approval Criteria

1 - The patient has been evaluated for adequate iron stores

AND

2 - Serum hemoglobin (Hb) results within seven days of PA (prior authorization) request (please document date and value)

AND

3 - BOTH of the following:

- Used for the treatment of anemia secondary to chronic kidney disease (CKD) in adults who have been receiving dialysis for at least three months
- Patient will achieve and maintain hemoglobin level of 11 g/dL or less

AND

4 - NOT used for the following:

- Any anemia in cancer or cancer treatment patients due to folate deficiency, B-12 deficiency, iron deficiency, hemolysis, bleeding, or bone marrow fibrosis
- Anemia associated with the treatment of acute and chronic myelogenous leukemias (AML, CML) or erythroid cancers
- Anemia of cancer not related to cancer treatment
- Any anemia associated only with radiotherapy
- Prophylactic use to prevent chemotherapy-induced anemia
- Prophylactic use to reduce tumor hypoxia
- Patients with erythropoietin-type resistance due to neutralizing antibodies
- Anemia due to cancer treatment if patients have uncontrolled hypertension

AND

5 - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
1/21/2026	Multiple criteria updates

Hemgenix

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-422564
Guideline Name	Hemgenix
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Hemgenix	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is at least 18 years of age

AND

2 - Prescribed by or in consultation with a hematologist

AND

3 - The patient has a diagnosis of moderately severe or severe congenital factor IX deficiency (e.g., pre-treatment factor IX less than or equal to 2%), as confirmed by blood coagulation testing

AND

4 - The patient has ONE or more of the following:

- Currently uses factor IX prophylaxis therapy
- Current or historical life-threatening hemorrhage

AND

5 - Repeated, serious spontaneous bleeding episodes

AND

6 - The patient has been recently tested (within two weeks prior to administration of Hemgenix) and found negative for factor IX inhibitors

AND

7 - The patient does not have active hepatitis B and/or hepatitis C infection

AND

8 - The patient does not have uncontrolled HIV infection

AND

9 - Liver health assessments including enzyme testing [ALT, AST, ALP and total bilirubin] and

hepatic ultrasound and elastography have been performed to rule out radiological liver abnormalities and/or sustained liver enzyme elevations **AND** **10** - The patient has not received previous gene therapy for Hemophilia B* **AND** **11** - Prescriber attestation that factor IX activity will be monitored periodically per package insert (e.g., weekly for three months) post-administration	
Notes	*Limited to one treatment per lifetime

2 . Revision History

Date	Notes
10/22/2025	1/1/2026 Implementation

Hereditary Angioedema Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-398222
Guideline Name	Hereditary Angioedema Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of HAE (hereditary angioedema)

AND

2 - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by ONE of the following:

- C1-INh antigenic level below the lower limit of normal
- C1-INh functional level below the lower limit of normal

AND

3 - ONE of the following:

3.1 The medication is being used as prophylaxis against attacks

OR

3.2 BOTH of the following:

- The medication is being used for the treatment of acute HAE attacks
- The medication is NOT used in combination with other approved treatment for acute HAE attacks

AND

4 - Prescribed by or in consultation with an allergist or immunologist

Product Name:Haegarda, Orladeyo, Takhzyro	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of HAE (hereditary angioedema)

AND

2 - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by ONE of the following:

- C1-INh antigenic level below the lower limit of normal
- C1-INh functional level below the lower limit of normal

AND

3 - The requested medication is being used as prophylaxis against attacks

AND

4 - Prescribed by or in consultation with an allergist or immunologist

Product Name:Brand Firazyr, generic icatibant, Brand Sajazir, Ruconest	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of HAE (hereditary angioedema)

AND

2 - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by ONE of the following:

- C1-INh antigenic level below the lower limit of normal
- C1-INh functional level below the lower limit of normal

AND

3 - The requested medication is being used for the treatment of acute HAE attacks

AND

4 - The requested medication is NOT used in combination with other approved treatment for acute HAE attacks

AND

5 - Prescribed by or in consultation with an allergist or immunologist

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

Approval Criteria

1 - Diagnosis of HAE (hereditary angioedema)

AND

2 - The patient is at least 12 years old

AND

3 - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by ONE of the following:

- C1-INh antigenic level below the lower limit of normal
- C1-INh functional level below the lower limit of normal

AND

4 - The requested medication is being used for the treatment of acute HAE attacks

AND

5 - The requested medication is NOT used in combination with other approved treatment for acute HAE attacks

AND

6 - Prescribed by or in consultation with an allergist or immunologist

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

Approval Criteria

1 - Diagnosis of HAE (hereditary angioedema)

AND

2 - Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (type I or II HAE) as documented by ONE of the following:

- C1-INh antigenic level below the lower limit of normal
- C1-INh functional level below the lower limit of normal

AND

3 - The requested medication is being used for the treatment of acute HAE attacks

AND

4 - The requested medication is NOT used in combination with other approved treatment for acute HAE attacks

AND

5 - Prescribed by or in consultation with an allergist or immunologist

AND

6 - ONE of the following:

- History of trial and failure, contraindication, or intolerance to Ruconest
- The patient is 12 years of age or younger and there is documentation that the patient has history of laryngeal attacks

2 . Revision History

Date	Notes
9/17/2025	New program

Hetlioz

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-397265
Guideline Name	Hetlioz
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Hetlioz capsules, generic tasimelteon capsules	
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 - The patient has a diagnosis of Non-24 disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernychthemeral syndrome)

AND

2 - The medication is being prescribed by or in consultation with a sleep specialist

AND

3 - The patient had an adverse reaction, contraindication, or an inadequate response (after at least three months of therapy) to a therapeutic dose of melatonin

Product Name:Brand Hetlioz capsules, generic tasimelteon capsules	
Diagnosis	Non-24-Hour Sleep-Wake Disorder (Non-24)
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 Hetlioz capsules, generic tasimelteon capsules, Hetlioz LQ	
Diagnosis	Smith-Magenis Syndrome (SMS)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Smith-Magenis Syndrome (SMS)

AND

2 - One of the following:

- For Hetlioz (tasimelteon) capsules, the patient is at least 16 years of age
- For Hetlioz LQ, the patient is 3 through 15 years of age

AND

3 - The patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking)

AND

4 - Prescribed by a neurologist or a specialist in sleep disorder

AND

5 - The patient had an adverse reaction, contraindication, or an inadequate response (after at least three months of therapy) to a therapeutic dose of melatonin

Product Name:Brand Hetlioz capsules, generic tasimelteon capsules, Hetlioz LQ	
Diagnosis	Smith-Magenis Syndrome (SMS)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (i.e., improvement in nighttime total sleep time, improvement in nighttime sleep quality)

2 . Revision History

Date	Notes
9/18/2025	New guideline

Hormones and Hormone Modifiers

Prior Authorization Guideline

Guideline ID	GL-420214
Guideline Name	Hormones and Hormone Modifiers
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Androgel, Natesto, Brand Testim, Brand Vogelxo, generic testosterone TD gel, testosterone soln	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is male	

AND

2 - The requested medication is being used for Primary (congenital or acquired) or Secondary (congenital or acquired) hypogonadism

AND

3 - Patient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used

AND

4 - Patient does NOT have any one of the following:

- Breast or prostate cancer
- A palpable prostate nodule or induration
- Prostate-specific antigen greater than 4 ng/ml (nanograms/milliliter)
- Severe lower urinary symptoms with an International Prostate Symptom Score (IPSS) greater than 19

AND

5 - Patient does not have a hematocrit greater than 50%

AND

6 - Patient does NOT have untreated severe obstructive sleep apnea

AND

7 - Patient does NOT have uncontrolled or poorly controlled heart failure

AND

8 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	
Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Brand Androgel, Natesto, Brand Testim, Brand Vogelxo, generic testosterone TD gel, testosterone soln	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is using the hormones to change their physical characteristics

AND

2 - Patient is a female-to-male transsexual

AND

3 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Xyosted	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Hypogonadism (e.g., testicular hypofunction, male hypogonadism, ICD-10 E29.1)

AND

2 - Patient is male at birth

AND

3 - One of the following:

3.1 Two pre-treatment serum total testosterone levels less than 300 ng/dL (nanograms/deciliter) [less than 10.4 nanomole (nmol)/L (liter)] or less than the reference range for the lab

OR

3.2 Both of the following:

- Patient has a condition that may cause altered sex hormone binding globulin (SHBG) (e.g., thyroid disorder, HIV, liver disorder, diabetes, obesity)
- One pre-treatment calculated free or bioavailable testosterone level less than 5 ng/dL (less than 0.17 nmol/L) or less than the reference range for the lab

OR

3.3 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

4 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Xyosted	
Diagnosis	Gender Dysphoria
Approval Length	If the patient is new to testosterone therapy, approval length is 6 months; Otherwise, approval length in 12 months
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is using the hormones to change their physical characteristics **AND** **2** - Patient is a female-to-male transsexual **AND** **3** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	
Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Tlando, Kyzatrex, Jatenzo, Undecatrex	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria	

1 - The patient is greater than 18 years of age

AND

2 - Patient is male

AND

3 - Patient has a diagnosis of primary hypogonadism or hypogonadotropic hypogonadism (congenital or acquired)

AND

4 - Patient has history of failure, contraindication, or intolerance to both testosterone cypionate and testosterone enanthate injection

AND

5 - Patient has signs/symptoms consistent with hypogonadism (e.g., low libido, decreased morning erections, loss of body hair, low bone mineral density, gynecomastia, small testes)

AND

6 - Patient does NOT have “age-related hypogonadism” or another hypogonadal condition not associated with structural or genetic etiologies

AND

7 - Patient has two morning pre-treatment testosterone levels below the lower limit of the normal testosterone reference range of the individual laboratory used

AND

8 - Patient is only receiving one androgen or anabolic agent

AND

9 - Patient does NOT have current or history of breast cancer

AND

10 - Patient does not have a HCT (hematocrit) greater than 50%

AND

11 - Patient does NOT have uncontrolled hypertension or heart failure

AND

12 - Patient does NOT have uncontrolled obstructive sleep apnea

AND

13 - Medication is prescribed by, or in consultation with, an endocrinologist or urologist

Product Name:Tlando, Kyzatrex, Jatenzo, Undecatrex	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is greater than 18 years of age

AND

2 - Patient is male

AND

3 - Patient has a diagnosis of primary hypogonadism or hypogonadotropic hypogonadism (congenital or acquired)

AND

4 - Patient has history of failure, contraindication, or intolerance to both testosterone cypionate and testosterone enanthate injection

AND

5 - Patient has signs/symptoms consistent with hypogonadism (e.g., low libido, decreased morning erections, loss of body hair, low bone mineral density, gynecomastia, small testes)

AND

6 - Patient does NOT have “age-related hypogonadism” or another hypogonadal condition not associated with structural or genetic etiologies

AND

7 - Patient is only receiving one androgen or anabolic agent

AND

8 - Patient does NOT have current or history of breast cancer

AND

9 - Patient does not have a HCT (hematocrit) greater than 50%

AND

10 - Patient does NOT have uncontrolled hypertension or heart failure

AND

11 - Patient does NOT have uncontrolled obstructive sleep apnea

AND

12 - Medication is prescribed by, or in consultation with, an endocrinologist or urologist

AND

13 - Patient has disease improvement and/or stabilization

Product Name:Tlando, Kyzatrex, Jatenzo, Undecatrex	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is using the hormones to change their physical characteristics

AND

2 - Patient is a female-to-male transsexual

AND

3 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Tlando, Kyzatrex, Jatenzo, Undecatrex	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient continues to meet initial authorization criteria

AND

2 - Patient has disease improvement and/or stabilization

2 . Revision History

Date	Notes
10/15/2025	New guideline

Ileal Bile Acid Transporter (IBAT) Inhibitor (D7F)

Prior Authorization Guideline

Guideline ID	GL-422514
Guideline Name	Ileal Bile Acid Transporter (IBAT) Inhibitor (D7F)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Patient is three months of age or older

AND

2 - Patient is diagnosed with progressive familial intrahepatic cholestasis (PFIC) type 1 or type 2, confirmed by a genetic test

AND

3 - Patient has elevated serum bile acid concentration

AND

4 - Patient experiences persistent moderate to severe pruritus

AND

5 - Patient does NOT have any of the following:

- Positive test for the ABCB11 gene variant that predicts complete absence of the bile salt export pump (BSEP) protein
- Prior hepatic decompensation event
- Another concomitant liver disease
- An international normalized ratio (INR) greater than 1.4
- Significant portal hypertension
- An alanine aminotransferase (ALT) or total bilirubin (TB) level more than 10 times the upper limit of normal (ULN)
- Medical history or ongoing chronic diarrhea
- Decompensated cirrhosis

AND

6 - The requested medication is prescribed by or in consultation with a specialist (e.g. gastroenterologist, hepatologist, dermatologist)

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

Approval Criteria

1 - Patient is three months of age or older

AND

2 - Patient is diagnosed with progressive familial intrahepatic cholestasis (PFIC) type 1 or type 2, confirmed by a genetic test

AND

3 - Patient experiences persistent moderate to severe pruritus

AND

4 - Patient does NOT have any of the following:

- Positive test for the ABCB11 gene variant that predicts complete absence of the bile salt export pump (BSEP) protein
- Prior hepatic decompensation event
- Another concomitant liver disease
- An international normalized ratio (INR) greater than 1.4
- Significant portal hypertension
- An alanine aminotransferase (ALT) or total bilirubin (TB) level more than 10 times the upper limit of normal (ULN)
- Medical history or ongoing chronic diarrhea
- Decompensated cirrhosis

AND

5 - The requested medication is prescribed by or in consultation with a specialist (e.g. gastroenterologist, hepatologist, dermatologist)

AND

6 - Patient has experienced a reduction in serum bile acids from baseline

AND

7 - Patient has experienced improvement in pruritus from baseline

AND

8 - Patient has not experienced any treatment-restricting adverse effects (e.g., persistent diarrhea; persistent fat-soluble vitamin deficiency despite Vitamin A, D, E, K supplementation; elevated liver function tests [alanine aminotransferase (ALT), total bilirubin (TB), direct bilirubin (DB])

Product Name:Livmarli	
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 - Patient is diagnosed with Alagille syndrome

AND

3 - Patient experiences persistent moderate to severe pruritus

AND

4 - Patient does NOT have any of the following:

- Chronic diarrhea requiring ongoing IV (intravenous) fluid or nutritional intervention
- Prior hepatic decompensation event
- Significant portal hypertension
- Decompensated cirrhosis
- Another concomitant liver disease

AND

5 - The requested medication is prescribed by or in consultation with a specialist (e.g. gastroenterologist, hepatologist, dermatologist)

AND

6 - Patient has failed an adequate trial, or is intolerant to, or has a contraindication to at least one pruritus treatment (e.g., ursodeoxycholic acid [ursodiol], cholestyramine, rifampin, naloxone, naltrexone, antihistamine)

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

Approval Criteria

1 - Patient continues to meet the initial authorization criteria

AND

2 - Patient has experienced a reduction in serum bile acids from baseline

AND

3 - Patient has experienced improvement in pruritus from baseline

AND **4** - Patient has not experienced any treatment-restricting adverse effects (e.g., persistent diarrhea; persistent fat-soluble vitamin deficiency despite Vitamin A, D, E, K supplementation; elevated liver function tests [alanine aminotransferase (ALT), aspartate aminotransferase (AST), total bilirubin (TB), direct bilirubin (DB])

2 . Revision History

Date	Notes
10/21/2025	New guideline

Immunomodulator Drugs

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-427217
Guideline Name	Immunomodulator Drugs
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR	
Diagnosis	Rheumatoid Arthritis (RA)
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria	

1 - The patient has a diagnosis of moderately to severely active Rheumatoid Arthritis (RA)

AND

2 - The patient has had a rheumatology consultation (please document date of consultation)

AND

3 - One of the following:

3.1 Patient has had RA for less than 6 months (early RA) and both of the following:

- Patient has high disease activity
- Patient has had an inadequate or adverse reaction to a disease modifying antirheumatic drug (DMARD) (methotrexate, hydroxychloroquine, leflunomide, minocycline, or sulfasalazine)

OR

3.2 Patient has had RA for 6 months or longer (intermediate or long-term disease duration) and one of the following:

3.2.1 Patient has high disease activity

OR

3.2.2 Patient has moderate disease activity and has an inadequate response to a DMARD (methotrexate, hydroxychloroquine, leflunomide, minocycline, or sulfasalazine)

AND

4 - Patient has a negative tuberculin test

AND

5 - The patient does not have an active infection or a history of recurring infections

AND

6 - The patient is not using more than one biologic at a time (combination therapy)

AND

7 - One of the following:

7.1 The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

OR

7.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

8 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

9 - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

9.1 The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

AND

9.2 Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

AND

10 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR	
Diagnosis	Psoriatic Arthritis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of moderate or severe psoriatic arthritis

AND

2 - The patient has had a rheumatology or dermatology consultation (please document date of consultation)

AND

3 - The patient has had an inadequate response or a contraindication to treatment with one of the following:

3.1 One nonsteroidal anti-inflammatory drug (NSAID)

OR

3.2 One of the following DMARDs (disease modifying antirheumatic drugs):

- Methotrexate
- Leflunomide
- Cyclosporine
- Sulfasalazine

AND

4 - Patient has a negative tuberculin test

AND

5 - The patient does not have an active infection or a history of recurring infections

AND

6 - The patient is not using more than one biologic at a time (combination therapy)

AND

7 - One of the following:

7.1 The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

OR

7.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

8 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

9 - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

9.1 The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

AND

9.2 Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

AND

10 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR	
Diagnosis	Ankylosing Spondylitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of ankylosing spondylitis

AND

2 - The patient has had an inadequate response to NSAIDs (nonsteroidal anti-inflammatory drugs)

AND

3 - Patient has a negative tuberculin test

AND

4 - The patient does not have an active infection or a history of recurring infections

AND

5 - The patient is not using more than one biologic at a time (combination therapy)

AND

6 - One of the following:

6.1 The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

OR

6.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

7 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

8 - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

8.1 The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

AND

8.2 Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

AND

9 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR	
Diagnosis	Juvenile RA/Juvenile Idiopathic Arthritis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of moderately or severely active juvenile RA (rheumatoid arthritis) or juvenile idiopathic arthritis

AND

2 - The patient has at least five swollen joints

AND

3 - The patient has three or more joints with limitation of motion and pain and/or tenderness

AND

4 - The patient has had inadequate response to one DMARD (disease modifying antirheumatic drug)

AND

5 - Patient has a negative tuberculin test

AND

6 - The patient does not have an active infection or a history of recurring infections

AND

7 - The patient is not using more than one biologic at a time (combination therapy)

AND

8 - One of the following:

8.1 The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

OR

8.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

9 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

10 - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

10.1 The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

AND

10.2 Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

AND

11 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR	
Diagnosis	Plaque Psoriasis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of chronic, moderate to severe plaque psoriasis

AND

2 - The requested medication is prescribed by a dermatologist

AND

3 - The patient has failed to adequately respond to a topical agent

AND

4 - The patient has failed to adequately respond to at least one oral treatment

AND

5 - Patient has a negative tuberculin test

AND

6 - The patient does not have an active infection or a history of recurring infections

AND

7 - The patient is not using more than one biologic at a time (combination therapy)

AND

8 - One of the following:

8.1 The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

OR

8.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

9 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

10 - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

10.1 The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

AND

10.2 Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

AND

11 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR

Diagnosis	Crohn’s Disease
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of moderate to severe Crohn’s Disease

AND

2 - One of the following:

2.1 The patient has failed to adequately respond to conventional therapy (e.g., sulfasalazine, mesalamine, antibiotics, corticosteroids, azathioprine, 6-mercaptopurine, leflunomide)

OR

2.2 The patient has fistulizing Crohn’s Disease

AND

3 - Patient has a negative tuberculin test

AND

4 - The patient does not have an active infection or a history of recurring infections

AND

5 - The patient is not using more than one biologic at a time (combination therapy)

AND

6 - One of the following:

6.1 The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

OR

6.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

7 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

8 - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

8.1 The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

AND

8.2 Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

AND

9 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of moderate to severe ulcerative colitis

AND

2 - The patient has failed to adequately respond to at least one of the following standard therapies:

- Corticosteroids
- 5-aminosalicylic acid agents
- Immunosuppressants

- Thiopurines

AND

3 - Patient has a negative tuberculin test

AND

4 - The patient does not have an active infection or a history of recurring infections

AND

5 - The patient is not using more than one biologic at a time (combination therapy)

AND

6 - One of the following:

6.1 The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

OR

6.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

7 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

8 - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

8.1 The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

AND

8.2 Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

AND

9 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR	
Diagnosis	Cryopyrin-Associated Periodic Syndromes (CAPS)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of one of the following:

- Familial Cold Autoinflammatory Syndromes (FCAS)
- Muckle-Wells Syndrome (MWS)
- Neonatal-Onset Multisystem Inflammatory Disease (NOMID)

AND

2 - Patient has a negative tuberculin test

AND

3 - The patient does not have an active infection or a history of recurring infections

AND

4 - The patient is not using more than one biologic at a time (combination therapy)

AND

5 - One of the following:

5.1 The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

OR

5.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

6 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

7 - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

7.1 The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

AND

7.2 Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

AND

8 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Actemra, Tofidence, Tyenne, Abrilada, Adalimumab (all products), Amjevita, Cyltezo, Hadlima, Hulio, Humira, Hyrimoz, Simlandi, Yuflyma, Yusimry, Arcalyst, Avsola, Inflectra, Infliximab, Remicade, Renflexis, Zymfentra, Bimzelx, Cimzia, Cosentyx, Enbrel, Enspryng, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Olumiant, Omvoh, Orencia, Otezla, Imudlosa, Otulfi, Pyzchiva, Selarsdi, Stelara, Steqeyma, Ustekinumab (all products), Wezlana, Yesintek, Rinvoq, Rinvoq LQ, Siliq, Simponi, Simponi Aria, Sotyktu, Skyrizi, Taltz, Tremfya, Velsipity, Xeljanz, Xeljanz XR	
Diagnosis	Refractory Atopic Dermatitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of refractory, moderate to severe atopic dermatitis (AD)

AND

2 - The patient has documented trial and failure to at least one other systemic option for AD

AND

3 - If the request is for Rinvoq, the patient weighs at least 40 kg (kilograms)

AND

4 - The requested medication is prescribed by, or in consultation with, one of the following:

- Dermatologist
- Allergist
- Immunologist
- Otolaryngologist

AND

5 - Patient has a negative tuberculin test

AND

6 - The patient does not have an active infection or a history of recurring infections

AND

7 - The patient is not using more than one biologic at a time (combination therapy)

AND

8 - One of the following:

8.1 The requested medication is being prescribed for an FDA-approved indication and patient is appropriate age per FDA labeling

OR

8.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

9 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

10 - If the request is for Avsola, Inflectra, Renflexis or Zymfentra, both of the following:

10.1 The requested medication is prescribed for an FDA-approved diagnosis and patient is appropriate age per FDA labeling

AND

10.2 Submission of medical records (e.g., chart notes) to justify that patient is not a candidate for Infliximab (e.g., product-specific past intolerance or contraindication)

AND

11 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Spevigo	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of generalized pustular psoriasis (GPP)

AND

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

- Dermatologist
- Immunologist
- Rheumatologist

AND

3 - The patient does not have any of the following conditions: synovitis, acne, pustulosis, hyperostosis, osteitis (SAPHO) syndrome, erythrodermic plaque psoriasis without pustules or with pustules restricted to psoriatic plaques, or drug-triggered acute generalized exanthematous pustulosis (AGEP)

AND

4 - The patient is experiencing an acute GPP flare of moderate to severe intensity defined by all the following:

- GPP Global Assessment (GPPGA) total score of greater than or equal to 3 (moderate)
- Presence of fresh pustules (new or worsening)
- A GPPGA pustulation sub score of at least 2 (mild)
- At least 5% of body surface area with erythema and the presence of pustules

AND

5 - Patient has a negative tuberculin test

AND

6 - The patient does not have an active infection or a history of recurring infections

AND

7 - The patient is not using more than one biologic at a time (combination therapy)

AND

8 - One of the following:

8.1 The requested medication is being prescribed for an FDA (Food and Drug Administration)-approved indication and patient is appropriate age per FDA labeling

OR

8.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

9 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

10 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

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

Approval Criteria

1 - The patient has been diagnosed with neuromyelitis optica spectrum disorder (NMOSD)

AND

2 - Patient has positive serologic test for anti-AQP4 antibodies

AND

3 - Patient has a history of at least 1 relapse that required rescue therapy within the year prior to treatment or at least 2 relapses that required rescue therapy in two years prior to treatment

AND

4 - Patient has an Expanded Disability Status Score (EDSS) of less than or equal to 8.0

AND

5 - Prescribed by, or in consultation with, a neurologist

AND

6 - Patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment and confirmed negative for active HBV

AND

7 - Prescriber attestation that serum immunoglobulin will be monitored at beginning, during, and after discontinuation of treatment until B-cell repletion

AND

8 - Patient has a negative tuberculin test

AND

9 - The patient does not have an active infection or a history of recurring infections

AND

10 - The patient is not using more than one biologic at a time (combination therapy)

AND

11 - One of the following:

11.1 The requested medication is being prescribed for an FDA-approved indication and patient is appropriate age per FDA labeling

OR

11.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

12 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

13 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Uplizna

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

Approval Criteria

1 - The patient has been diagnosed with neuromyelitis optica spectrum disorder (NMOSD)

AND

2 - Patient has positive serologic test for anti-AQP4 antibodies

AND

3 - Prescribed by, or in consultation with, a neurologist

AND

4 - Patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment and confirmed negative for active HBV

AND

5 - Prescriber attestation that serum immunoglobulin will be monitored at beginning, during, and after discontinuation of treatment until B-cell repletion

AND

6 - Patient has a negative tuberculin test

AND

7 - The patient does not have an active infection or a history of recurring infections

AND

8 - The patient is not using more than one biologic at a time (combination therapy)

AND

9 - One of the following:

9.1 The requested medication is being prescribed for an FDA-approved indication and patient is appropriate age per FDA labeling

OR

9.2 The prescriber has provided clinical justification for off-label usage (please document clinical justification)

AND

10 - The patient has not received live or live-attenuated vaccines within the past four weeks and will not receive live or live-attenuated vaccines during treatment with an immunomodulator

AND

11 - Documentation of positive disease response as indicated by stabilization/improvement one of the following:

- Neurologic symptoms as evidence by a decreased in acute relapses
- Stability or improvement in Expanded Disability Status Score (EDSS)
- Reduced hospitalizations
- Reduction in plasma exchange treatments

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
10/23/2025	Corrected "." to "," in product names after (all products). Updated lan guage for Avsola, Inflectra, Renflexis or Zymfentra to require submiss ion of medical records.

Increlex

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-458264
Guideline Name	Increlex
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Submission of medical records documenting all of the following:

1.1 Diagnosis of severe primary IGF-1 deficiency (PIGFD)

AND

1.2 Documentation of height below -3.0 SD (standard deviation) mean for age and gender

AND

1.3 Documentation of IGF-1 below -3.0 SD mean for age and gender

AND

1.4 Documentation of both of the following:

- Growth charts for length/height and weight for age and gender with evidence of growth velocity deceleration over time
- Calculated growth velocity

AND

1.5 One of the following:

1.5.1 Patient is unresponsive to a trial of growth hormone therapy

OR

1.5.2 Documentation of one of the following:

- Very low or undetectable level of GHBP
- Very low or undetectable level of GHR mutations known to cause Laron syndrome/GH insensitivity syndrome
- GH1 gene deletion (GHD type 1A)
- GH-neutralizing antibodies
- STT5b gene mutation
- IGF-1 gene deletion or mutation

AND

2 - Other causes of low IGF-I levels have been ruled out (e.g., growth hormone deficiency, undernutrition, hepatic disease)

AND

3 - Patient will not be treated with concurrent growth hormone therapy

AND

4 - Prescribed by an endocrinologist

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

Approval Criteria

1 - Submission of medical records documenting a height increase of at least 2 centimeters/year over the previous year of treatment as confirmed by all of the following:

- Previous length/height and date obtained
- Current length/height and date obtained
- Calculated growth velocity
- Growth chart for height for age and gender

AND

2 - Submission of medical records documenting 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

2 . Revision History

Date	Notes
12/3/2025	New guideline

Incretin Mimetics

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-458408
Guideline Name	Incretin Mimetics
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Trulicity, Exenatide, liraglutide (generic Victoza), Brand Victoza, Rybelsus, Ozempic, Mounjaro, Xultophy, Soliqua	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Used for ONE of the following:

- Adjunct to diet and exercise to improve glycemic control in patients with type 2 diabetes mellitus (T2DM)

- Reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in recipients with type 2 diabetes and established cardiovascular disease

AND

2 - Documentation of A1C lab result within past 180 days

AND

3 - Patient does NOT have any of the following:

- History of pancreatitis
- Type 1 diabetes mellitus (T1DM)

AND

4 - Medication is not being prescribed for weight loss in absence of T2DM indication

AND

5 - Medication prescribed at FDA-approved dose for T2DM indication

AND

6 - Patient is appropriate age per FDA label

AND

7 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Trulicity, Exenatide, liraglutide (generic Victoza), Brand Victoza, Rybelsus, Ozempic, Mounjaro, Xultophy, Soliqua	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient continues to meet initial authorization criteria

AND

2 - Documentation of positive response from therapy

Product Name:Wegovy	
Diagnosis	Risk reduction of major adverse cardiovascular events
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Medication is being prescribed for risk reduction of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity or overweight

AND

2 - Patient is at least 18 years of age

AND

3 - Documentation that patient has a body mass index (BMI) at least 27 kg/m2

AND

4 - Established cardiovascular (CV) disease as evidenced by at least ONE of the following criteria:

- Prior myocardial infarction
- Prior ischemic or hemorrhagic stroke
- Symptomatic peripheral arterial disease (PAD), as evidenced by intermittent claudication with ankle-brachial index (ABI) < 0.85 (at rest), or peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease
- Patient has established CV disease verified by specialist and the specialist has provided documentation to confirm medication is being prescribed to reduce the patient's specific CV risk (submission of documentation required)

AND

5 - Prescribed by, or in consultation with, a cardiologist or vascular specialist

AND

6 - ONE of the following:

- Patient does NOT have type 1 or type 2 diabetes
- Patient does have type 1 or type 2 diabetes and is receiving appropriate diabetic care with an alternative medication therapy

AND

7 - Patient does NOT have any contraindications for use of Wegovy

AND

8 - Medication will not be used in combination with another glucagon-like peptide (GLP-1) therapy

AND

9 - Documentation that patient has received individualized healthy lifestyle counseling

AND

10 - Provider attestation that in addition to Wegovy, the provider will maintain standard of care treatment for the patient's established CV disease

Product Name:Wegovy	
Diagnosis	Risk reduction of major adverse cardiovascular events
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

- Dose has been titrated to 2.4 mg once weekly
- There is a reason why the 2.4 mg once weekly maintenance dose is not appropriate (prescriber must document reasoning)

Product Name:Wegovy	
Diagnosis	Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with fibrosis stage 2 or 3 confirmed by submission of medical records of at least one of the following:

- Liver biopsy
- Vibration-controlled transient elastography (VCTE) (e.g., FibroScan)
- Magnetic resonance elastography (MRE)

AND

2 - Patient is at least 18 years of age

AND

3 - Patient does not have any contraindications for use of the requested medication (e.g. personal or family history of MTC, MEN 2, or hypersensitivity)

AND

4 - Medication will not be used in combination with another glucagon-like peptide (GLP-1) therapy

AND

5 - Prescriber attestation that the requested medication is being prescribed in conjunction with diet and exercise

Product Name:Wegovy	
Diagnosis	Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - One of the following:

- Patient is being prescribed the FDA-(Food and Drug Administration) recommended maintenance dose of 2.4mg weekly
- Dose was decreased to 1.7mg weekly due to intolerance

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

Approval Criteria

1 - The patient is at least 18 years of age

AND

2 - Submission of medical records documenting Medication is being prescribed for moderate to severe obstructive sleep apnea (OSA) in adults with obesity, with OSA defined by one of the following:

2.1 The patient has had 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study from a certified or accredited sleep disorder facility

OR

2.2 Both of the following:

- Five or more obstructive respiratory events per hour of sleep confirmed by a sleep study from a certified or accredited sleep disorder facility

- One of the following signs/symptoms are present: Daytime sleepiness; Nonrestorative sleep; Fatigue; Insomnia; Waking up with breath holding, gasping, or choking; Habitual snoring noted by a bed partner or other observer; Observed apnea

OR

2.3 Both of the following:

- The patient is not an appropriate candidate for a facility sleep study due to immobility, safety, or critical illness
- Zepbound is being prescribed by, or in consultation with, a board-certified sleep specialist or pulmonologist for a diagnosis of moderate to severe OSA

AND

3 - The patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g., CPAP, BiPAP), unless there is rationale from provider as to why treatment is not indicated

AND

4 - Documentation that the patient has a body mass index (BMI) > 30 kg/m2

AND

5 - ONE of the following:

- Patient does NOT have type 1 or type 2 diabetes
- Patient does have type 1 or type 2 diabetes and is receiving appropriate diabetic care with an alternative medication therapy

AND

6 - The patient does not have any contraindications for use of Zepbound

AND

7 - Provider attests that this medication will be used in combination with a reduced calorie diet and increased physical activity

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - The patient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction (e.g., CPAP, BiPAP), unless there is rationale from provider as to why treatment is not indicated

2 . Revision History

Date	Notes
12/8/2025	Added MASH diagnosis for Wegovy.

Insulin Pen Needles and Syringes

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439210
Guideline Name	Insulin Pen Needles and Syringes
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Arizona (ACUAZ, ACUAZEC) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Community & State Kansas (ACUKS, ACUKSC, ACUKSEC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Non-preferred insulin pen needles and insulin syringes	
Diagnosis	Non-Preferred
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - If the request is non-preferred*, history of failure to a preferred* Embecta insulin pen needle or syringe as confirmed by claims history or submission of medical records **OR** **2** - If the request is non-preferred*, physician has provided documentation as to why the patient is unable to use a preferred* Embecta product (document rationale)	
Notes	*PDL links are listed in Background.

Product Name:All insulin pen needles and insulin syringes	
Diagnosis	Requests exceeding 6 pen needles or syringes per day*
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria **1** - Physician confirmation that the patient requires a greater quantity because of more frequent delivery of insulin	
Notes	*The quantity limit for both pen needles and syringes is 6 of each per day.

2 . Background

Benefit/Coverage/Program Information
PDL links **CO**: https://www.uhcprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-pharmacy.html **HI**: https://www.uhcprovider.com/en/health-plans-by-state/hawaii-health-plans/hi-comm-plan-home/hi-cp-pharmacy.html **MD**: https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-cp-pharmacy.html **NJ**: https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-cp-pharmacy.html **NY/NY EPP**: https://www.uhcprovider.com/en/health-plans-by-state/new-york-health-plans/ny-comm-plan-home/ny-cp-pharmacy.html **PA**: https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP **RI**: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html **AZ**: https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP **KS**: https://www.uhcprovider.com/en/health-plans-by-state/kansas-health-plans/ks-comm-plan-home/ks-cp-pharmacy.html **NM**: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html **VA**: https://www.uhcprovider.com/en/health-plans-by-state/virginia-health-plans/va-comm-plan-home/va-cp-pharmacy.html **WA**: https://www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home/wa-cp-pharmacy.html **NE**: https://www.uhcprovider.com/en/health-plans-by-state/nebraska-health-plans/ne-comm-plan-home/ne-cp-pharmacy.html

IN: https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html

3 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Iron Chelators

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439211
Guideline Name	Iron Chelators
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Exjade, Brand Jadenu, generic deferasirox	
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

OR

2 - ALL of the following:

- Diagnosis of chronic iron overload in non-transfusion dependent thalassemia (NTDT) syndrome
- 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 the requested medication
- Patient has serum ferritin levels consistently greater than 300 micrograms per liter prior to initiation of treatment with the requested medication

Product Name:Brand Ferriprox, generic deferiprone	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of transfusional iron overload due to thalassemia syndromes, sickle cell disease or other anemias

AND

2 - Requested medication will NOT be used for the treatment of transfusional iron overload due to myelodysplastic syndrome or Diamond Blackfan anemia

Product Name:Brand Exjade, Brand Jadenu, generic deferasirox, Brand Ferriprox, generic deferiprone	
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
11/5/2025	Added Nevada Formulary

Isotretinoin

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439212
Guideline Name	Isotretinoin
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN)

Product Name:Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
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

Product Name:Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Acne
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

- Diagnosis of severe recalcitrant nodular acne unresponsive to conventional therapy
- Diagnosis of treatment resistant acne

AND

2 - ONE of the following:

2.1 Failure to an adequate trial on TWO of the following conventional therapy regimens confirmed by claims history or submission of medical records:

- Topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)]
- Oral antibiotic [e.g., Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)]
- Topical antibiotic with or without benzoyl peroxide [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

OR

2.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- Topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)]
- Oral antibiotic [e.g., Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)]
- Topical antibiotic with or without benzoyl peroxide [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

AND

3 - If the request is non-preferred*, the prescriber has given a clinical reason or special circumstance why the patient is unable to use the preferred product (please document reason or special circumstance)

Notes	*PDL links are listed in Background.

Product Name:Accutane, generic isotretinoin, Claravis, Amnesteem, Zenatane, Brand Absorica, Absorica LD	
Diagnosis	Acne
Approval Length	6 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 **OR** **2** - Total cumulative dose for total duration of therapy is less than 150 mg/kg (document patient's dose and weight)*

Notes	*Will be approved up to a total of 150 mg/kg

2 . Background

Benefit/Coverage/Program Information
PDL links **CO**: https://www.uhcprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-pharmacy.html **HI**: https://www.uhcprovider.com/en/health-plans-by-state/hawaii-health-plans/hi-comm-plan-home/hi-cp-pharmacy.html **MD**: https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-cp-pharmacy.html **NJ**: https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-cp-pharmacy.html **NY/NY EPP**: https://www.uhcprovider.com/en/health-plans-by-state/new-york-health-plans/ny-comm-plan-home/ny-cp-pharmacy.html **PA CHIP**: https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP **RI**: https://www.uhcprovider.com/en/health-plans-by-state/rhode-island-health-plans/ri-comm-plan-home/ri-cp-pharmacy.html

VA: https://www.uhcprovider.com/en/health-plans-by-state/virginia-health-plans/va-comm-plan-home/va-cp-pharmacy.html

NE: https://www.uhcprovider.com/en/health-plans-by-state/nebraska-health-plans/ne-comm-plan-home/ne-cp-pharmacy.html

NM: https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html

3 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Isturisa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439213
Guideline Name	Isturisa
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Isturisa	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Cushing's syndrome

AND

2 - ONE of the following:

- Patient is not a candidate for pituitary surgery
- Pituitary surgery has not been curative

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

Approval Criteria

1 - Documentation of positive response to Isturisa therapy

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Joenja (leniolisib)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-422537
Guideline Name	Joenja (leniolisib)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is 12 years of age or older

AND

2 - The patient weighs at least 45 kg

AND

3 - The patient has a diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS) confirmed by genetic mutation of either the PIK3CD or PIK3R1 gene

AND

4 - Prescribed by or in consultation with immunologist

AND

5 - The patient has nodal and/or extra-nodal lymphoproliferation, with the presence of greater than or equal to 1 measurable nodal lesion as confirmed by prescriber attestation of palpable diagnosis (and/or on computed tomography (CT) or MRI

AND

6 - The patient has clinical findings and manifestations compatible with APDS (e.g., history of repeated oto-sinopulmonary infections, organ dysfunction [e.g., lung, liver])

AND

7 - If the patient is a female of reproductive potential, pregnancy status will be confirmed prior to initiating therapy and highly effective methods of contraception will be used during treatment

AND

8 - The patient is not on concurrent immunosuppressive therapy (e.g., mammalian target of rapamycin (mTOR) inhibitors, B-cell depleters, glucocorticoids [doses greater than 25 mg/day of prednisone equivalent

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

Approval Criteria

1 - The patient continues to meet the initial authorization criteria

AND

2 - The patient must have disease response with treatment as defined by stabilization of or improvement of disease signs and symptoms (e.g., decrease in the frequency and/or severity of infections, decreased lymphadenopathy, increased percentage of naïve B cells, decrease in disease-related hospitalizations)

AND

3 - The patient has not experienced any treatment-restricting adverse effects (e.g., severe neutropenia: ANC less than 500 cells/µL)

2 . Revision History

Date	Notes
10/22/2025	1/1/2026 Implementation

Juxtapid (lomitapide)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-402204
Guideline Name	Juxtapid (lomitapide)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Juxtapid	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is greater than 18 years of age

AND

2 - Diagnosis of homozygous familial hypercholesterolemia (HoFH), confirmed by ONE of the following:

2.1 Genetic testing to confirm two mutant alleles at the LDLR, APOB PCSK9, or LDLRAP1 gene locus

OR

2.2 An untreated LDL greater than 500 mg/dL (or treated LDL >300 mg/dL) together with ONE of the following:

- Cutaneous or tendon xanthoma before the age of 10 years
- Untreated elevated LDL levels consistent with heterozygous FH in both parents

AND

3 - Prescribed by, or in consultation with, an endocrinologist, cardiologist, or lipidologist

AND

4 - The patient is currently receiving maximum tolerated statin and one other lipid lowering therapy (e.g., ezetimibe, nicotinic acid, bile acid sequestrant, fibrate, LDL apheresis), unless contraindicated or not tolerated

AND

5 - The patient has history of intolerance, failure, or contraindication to PCSK9-inhibitor (e.g., Praluent, Repatha)

AND

6 - The requested medication will not be used in combination with a PCSK9-inhibitor

AND

7 - The patient has been counseled to follow a low-fat diet

AND

8 - The patient does not have moderate or severe hepatic impairment or active liver disease

AND

9 - The requested medication will not be prescribed concomitantly with strong or moderate CYP3A4 inhibitors

AND

10 - If the request is for a female patient of reproductive potential, BOTH of the following:

- Must have a negative pregnancy test prior to initiating therapy
- Must be counseled to use effective contraception during treatment

AND

11 - The patient's total Juxtapid dose does not exceed 60 mg (milligrams) daily

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

Approval Criteria

1 - The patient continues to meet initial authorization criteria

AND

2 - Documentation of positive response to therapy

2 . Revision History

Date	Notes
9/26/2025	Added dosing max. Formatting update to step 4 if initial auth to remo ve “;”

Kerendia

Prior Authorization Guideline

Guideline ID	GL-439215
Guideline Name	Kerendia
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Kerendia	
Diagnosis	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) associated with type 2 diabetes (T2D)

AND

2 - BOTH of the following:

2.1 UACR (urinary albumin-to-creatinine ratio) greater than or equal to 30 mg/g

AND

2.2 eGFR (estimated glomerular filtration rate) greater than or equal to 25 mL/min/1.73 m2

AND

3 - Kerendia is being used to reduce the risk of at least ONE of the following:

- Sustained eGFR decline
- End-stage kidney disease
- Cardiovascular death
- Non-fatal myocardial infarction
- Hospitalization for heart failure

AND

4 - Serum potassium level is less than or equal to 5 mEQ/L (milliequivalents/liter) prior to initiating treatment

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

AND

6 - Prescriber attests the patient's diabetes is being managed with a diabetes medication with proven CKD benefit [e.g., SGLT2 inhibitor (e.g., Jardiance), GLP1 receptor agonist (e.g., Ozempic)]

Product Name:Kerendia	
Diagnosis	Heart Failure with Preserved Ejection Fraction (HFpEF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of heart failure with preserved ejection fraction (HFpEF)

AND

2 - Ejection fraction is greater than or equal to 50%

AND

3 - An eGFR of greater than or equal to 25 mL/min/1.73 m2

AND

4 - Serum potassium level is less than or equal to 5 mEQ/L prior to initiating treatment

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)
- Maximally tolerated angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., sacubitril/valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify allergy, contraindication, or intolerance)

AND

6 - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a SGLT-2 inhibitor (e.g., Jardiance) as confirmed by claims history or submission of medical records
- Patient has an allergy, contraindication, or intolerance to a SGLT-2 inhibitor (e.g., Jardiance) (please specify allergy, contraindication, or intolerance)

AND

7 - ONE of the following:

- History of trial and failure to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] as confirmed by claims history or submission of medical records
- Patient has an intolerance or contraindication to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] (please specify intolerance or contraindication)

Product Name:Kerendia	
Diagnosis	Heart Failure with mildly reduced ejection fraction (HFmrEF)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of heart failure with mildly reduced ejection fraction (HFmrEF)

AND

2 - Ejection fraction 40% to less than 50%

AND

3 - An eGFR of greater than or equal to 25 mL/min/1.73 m2

AND

4 - Serum potassium level is less than or equal to 5 mEQ/L prior to initiating treatment

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following as confirmed by claims history or submission of medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)
- Maximally tolerated angiotensin receptor-neprilysin inhibitor (ARNI) (e.g., sacubitril/valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors, ARBs, and ARNIs (please specify allergy, contraindication, or intolerance)

AND

6 - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a SGLT-2 inhibitor (e.g., Jardiance) as confirmed by claims history or submission of medical records
- Patient has an allergy, contraindication, or intolerance to a SGLT-2 inhibitor (e.g., Jardiance) (please specify allergy, contraindication, or intolerance)

AND

7 - ONE of the following:

- Patient is on a stabilized dose and receiving concomitant therapy with a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) as confirmed by claims history or submission of medical records
- Patient has an allergy, contraindication, or intolerance to a beta-blocker (e.g., carvedilol, metoprolol succinate, bisoprolol) (please specify allergy, intolerance, or contraindication)

AND

8 - ONE of the following:

- History of trial and failure to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] as confirmed by claims history or submission of medical records
- Patient has an intolerance or contraindication to a mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)] (please specify intolerance or contraindication)

Product Name:Kerendia	
Diagnosis	CKD, HFpEF, HFmrEF
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
11/5/2025	Added Nevada Formulary

Keveyis, Ormalvi

Prior Authorization Guideline

Guideline ID	GL-439216
Guideline Name	Keveyis, Ormalvi
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Keveyis, generic dichlorphenamide, Brand Ormalvi	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary hyperkalemic periodic paralysis or related variant

OR

2 - Diagnosis of primary hypokalemic periodic paralysis or related variant

Product Name:Brand Keveyis, generic dichlorphenamide, Brand Ormalvi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Korlym

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439217
Guideline Name	Korlym
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Korlym, generic mifepristone

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

Approval Criteria

1 - Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)

AND

2 - ONE of the following:

- Diagnosis of type 2 diabetes mellitus
- Diagnosis of glucose intolerance

AND

3 - ONE of the following:

- Patient has failed surgery
- Patient is not a candidate for surgery

Product Name:Brand Korlym, generic mifepristone	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of a positive clinical response while on the requested therapy

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Kuvan, Zelvysia

Prior Authorization Guideline

Guideline ID	GL-507575
Guideline Name	Kuvan, Zelvysia
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Brand Kuvan, generic sapropterin, Zelvysia	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria **1** - Diagnosis of phenylketonuria (PKU)

2 . Revision History

Date	Notes
1/27/2026	Updated guideline name. Added Zelvysia as a target. Updated produ ct name list and GPI table, accordingly. Removed dx header. Remov ed PACAID formulary as it will be standalone. No changes to clinical criteria.

Leqselvi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439220
Guideline Name	Leqselvi
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

1 - Diagnosis of severe alopecia areata

AND

2 - Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecia, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)

AND

3 - Patient requesting therapy for current episode of alopecia areata

AND

4 - ONE of the following:

- Failure to Olumiant confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Olumiant (please specify intolerance or contraindication)

AND

5 - Patient is not receiving Leqselvi in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib), Litfulo (ritlecitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

6 - Prescribed by or in consultation with a dermatologist

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Leqselvi therapy

AND

2 - Patient is not receiving Leqselvi in combination with any of the following:

- Targeted immunomodulator [e.g., Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib), Litfulo (ritlecitinib), Olumiant (baricitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Lidoderm 5% Patches

Prior Authorization Guideline

Guideline ID	GL-395193
Guideline Name	Lidoderm 5% Patches
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Tridacaine patch, Lidocan Patch, Brand Lidoderm, generic Lidocaine patch	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has one of the following diagnosis:

- Herpes zoster
- Post herpetic neuralgia/ neuropathy

AND **2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

2 . Revision History

Date	Notes
9/22/2025	New

Litfulo

Prior Authorization Guideline

Guideline ID	GL-439221
Guideline Name	Litfulo
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

1 - Diagnosis of severe alopecia areata

AND

2 - Other causes of hair loss have been ruled out (e.g., androgenetic alopecia, cicatricial alopecia, secondary syphilis, tinea capitis, triangular alopecia, and trichotillomania)

AND

3 - Patient requesting therapy for current episode of alopecia areata

AND

4 - ONE of the following:

4.1 Patient is less than 18 years of age

OR

4.2 Failure to Olumiant confirmed by claims history or submission of medical records

OR

4.3 History of intolerance or contraindication to Olumiant (please specify intolerance or contraindication)

AND

5 - Patient is not receiving Litfulo in combination with either of the following:

- Targeted immunomodulator [e.g., Olumiant (baricitinib), Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

AND

6 - Prescribed by or in consultation with a dermatologist

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

Approval Criteria

1 - Documentation of positive clinical response to Litfulo therapy

AND

2 - Patient is not receiving Litfulo in combination with either of the following:

- Targeted immunomodulator [e.g., Olumiant (baricitinib), Enbrel (etanercept), Cimzia (certolizumab), Simponi (golimumab), Orencia (abatacept), adalimumab, Xeljanz (tofacitinib), Rinvoq (upadacitinib)]
- Potent immunosuppressant (e.g., azathioprine or cyclosporine)

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Livtencity

Prior Authorization Guideline

Guideline ID	GL-422516
Guideline Name	Livtencity
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Livtencity	
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 - Patient weighs greater than 35 kilograms

AND

3 - Patient has had a hematopoietic stem cell or solid organ transplant

AND

4 - Patient has a documented cytomegalovirus (CMV) infection in whole blood or plasma (screening value at least 2,730 IU/mL in whole blood or at least 910 IU/mL in plasma) in TWO consecutive assessments separated by at least 1 day

AND

5 - Current CMV infection is refractory (defined as failure to achieve greater than 1 log10 decrease in CMV DNA level in whole blood or plasma after at least 14 days treatment) to anti-CMV treatment agents (ganciclovir, valganciclovir, cidofovir, or foscarnet), even with documented genetic mutations associated with resistance

AND

6 - Medication will not be co-administered with ganciclovir or valganciclovir

AND

7 - Patient will be monitored for clinically important drug interactions that could result in decreased therapeutic effect of Livtencity

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

Approval Criteria

1 - Patient continues to meet the initial criteria

AND

2 - Disease improvement and/or stabilization or improvement in the slope of decline (greater than 1 log10 decrease in CMV DNA level in whole blood or plasma after 14 days or longer treatment)

AND

3 - Patient has not experienced any treatment-restricting adverse effects (e.g., dysgeusia, diarrhea, nausea, and recurrence of underlying disease)

AND

4 - Patient is not a non-responder (resistant) to Livtencity

2 . Revision History

Date	Notes
10/21/2025	New

Long Acting Narcotics

Prior Authorization Guideline

Guideline ID	GL-404233
Guideline Name	Long Acting Narcotics
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Patient cannot be managed by lesser means such as acetaminophen-opioid combinations, nonsteroidal analgesics, or PRN (as needed) dosing with short-acting opioid

AND

2 - Patient requires continuous opioid administration

AND

3 - Prescriber has checked the Nevada State Board of Pharmacy's (BOP) Prescription Monitoring Program (PMP) prior to prescribing narcotic analgesics

AND

4 - If transitioning from another opioid, daily morphine equivalent doses are used to calculate the appropriate fentanyl patch dose

Product Name:tramadol ER, Conzip	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is 18 years of age or older

AND

2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:generic morphine sulfate ER/CR tabs, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, Xtampza ER, methadone 5 mg or 10 mg tabs/soln, generic methadone conc, Brand Methadose conc, methadose tablet for oral susp, methadone tablet for oral susp, Belbuca, Brand Butrans, generic buprenorphine patch	
Approval Length	12 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, Xtampza ER, methadone 5 mg or 10 mg tabs/soln, generic methadone conc, Brand Methadose conc, methadose tablet for oral susp, methadone tablet for oral susp, tramadol ER, Conzip, Belbuca, Brand Butrans, generic buprenorphine patch

Approval Length	3 month(s)
Guideline Type	Quantity Limit

Approval Criteria

1 - The patient has a diagnosis of terminal cancer

OR

2 - All of the following:

2.1 The patient is 18 years of age or older

AND

2.2 The requested medication will be used for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment

AND

2.3 Documentation that alternative agents (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain

Product Name:generic morphine sulfate ER/CR tabs, fentanyl patches, hydrocodone bitartrate ER caps, oxymorphone ER, morphine sulfate ER caps, hydromorphone ER, generic hydrocodone bitartrate ER tabs, Brand Hysingla ER, Brand MS Contin, Nucynta ER, Oxycodone ER, Oxycontin, Xtampza ER, methadone 5 mg or 10 mg tabs/soln, generic methadone conc, Brand Methadose conc, methadose tablet for oral susp, methadone tablet for oral susp, tramadol ER, Conzip, Belbuca, Brand Butrans, generic buprenorphine patch	
Diagnosis	Requests exceeding Morphine Milligram Equivalents (MME)
Approval Length	For patients less than 18 years of age, approval length is 3 months; For patients greater than or equal to 18 years of age, approval length is 12 months
Guideline Type	DUR

Approval Criteria

1 - One of the following:

1.1 All of the following:

- The patient has chronic pain or requires an extended opioid therapy and is under the supervision of a licensed prescriber
- Pain cannot be controlled through the use of non-opioid therapy [e.g., acetaminophen, NSAIDs (nonsteroidal anti-inflammatory drugs), antidepressants, anti-seizure medications, physical therapy, chiropractic treatment, etc.]
- The lowest effective dose is being prescribed
- A pain contract is on file

OR

1.2 One of the following:

- Patient has cancer/malignancy related pain
- Patient is post-surgery with an anticipated prolonged recovery (greater than 3 months)
- Patient is receiving palliative care, hospice, or end-of-life care
- Patient is residing in a long-term care facility
- Patient is receiving treatment for HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome)

• Prescribed by, or in consultation with, a pain specialist

2 . Revision History

Date	Notes
10/8/2025	New guideline

Long-Acting Injectable (LAI) Antipsychotics

Prior Authorization Guideline

Guideline ID	GL-387226
Guideline Name	Long-Acting Injectable (LAI) Antipsychotics
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Abilify Asimtufii, Abilify Maintena, Aristada, Aristada Initio, Invega Sustenna, Perseris, Brand Risperdal Consta, generic risperidone ER IM, Uzedy, Zyprexa Relprevv	
Approval Length	*Approval length for patients discharged from an institutional facility or starting therapy and stable is up to 6 month(s) from discharge date or start date, otherwise approval length is 12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - If patient is treatment naive to long acting injectables, documentation of tolerance to the oral formulation prior to transitioning to the requested medication	

AND

2 - If the patient is less than 18 years of age, one of the following:

2.1 Patient has been discharged from an institutional facility within the past 6 months* (please document name of discharge institution and date of discharge)

OR

2.2 Patient has been started on the requested medication within the past 6 months and is stabilized* (please document start date of medication)

OR

2.3 All of the following:

2.3.1 The requested medication is prescribed by or in consultation with a child psychiatrist

AND

2.3.2 The requested medication is part of a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy

AND

2.3.3 Physician and/or prescriber monitoring is required while the patient is utilizing the requested medication as defined by one of the following:

2.3.3.1 For patients who are in initial treatment (have not received any doses previously) or are continuing therapy but are considered unstable (has had a dose change in the last three months), submission of medical records confirming a monthly or more frequent visit with the physician and/or prescriber [If the patient was discharged from an institution on the medication, the follow-up visit(s) can be with their treating physician and/or prescriber]

OR

2.3.3.2 For patients who are considered stable in their medication therapy, submission of medical records confirming visits with the treating physician at least every three months

AND

2.3.4 If the patient is less than 6 years of age, the requested medication is being utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

AND

3 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

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

Approval Criteria

1 - The patient has a diagnosis of schizophrenia

AND

2 - The patient has been stabilized on once-monthly paliperidone palmitate injection (Invega Sustenna) for at least four months with the two most recent doses of the once-monthly injection being the same strength

AND

3 - The patient is 18 years of age or older

AND

4 - The requested dose is one injection every three months

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

Approval Criteria

1 - The patient has a diagnosis of schizophrenia

AND

2 - The patient has been stabilized on once-monthly paliperidone palmitate extended-release injectable suspension (Invega Sustenna) for at least four months, the two most recent doses of the once-monthly injection being the same strength or one dose of three-month IM paliperidone (Invega Trinza)

AND

3 - The patient is 18 years of age or older

AND

4 - The requested dose is one injection every six months

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

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation confirming a positive response from therapy	

2 . Revision History

Date	Notes
9/25/2025	New guideline

Lupkynis

Prior Authorization Guideline

Guideline ID	GL-439223
Guideline Name	Lupkynis
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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 - Provider attests to ONE of the following:

3.1 Clinical progression (e.g., worsening of proteinuria or serum creatinine) after 3 months of induction therapy with immunosuppressive agents (e.g., mycophenolate, cyclophosphamide, methylprednisolone), as confirmed by claims history or submission of medical records

OR

3.2 Failure to respond after 6 months of induction therapy with immunosuppressive agents (e.g., mycophenolate, cyclophosphamide, methylprednisolone), as confirmed by claims history or submission of medical records

AND

4 - Prescribed in combination with a background immunosuppressive therapy regimen (e.g., mycophenolate mofetil and corticosteroids)

AND

5 - Patient is NOT receiving Lupkynis in combination with either of the following:

- Cyclophosphamide
- Benlysta (belimumab)

AND

6 - 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

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Medications for the Treatment of Acne

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-422470
Guideline Name	Medications for the Treatment of Acne
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Acanya, Brand Onexton, generic clindamycin/benzoyl peroxide gel, Azelex, benzoyl peroxide 2.5%, 5%, and 10% (all Rx and OTC products), clindamycin 1% (all Rx and OTC products), Brand Benzamycin, generic erythromycin/benzoyl peroxide gel, Brand Aczone, generic dapsone gel, Amzeeq, Ery Pads, erythromycin 2%, sodium sulfacetamide/sulfur (all Rx and OTC products), sodium sulfacetamide lotion/wash/gel/shampoo (all Rx and OTC products), Winlevi, Brand Differin, Adapalene, generic adapalene, Brand Atralin, Brand Retin-A, generic tretinoin, Altreno, Brand Retin-A Micro, generic tretinoin microsphere, Brand Ziana, generic clindamycin/tretinoin, Arazlo, Fabior, Tazarotene foam, Brand Tazorac, generic tazarotene, Brand Epiduo, Brand Epiduo Forte, Adapalene/benzoyl peroxide, generic adapalene/benzoyl peroxide	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria **1** - One of the following: **1.1** Patient is less than 21 years of age **OR** **1.2** Patient is 21 years of age or older and has a diagnosis of moderate to severe acne (Grade III or higher) **AND** **2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	
Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
10/20/2025	New guideline

Mepron

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-439225
Guideline Name	Mepron
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Mepron, generic atovaquone	
Diagnosis	Pneumocystis Jirovecii Pneumonia (PCP) Prophylaxis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis [e.g., HIV (human immunodeficiency virus)] warranting PCP (pneumocystis jirovecii pneumonia) infection prophylaxis

AND

2 - The patient has a documented intolerance or contraindication to trimethoprim-sulfamethoxazole (TMP-SMX) and dapsone (please specify intolerance or contraindication)

Product Name:Brand Mepron, generic atovaquone	
Diagnosis	Pneumocystis Jirovecii Pneumonia (PCP) Treatment
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of mild to moderate pneumonia caused by pneumocystis jirovecii

AND

2 - ONE of the following:

2.1 Failure of trimethoprim-sulfamethoxazole (TMP-SMX) confirmed by claims history or submitted medical records

OR

2.2 History of intolerance or contraindication to TMP-SMX (please specify intolerance or contraindication)

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Movement Disorder Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-422550
Guideline Name	Movement Disorder Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Austedo, Austedo XR, Ingrezza	
Diagnosis	Chorea Associated with Huntington's Disease
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chorea associated with Huntington's disease	

AND

2 - Patient is 18 years of age or older

AND

3 - Prescribed by or in consultation with a neurologist

Product Name:Austedo, Austedo XR, Ingrezza	
Diagnosis	Tardive Dyskinesia (TD)
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

- Austedo/Austedo XR: diagnosis of Tardive Dyskinesia (TD)
- Ingrezza: diagnosis of severe Tardive Dyskinesia (TD)

AND

2 - Patient is 18 years of age or older

AND

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

AND

4 - ONE of the following:

- Persistent symptoms of TD despite a trial of dose reduction, tapering or discontinuation of the offending medication
- The patient is NOT a candidate for trial of dose reduction, tapering or discontinuation of the offending medication

Product Name:Austedo, Austedo XR, Ingrezza	
Diagnosis	Chorea Associated with Huntington's Disease, Tardive Dyskinesia (TD)
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
10/22/2025	New program

Mozobil

Prior Authorization Guideline

Guideline ID	GL-439226
Guideline Name	Mozobil
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Mozobil, generic plerixafor

Diagnosis	Hematopoietic Stem Cell Mobilization
Approval Length	30 Day(s)
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

Product Name:Brand Mozobil, generic plerixafor	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name:Brand Mozobil, generic plerixafor	
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 the requested therapy

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Mulpleta

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-485191
Guideline Name	Mulpleta
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: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

2 . Revision History

Date	Notes
12/18/2025	Removed IN from formularies - see state specific GL-475187 for IN 1 .1.26. No other changes to guideline.

Multaq

Prior Authorization Guideline

Guideline ID	GL-438187
Guideline Name	Multaq
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - ALL of the following:

1.1 Diagnosis of ONE of the following:

- Paroxysmal Atrial Fibrillation (AF)
- Persistent AF defined as AF less than 6 months duration

AND

1.2 ONE of the following:

- Patient is in sinus rhythm
- Patient is planned to undergo cardioversion to sinus rhythm

AND

1.3 Patient does NOT have New York Heart Association (NYHA) Class IV heart failure

AND

1.4 Patient does NOT have symptomatic heart failure with recent decompensation requiring hospitalization

OR

2 - For continuation of current therapy

2 . Revision History

Date	Notes

11/5/2025	Combined formularies - added NV, VA, IN, NE, NM. No clinical chang es.

Multiple Sclerosis (MS) Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-461251
Guideline Name	Multiple Sclerosis (MS) Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Ampyra, generic dalfampridine	
Approval Length	Initial authorization approval length is 3 month; Reauthorization approval length is 12 months
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of MS (multiple sclerosis)

AND

2 - The requested medication is being used to improve the patient's walking speed

AND

3 - The requested medication is being prescribed by, or in consultation with, a neurologist

AND

4 - The patient is ambulatory and has an EDSS (expanded disability status scale) score between 2.5 and 6.5

AND

5 - The patient does NOT have moderate to severe renal dysfunction [creatinine clearance (CrCl) less than 50 ml/min (milliliters per minute)]

AND

6 - The patient does NOT have a history of seizures

AND

7 - The patient is NOT currently pregnant or attempting to conceive

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

Approval Criteria

1 - The patient has a diagnosis of a relapsing form of MS (multiple sclerosis) [e.g., relapsing-remitting MS (RRMS), secondary-progressive MS (SPMS) with relapses]

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 The patient has NOT been previously treated with Lemtrada (alemtuzumab)

AND

2.1.2 The patient has had failure after a trial of at least four weeks; a contraindication, or intolerance to two of the following disease-modifying therapies for MS:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone/Glatopa (glatiramer acetate)
- Extavia (interferon beta-1b)
- Gilenya (fingolimod)
- Mavenclad (cladribine)
- Mayzent (siponimod)
- Ocrevus (ocrelizumab)
- Plegridy (peginterferon beta-1a)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Tysabri (natalizumab)
- Zinbryta (daclizumab)

OR

2.2 Both of the following:

- The patient has been previously treated with Lemtrada (alemtuzumab)
- The patient has had at least 12 months elapsed or will have elapsed since the most recent treatment with Lemtrada (alemtuzumab)

AND

3 - The requested medication will NOT be used in combination with another disease-modifying therapy for MS

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

Approval Criteria

1 - The patient has a diagnosis of a relapsing form of MS (multiple sclerosis) [e.g., relapsing-remitting MS (RRMS), secondary-progressive MS (SPMS) with relapses]

AND

2 - One of the following:

2.1 Both of the following:

2.1.1 The patient has NOT been previously treated with Mavenclad (cladribine)

AND

2.1.2 The patient has had failure after a trial of at least four weeks; a contraindication, or intolerance to, two of the following disease-modifying therapies for MS:

- Aubagio (teriflunomide)
- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone/Glatopa (glatiramer acetate)
- Extavia (interferon beta-1b)
- Gilenya (fingolimod)
- Lemtrada (alemtuzumab)
- Mayzent (siponimod)
- Ocrevus (ocrelizumab)
- Plegridy (peginterferon beta-1a)
- Rebif (interferon beta-1a)
- Tecfidera (dimethyl fumarate)
- Tysabri (natalizumab)
- Zinbryta (daclizumab)

OR

2.2 Both of the following:

- The patient has been previously treated with Mavenclad (cladribine)
- The patient has NOT already received the FDA (Food and Drug Administration)-recommended lifetime limit of two treatment courses (or four treatment cycles total) of cladribine

AND

3 - The requested medication will NOT be used in combination with another disease-modifying therapy for MS

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

Approval Criteria

1 - The patient has a confirmed diagnosis of MS (multiple sclerosis) as documented by laboratory report (i.e., magnetic resonance imagining (MRI)] and one of the following:

1.1 The patient has a diagnosis of a relapsing form of MS (multiple sclerosis) [i.e., relapsing-remitting MS (RRMS), secondary-progressive MS (SPMS) with relapses or clinically isolated syndrome (CIS)]

OR

1.2 The patient has a diagnosis of primary progressive MS (PPMS) and both of the following:

- Patient is less than 65 years of age
- Patient has an EDSS (expanded disability status scale) score of less than or equal to 6.5

AND

2 - The patient is at least 18 years of age

AND

3 - The patient has been screened for the presence of HBV prior to initiating treatment and does NOT have active disease [i.e., positive Hepatitis B surface antigen (HBsAg) and anti-HBV tests]

AND

4 - The patient has had baseline serum immunoglobulins assessed

AND

5 - The patient will NOT receive live or live-attenuated vaccines while on therapy or within four weeks prior to initiation of treatment

AND

6 - The patient does NOT have an active infection

AND

7 - The requested medication will be used as single agent therapy

AND

8 - If the request is for a non-preferred product*, the patient has had a trial of one preferred product

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

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

Approval Criteria

1 - The patient continues to meet initial authorization criteria

AND

2 - The patient has NOT received a dose of Ocrevus (ocrelizumab) within the past five months

AND

3 - Absence of unacceptable toxicity from the drug (examples of unacceptable toxicity include: severe infusion reactions, severe infections, progressive multifocal leukoencephalopathy malignancy, hypogammaglobulinemia, immune-mediated colitis, etc.)

AND

4 - Continuous monitoring of response to therapy indicates a beneficial response

AND

5 - If the patient has a diagnosis of primary progressive MS (PPMS), patient continues ambulatory, defined as an EDSS (expanded disability status scale) score of less than 7.5

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

Approval Criteria

1 - The patient has a diagnosis of a relapsing form of MS (multiple sclerosis) [e.g., relapsing-remitting MS (RRMS), secondary-progressive MS (SPMS) with relapses or clinically isolated syndrome (CIS)]

AND

2 - The patient will NOT be initiating therapy after previous treatment with Lemtrada (alemtuzumab)

AND

3 - Prescribed by, or in consultation with, neurologist

AND

4 - One of the following:

4.1 The requested medication is being used for continuation of therapy

OR

4.2 The patient has had failure after a trial of at least four weeks, contraindication, or intolerance to at least one of the following disease-modifying therapies for MS:

- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone/Glatopa (glatiramer acetate)
- Tysabri (natalizumab)
- Tecfidera (dimethyl fumarate)
- Aubagio (teriflunomide)
- Gilenya (fingolimod)

Product Name:Ponvory

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

Approval Criteria

1 - The patient has documentation of positive clinical response to therapy (e.g., improvement in radiologic disease activity, clinical relapses, disease progression)

AND

2 - Prescribed by, or in consultation with, neurologist

Product Name:Avonex, Betaseron, Briumvi, Brand Copaxone, Glatopa, generic glatiramer, Kesimpta, Plegridy, Rebif, Tysabri	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of multiple sclerosis (MS)

AND

2 - If the request is for a non-preferred product*, the patient has had a trial of one preferred product

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Brand Aubagio, generic Brand Tecfidera, generic dimethyl fumarate, Brand Gilenya, generic fingolimod, Bafiertam, Mayzent, Vumerity	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria **1** - The patient has a diagnosis of multiple sclerosis (MS) **AND** **2** - If the request is for a non-preferred product*, the patient has had a trial of two preferred products	
Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
11/25/2025	Removed therapy stage from last 2 criteria boxes.

Myalept

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-442188
Guideline Name	Myalept
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Myalept	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of congenital or acquired generalized lipodystrophy associated with leptin deficiency

AND

2 - Used as an adjunct to diet modification

AND

3 - Prescribed by an endocrinologist

AND

4 - 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 200 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
11/6/2025	Added Nevada Formulary

Mycapssa

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-442189
Guideline Name	Mycapssa
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Mycapssa	
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 > 1 ng/mL (nanogram/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:

- Surgical resection
- Pituitary irradiation
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

OR

1.2.2 Not a candidate for ALL of the following:

- Surgical resection
- Pituitary irradiation
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

AND

1.3 Patient has responded to and tolerated treatment with ONE of the following somatostatin analogs:

- Sandostatin (octreotide) or Sandostatin LAR

• Somatuline Depot (lanreotide) [Note: Somatuline Depot (lanreotide) might not be covered on your pharmacy prescription drug benefit. Coverage might be available on your medical benefit.] **AND** **1.4** The provider has submitted clinical justification why the patient is unable to be maintained on current octreotide or lanreotide therapy* **OR** **2** - Patient is currently on Mycapssa therapy for acromegaly

Notes	*UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens, an indication of medical necessity.

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

Approval Criteria

1 - Documentation of a positive clinical response to Mycapssa therapy

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Narcolepsy Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-397257
Guideline Name	Narcolepsy Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Nuvigil, generic armodafinil, Brand Provigil, generic modafinil	
Diagnosis	Narcolepsy
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of narcolepsy

AND

2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Brand Nuvigil, generic armodafinil, Brand Provigil, generic modafinil	
Diagnosis	Excessive sleepiness associated with shift work disorder
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of excessive sleepiness associated with shift work disorder

AND

2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Brand Nuvigil, generic armodafinil, Brand Provigil, generic modafinil	
Diagnosis	Excessive sleepiness associated with shift work disorder
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 Nuvigil, generic armodafinil, Brand Provigil, generic modafinil	
Diagnosis	Obstructive Sleep Apnea (OSA)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of obstructive Sleep Apnea (OSA) defined by one of the following:

1.1 The patient has had 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)

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 (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)

AND

1.2.2 One of the following signs/symptoms are present:

- Daytime sleepiness
- Nonrestorative sleep
- Fatigue
- Insomnia
- Waking up with breath holding, gasping, or choking
- Habitual snoring noted by a bed partner or other observer
- Observed apnea

AND

2 - Both the following:

2.1 The patient has used a standard treatment(s) for the underlying obstruction for one month or longer [e.g., continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP)]

AND

2.2 The patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction

AND

3 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Sunosi	
Diagnosis	Obstructive Sleep Apnea (OSA)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of obstructive Sleep Apnea (OSA) defined by one of the following:

1.1 The patient has had 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)

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 (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)

AND

1.2.2 One of the following signs/symptoms are present:

- Daytime sleepiness
- Nonrestorative sleep
- Fatigue
- Insomnia
- Waking up with breath holding, gasping, or choking
- Habitual snoring noted by a bed partner or other observer
- Observed apnea

AND

2 - Both the following:

2.1 The patient has used a standard treatment(s) for the underlying obstruction for one month or longer [e.g., continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP)]

AND

2.2 The patient is fully compliant with ongoing treatment(s) for the underlying airway obstruction

AND

3 - The patient has had trial and failure, contraindication, or intolerance to both of the following:

- Provigil
- Nuvigil

Product Name:Brand Nuvigil, generic armodafinil, Brand Provigil, generic modafinil, Sunosi	
Diagnosis	Obstructive Sleep Apnea (OSA)
Approval Length	Approval length for Sunosi is 6 months; all other products approval length is 12 months
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

AND

2 - The patient continues to be fully compliant with ongoing treatment(s) for the underlying airway obstruction [e.g., continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP)]

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

Approval Criteria

1 - The patient has a diagnosis of narcolepsy confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)

AND

2 - The patient has had trial and failure, contraindication, or intolerance to both of the following:

- Provigil
- Nuvigil

Product Name:Sunosi	
Diagnosis	Narcolepsy

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

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

Approval Criteria

1 - The patient has a diagnosis of narcolepsy confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)

AND

2 - The patient is 18 years of age and older

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

Approval Criteria

1 - Documentation of positive clinical response to therapy

Product Name:Xywav, Xyrem, Sodium Oxybate, Lumryz	
Diagnosis	Narcolepsy with Cataplexy (Narcolepsy Type 1)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of narcolepsy confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)

AND

2 - The patient has present symptoms of cataplexy

AND

3 - The patient has symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep)

AND

4 - The requested medication is prescribed by or in consultation with one of the following:

- A neurologist
- A psychiatrist
- A Sleep Medicine Specialist

AND

5 - The patient meets the FDA (Food and Drug Administration) approved minimum age for the requested medication and indication

AND

6 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Xywav, Xyrem, Sodium Oxybate, Lumryz	
Diagnosis	Narcolepsy with Cataplexy (Narcolepsy Type 1)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Documentation demonstrating a reduction in the frequency of cataplexy attacks associated with therapy

OR

1.2 Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy

Product Name:Xywav, Xyrem, Sodium Oxybate, Lumryz	
Diagnosis	Narcolepsy without Cataplexy (Narcolepsy Type 2)
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of narcolepsy confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible) (please document justification if applicable)

AND

2 - The symptoms of cataplexy are absent in the patient

AND

3 - The patient has symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep)

AND

4 - Patient has trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age/weight), or intolerance to both of the following:

- Provigil or Nuvigil
- Sunosi

AND

5 - One of the following

5.1 The patient has trial and failure, contraindication, or intolerance to an amphetamine (e.g., amphetamine, dextroamphetamine) or methylphenidate-based stimulant

OR

5.2 The patient has history of or potential for substance use disorder

AND

6 - The requested medication is prescribed by or in consultation with one of the following:

- A neurologist
- A psychiatrist
- A Sleep Medicine Specialist

AND

7 - The patient meets the FDA (Food and Drug Administration) approved minimum age for the requested medication and indication

AND

8 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Product Name:Xywav, Xyrem, Sodium Oxybate, Lumryz	
Diagnosis	Narcolepsy without Cataplexy (Narcolepsy Type 2)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy

Product Name:Xywav	
Diagnosis	Idiopathic Hypersomnia
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of idiopathic hypersomnia with all 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 The absence of cataplexy

AND

1.3 Fewer than two sleep onset REM periods (SOREMPs) are found on a multiple sleep latency test (MSLT) performed according to standard techniques, or no SOREMPs if the REM sleep latency on the preceding polysomnogram was less than 15 minutes

AND

1.4 One of the following:

- A mean sleep latency of less than or equal to 8 minutes
- Total 24-hour sleep time greater than or equal to 660 minutes

AND

1.5 Other causes of sleepiness have been ruled out

AND

1.6 The medication is prescribed by or in consultation with one of the following:

- A neurologist
- A psychiatrist
- A Sleep Medicine Specialist

AND

1.7 Patient is at least 18 years old

Product Name:Xywav	
Diagnosis	Idiopathic Hypersomnia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy

2 . Revision History

Date	Notes
9/17/2025	New guideline

Neurokinin-1 Antagonists and Combinations

Prior Authorization Guideline

Guideline ID	GL-422527
Guideline Name	Neurokinin-1 Antagonists and Combinations
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:generic aprepitant, brand Emend, Aponvie, Cinvanti	
Approval Length	6 month(s)
Guideline Type	Quantity Limit
Approval Criteria **1** - The requested medication is being used for an FDA-approved indication **AND** **2** - Prescribed by an oncologist or in consultation with an oncologist	

AND

3 - ONE of the following:

- The patient is 18 years of age or older
- The patient is 12 years of age or older, the requested medication is aprepitant (Emend) and the patient is diagnosed with nausea and vomiting caused by chemotherapy

AND

4 - It is medically necessary for the patient to exceed the quantity limit (e.g., duration of chemotherapy cycle)

2 . Revision History

Date	Notes
10/21/2025	New program

Niemann-Pick Disease Type C (NPC) Agents

Prior Authorization Guideline

Guideline ID	GL-458419
Guideline Name	Niemann-Pick Disease Type C (NPC) Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Patient has diagnosis of Niemann-Pick disease type C (NPC) genetically confirmed by mutation analysis of NPC1 andNPC2 genes

AND

2 - The requested medication is being used to treat neurological manifestations of NPC

AND

3 - Patient weighs at least 15 kg (kilograms)

AND

4 - The requested medication is being dosed per FDA-(Food and Drug Administration) label based on actual body weight

AND

5 - If the request is for a female of reproductive potential, both of the following:

- The patient has a negative pregnancy test prior to initiating the requested medication
- The patient has been counseled to use effective contraception during treatment and for seven days after last dose if discontinued

AND

6 - The requested medication will not be used in combination with Miplyffa

AND

7 - The requested medication is prescribed by, or in consultation with, a geneticist, neurologist, or other specialist with advanced knowledge in treating NPC

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has diagnosis of Niemann-Pick disease type C (NPC) genetically confirmed by mutation analysis of NPC1 andNPC2 genes

AND

2 - The requested medication is being used to treat neurological manifestations of NPC

AND

3 - Patient is at least 2 years of age

AND

4 - The requested medication is being dosed (in combination with miglustat) per FDA-(Food and Drug Administration) label based on patient's actual body weight

AND

5 - The requested medication will not be used in combination with Aqneursa

AND

6 - The requested medication is prescribed by, or in consultation with, a geneticist, neurologist, or other specialist with advanced knowledge in treating NPC

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

Approval Criteria

1 - Patient continues to meet initial authorization criteria

AND

2 - Documentation of positive response to therapy

2 . Revision History

Date	Notes
12/10/2025	New guideline

Nityr

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-442190
Guideline Name	Nityr
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Nityr	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of hereditary tyrosinemia type 1	

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Non-Preferred Drugs

Prior Authorization Guideline

Guideline ID	GL-504209
Guideline Name	Non-Preferred Drugs
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Non-Preferred Drugs	
Approval Length	*Patients discharged from an institution on a non-preferred psychotropic and/or non-preferred anti-depressant medication(s), approval length is up to 6 month(s) from discharge date; otherwise, approval length is 12 month(s)
Guideline Type	Administrative
Approval Criteria **1** - The patient has been discharged from an institution on a non-preferred psychotropic and/or non-preferred anti-depressant medication(s) within the past 6 months* (please document date of discharge)	

OR

2 - All of the following:

2.1 One of the following:

2.1.1 If the requested medication is being prescribed for a psychiatric condition [defined as a mental disorder for which criteria are prescribed in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA)], all of the following:

2.1.1.1 Submission of medical records confirming one of the following:

- The patient has an FDA (Food and Drug Administration) approved indication for the requested medication
- The use of the requested medication to treat the patient's condition is supported by medical or scientific evidence

AND

2.1.1.2 The prescriber is one of the following:

- A psychiatrist
- A physician assistant under the supervision of a psychiatrist
- An Advanced Practice Registered Nurse (APRN) who has the psychiatric training and experience prescribed by the State Board of Nursing pursuant to NRS 632.120
- A primary care provider that is providing care in consultation with any practitioner listed above, and the closest practitioner above who participates in the network plan of the patient is located 60 miles or more from the residence of the patient

AND

2.1.1.3 One of the following:

2.1.1.3.1 Allergy to all preferred medications within the same class

OR

2.1.1.3.2 Contraindication to or drug-to-drug interaction with all preferred medications within the same class

OR

2.1.1.3.3 History of unacceptable/toxic side effects to all preferred medications within the same class

OR

2.1.1.3.4 Therapeutic failure of two preferred medications within the same class (If there are not two preferred medications within the same class, therapeutic failure only needs to occur on the one preferred medication), UNLESS the requested medication is for an atypical or typical antipsychotic or anticonvulsant then the patient demonstrated therapeutic failure on one preferred agent

OR

2.1.1.3.5 The requested medication has an indication which is unique to a non-preferred agent, and is supported by peer-reviewed literature or an FDA-approved indication

OR

2.1.1.3.6 Both of the following:

- The prescriber believes based on the medical history of the patient or reasonably expects each preferred drug within the same class to be ineffective at treating the psychiatric condition
- Submission of supportive clinical documentation demonstrating the reasoning for use of the requested medication

OR

2.1.2 Otherwise, one of the following:

- Allergy to all preferred medications within the same class
- Contraindication to or drug-to-drug interaction with all preferred medications within the same class
- History of unacceptable/toxic side effects to all preferred medications within the same class

- Therapeutic failure of two preferred medications within the same class (If there are not two preferred medications within the same class, therapeutic failure only needs to occur on the one preferred medication), UNLESS the requested medication is for an atypical or typical antipsychotic, anticonvulsant, antidiabetic, dopamine precursor, injectable multiple sclerosis or non-sedating H1 blocker medication, then the patient demonstrated therapeutic failure on one preferred agent
- The requested medication has an indication which is unique to a non-preferred agent, and is supported by peer-reviewed literature or an FDA-approved indication

AND

2.2 If the request is for a multi-source brand medication, OR a branded medication with an authorized generic, one of the following:

- The brand is being requested because of an adverse reaction, allergy or sensitivity to a generic/authorized generic equivalent (specify the adverse reaction, allergy, or sensitivity)
- The brand is being requested due to an incomplete response with a generic/authorized generic equivalent, as documented by submission of medical records
- The brand is being requested because transition to a generic/authorized generic equivalent could result in destabilization of the patient
- Special clinical circumstances exist that preclude the use of a generic/authorized generic equivalent of the brand medication for the patient (document special clinical circumstances)

AND

2.3 If the request is for a generic when there is a brand available and the brand is the preferred formulation, one of the following:

- The generic is being requested because of an adverse reaction, allergy or sensitivity to the brand (specify the adverse reaction, allergy, or sensitivity)
- The generic is being requested due to an incomplete response with the brand, as documented by submission of medical records
- The generic is being requested because transition to the brand could result in destabilization of the patient
- Special clinical circumstances exist that preclude the use of the brand equivalent of the generic medication for the patient (document special clinical circumstances)

AND

2.4 If the request is for an oral non-solid dosage form (e.g., suspension) when there is an equivalent solid dosage form available, one of the following:

- Patient is unable to swallow a solid dosage form
- Patient utilizes a feeding tube for medication administration
- Request is for a nebulized formulation of an inhaled agent for a patient who has an inability to effectively utilize an agent in an inhaler formulation due to neuromuscular or cognitive disability, or other evidence of lack of response to the inhaled formulation supported by clinical documentation

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:PA Required Medications For a New Indication Not Addressed in Drug Specific Guideline	
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - Both of the following:

1.1 Diagnosis is consistent with an indication listed in the product's FDA-approved prescribing information (or package insert)

AND

1.2 All of the following labeling requirements have been met:

1.2.1 All requirements listed in the “Indications and Use” have been met (e.g., pre-requisite treatment, any testing requirements have been met, etc.)

AND

1.2.2 Prescribed medication is approved for the patient’s age

AND **1.2.3** “Dosage and Administration” section of the prescribing information (or package insert) has been met **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** - If the requested medication is non-preferred, patient meets the non-preferred criteria as applicable

Notes	These criteria come from PA Required Medications For a New Indicati on Not Addressed in Drug Specific Guideline policy.

2 . Revision History

Date	Notes
1/16/2026	Added criteria for non-solid dosage forms.

Northera

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-442191
Guideline Name	Northera
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Northera, generic droxidopa	
Approval Length	12 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 - ONE of the following:

7.1 Failure (after a trial of at least 30 days) of BOTH of the following confirmed by claims history or submitted medical records:

- fludrocortisone (generic Florinef)
- midodrine (generic ProAmatine)

OR

7.2 History of contraindication or intolerance to BOTH of the following:

- fludrocortisone (generic Florinef)
- midodrine (generic ProAmatine)

Product Name:Brand Northera, generic droxidopa	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria
1 - Documentation of positive clinical response to the requested therapy **AND** **2** - Physiological countermeasures for neurogenic orthostatic hypotension (nOH) continue to be employed

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Nuzyra

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-442192
Guideline Name	Nuzyra
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Nuzyra tablets	
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 Nuzyra

AND

3.3 ONE of the following:

3.3.1 Failure to THREE of the following antibiotics or antibiotic regimens, as confirmed by claims history or submission of medical records:

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

OR

3.3.2 History of intolerance or contraindication to ALL of the following antibiotics or antibiotic regimens (please specify intolerance or contraindication):

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

OR

4 - ALL of the following:

4.1 ONE of the following diagnoses:

4.1.1 BOTH of the following:

4.1.1.1 Acute bacterial skin and skin structure infections

AND

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

OR

4.1.2 BOTH of the following:

4.1.2.1 Empirical treatment of a patient with acute bacterial skin and skin structure infections

AND

4.1.2.2 Presence of MRSA infection is likely

AND

4.2 ONE of the following:

4.2.1 Failure to linezolid (generic Zyvox) as confirmed by claims history or submission medical records

OR

4.2.2 History of intolerance or contraindication to linezolid (generic Zyvox) (please specify intolerance or contraindication)

AND

4.3 ONE of the following:

4.3.1 Failure to ONE of the following antibiotics as confirmed by claims history or submission medical records:

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

OR

4.3.2 History of intolerance or contraindication to ALL of the following antibiotics (please specify intolerance or contraindication):

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

OR

5 - ALL of the following:

5.1 Diagnosis of acute bacterial skin and skin structure infections

AND

5.2 Infection caused by an organism that is confirmed to be or likely to be susceptible to treatment with Nuzyra

AND

5.3 ONE of the following:

5.3.1 Failure to THREE of the following antibiotics confirmed by claims history or submission medical records:

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

OR

5.3.2 History of intolerance or contraindication to ALL of the following antibiotics (please specify intolerance or contraindication):

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

OR

6 - The drug has been recognized for treatment of the indication by the Infectious Diseases Society of America (IDSA)

Notes	Authorization duration for CABP and acute bacterial skin and skin stru cture infections will be issued for up to 14 days. For all IDSA recogniz ed indications, authorization duration is based on provider and IDSA r ecommended treatment durations, up to 6 months.

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Ocaliva (obeticholic acid), Iqirvo (elafibranor), Livdelzi (seladelpar)

Prior Authorization Guideline

Guideline ID	GL-504211
Guideline Name	Ocaliva (obeticholic acid), Iqirvo (elafibranor), Livdelzi (seladelpar)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Ocaliva, Iqirvo, Livdelzi	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is greater than or equal to 18 years of age

AND

2 - The patient has a diagnosis of primary biliary cholangitis (PBC) confirmed by TWO of the following:

- Biochemical evidence of cholestasis with an alkaline phosphatase (ALP) elevation
- Presence of anti-mitochondrial antibodies (AMAs) or other PBC-specific antibodies (anti-sp100, anti gp210, Anti-Kelch-Like 12, and/or Anti-Hexokinase 1)
- Histopathologic evidence of nonsuppurative cholangitis and destruction of small or medium bile ducts on liver biopsy

AND

3 - ONE of the following:

- The requested medication is being prescribed in combination with ursodeoxycholic acid (UDCA) due to inadequate response to trial of at least 12 months with UDCA
- The patient has a history of intolerance or contraindication to UDCA

AND

4 - Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or other specialist with advanced knowledge of treating PBC

AND

5 - The prescriber attests that the patient does not have any FDA-labeled contraindications to the requested medication (e.g., complete biliary obstruction, decompensated cirrhosis)

Product Name:Ocaliva, Iqirvo, Livdelzi	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient continues to meet the initial authorization criteria

AND **2** - Documentation of positive response to therapy

2 . Revision History

Date	Notes
1/20/2026	Specified Anti-Hexokinase 1 in initial auth. Deleted ";" at the end of fir st bullet point in step 3.

Opfolda

Prior Authorization Guideline

Guideline ID	GL-442194
Guideline Name	Opfolda
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of late-onset Pompe disease as confirmed by ONE of the following:

1.1 Absence or deficiency (less than 40% of the lab specific normal mean) of acid alpha-glucosidase (GAA) activity in lymphocytes, fibroblasts or muscle

OR

1.2 Molecular genetic testing for deletion or mutations in the GAA gene

AND

2 - Presence of clinical signs and symptoms of the disease (e.g., cardiac hypertrophy, respiratory distress, skeletal muscle weakness, etc.)

AND

3 - Provider attests that the patient is not improving on their current enzyme replacement therapy (ERT) (e.g., Lumizyme, Nexviazyme) for the treatment of late-onset Pompe disease and this therapy will be stopped

AND

4 - Patient weighs at least 40kg

AND

5 - Opfolda will be prescribed in combination with Pombiliti (cipaglucosidase alfa-atga)

Product Name:Opfolda	
Approval Length	12 month(s)

Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Opfolda plus Pombiliti

AND

2 - Opfolda continues to be prescribed in combination with Pombiliti

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Opioid Containing Cough Preparations

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-404229
Guideline Name	Opioid Containing Cough Preparations
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Hycodan tab and syrup, generic hydrocodone/homatropine tabs and syrup, Hydromet syrup, Tuxarin ER, promethazine-codeine syrup, hydrocodone polst-chlorphen polst ER, Poly-Tussin AC, Maxi-Tuss CD, Pro-Red AC, Rydex, Ninjacof-XG, Coditussin AC, Mar-Cof CG, all guaifenesin/codeine 100-10mg/5ml products, Coditussin DAC	
Approval Length	6 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The patient is 18 years of age or older	

AND **2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	
Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
10/8/2025	New guideline

Oral Oncology Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-427223
Guideline Name	Oral Oncology Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Cyclophosphamide tablets, temozolomide caps, Tukysa, Hernexeos, Onureg, Brand Purixan susp, generic mercaptopurine susp, Jylamvo, Xatmep, Trexall, Inlyta, Fruzaqla, Lenvima, Gilotrif, Vizimpro, Brand Tarceva, generic erlotinib, Brand Iressa, generic gefitinib, Lazcluze, Tagrisso, Daurismo, Odomzo, Erivedge, Lysodren, Erleada, Brand Casodex, Nubeqa, Xtandi, nilutamide, Soltamox, Brand Fareston, Brand Arimidex, Brand Aromasin, Brand Femara, Orserdu, Orgovyx, Brand Zytiga, generic abiraterone, Abirtega, Yonsa, Akeega, Pomalyst, Venclexta, Revuforj, Ayvakit, Truqap, Alecensa, Alunbrig, Zykadia, Xalkori, Lorbrena, Verzenio, Ibrance, Kisqali, Zolinza, Romvimza, Scemblix, Bosulif, Brand Sprycel, generic dasatinib, Phyrago, Brand Gleevec, generic imatinib, Imkeldi, Nilotinib, Brand Tasigna, generic nilotinib, Danziten, Iclusig, Tafinlar, Ojemda, Zelboraf, Calquence, Imbruvica, Jaypirca, Brukinsa, Balversa, Lytgobi, Pemazyre, Ogsiveo, Krazati, Lumakras, Brand Afinitor, generic everolimus tabs, Torpenz, Brand Afinitor Disperz, generic everolimus tbso, Cabometyx, Cometriq, Xospata, Brand Tykerb, generic lapatinib, Rydapt, Nerlynx, Brand Votrient, generic pazopanib, Turalio, Vanflyta, Stivarga, Qinlock, Brand Nexavar, generic sorafenib, Brand Sutent, generic sunitinib, Fotivda, Caprelsa, Mektovi, Cotellic, Gomekli, Koselugo, Mekinist, Tazverik, Tabrecta, Tepmetko, Rozlytrek, Vitrakvi, Augtyro, Ibtrozi, Tibsovo, Idhifa, Voranigo, Zejula, Lynparza, Rubraca, Talzenna, Gavreto, Retevmo,

Ninlaro, Inrebic, Ojjaara, Vonjo, Jakafi, Piqray, Copiktra, Zydelig, Itovebi, Hycamtin caps, Xpovio, Modeyso, Brand Hydrea, Matulane, generic bexarotene, Iwilfin, Avmapki Fakzynja co-pack, Inqovi, Lonsurf, Thalomid, Revlimid, lenalidomide, Vijoice	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis that is indicated in the FDA (Food and Drug Administration) approved package insert or listed in nationally recognized compendia

AND

2 - One of the following:

2.1 The requested medication is indicated as a first line agent, either in the FDA approved package insert or nationally recognized compendia

OR

2.2 The requested medication is NOT indicated as a first line agent, either in the FDA approved package insert or nationally recognized compendia, then there is documentation of previous therapies tried and failed

AND

3 - The requested medication is prescribed by, or in consultation with, an oncologist or hematologist

AND

4 - The patient does NOT have any contraindications to the requested medication

AND

5 - The requested quantity and dosing regimen falls within the manufacturer's published dosing guidelines or nationally recognized compendia and is appropriate for the patient's age

AND

6 - The requested medication will be used in combination with other chemotherapeutic or adjuvant agents according to the FDA-approved prescribing information, if applicable

AND

7 - One of the following, if applicable:

7.1 If an FDA-approved companion diagnostic test for the requested medication exists, then there is documentation that the test was performed to confirm the diagnosis

OR

7.2 If a test with adequate ability to confirm a disease mutation exists, then there is documentation that the test was performed to confirm the diagnosis

AND

8 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Cyclophosphamide tablets, temozolomide caps, Tukysa, Hernexeos, Onureg, Brand Purixan susp, generic mercaptopurine susp, Jylamvo, Xatmep, Trexall, Inlyta, Fruzaqla, Lenvima, Gilotrif, Vizimpro, Brand Tarceva, generic erlotinib, Brand Iressa, generic gefitinib, Lazcluze, Tagrisso, Daurismo, Odomzo, Erivedge, Lysodren, Erleada, Brand Casodex, Nubeqa, Xtandi, nilutamide, Soltamox, Brand Fareston, Brand Arimidex, Brand Aromasin, Brand Femara, Orserdu, Orgovyx, Brand Zytiga, generic abiraterone, Abirtega, Yonsa, Akeega, Pomalyst, Venclexta, Revuforj, Ayvakit, Truqap, Alecensa, Alunbrig, Zykadia, Xalkori, Lorbrena, Verzenio, Ibrance, Kisqali, Zolinza, Romvimza, Scemblix, Bosulif, Brand Sprycel, generic dasatinib, Phyrago, Brand Gleevec, generic imatinib, Imkeldi, Nilotinib, Brand Tasigna, generic nilotinib, Danziten, Iclusig, Tafinlar, Ojemda, Zelboraf, Calquence, Imbruvica, Jaypirca, Brukinsa, Balversa, Lytgobi, Pemazyre, Ogsiveo, Krazati, Lumakras,

Brand Afinitor, generic everolimus tabs, Torpenz, Brand Afinitor Disperz, generic everolimus tbso, Cabometyx, Cometriq, Xospata, Brand Tykerb, generic lapatinib, Rydapt, Nerlynx, Brand Votrient, generic pazopanib, Turalio, Vanflyta, Stivarga, Qinlock, Brand Nexavar, generic sorafenib, Brand Sutent, generic sunitinib, Fotivda, Caprelsa, Mektovi, Cotellic, Gomekli, Koselugo, Mekinist, Tazverik, Tabrecta, Tepmetko, Rozlytrek, Vitrakvi, Augtyro, Ibtrozi, Tibsovo, Idhifa, Voranigo, Zejula, Lynparza, Rubraca, Talzenna, Gavreto, Retevmo, Ninlaro, Inrebic, Ojjaara, Vonjo, Jakafi, Piqray, Copiktra, Zydelig, Itovebi, Hycamtin caps, Xpovio, Modeyso, Brand Hydrea, Matulane, generic bexarotene, Iwilfin, Avmapki Fakzynja co-pack, Inqovi, Lonsurf, Thalomid, Revlimid, lenalidomide, Vijoice	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of a positive clinical response to the requested treatment	

2 . Revision History

Date	Notes
10/27/2025	New guideline

Osphena

Prior Authorization Guideline

Guideline ID	GL-442195
Guideline Name	Osphena
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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 - ONE of the following:

2.1 Failure to BOTH of the following as confirmed by claims history or submission of medical records:

- Estradiol vaginal cream
- Estradiol vaginal tablet

OR

2.2 History of intolerance or contraindication to BOTH of the following (please specify intolerance or contraindication):

- 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
11/6/2025	Added Nevada Formulary

Osteoporosis Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-504224
Guideline Name	Osteoporosis Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of postmenopausal osteoporosis or osteopenia

AND

2 - ONE of the following:

2.1 BOTH of the following:

2.1.1 The patient's Bone Mineral Density (BMD) T-score is -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

AND

2.1.2 ONE of the following:

- The patient has a documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm
- The patient has a documented trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

OR

2.2 BOTH of the following:

2.2.1 The patient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

AND

2.2.2 ONE of the following:

2.2.2.1 The patient has a documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm

OR

2.2.2.2 BOTH of the following:

2.2.2.2.1 The patient has a documented trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

AND

2.2.2.2.2 ONE of the following Fracture Risk Assessment Tool (FRAX) 10-year probabilities:

- The patient has a major osteoporotic fracture at 20% or more
- The patient has a hip fracture at 3% or more

AND

3 - The patient has a documented trial and failure, contraindication, or intolerance to ONE of the following:

- Teriparatide (e.g., Forteo, Bonsity)
- Tymlos (abaloparatide)

AND

4 - Treatment duration of Evenity (romosozumab-aqqg) has not exceeded a total of 12 months during the patient's lifetime

Product Name:Brand Forteo, Bonsity, Teriparatide, generic teriparatide	
Approval Length	24 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - For Postmenopausal Osteoporosis or Osteopenia, or Men with Primary or Hypogonadal Osteoporosis or Osteopenia at High Risk for Fracture, BOTH of the following:

1.1 ONE of the following:

1.1.1 BOTH of the following:

1.1.1.1 The patient has a BMD T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

AND

1.1.1.2 ONE of the following:

- The patient has a documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm
- Documented trial and failure, contraindication, or intolerance to ONE osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

OR

1.1.2 BOTH of the following:

1.1.2.1 The patient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

AND

1.1.2.2 ONE of the following:

1.1.2.2.1 Patient has a documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm

OR

1.1.2.2.2 BOTH of the following:

1.1.2.2.2.1 Patient has a documented trial and failure, contraindication, or intolerance to ONE osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

AND

1.1.2.2.2.2 ONE of the following FRAX 10-year probabilities:

- Major osteoporotic fracture at 20% or more
- Hip fracture at 3% or more

AND

1.2 Patient's treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during the patient's lifetime

OR

2 - For Glucocorticoid-Induced Osteoporosis at High Risk for Fracture, ALL of the following:

2.1 The patient has a documented history of prednisone or its equivalent at a dose at least 5 mg/day for at least 3 months

AND

2.2 ONE of the following:

2.2.1 BMD T-score of -2.5 or lower based on BMD measurements from lumbar spine, femoral neck, total hip, or radius (one-third radius site)

OR

2.2.2 The patient has one of the following FRAX 10-year probabilities:

- Major osteoporotic fracture at 20% or more
- Hip fracture at 3% or more

OR

2.2.3 The patient has a documented history of one of the following fractures 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

AND

2.3 Documented trial and failure, contraindication, or intolerance to ONE bisphosphonate (e.g., alendronate)

AND

2.4 The patient's treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during the patient's lifetime

Product Name:Tymlos	
Approval Length	24 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of osteoporosis or osteopenia

AND

2 - ONE of the following:

- Postmenopausal female at high risk for fracture or has failed or is intolerant to other available osteoporosis therapy
- Male at high risk for fracture or has failed or is intolerant to other available osteoporosis therapy

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 BMD T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

AND

3.1.2 ONE of the following:

- Documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm
- Documented trial and failure, contraindication, or intolerance to ONE osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

OR

3.2 BOTH of the following:

3.2.1 Patient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)

AND

3.2.2 ONE of the following:

3.2.2.1 Patient has a documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm

OR

3.2.2.2 BOTH of the following:

3.2.2.2.1 Documented trial and failure, contraindication, or intolerance to ONE osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])

AND

3.2.2.2.2 The patient has ONE of the following FRAX 10-year probabilities:

- Major osteoporotic fracture at 20% or more
- Hip fracture at 3% or more

AND **4** - Patient's treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during their lifetime

2 . Revision History

Date	Notes
1/21/2026	New program

Oxervate

Prior Authorization Guideline

Guideline ID	GL-423406
Guideline Name	Oxervate
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Patient is 2 years of age or older

AND

2 - Diagnosis of moderate to severe (stage two or stage three) neurotrophic keratitis (NK)

AND

3 - Prescribed by or in consultation with an ophthalmologist

AND

4 - Prescriber attestation that patient or caregiver has been counseled on proper administration technique

AND

5 - Patient has not exceeded eight kits per affected eye per lifetime

2 . Revision History

Date	Notes
10/22/2025	New

Palforzia

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-442196
Guideline Name	Palforzia
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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:

- A serum peanut-specific IgE (immunoglobulin E) level of greater than or equal to 0.35 kUA/L (kilounits of allergen/liter)
- A mean wheal diameter that is at least 3 mm (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 any 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/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/immunologist

AND

4 - Prescriber is certified/enrolled in the Palforzia REMS (Risk Evaluation and Mitigation Strategy) Program

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Palynziq

Prior Authorization Guideline

Guideline ID	GL-501215
Guideline Name	Palynziq
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of phenylketonuria (PKU)

AND

2 - Patient is actively on a phenylalanine-restricted diet

AND

3 - ONE of the following:

3.1 Failure to sapropterin as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to sapropterin therapy (please specify contraindication or intolerance)

OR

3.3 Patient is not an appropriate candidate for sapropterin due to two null mutations in trans

AND

4 - Physician attestation that the patient will not be receiving Palynziq in combination with sapropterin dihydrochloride or Sephience (sepiapterin)

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/liter

Product Name:Palynziq	
Approval Length	12 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/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 Patient is in initial titration/maintenance phase of dosing regimen and dose is being titrated based on blood phenylalanine concentration response up to maximum labeled dosage of 60 milligrams once daily

AND

3 - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is not receiving Palynziq in combination with sapropterin dihydrochloride or Sephience (sepiapterin) [Prescription claim history that does not show any concomitant sapropterin dihydrochloride or Sephience (sepiapterin) claim within 60 days of reauthorization request may be used as documentation]

2 . Revision History

Date	Notes
1/15/2026	Removed PACAID. Added Sephience to combination use criteria. Up dated initial auth to remove specified length of sapropterin therapy tri al requirement and to exclude patients with two null mutations in tran s.

Penicillamine

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-422568
Guideline Name	Penicillamine
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
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	

AND

2 - Prescribed by or in consultation with a gastroenterologist, hepatologist, rheumatologist, or liver transplant physician

Product Name:Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
Diagnosis	Wilson's Disease
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient continues to meet initial authorization criteria

AND

2 - Documentation of positive clinical response to therapy

Product Name:Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
Diagnosis	Cystinuria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cystinuria

AND

2 - Patient has a history of failure, contraindication, or intolerance to conservative treatment measures (e.g., use of urinary alkalinization such as potassium citrate, high fluid intake, sodium, and protein restriction)

AND

3 - Prescribed by or in consultation with a nephrologist or urologist

Product Name:Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
Diagnosis	Cystinuria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of cystinuria

AND

2 - Prescribed by or in consultation with a nephrologist or urologist

AND

3 - Documentation of positive clinical response to therapy

Product Name:Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
Diagnosis	Rheumatoid arthritis (RA)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe active rheumatoid arthritis (RA)

AND

2 - Patient has a contraindication to or documented intolerance or failure with an adequate trial (6-12 weeks) of at least one non-biologic DMARD (e.g., methotrexate, leflunomide, azathioprine)

AND

3 - Prescribed by or in consultation with a rheumatologist

Product Name:Brand Cuprimine, Brand Depen Titratabs, generic penicillamine	
Diagnosis	Rheumatoid arthritis (RA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe active rheumatoid arthritis (RA)

AND

2 - Prescribed by or in consultation with a rheumatologist

AND **3** - Documentation of positive clinical response to therapy

2 . Revision History

Date	Notes
10/23/2025	New program

Phexxi

Prior Authorization Guideline

Guideline ID	GL-442198
Guideline Name	Phexxi
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Arizona (ACUAZ, ACUAZEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Used for the prevention of pregnancy

AND

2 - ONE of the following:

2.1 Failure to ALL of the following methods of contraception as confirmed by claims history or submission of medical records:

- Injection (e.g., Depo-Provera)
- Oral Contraceptive [e.g., norethindrone (generic Micronor), Yaz]
- Transdermal Patch (e.g., Twirla, Xulane)
- Vaginal Contraceptive Ring (e.g., Annovera, NuvaRing)
- Diaphragm
- Cervical Cap (e.g., FemCap)
- Female Condom

OR

2.2 History of intolerance or contraindication to ALL of the following methods of contraception (please document intolerance or contraindication):

- Injection (e.g., Depo-Provera)
- Oral Contraceptive [e.g., norethindrone (generic Micronor), Yaz]
- Transdermal Patch (e.g., Twirla, Xulane)
- Vaginal Contraceptive Ring (e.g., Annovera, NuvaRing)
- Diaphragm
- Cervical Cap (e.g., FemCap)
- Female Condom

AND

3 - ONE of the following:

3.1 Failure to nonoxynol-9 based spermicide as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to nonoxynol-9 based spermicide (please document intolerance or contraindication)

AND

4 - Provider attests they have counseled the patient regarding higher rate of pregnancy prevention with the use of other methods of contraception (e.g., injection, oral contraception, transdermal patch, vaginal ring) compared to Phexxi

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Platelet Inhibitors

Prior Authorization Guideline

Guideline ID	GL-420211
Guideline Name	Platelet Inhibitors
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Brilinta, generic ticagrelor	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Acute Coronary Syndrome (ACS) (i.e., unstable angina, non-ST elevation myocardial infarction or ST elevation myocardial infarction)

AND

2 - The patient does not have an active pathological bleed or history of intracranial hemorrhage

AND

3 - The patient will be receiving concomitant treatment with aspirin dosed less than 100 mg/daily

AND

4 - ONE of the following:

- The patient has been started and stabilized on the requested medication
- The patient has experienced an adverse event with or has an allergy or contraindication to clopidogrel
- Another clinically appropriate rationale is provided for why clopidogrel cannot be used (document rationale)

AND

5 - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Brand Effient, generic prasugrel	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Acute Coronary Syndrome (ACS) (i.e., unstable angina, non-ST elevation myocardial infarction or ST elevation myocardial infarction)

AND

2 - The patient does not have an active pathological bleed or history of transient ischemic attack or cerebral vascular accident (CVA)

AND

3 - The patient will be receiving concomitant treatment with aspirin dosed less than 100 mg/daily

AND

4 - The patient has a history of percutaneous coronary intervention

AND

5 - ONE of the following:

- The patient has been started and stabilized on the requested medication
- The patient has experienced an adverse event with or has an allergy or contraindication to clopidogrel
- Another clinically appropriate rationale is provided for why clopidogrel cannot be used (document rationale)

AND

6 - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes

10/9/2025	New program

Polyneuropathy of Hereditary Amyloidosis Agents

Prior Authorization Guideline

Guideline ID	GL-395190
Guideline Name	Polyneuropathy of Hereditary Amyloidosis Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is greater than or equal to 18 years of age

AND

2 - Diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis confirmed by testing (e.g., genetic testing, biopsy)

AND

3 - Prescribed by, or in consultation with, a cardiologist, geneticist, neurologist, or other specialist with advanced knowledge in treating hereditary transthyretin mediated amyloidosis

AND

4 - The patient has clinical manifestations of polyneuropathy

AND

5 - Onpattro will not be used in combination with other transthyretin (TTR) reducing or stabilizing agents (e.g., eplontersen, inotersen, tafamidis, vutrisiran, etc.)

AND

6 - The patient does not have any of the following conditions:

- Severe renal impairment or end-stage renal disease
- Moderate or severe hepatic impairment
- Prior liver transplant

AND

7 - Prescriber will supplement vitamin A at the recommended daily allowance as appropriate and refer to an ophthalmologist if ocular symptoms suggestive of vitamin A deficiency (e.g., night blindness, dry eyes) occur

AND

8 - Onpattro will be dosed every three weeks per FDA-label based on patient actual body weight

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

Approval Criteria

1 - The patient continues to meet the initial authorization criteria

AND

2 - The patient has demonstrated a clinical benefit based on improvement in clinical manifestations of polyneuropathy from baseline

AND

3 - The patient has not experienced any treatment restricting adverse effects (e.g., severe ocular symptoms related to vitamin A deficiency)

2 . Revision History

Date	Notes
9/10/2025	1/1/2026 Implementation

Preferred Non-Solid Dosage Forms

Prior Authorization Guideline

Guideline ID	GL-483575
Guideline Name	Preferred Non-Solid Dosage Forms
Formulary	• Medicaid - Community & State Arizona (ACUAZ, ACUAZEC) • Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State North Carolina (ACUNC) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Diagnosis	Requests for Non-Solid Dosage Forms
Approval Length	12 month(s)
Guideline Type	Administrative

Approval Criteria

1 - ONE of the following:

1.1 Requested drug must be used for an FDA (Food and Drug Administration)-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 Pharmacopeia-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 plans' program

AND

3 - ONE of the following:

3.1 BOTH of the following:

3.1.1 The patient is able to swallow a solid dosage form

AND

3.1.2 ONE of the following:

3.1.2.1 History of failure to at least THREE preferred* solid oral dosage forms as confirmed by claims history or submission of medical records. NOTE: In instances where there are fewer

than three preferred alternatives, the patient must have a history of failure to ALL of the preferred products. **OR** **3.1.2.2** History of contraindication or intolerance to THREE preferred* solid oral dosage forms (please specify contraindication or intolerance). NOTE: In instances where there are fewer than three preferred alternatives, the patient must have a history of contraindication or intolerance to ALL of the preferred products. **OR** **3.1.2.3** There are no preferred formulary alternatives for the requested drug **OR** **3.2** Patient is unable to swallow a solid dosage form **OR** **3.3** Patient utilizes a feeding tube for medication administration **OR** **3.4** Request is for a nebulized formulation of an inhaled medication for a patient who has an inability to effectively utilize an agent in an inhaler formulation due to neuromuscular or cognitive disability, or other evidence of lack of response to the inhaled formulation supported by clinical documentation	
Notes	*See Table 1 in Background for PDL links. Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request.

2 . Background

Benefit/Coverage/Program Information

Table 1. PDL Links

Arizona	https://www.uhcprovider.com/en/health-plans-by-state/arizona-health-plans/az-comm-plan-home/az-cp-pharmacy.html?rfid=UHCCP
Colorado	https://www.uhcprovider.com/en/health-plans-by-state/colorado-health-plans/co-comm-plan-home/co-cp-pharmacy.html
Hawaii	https://www.uhcprovider.com/en/health-plans-by-state/hawaii-health-plans/hi-comm-plan-home/hi-cp-pharmacy.html
Indiana	https://www.uhcprovider.com/en/health-plans-by-state/indiana-health-plans/in-comm-plan-home/in-cp-pharmacy.html
Maryland	https://www.uhcprovider.com/en/health-plans-by-state/maryland-health-plans/md-comm-plan-home/md-cp-pharmacy.html
Michigan	https://www.uhcprovider.com/en/health-plans-by-state/michigan-health-plans/mi-comm-plan-home/mi-cp-pharmacy.html
New Jersey	https://www.uhcprovider.com/en/health-plans-by-state/new-jersey-health-plans/nj-comm-plan-home/nj-cp-pharmacy.html
New Mexico	https://www.uhcprovider.com/en/health-plans-by-state/new-mexico-health-plans/nm-comm-plan-home/nm-cp-pharmacy.html
North Carolina	https://www.uhcprovider.com/en/health-plans-by-state/north-carolina-health-plans/nc-comm-plan-home/nc-cp-pharmacy.html
Pennsylvania CAID/CHIP	https://www.uhcprovider.com/en/health-plans-by-state/pennsylvania-health-plans/pa-comm-plan-home/pa-cp-pharmacy.html?rfid=UHCCP

3 . Revision History

Date	Notes
12/19/2025	Removed NY/NY EPP

Pretomanid

Prior Authorization Guideline

Guideline ID	GL-442201
Guideline Name	Pretomanid
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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
11/6/2025	Added Nevada Formulary

Prevymis

Prior Authorization Guideline

Guideline ID	GL-435235
Guideline Name	Prevymis
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Prevymis tabs	
Diagnosis	Cytomegalovirus Prophylaxis
Approval Length	9 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - ALL of the following:

1.1 Patient is a recipient of an allogeneic hematopoietic stem cell transplant

AND

1.2 Patient is cytomegalovirus (CMV)-seropositive

AND

1.3 Provider attests to both of the following:

- Prevymis will be initiated between Day 0 and Day 28 post-transplantation (before or after engraftment)
- Prevymis is being prescribed as prophylaxis and not treatment of CMV infection

OR

2 - ALL of the following:

2.1 Patient is a recipient of a kidney transplant

AND

2.2 Patient is CMV-seronegative

AND

2.3 Donor is CMV-seropositive

AND

2.4 Provider attests to both of the following:

- Prevymis will be initiated between Day 0 and Day 7 post-transplantation (before or after engraftment)
- Prevymis is being prescribed as prophylaxis and not treatment of CMV infection

2 . Revision History

Date	Notes
11/3/2025	Updated formatting of attestations. Combined VA, NE, NM formularies. Added NV formulary.

Primary Hyperoxaluria Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-475235
Guideline Name	Primary Hyperoxaluria Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient has a definitive diagnosis of primary hyperoxaluria type 1 (PH1) as evidenced by ONE of the following:

- Biallelic pathogenic mutation in the alanine: glyoxylate aminotransferase (AGXT) gene as identified on molecular genetic testing

- Identification of alanine: glyoxylate aminotransferase (AGT) enzyme deficiency on liver biopsy

AND

2 - Oxlumo will be used to lower urinary oxalate levels

AND

3 - Prescribed by, or in consultation with, a nephrologist, urologist, or geneticist

AND

4 - The patient has not had a liver transplant

AND

5 - Oxlumo will not be used in combination with other urinary oxalate reducing agents (e.g. Rivfloza)

AND

6 - The patient has a baseline assessment for at least ONE of the following:

- Urinary oxalate excretion level (corrected for BSA)
- Spot urinary oxalate: creatinine ratio
- eGFR
- Plasma oxalate level

AND

7 - Oxalate will be dosed per FDA label based on patient's weight.

Product Name:Rivfloza	
Approval Length	6 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is greater than or equal to 9 years of age

AND

2 - The patient has a definitive diagnosis of primary hyperoxaluria type 1 (PH1) as evidenced by ONE of the following:

- Biallelic pathogenic mutation in the AGXT gene as identified on molecular genetic testing
- Identification of AGT enzyme deficiency on liver biopsy

AND

3 - Rivfloza will be used to lower urinary oxalate levels

AND

4 - Prescribed by, or in consultation with, a nephrologist, urologist, or geneticist

AND

5 - The patient does not have renal impairment defined as an eGFR less than 30 mL/min/1.73 m2

AND

6 - The patient has not had a liver transplant

AND

7 - Rivfloza will not be used in combination with other urinary oxalate reducing agents (e.g., Oxlumo)

AND

8 - The patient has a baseline assessment for at least ONE of the following:

- Urinary oxalate excretion level (corrected for BSA)
- Spot urinary oxalate: creatinine ratio
- eGFR
- Plasma oxalate level

AND

9 - Rivloza will be dosed per FDA label based on the patient's weight

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

Approval Criteria

1 - The patient continues to meet initial authorization criteria

AND

2 - The patient has ONE of the following disease responses:

- Decrease in urinary oxalate excretion level (corrected for BSA) from baseline
- Reduction in spot urinary oxalate: creatinine ratio from baseline
- Stabilization of eGFR

• Decrease in plasma oxalate level from baseline

2 . Revision History

Date	Notes
12/11/2025	Updated therapy stage of first criteria box for Oxlumo from Reauthorization to Initial Authorization.

Procysbi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-442202
Guideline Name	Procysbi
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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 - ONE of the following*:

3.1 Failure to Cystagon as confirmed by claims history or submission of medical records

OR

3.2 History of intolerance or contraindication to Cystagon (please specify intolerance or contraindication)

Notes	*UHC 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
11/6/2025	Added Nevada Formulary

Progesterone - Non-Oral

Prior Authorization Guideline

Guideline ID	GL-442203
Guideline Name	Progesterone - Non-Oral
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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
11/6/2025	Added Nevada Formulary

Progesterone - Oral

Prior Authorization Guideline

Guideline ID	GL-442204
Guideline Name	Progesterone - Oral
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Arizona (ACUAZ, ACUAZEC) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Prometrium, generic progesterone caps	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Amenorrhea
- Endometrial hyperplasia or prevention of endometrial hyperplasia
- Abnormal uterine or vaginal bleeding
- History of preterm birth
- Prevention of preterm delivery for current pregnancy

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Promacta, Alvaiz

Prior Authorization Guideline

Guideline ID	GL-485189
Guideline Name	Promacta, Alvaiz
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of chronic idiopathic thrombocytopenic purpura (ITP)

AND

2 - ONE of the following:

2.1 Failure to at least ONE of the following as confirmed by claims history or submission of medical records:

- Corticosteroids
- Immunoglobulins
- Splenectomy

OR

2.2 History of contraindication or intolerance to ALL of the following (please specify intolerance or contraindication):

- Corticosteroids
- Immunoglobulins
- Splenectomy

AND

3 - If the request is for Alvaiz, ONE of the following:

3.1 Failure to eltrombopag (generic Promacta) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)

AND

4 - If the request is for Promacta powder for oral suspension, ONE of the following:

4.1 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- oral/motor difficulties
- dysphagia

OR

4.2 Patient utilizes a feeding tube for medication administration

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Chronic Immune Thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Promacta (eltrombopag) or Alvaiz therapy

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Chronic Hepatitis C-Associated Thrombocytopenia
Approval Length	12 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 - If the request is for Alvaiz, ONE of the following:

3.1 Failure to eltrombopag (generic Promacta) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)

AND

4 - If the request is for Promacta powder for oral suspension, ONE of the following:

4.1 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- oral/motor difficulties
- dysphagia

OR

4.2 Patient utilizes a feeding tube for medication administration

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Chronic Hepatitis C-Associated Thrombocytopenia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Promacta (eltrombopag) or Alvaiz therapy

AND

2 - Patient is currently on antiviral interferon therapy for treatment of chronic hepatitis C

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Aplastic Anemia
Approval Length	12 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 - If the request is for Alvaiz, ONE of the following:

3.1 Failure to eltrombopag (generic Promacta) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)

AND

4 - If the request is for Promacta powder for oral suspension, ONE of the following:

4.1 Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to ONE of the following:

- Age
- oral/motor difficulties
- dysphagia

OR

4.2 Patient utilizes a feeding tube for medication administration

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	Aplastic Anemia
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to Promacta (eltrombopag) or Alvaiz therapy

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name:Brand Promacta, generic eltrombopag, Alvaiz	
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

12/18/2025	Removed IN from formularies - see state specific GL-475187 for IN 1 .1.26. No other changes to guideline.

Proton Pump Inhibitors (PPIs)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-404254
Guideline Name	Proton Pump Inhibitors (PPIs)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:All RX and OTC products of the following: omeprazole, Prilosec, pantoprazole, Protonix, rabeprazole, Aciphex, dexlansoprazole, Dexilant, esomeprazole, Nexium, lansoprazole, Prevacid	
Diagnosis	Requests exceeding once daily dosing
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria **1** - The patient has failed an appropriate duration of once daily dosing	

OR **2** - The patient has a diagnosis of a hypersecretory condition (e.g., Zollinger-Ellison Syndrome), esophagitis, Barrett's esophagitis, reflux esophagitis, or treatment of an ulcer caused by H. Pylori

Product Name:All RX and OTC products of the following: omeprazole, Prilosec, pantoprazole, Protonix, rabeprazole, Aciphex, dexlansoprazole, Dexilant, esomeprazole, Nexium, lansoprazole, Prevacid	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	

2 . Revision History

Date	Notes
10/2/2025	Added NP check

Psychotropic Polypharmacy for Patients Under 18 years of age

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-504207
Guideline Name	Psychotropic Polypharmacy for Patients Under 18 years of age
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Brand Lunesta, generic eszopiclone, zaleplon, Zolpidem, Brand Ambien, generic zolpidem, Brand Ambien CR, generic zolpidem CR, zolpidem SL, Edluar, Brand Rozerem, generic ramelteon, Brand Silenor, generic doxepin (sleep) 3mg and 6 mg tabs, Belsomra, Dayvigo, Quviviq, Brand Precedex, generic dexmedetomidine, Igalmi, Brand Hetlioz, generic tasimelteon, Hetlioz LQ, Brand Restoril, generic temazepam, Brand Halcion, generic triazolam, Brand Doral, generic quazepam, flurazepam, estazolam, Abilify Maintena, Opipza, Aristada, Abilify Asimtufii, aripiprazole oral soln, Brand Abilify, generic aripiprazole tab, aripiprazole ODT, Abilify Mycite, Secuado, Brand Saphris, generic asenapine, Rexulti, Vraylar, chlorpromazine, fluphenazine, haloperidol, Fanapt, Adasuve, loxapine, Caplyta, Brand Latuda, generic lurasidone, molindone, Brand Zyprexa, generic olanzapine, Brand Zyprexa Zydis, generic olanzapine ODT, Zyprexa Relprevv, Brand Symbyax, generic olanzapine/fluoxetine, Lybalvi, Brand Invega, generic paliperidone, Invega Sustenna, Erzofri, Invega Trinza, Invega Hafyera, perphenazine, perphenazine/amitriptyline, Nuplazid, pimozide, Brand Seroquel, generic quetiapine, Brand Seroquel XR, generic quetiapine ER, Perseris, Uzedy, Rykindo, Brand Risperdal, generic risperidone, risperidone ODT, generic risperidone IM, thioridazine, trifluoperazine, Cobenfy, Brand Geodon caps, generic ziprasidone caps, amitriptyline, amoxapine, chlordiazepoxide/amitriptyline, Brand Celexa, generic citalopram,

Brand Anafranil, generic clomipramine, Brand Norpramin, generic desipramine, Desvenlafaxine, Brand Pristiq, generic desvenlafaxine, doxepin caps/conc, Drizalma, duloxetine, Escitalopram, Brand Lexapro, generic escitalopram, Exxua, Brand Prozac, generic fluoxetine, fluvoxamine, imipramine, Marplan, Fetzima, Savella, Brand Pamelor, generic nortriptyline, Brand Paxil, generic paroxetine, Brand Paxil CR, generic paroxetine ER, Brand Nardil, generic phenelzine, protriptyline, Emsam, Brand Zoloft, generic sertraline, Duloxicaine, Brand Parnate, generic tranylcypromine, trimipramine, Venlafaxine, generic venlafaxine, Brand Effexor XR, generic venlafaxine ER, Zurzuvae, Epitol, Brand Tegretol, generic carbamazepine, Brand Tegretol XR, generic carbamazepine ER, Brand Tegretol, generic carbamazepine, Brand Carbatrol, Brand Tegretol XR, generic carbamazepine, generic carbamazepine ER, Equetro, Brand Depakote, generic divalproex, Brand Depakote ER, generic divalproex ER, Brand Lamictal, Subvenite, generic lamotrigine, Brand Lamictal ODT, generic lamotrigine ODT, Brand Lamictal XR, generic lamotrigine ER, lithium, Brand Lithobid, generic lithium ER, Brand Trileptal, generic oxcarbazepine, Brand Oxtellar XR, generic oxcarbazepine ER, valproic acid, Brand Xanax, generic alprazolam, alprazolam ODT, Brand Xanax XR, generic alprazolam ER, chlordiazepoxide, Brand Klonopin, generic clonazepam, clonazepam ODT, clorazepate, Diazepam, Brand Valium, generic diazepam, Loreev XR, Brand Ativan, generic lorazepam, oxazepam	
Diagnosis	DUR: Therapeutic Duplication
Approval Length	*If the requested medication is being cross tapered, approval length is 30 days; otherwise, approval length is 12 months
Guideline Type	Administrative

Approval Criteria

1 - Both of the following:

- The request is for an antidepressant, antipsychotic, anticonvulsant, or mood stabilizer
- The requested medication is prescribed by a board-certified child psychiatrist

OR

2 - All of the following:

2.1 One of the following:

2.1.1 The requested medication(s) will be used for cross tapering and situations where the patient will be discontinuing the previously prescribed medication*

OR

2.1.2 Both of the following:

- The requested medication is being given to augment the effect of another psychotropic medication
- Each medication is supported by individual authorizations

AND

2.2 The patient has a trial of each individual medication alone (please document the reasons for an inadequate response)

AND

2.3 All psychotropic medications included in the must be utilized for a medically accepted indication as established by the FDA (Food and Drug Administration) and/or peer reviewed literature

2 . Revision History

Date	Notes
1/16/2026	Added Exxua

Pulmonary Arterial Hypertension Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-507187
Guideline Name	Pulmonary Arterial Hypertension Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Tyvaso, Tyvaso DPI, Orenitram, brand Tracleer, generic bosentan, Adempas, Brand Letairis, generic ambrisentan, Opsumit, Uptravi	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Pulmonary Arterial Hypertension
- Pulmonary Hypertension, Unspecified
- Secondary Pulmonary Arterial Hypertension
- Pulmonary Hypertension Due to Left Heart Disease

- Pulmonary Hypertension Due to Lung Diseases and Hypoxia
- Pulmonary Heart Disease, Unspecified

AND

2 - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Brand Adcirca, Alyq, generic tadalafil (PAH, generic of Adcirca), Brand Revatio, generic sildenafil 20 mg, generic sildenafil susp, Opsynvi, Tadliq	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of one of the following:

- Pulmonary Arterial Hypertension
- Pulmonary Hypertension, Unspecified
- Secondary Pulmonary Arterial Hypertension
- Pulmonary Hypertension Due to Left Heart Disease
- Pulmonary Hypertension Due to Lung Diseases and Hypoxia
- Pulmonary Heart Disease, Unspecified

AND

2 - Medication is NOT being prescribed for impotence or erectile dysfunction

AND

3 - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
1/22/2026	Updated GPIs. Separated sildenafil and tadalafil into separate sectio n to include criteria about ED

Pulmozyme

Prior Authorization Guideline

Guideline ID	GL-442206
Guideline Name	Pulmozyme
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Pulmozyme	
Approval Length	12 month(s)

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of cystic fibrosis	

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Pyrukynd (mitapivat)

Prior Authorization Guideline

Guideline ID	GL-382198
Guideline Name	Pyrukynd (mitapivat)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Pyrukynd Taper Pack, Pyrukynd	
Approval Length	6 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is greater than or equal to 18 years of age

AND

2 - Diagnosis of pyruvate kinase deficiency (PDK) defined by documented presence of at least two variant alleles in the PKLR gene, of which at least one was a missense variant

AND

3 - Patient is not homozygous for the c.1436G>A (p.R47oH) variant

AND

4 - Patient does not have two non-missense variants (without the presence of another missense variant) in the PKLR gene

AND

5 - One of the following:

- Patient has a baseline serum hemoglobin level less than 10 g/dL
- Patient required more than six transfusions in the prior year

AND

6 - Other causes of hemolytic anemia have been ruled out (e.g., immune hemolysis, other enzyme deficiencies, vitamin/mineral deficiencies)

AND

7 - Patient does not have moderate or severe hepatic impairment

AND

8 - Prescriber will advise patients currently on hormonal contraceptives to use an alternative non-hormonal contraceptive method or add a barrier method of contraception during treatment

AND

9 - The request does not exceed 60 tablets/30 days (max dose 100 mg/day)

Product Name:Pyrukynd Taper Pack, Pyrukynd	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient continues to meet initial authorization criteria

AND

2 - The patient has shown a beneficial response to therapy compared to pre-treatment baseline in ONE of the following:

2.1 Hemoglobin (Hb) response (defined as a greater than or equal to 1.5 g/dL increase in Hb level without transfusion over a four week or longer time period)

OR

2.2 Transfusion reduction response (defined as a greater than or equal to 33% reduction in the number of red blood cell [RBC] units transfused compared to historical transfusion burden)

OR

2.3 Patient had an increase in Hb and/or decrease in transfusion requirement, to a lesser extent than the above, and also had an improvement in the signs and symptoms (e.g., fatigue, jaundice, shortness of breath) and/or markers of hemolysis (e.g., indirect bilirubin, reticulocyte count, lactate dehydrogenase [LDH], haptoglobin)

2 . Revision History

Date	Notes
9/4/2025	New GL. 1/1/2026 Implementation

Qalsody

Prior Authorization Guideline

Guideline ID	GL-431189
Guideline Name	Qalsody
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of Amyotrophic Lateral Sclerosis (ALS) based on validated criteria (e.g., revised El Escorial criteria, Awaji criteria, Gold Coast criteria)

AND

2 - The patient is 18 years of age or older

AND

3 - The patient has a baseline measure of plasma neurofilament light chain (NfL)

AND

4 - Prescribed by or in consultation with a neurologist

AND

5 - The patient has the presence of a superoxide dismutase 1 (SOD1) gene mutation

AND

6 - Dosing is in accordance with FDA approved labeling

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

Approval Criteria

1 - Prescribed by or in consultation with a neurologist

AND

2 - The patient must have stabilization or improvement in plasma NfL compared to baseline

AND

3 - The patient has responded to therapy compared to pretreatment baseline with disease stability or mild progression (patient has not experienced rapid disease progression while on therapy)

AND

4 - Dosing is in accordance with FDA approved labeling

2 . Revision History

Date	Notes
10/23/2025	New program

Quantity Limits

Prior Authorization Guideline

Guideline ID	GL-442207
Guideline Name	Quantity Limits
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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 (Food and Drug Administration)-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 - ONE of the following:

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

OR

2.2 The request 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 appropriate 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
11/6/2025	Added Nevada Formulary

Qutenza (capsaicin)

Prior Authorization Guideline

Guideline ID	GL-422548
Guideline Name	Qutenza (capsaicin)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Qutenza	
Approval Length	3 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Neuropathic pain associated with postherpetic neuralgia
- Neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet

AND

2 - History of failure or intolerance to over-the-counter capsaicin

Product Name:Qutenza	
Approval Length	3 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - At least three months have transpired since the last Qutenza application/administration

AND

2 - The patient experienced pain relief with a prior course of therapy

AND

3 - The patient is experiencing a return of neuropathic pain

2 . Revision History

Date	Notes
10/22/2025	New program

Radicava ORS

Prior Authorization Guideline

Guideline ID	GL-442209
Guideline Name	Radicava ORS
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Radicava ORS	
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - BOTH of the following:

1.1 Patient has been established on therapy with edaravone for amyotrophic lateral sclerosis (ALS) under an active UnitedHealthcare medical benefit prior authorization

AND

1.2 ALL of the following:

1.2.1 Diagnosis of ALS

AND

1.2.2 Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

1.2.3 Patient is currently receiving edaravone therapy

AND

1.2.4 Patient is not dependent on invasive ventilation

OR

2 - ALL of the following:

2.1 Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including: imaging, nerve conduction studies, laboratory values) to support the diagnosis of ALS

AND

2.2 Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

2.3 Submission of the most recent ALS Functional Rating Scale-Revised (ALSFRS-R) score confirming that the patient has scores greater than or equal to 2 in all items of the ALSFRS-R criteria at the start of treatment

AND

2.4 Submission of medical records (e.g., chart notes, laboratory values) confirming that the patient has a % forced vital capacity (%FVC) greater than or equal to 80% at the start of treatment

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

Approval Criteria

1 - Diagnosis of amyotrophic lateral sclerosis (ALS)

AND

2 - Prescribed by, or in consultation with, a neurologist with expertise in the diagnosis of ALS

AND

3 - Patient is currently receiving Radicava ORS therapy

AND **4** - Patient is not dependent on invasive ventilation

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Ravicti

Prior Authorization Guideline

Guideline ID	GL-442210
Guideline Name	Ravicti
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of urea cycle disorders (UCDs)

AND

2 - Patient does not have N-acetylglutamate synthase (NAGS) deficiency

AND

3 - Inadequate response to ONE of the following:

- Dietary protein restriction
- Amino acid supplementation

AND

4 - Will be used concomitantly with dietary protein restriction and, in some cases, dietary supplements (e.g., essential amino acids, arginine, citrulline, protein-free calorie supplements)

AND

5 - ONE of the following:

5.1 BOTH of the following:

5.1.1 Failure to sodium phenylbutyrate (Buphenyl) as confirmed by claims history or submission of medical records*

AND

5.1.2 Submission of medical records (e.g., chart notes, laboratory values) documenting ONE of the following while on sodium phenylbutyrate

- Fasting ammonia level greater than 0.5 ULN
- Any ammonia level (fasting/non-fasting) above the ULN

OR

5.2 History of intolerance or contraindication to sodium phenylbutyrate (Buphenyl) (please specify contraindication or intolerance)*

OR

5.3 Patient is currently on Ravicti therapy

Notes	*UHC generally does not consider frequency of dosing and/or lack of compliance to dosing regimens an indication of medical necessity

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

Approval Criteria

1 - Documentation of positive clinical response to Ravicti therapy

AND

2 - Patient is actively on 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
11/6/2025	Added Nevada Formulary

Rayaldee (calcifediol)

Prior Authorization Guideline

Guideline ID	GL-390215
Guideline Name	Rayaldee (calcifediol)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Patient is greater than or equal to 18 years of age

AND

2 - Patient has a diagnosis of secondary hyperparathyroidism (HPT)

AND

3 - Patient has BOTH of the following:

3.1 Serum total 25-hydroxyvitamin D level less than 30 ng/mL (nanograms/milliliter)

AND

3.2 Serum corrected total calcium below 9.8 mg/dL (milligrams/deciliter)

AND

4 - Patient has chronic kidney disease (CKD) Stage 3 or 4

AND

5 - Patient does NOT have CKD Stage 5 or end stage renal disease (ESRD) on dialysis

AND

6 - Patient has a history of failure, contraindication, or intolerance to an adequate trial of ALL of the following:

- Calcitriol
- Doxercalciferol
- Paricalcitol

AND

7 - Prescribed by or in consultation with a nephrologist or endocrinologist

Product Name:Rayaldee

Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has demonstrated positive response to treatment as defined by increase in serum total 25-hydroxyvitamin D level and/or decrease in intact parathyroid hormone (iPTH)

AND

2 - Prescribed by or in consultation with a nephrologist or endocrinologist

2 . Revision History

Date	Notes
9/10/2025	New program.

Rayos (prednisone delayed release), Eohilia (budesonide oral suspension)

Prior Authorization Guideline

Guideline ID	GL-458406
Guideline Name	Rayos (prednisone delayed release), Eohilia (budesonide oral suspension)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Rayos	
Approval Length	Initial authorization length is 3 months; Reauthorization length is 12 months
Guideline Type	Prior Authorization
Approval Criteria **1** - The requested medication is being used for an FDA (Food and Drug Administration) approved indication	

AND

2 - Documentation of an inadequate response or adverse reaction to generic prednisone immediate-release tablets

Product Name:Eohilia	
Approval Length	12 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 11 years of age or older

AND

2 - Patient has a documented diagnosis of Eosinophilic Esophagitis (EoE)

AND

3 - Patient has experienced an inadequate response to at least an 8-week trial of proton pump inhibitor (PPI), unless contraindicated or not tolerated

AND

4 - Both of the following:

- The requested medication is being dosed per FDA-(Food and Drug Administration) label
- The patient has not exceeded a maximum 12-week course

AND

5 - The requested medication is prescribed by, or in consultation with, an allergist/immunologist or gastroenterologist

2 . Revision History

Date	Notes
12/8/2025	Added Eohilia

Reblozyl

Prior Authorization Guideline

Guideline ID	GL-504228
Guideline Name	Reblozyl
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Reblozyl	
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 - All other causes of anemia (e.g., nutritional deficiencies, viral infection, environmental factors, marrow suppressing medications) have been evaluated and treated, if applicable

AND

3 - Females of reproductive potential have obtained a negative pregnancy test prior to start of therapy and have been advised to use an effective method of contraception during treatment and at least for three months after treatment

AND

4 - Medication is being dosed per FDA-label

AND

5 - Prescribed by, or in consultation with, a hematologist or oncologist

AND

6 - ONE of the following:

6.1 ALL of the following:

- Diagnosis of beta thalassemia
- Patient does not have Hemoglobin S/beta-thalassemia or alpha-thalassemia
- Patient has not had a transfusion-free period greater than 35 days in the past 24 weeks

OR

6.2 ALL of the following:

- Diagnosis of myelodysplastic syndromes with ring sideroblasts (MDS-RS) or myelodysplastic/myeloproliferative neoplasm with ring sideroblasts and thrombocytosis (MDS/MPN-RS-T)
- Patient has very low- to intermediate-risk disease
- Patient has experienced inadequate response to prior treatment with erythropoiesis-stimulating agent (ESA) therapy

- Patient has required at least two units of packed red blood cells (pRBCs) in the prior eight weeks
- If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

OR

6.3 ALL of the following:

- Diagnosis of myelodysplastic syndromes (MDS)
- Patient has very low- to intermediate-risk disease
- Patient is erythropoiesis-stimulating agent (ESA)-naïve (without prior ESA use)

Notes	*PDL: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

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

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g. decrease in the number of RBC transfusions, increase in baseline hemoglobin)

AND

2 - Medication is prescribed by, or in consultation with, a hematologist or oncologist

2 . Revision History

Date	Notes
1/22/2026	New program

Rectiv

Prior Authorization Guideline

Guideline ID	GL-438188
Guideline Name	Rectiv
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Rectiv ointment, generic nitroglycerin ointment	
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
11/5/2025	Combined formularies - added MI, NV, VA, IN, NE, NM. No clinical changes.

Repository Corticotropins

Prior Authorization Guideline

Guideline ID	GL-442211
Guideline Name	Repository Corticotropins
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Acthar, Cortrophin	
Diagnosis	Infantile spasm (i.e., West Syndrome)*
Approval Length	1 month(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

Notes	*Acthar gel and Cortrophin gel are not medically necessary for treatment of acute exacerbations of multiple sclerosis. See Background for more information.

Product Name:Acthar, Cortrophin	
Diagnosis	Opsoclonus-myoclonus syndrome (i.e., Kinsbourne Syndrome)*
Approval Length	3 month(s)
Guideline Type	Prior Authorization

Approval Criteria

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

AND

2 - If the request is for Acthar gel, provider submits documentation of reason or special circumstance patient cannot use Cortrophin Gel

Notes	*Acthar gel and Cortrophin gel are not medically necessary for treatment of acute exacerbations of multiple sclerosis. See Background for more information.

2 . Background

Benefit/Coverage/Program Information

More Information:

The Acthar Gel and Purified Cortrophin Gel package inserts have listed other conditions in which it may be used. UHCP has determined that use of Acthar Gel and Purified Cortrophin Gel is not medically necessary for treatment of the following disorders and diseases: multiple sclerosis; rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; and edematous state.

3 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Respirator and Allergy Biologics

Prior Authorization Guideline

Guideline ID	GL-507188
Guideline Name	Respirator and Allergy Biologics
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Xolair	
Diagnosis	Moderate to severe persistent asthma
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of moderate to severe persistent asthma

AND

2 - The patient is 6 years of age or older

AND

3 - The patient has a history of a positive skin test or radioallergosorbent (RAST) test to a perennial aeroallergen

AND

4 - Prescribed by one of the following:

- Pulmonologist
- Allergist/Immunologist

AND

5 - The patient has had an inadequate response, adverse reaction, or contraindication to inhaled corticosteroids

AND

6 - The patient has had an inadequate response, adverse reaction, or contraindication to a leukotriene receptor antagonist

AND

7 - The patient has a pretreatment serum total Immunoglobulin E (IgE) level between 30 IU/mLand 700 IU/mL (document IgE)

AND

8 - The patient's current weight is recorded (please document patient weight)

AND

9 - The requested dose is appropriate for the patient's pre-treatment serum IgE and body weight per Table 1 in background

AND

10 - The patient will NOT use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies

AND

11 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Xolair	
Diagnosis	Chronic idiopathic urticaria (CIU)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of chronic idiopathic urticaria (CIU)

AND

2 - The patient is 12 years of age or older

AND

3 - The patient has had an inadequate response, adverse reaction, or contraindication to two different oral second-generation antihistamines

AND

4 - The patient has had an inadequate response, adverse reaction, or contraindication to an oral second-generation antihistamine in combination with a leukotriene receptor antagonist

AND

5 - Prescribed by, or documentation that consultation regarding diagnosis and treatment recommendations was done by, one of the following:

- Allergist/immunologist
- Dermatologist
- Rheumatologist

AND

6 - One of the following:

6.1 The request is for initiation of therapy and the dose will be 150 mg every four weeks

OR

6.2 The request is for initiation of therapy and the dose will be 300 mg every four weeks, and submission of medical records confirming clinical rationale for starting therapy at 300 mg every four weeks

OR

6.3 The request is for continuation of therapy and the dose will be 150 mg or 300 mg every four weeks

AND

7 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	
Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Xolair	
Diagnosis	Nasal Polyps (NP)
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Nasal Polyps (NP)

AND

2 - The patient is 18 years of age or older

AND

3 - The patient has had an inadequate response, adverse reaction, or contraindication to at least 2 months of therapy with an intranasal corticosteroid

AND

4 - Prescribed by, or documentation that consultation regarding diagnosis and treatment recommendations was done by, one of the following:

- Allergist/immunologist
- Dermatologist
- Rheumatologist

AND

5 - One of the following:

5.1 The patient will continue intranasal corticosteroid treatment along with omalizumab therapy

OR

5.2 The prescriber has provided valid medical rationale for not continuing intranasal corticosteroid treatment along with omalizumab therapy (please document rationale)

OR

5.3 The request is for continuation of therapy and there is documentation of a positive clinical response to therapy (e.g., reduction in NP score [NPS; 0-8 scale], improvement in nasal congestion/obstruction score [NCS; 0-3 scale])

AND

6 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

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

Approval Criteria

1 - The patient has a diagnosis of severe eosinophilic-phenotype asthma

AND

2 - Patient is 18 years of age or older

AND

3 - Prescribed by one of the following:

- Pulmonologist
- Allergist/Immunologist

AND

4 - The patient is uncontrolled on current therapy including high dose corticosteroid and/or on a secondary asthma inhaler

AND

5 - There is documentation of the patient's vaccination status

AND

6 - The requested dose is 3 mg/kg (milligrams/kilogram) via IV (intravenous) infusion of 20 to 50 minutes every four weeks

AND

7 - The patient will NOT use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies

AND

8 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Nucala

Diagnosis	Asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of severe asthma

AND

2 - Asthma is an eosinophilic phenotype as defined by ONE of the following:

- Baseline (pre-treatment) peripheral blood eosinophil level 150 cells/microliter or more
- Peripheral blood eosinophil levels were 300 cells/microliter or more within the past 12 months

AND

3 - ONE of the following:

- The patient has had at least one or more asthma exacerbations requiring systemic corticosteroid within the past 12 months
- The patient has had prior intubation for an asthma exacerbation
- The patient has had prior asthma-related hospitalization within the past 12-months

AND

4 - The patient is currently being treated with ONE of the following (unless there is a contraindication or intolerance to these medications):

4.1 BOTH the following:

- High dose inhaled corticosteroid (ICS) (e.g., > 500 mcg fluticasone propionate equivalent/day)
- Additional asthma controller medication (e.g., leukotriene receptor antagonist, long-acting beta-2 agonist [LABA], theophylline)

OR

4.2 One maximally dosed combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol])

AND

5 - The patient is at least 6 years of age

AND

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

- Pulmonologist
- Allergist/Immunologist

Product Name:Nucala	
Diagnosis	Asthma
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 in exacerbations, improvement in forced expiratory volume in one second [FEV1], decreased use of rescue medications)

AND

2 - The patient is currently being treated with ONE of the following unless there is a contraindication or intolerance to these medications:

2.1 BOTH the following:

- ICS
- Additional asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)

OR

2.2 A combination ICS/LABA product (e.g., Advair [fluticasone propionate/salmeterol], Dulera [mometasone/formoterol], Symbicort [budesonide/formoterol])

AND

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

- Pulmonologist
- Allergy/Immunologist

Product Name:Nucala, Fasenra	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Eosinophilic Granulomatosis with Polyangiitis (EGPA)

AND

2 - Patient is 18 years of age or older

AND

3 - The patient's disease has relapsed or is refractory to standard of care therapy (i.e. corticosteroid treatment with or without immunosuppressive therapy)

AND

4 - The patient is currently receiving corticosteroid therapy

AND

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

- Pulmonologist
- Rheumatologist
- Allergist/Immunologist

Product Name:Nucala, Fasenra	
Diagnosis	Eosinophilic Granulomatosis with Polyangiitis (EGPA)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of 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:Nucala	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of uncontrolled Hypereosinophilic Syndrome (HES) for at least 6 months defined by both of the following:

- History of at least 2 flares over the past 12 months
- Baseline (pre-treatment) blood eosinophil count greater than or equal to 1,000 cells/mL (cells/milliliter)

AND

2 - Patient is 12 years of age or older

AND

3 - There is no identifiable non-hematologic secondary cause of the HES

AND

4 - Patient does NOT have FIP1L1-PDGFRa kinase-positive HES

AND

5 - Patient is currently receiving a stable dose of background HES therapy (e.g., episodic oral corticosteroids, immunosuppressive, or cytotoxic therapy)

AND

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

- Allergist
- Immunologist
- Pulmonologist
- Rheumatologist

Product Name:Nucala	
Diagnosis	Hypereosinophilic Syndrome (HES)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., decreased number of flares, improved fatigue, reduced corticosteroids requirements, and decreased eosinophil levels)

AND

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

- Allergist
- Immunologist
- Pulmonologist
- Rheumatologist

Product Name:Nucala	
Diagnosis	Chronic Rhinosinusitis with NP (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Chronic Rhinosinusitis with nasal polyps (CRSwNP)

AND

2 - Patient is 18 years of age or older

AND

3 - Unless contraindicated, the patient has had an inadequate response to at least two months of treatment with an intranasal corticosteroid

AND

4 - The requested medication will be used as add-on medication to maintenance therapy (e.g. intranasal corticosteroid, saline nasal irrigations, systemic corticosteroids, antibiotics)

AND

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

- Allergist/immunologist
- Otolaryngologist/ENT

Product Name:Nucala	
Diagnosis	Chronic Rhinosinusitis with NP (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of Chronic Rhinosinusitis with nasal polyps (CRSwNP)

AND

2 - Patient is 18 years of age or older

AND

3 - The requested medication will be used as add-on medication to maintenance therapy (e.g. intranasal corticosteroid, saline nasal irrigations, systemic corticosteroids, antibiotics)

AND

4 - Documentation of positive clinical response to Nucala (mepolizumab)

AND

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

- Allergist/immunologist
- Otolaryngologist/ENT

Product Name:Fasenra	
Diagnosis	Severe eosinophilic phenotype asthma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of severe eosinophilic phenotype asthma

AND

2 - The patient is 6 years of age or older

AND

3 - The requested medication is dosed per FDA (Food and Drug Administration) label based on age and weight

AND

4 - One of the following:

- Patient has had at least one or more asthma exacerbations requiring systemic corticosteroids within the past 12 months
- Any prior intubation for an asthma exacerbation
- Prior asthma-related hospitalization within the past 12 months

AND

5 - One of the following:

5.1 Patient is currently being treated with one of the following:

- Both a high-dose ICS (inhaled corticosteroid) [e.g., greater than 500 micrograms (mcg) fluticasone propionate equivalent/day] and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]
- One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

OR

5.2 Patient has a contraindication or intolerance to all of the following:

- High-dose ICS (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- Maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

AND

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

- Pulmonologist
- Allergy/Immunology specialist

AND

7 - The patient will NOT use the requested antiasthmatic monoclonal antibody in combination with other antiasthmatic monoclonal antibodies

Product Name:Fasenra	
Diagnosis	Severe eosinophilic phenotype asthma
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - There is documentation of a positive clinical response (e.g., reduction in exacerbation)

AND

2 - One of the following:

2.1 Patient is currently being treated with one of the following:

- Both an ICS (inhaled corticosteroid) and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]
- A combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

OR

2.2 Patient has a contraindication or intolerance to all of the following:

- ICS
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- Combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

AND

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

- Pulmonologist
- Allergy/Immunology specialist

Product Name:Dupixent, Nemluvio, Ebglyss	
Diagnosis	Moderate to severe atopic dermatitis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of moderate to severe atopic dermatitis

AND

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

- Dermatologist
- Allergy/Immunologist
- Otolaryngologist

AND

3 - One of the following:

3.1 Trial and failure, contraindication, or intolerance to one medium to high potency topical corticosteroid (e.g. betamethasone, triamcinolone)

OR

3.2 Trial and failure, or intolerance to one of the following, unless the patient is not a candidate for therapy (e.g. immunocompromised):

- Pimecrolimus topical cream
- Tacrolimus topical ointment

AND

4 - If the request is for Nemluvio, BOTH of the following:

- The patient is at least 12 years of age
- Medication will be used in combination with topical corticosteroids and/or calcineurin inhibitors

AND

5 - If the request is for Ebglyss, BOTH of the following:

- The patient is at least 12 years of age
- The patient weighs at least 40 kg

AND

6 - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Dupixent, Nemluvio, Ebglyss	
Diagnosis	Moderate to severe atopic dermatitis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - There is documentation of a positive clinical response to therapy

AND

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

- Dermatologist
- Allergist/Immunologist
- Otolaryngologist

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

Approval Criteria

1 - Diagnosis of moderate to severe asthma

AND

2 - ONE of the following:

2.1 The patient is currently dependent on oral corticosteroids for the treatment of asthma and one of the following:

- One or more asthma exacerbations requiring systemic corticosteroids within the past 12 months
- Any prior intubation for an asthma exacerbation
- Prior asthma-related hospitalization within the past 12 months

OR

2.2 BOTH of the following:

2.2.1 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

2.2.2 ONE of the following:

- One or more asthma exacerbations requiring systemic corticosteroid within the past 12 months
- Any prior intubation for an asthma exacerbation
- Prior asthma-related hospitalization within the past 12 months

AND

3 - ONE of the following:

3.1 Patient is currently being treated with ONE of the following:

- Both a high-dose ICS (inhaled corticosteroid) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]

- One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

OR

3.2 Patient has a contraindication or intolerance to ALL of the following:

- High-dose ICS (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- Maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

AND

4 - The patient is 6 years of age or older

AND

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

- Pulmonologist
- Allergy/Immunology specialist

Product Name:Dupixent	
Diagnosis	Asthma
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 in exacerbations, improvement in FEV1, decreased use of rescue medications)

AND

2 - ONE of the following:

2.1 Patient is currently being treated with ONE of the following:

- Both a high dose ICS (e.g., > 500mcg fluticasone propionate equivalent/day) and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]
- One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

OR

2.2 Patient has a contraindication or intolerance to ALL of the following:

- High dose ICS
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

AND

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

- Pulmonologist
- Allergy/Immunology specialist

Product Name:Dupixent	
Diagnosis	Chronic Rhinosinusitis with NP (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Chronic Rhinosinusitis with nasal polyps (CRSwNP)

AND

2 - Patient is 12 years of age or older

AND

3 - Unless contraindicated, the patient has had an inadequate response to at least two months of treatment with an intranasal corticosteroid (e.g., fluticasone, mometasone) (Please document drug(s), dose, duration, and date of trial)

AND

4 - The requested medication will NOT be used in combination with another biologic therapy (e.g., Nucala, Xolair) for CRSwNP

AND

5 - Prescribed by, or in consultation with, an allergist/immunologist/otolaryngologists/ENTs

Product Name:Dupixent	
Diagnosis	Chronic Rhinosinusitis with NP (CRSwNP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

AND

2 - The requested medication will NOT be used in combination with another biologic therapy (e.g., Nucala, Xolair) for CRSwNP

AND

3 - Prescribed by, or in consultation with, an allergist/immunologist/otolaryngologists/ENTs

Product Name:Dupixent	
Diagnosis	Eosinophilic Esophagitis (EoE)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Eosinophilic Esophagitis (EoE)

AND

2 - Patient is 1 year of age or older

AND

3 - Patient weighs at least 15 kg (kilograms)

AND

4 - The requested medication is dosed per FDA (Food and Drug Administration) label based on age and weight

AND

5 - Prescribed by, or in consultation with, an allergist/immunologist or gastroenterologist

AND

6 - Patient did not respond clinically to treatment with a topical glucocorticosteroid or proton pump inhibitor

Product Name:Dupixent	
Diagnosis	Eosinophilic Esophagitis (EoE)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to requested therapy

AND

2 - Prescribed by, or in consultation with an, allergist or gastroenterologist

Product Name:Dupixent, Nemluvio	
Diagnosis	Prurigo Nodularis (PN)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Prurigo Nodularis (PN)

AND

2 - Patient is 18 years of age or older

AND

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

- Dermatologist
- Allergist
- Immunologist

AND

4 - If the request is for a non-preferred* product, the "Non-Preferred Drugs" approval criteria have been met

Notes	*PDL: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Dupixent, Nemluvio	
Diagnosis	Prurigo Nodularis (PN)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to requested therapy

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent, Nucala	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has confirmed diagnosis of inadequately controlled Chronic Obstructive Pulmonary Disease (COPD) with eosinophilic phenotype, defined by BOTH of the following:

1.1 History of greater than or equal to 2 moderate exacerbations or greater than or equal to 1 severe exacerbation within the past 12 months

AND

1.2 ONE of the following:

- For Dupixent: Blood eosinophil count greater than or equal to 300 cells/microliter
- For Nucala: Blood eosinophil count greater than or equal to 150 cells/microliter

AND

2 - Patient is 18 years of age or older

AND

3 - Inadequate response, intolerable adverse effects, or contraindications to at least a 3-month trial of ALL of the following treatments:

- LABA (long-acting beta-agonist)
- LAMA (long-acting muscarinic antagonist/anticholinergic)
- ICS (inhaled corticosteroid) [Note: trial of double therapy (LABA plus LAMA) permitted if ICS is contraindicated]

AND

4 - Patient will continue to receive maintenance therapy concomitantly with the requested medication

AND

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

- Pulmonologist
- Allergist/immunologist

Product Name:Dupixent, Nucala	
Diagnosis	Chronic Obstructive Pulmonary Disease (COPD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to requested therapy

AND

2 - Patient continues to receive maintenance therapy concomitantly with the requested medication

AND

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

- Pulmonologist
- Allergist/immunologist

Product Name:Dupixent	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Chronic Spontaneous Urticaria (CSU)

AND

2 - Patient is 12 years of age or older

AND

3 - Patient has experienced spontaneous onset urticaria with no known cause, with or without angioedema

AND

4 - Patient had an inadequate response, intolerable adverse effects, or contraindication to an H1 antihistamine

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Chronic Spontaneous Urticaria (CSU)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to requested therapy

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent

Diagnosis	Bullous Pemphigoid (BP)
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Bullous Pemphigoid (BP)

AND

2 - Patient is 18 years of age or older

AND

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

- Dermatologist
- Allergist
- Immunologist

Product Name:Dupixent	
Diagnosis	Bullous Pemphigoid (BP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to requested therapy

AND

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

- Dermatologist
- Allergist
- Immunologist

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

Approval Criteria

1 - Diagnosis of severe asthma

AND

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

- Pulmonologist
- Allergist/immunologist

AND

3 - The patient is 12 years of age or older

AND

4 - One of the following:

4.1 Patient is currently being treated with one of the following:

- Both a high-dose ICS (inhaled corticosteroid) [e.g., greater than 500 micrograms (mcg) fluticasone propionate equivalent/day] and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]
- One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

OR

4.2 Patient has a contraindication or intolerance to all of the following:

- High-dose ICS (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- Maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

AND

5 - One of the following:

- Patient has had at least one or more asthma exacerbations requiring systemic corticosteroids within the past 12 months
- Any prior intubation for an asthma exacerbation
- Prior asthma-related hospitalization within the past 12 months

AND

6 - Medication will NOT be used in combination with other monoclonal antibodies for asthma treatment

AND

7 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

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

Approval Criteria

1 - Diagnosis of severe asthma

AND

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

- Pulmonologist
- Allergist/immunologist

AND

3 - The patient is 12 years of age or older

AND

4 - One of the following:

4.1 Patient is currently being treated with one of the following:

- Both a high-dose ICS (inhaled corticosteroid) [e.g., greater than 500 micrograms (mcg) fluticasone propionate equivalent/day] and an additional asthma controller medication [e.g., leukotriene receptor antagonist, LABA (long-acting beta-agonist), theophylline]
- One maximally dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

OR

4.2 Patient has a contraindication or intolerance to all of the following:

- High-dose ICS (e.g., greater than 500 mcg fluticasone propionate equivalent/day)
- Asthma controller medication (e.g., leukotriene receptor antagonist, LABA, theophylline)
- Maximally dosed combination ICS)/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Dulera (mometasone/formoterol), Symbicort (budesonide/ formoterol)]

AND

5 - Medication will not be used in combination with other monoclonal antibodies for asthma treatment

AND

6 - Documentation of positive clinical response to therapy (e.g., reduction in exacerbations, improvement in FEV1, decreased use of rescue medications)

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

Approval Criteria

1 - The patient has a diagnosis of moderate to severe atopic dermatitis

AND

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

- Dermatologist
- Allergy/Immunologist
- Otolaryngologist

AND

3 - One of the following:

3.1 Trial and failure, contraindication, or intolerance to one medium to high potency topical corticosteroid (e.g. betamethasone, triamcinolone)

OR

3.2 Trial and failure, or intolerance to one of the following, unless the patient is not a candidate for therapy (e.g. immunocompromised):

- Pimecrolimus topical cream
- Tacrolimus topical ointment

AND

4 - Patient is at least 12 years of age

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

Approval Criteria

1 - There is documentation of a positive clinical response to therapy

AND

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

- Dermatologist
- Allergy/Immunologist

- Otolaryngologist

2 . Background

Benefit/Coverage/Program Information

Table 1: Dosing for Xolair (omalizumab)

Pre-treatment Serum IgE (IU/mL)	Body Weight (kg)			
	30-60	**>60-70**	**>70-90**	**>90-150**
≥30-100	150 mg	150 mg	150 mg	300 mg
>100-200	300 mg	300 mg	300 mg	225 mg
>200-300	300 mg	225 mg	225 mg	300 mg
>300-400	225 mg	225 mg	300 mg	
>400-500	300 mg	300 mg	375 mg	
>500-600	300 mg	375 mg		
>600-700	375 mg		**DO NOT DOSE**	
Every 2 Weeks Dosing				
Every 4 Weeks Dosing				

3 . Revision History

Date	Notes
1/22/2026	Separated Nucala asthma criteria from Cinqair. Updated Nucala CR wNP criteria. Added COPD criteria for Nucala. Updated Dupixent crit eria for asthma and EoE. Added CSU and BP criteria for Dupixent. U pdated auth duration for Tezspire. Added Nemluvio and Ebglyss

Rezdiffra

Prior Authorization Guideline

Guideline ID	GL-458413
Guideline Name	Rezdiffra
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Patient has a diagnosis of Noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH) with fibrosis stage 2 or 3 confirmed by submission of medical records of at least one of the following:

- Liver biopsy

- Vibration-controlled transient elastography (VCTE) (e.g., FibroScan)
- Magnetic resonance elastography (MRE)

AND

2 - Patient is at least 18 years of age

AND

3 - Patient does NOT have decompensated cirrhosis

AND

4 - The requested medication is prescribed by, or in consultation with, a gastroenterologist, hepatologist, or endocrinologist

AND

5 - One of the following:

- Patient has inadequate response, intolerance, or contraindication to Wegovy (semaglutide) for MASH treatment
- Specialist has submitted justification to reasonably expect Wegovy (semaglutide) to be ineffective for patient's specific treatment

AND

6 - Prescriber attestation that the requested medication is being prescribed in conjunction with diet and exercise

Product Name:Rezdiffra	
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 is without any treatment-restricting adverse events (including hepatotoxicity or gallbladder related adverse reaction)

AND

3 - The requested medication is prescribed by, or in consultation with, a gastroenterologist, hepatologist, or endocrinologist

2 . Revision History

Date	Notes
12/8/2025	New guideline

Rezurock

Prior Authorization Guideline

Guideline ID	GL-448298
Guideline Name	Rezurock
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization
Approval Criteria **1** - Diagnosis of chronic graft-versus-host disease (chronic GVHD) **AND** **2** - History of failure of at least TWO prior lines of systemic therapy (e.g., corticosteroids, mycophenolate, tacrolimus, etc.) confirmed by claims history or submitted medical records	

Product Name:Rezurock	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Rezurock therapy	

2 . Revision History

Date	Notes
11/12/2025	Combined formularies including NV for eff 1/1/26. No changes to clini cal criteria.

Riomet (metformin solution)

Prior Authorization Guideline

Guideline ID	GL-418221
Guideline Name	Riomet (metformin solution)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Riomet, generic metformin solution	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The patient is unable to have oral tablets appropriately administered	

2 . Revision History

Date	Notes
10/10/2025	1/1/2026 Implementation

Roctavian

Prior Authorization Guideline

Guideline ID	GL-422547
Guideline Name	Roctavian
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Roctavian	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is 18 years of age or older

AND

2 - Prescribed by or in consultation with a hematologist

AND

3 - The patient has a diagnosis of severe congenital factor VIII deficiency (e.g., pre-treatment factor VIII activity less than 1 IU/dL), as confirmed by blood coagulation testing

AND

4 - The patient is on a stable dose of regularly administered exogenous factor VIII for the prevention and control of bleeding episodes

AND

5 - The patient does not have an active infection, either acute (e.g., acute respiratory infection or acute hepatitis) or uncontrolled chronic (e.g., chronic active hepatitis B)

AND

6 - The patient does not have significant hepatic fibrosis (stage 3 or 4) or cirrhosis

AND

7 - The patient has not received prior hemophilia adeno-associated virus (AAV)-vector-based gene therapy*

AND

8 - The patient is AAV serotype 5 (AAV5) antibody negative as determined by an FDA-approved or CLIA compliant test

AND

9 - The patient has been tested and found negative for active factor VIII inhibitors (e.g., results from a Bethesda assay or Bethesda assay with Nijmegen modification of under 0.6 Bethesda

Units (BU) on two consecutive occasions greater than or equal to 1 week apart within the past 12 months) and is not receiving a bypassing agent (e.g., Feiba) **AND** **10** - Prescriber attests to BOTH of the following: **10.1** Factor VIII activity will be monitored periodically post-administration **AND** **10.2** ONE of the following: **10.2.1** Patients with factor VIII activity levels greater than 5 IU/dL will discontinue routine prophylactic exogenous factor VIII **OR** **10.2.2** If factor VIII activity levels decrease and/or if bleeding is not controlled, prescriber will assess presence of factor VIII inhibitors, and assess the need for hemostatic prophylaxis	
Notes	*Limited to one treatment per lifetime

2 . Revision History

Date	Notes
10/22/2025	1/1/2026 Implementation

Sandostatin

Prior Authorization Guideline

Guideline ID	GL-442213
Guideline Name	Sandostatin
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Sandostatin, generic octreotide

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:

- Surgical resection
- Pituitary irradiation
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

OR

2.2 NOT a candidate for any of the following:

- Surgical resection
- Pituitary irradiation
- Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

Product Name:Brand Sandostatin, generic octreotide	
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 surgically inaccessible

AND

3 - ONE of the following:

- Disease is recurrent
- Disease is progressive

AND

4 - Radiation is not possible

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	Neuroendocrine and Adrenal Tumors
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a neuroendocrine tumor [i.e., carcinoid tumors, Islet cell tumors, gastrinomas, glucagonomas, insulinomas, lung tumors, somatostatinomas, tumors of the pancreas, GI (gastrointestinal) tract, lung and thymus, adrenal glands, and vasoactive intestinal polypeptidomas (VIPomas)]

OR

2 - BOTH of the following:

2.1 ONE of the following:

- Diagnosis of Pheochromocytoma or Paraganglioma
- Well-differentiated grade 3 neuroendocrine tumor

AND

2.2 Disease is ONE of the following:

- Locally unresectable
- Metastatic

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	Neuroendocrine and Adrenal Tumors
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 the requested therapy

OR

2 - Documentation of positive clinical response (e.g., suppression of severe diarrhea, flushing, etc.) to the requested therapy

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	Thymoma or Thymic Carcinoma
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of thymoma or thymic carcinoma

AND

2 - ONE of the following:

2.1 Used as a second-line therapy for ONE of the following:

- Unresectable locally advanced disease
- Solitary metastasis or ipsilateral pleural metastasis
- Extrathoracic metastatic disease

OR

2.2 BOTH of the following:

2.2.1 Used as first line therapy for ONE of the following:

- Potentially resectable locally advanced disease
- Potentially resectable solitary metastasis or ipsilateral pleural metastasis
- Consideration following surgery for solitary metastasis or ipsilateral pleural metastasis
- Medically inoperable/unresectable solitary metastasis or ipsilateral pleural metastasis
- Extrathoracic metastatic disease
- Postoperative treatment for thymoma after R2 resection
- Preoperative systemic therapy for surgically resectable disease if R0 resection uncertain

AND

2.2.2 Patient is unable to tolerate first-line combination regimens

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	Meningioma, Thymoma or 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 the requested therapy

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	Malignant Bowel Obstruction
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of malignant bowel obstruction

AND

2 - Gut function cannot be maintained

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	Chemotherapy- and/or Radiation-Induced Diarrhea
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of diarrhea due to concurrent cancer chemotherapy and/or radiation

AND

2 - ONE of the following:

2.1 Presence of Grade 3 or 4 severe diarrhea

OR

2.2 Patient is in palliative or end of life care

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	Bleeding Gastroesophageal Varices
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of bleeding gastroesophageal varices associated with liver disease

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name:Brand Sandostatin, generic octreotide	
Diagnosis	Acromegaly, Malignant Bowel Obstruction, Chemotherapy- and/or Radiation-Induced Diarrhea, Bleeding Gastroesophageal Varices, NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to the requested therapy

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Saphnelo (anifrolumab-fnia)

Prior Authorization Guideline

Guideline ID	GL-398288
Guideline Name	Saphnelo (anifrolumab-fnia)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Patient is greater than or equal to 18 years of age

AND

2 - Patient has a diagnosis of moderate to severe systemic lupus erythematosus (SLE)

AND

3 - Prescribed by or in consultation with a rheumatologist

AND

4 - Patient does NOT have any of the following exclusions to therapy:

- Severe active central nervous system (CNS) lupus
- Severe active lupus nephritis (LN)

AND

5 - Patient has failed to respond adequately to at least one standard therapy (e.g., antimalarials, corticosteroids, or immunosuppressives)

AND

6 - The medication will be used in combination with standard therapy (e.g., antimalarials, corticosteroids, non-steroidal anti-inflammatory drugs, immunosuppressives)

AND

7 - Patient does NOT have a clinically significant active infection

AND

8 - Patient will NOT receive a live or live-attenuated vaccine concurrently with treatment

AND

9 - The medication will NOT be used in combination with other biologic therapies, including B-cell targeted therapies (e.g., belimumab [Benlysta], voclosporin [Lupkynis], or cyclophosphamide)

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

Approval Criteria

1 - Documentation of positive clinical response to Saphnelo therapy

AND

2 - Patient is greater than or equal to 18 years of age

AND

3 - Patient has a diagnosis of moderate to severe systemic lupus erythematosus (SLE)

AND

4 - Prescribed by or in consultation with a rheumatologist

AND

5 - Patient does NOT have any of the following exclusions to therapy:

- Severe active central nervous system (CNS) lupus
- Severe active lupus nephritis (LN)

AND

6 - The medication will be used in combination with standard therapy (e.g., antimalarials, corticosteroids, non-steroidal anti-inflammatory drugs, immunosuppressives)

AND

7 - Patient does NOT have a clinically significant active infection

AND

8 - Patient will NOT receive a live or live-attenuated vaccine concurrently with treatment

AND

9 - The medication will NOT be used in combination with other biologic therapies, including B-cell targeted therapies (e.g., belimumab [Benlysta], voclosporin [Lupkynis], or cyclophosphamide)

2 . Revision History

Date	Notes
9/22/2025	New program.

Savella

Prior Authorization Guideline

Guideline ID	GL-416254
Guideline Name	Savella
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Savella	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - The patient a diagnosis of Fibromyalgia and/or Myalgia and Myositis, unspecified	

2 . Revision History

Date	Notes
10/7/2025	New guideline

Sensipar

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-442214
Guideline Name	Sensipar
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Arizona (ACUAZ, ACUAZEC) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Sensipar, generic cinacalcet

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

Approval Criteria

1 - Prescribed by or in consultation with an oncologist, endocrinologist, or nephrologist

AND

2 - ONE of the following:

2.1 BOTH of the following:

- Diagnosis of secondary hyperparathyroidism with chronic kidney disease
- Patient is on dialysis

OR

2.2 Diagnosis of hypercalcemia with parathyroid carcinoma

OR

2.3 ALL of the following:

- Diagnosis of primary hyperparathyroidism (HPT)
- Severe hypercalcemia [serum calcium level greater than 12.5 mg/dL (milligrams/deciliter)] due to primary HPT
- Patient is unable to undergo parathyroidectomy

Product Name:Brand Sensipar, generic cinacalcet	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria **1** - Patient has experienced a reduction in serum calcium from baseline

2 . Revision History

Date	Notes
11/6/2025	Added Nevada Formulary

Sephience

Prior Authorization Guideline

Guideline ID	GL-503346
Guideline Name	Sephience
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Nebraska (ACUNE)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of phenylketonuria (PKU)

AND

2 - Patient is actively on a phenylalanine-restricted diet

AND

3 - One of the following:

3.1 Failure to sapropterin as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to sapropterin therapy (please specify contraindication or intolerance)

OR

3.3 Patient is not an appropriate candidate for sapropterin due to two null mutations in trans

AND

4 - Physician attestation that the patient will not be receiving Sephience in combination with sapropterin dihydrochloride or Palynziq (pegvaliase-pqpz)

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

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient is actively on a Phe-restricted diet **AND** **2** - Blood Phe levels continue to remain lower than baseline level **AND** **3** - Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is not receiving Sephience in combination with sapropterin dihydrochloride or Palynziq (pegvaliase-pqpz) *	
Notes	*Prescription claim history that does not show any concomitant sapropterin dihydrochloride or Palynziq (pegvaliase-pqpz) claim within 60 days of reauthorization request may be used as documentation

2 . Revision History

Date	Notes
1/21/2026	New

Short Acting Opioids

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-510236
Guideline Name	Short Acting Opioids
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:butorphanol nasal sol, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, tramadol, Qdolo, Tramadol soln, Brand tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Seglentis, Roxybond, Oxycodone abuse deterrent tabs, Xyvona	
Diagnosis	Requests exceeding the 7 days' supply limit
Approval Length	For patients less than 18 years of age, approval length is 3 months; For patients greater than or equal to 18 years of age, approval length is 12 months

Guideline Type	Quantity Limit

Approval Criteria

1 - One of the following:

1.1 The patient has filled an opioid in the past 45 days

OR

1.2 All of the following:

- The patient has chronic pain or requires an extended opioid therapy and is under the supervision of a licensed prescriber
- Pain cannot be controlled through the use of non-opioid therapy [e.g., acetaminophen, NSAIDs (nonsteroidal anti-inflammatory drugs), antidepressants, anti-seizure medications, physical therapy, chiropractic treatment, etc.]
- The lowest effective dose is being prescribed
- A pain contract is on file

OR

1.3 One of the following:

- Patient has cancer/malignancy related pain
- Patient is post-surgery with an anticipated prolonged recovery (greater than 3 months)
- Patient is receiving palliative care, hospice or end-of-life care
- Patient is residing in a long-term care facility
- Patient is receiving treatment for HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome)
- Prescribed by, or in consultation with, a pain specialist

Product Name:butorphanol nasal sol, codeine, acetaminophen w/codeine soln and tabs, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, generic oxycodone tabs, Brand Percocet, Prolate tabs and soln, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, tramadol,

Qdolo, Tramadol soln, Brand tramadol/acetaminophen, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Seglentis, Roxybond, Oxycodone abuse deterrent tabs, Xyvona	
Diagnosis	Requests exceeding Morphine Milligram Equivalents (MME)
Approval Length	For patients less than 18 years of age, approval length is 3 months; For patients greater than or equal to 18 years of age, approval length is 12 months
Guideline Type	DUR

Approval Criteria

1 - One of the following:

1.1 All of the following:

- The patient has chronic pain or requires an extended opioid therapy and is under the supervision of a licensed prescriber
- Pain cannot be controlled through the use of non-opioid therapy [e.g., acetaminophen, NSAIDs (nonsteroidal anti-inflammatory drugs), antidepressants, anti-seizure medications, physical therapy, chiropractic treatment, etc.]
- The lowest effective dose is being prescribed
- A pain contract is on file

OR

1.2 One of the following:

- Patient has cancer/malignancy related pain
- Patient is post-surgery with an anticipated prolonged recovery (greater than 3 months)
- Patient is receiving palliative care, hospice, or end-of-life care
- Patient is residing in a long-term care facility
- Patient is receiving treatment for HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome)
- Prescribed by, or in consultation with, a pain specialist

Product Name:codeine, acetaminophen w/codeine soln and tabs	
Approval Length	For patients less than 18 years of age, approval length is 1 month; For patients greater than or equal to 18 years of age, approval length is 12 months

Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Patient is 18 years of age or older

OR

1.2 Patient is less than 18 years of age and all of the following:

1.2.1 Patient is 12 years of age or older

AND

1.2.2 The lowest effective dose for the shortest period of time is being requested

AND

1.2.3 The patient is not obese [BMI (body mass index) greater than 30 kilograms per square meter] and does not have obstructive sleep apnea or severe lung disease

AND

1.2.4 The patient is not being prescribed the drug for post-surgical pain following a tonsillectomy and/or adenoidectomy

AND

2 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:tramadol, Qdolo, Tramadol soln, Brand tramadol/acetaminophen	
Approval Length	For patients less than 18 years of age, approval length is 1 month; For patients greater than or equal to 18 years of age, approval length is 12 months
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Patient is 18 years of age or older

OR

1.2 Patient is less than 18 years of age and all of the following:

1.2.1 Patient is 12 years of age or older

AND

1.2.2 The lowest effective dose for the shortest period of time is being requested

AND

1.2.3 The patient is not obese [BMI (body mass index) greater than 30 kilograms per square meter] and does not have obstructive sleep apnea or severe lung disease

AND

1.2.4 The patient is not being prescribed the drug for post-surgical pain following a tonsillectomy and/or adenoidectomy

AND

1.2.5 The requested dose does not exceed 200 mg/day (milligrams per day) and does not exceed a five-day supply **AND** **2** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:butorphanol nasal sol, Brand Fioricet/codeine, generic butalbital/acetaminophen/caffeine w/codeine, Ascomp/codeine, generic butalbital/aspirin/caffeine w/codeine, morphine supp, tabs and soln, hydrocodone/acetaminophen soln, Brand Xodol, generic hydrocodone/acetaminophen tabs, hydrocodone/ibuprofen, Brand Dilaudid, generic hydromorphone, oxycodone caps, soln and conc, Brand Roxicodone, generic oxycodone tabs, Brand Percocet, Nalocet, Endocet, Oxycodone-acetaminophen soln and tabs, generic oxycodone/acetaminophen soln and tabs, oxymorphone, pentazocine w/naloxone, Nucynta, meperidine, levorphanol, Brand Trezix, generic acetaminophen/caffeine/dihydrocodeine, generic belladonna alkaloids/opium, opium, Seglentis, Roxybond, Oxycodone abuse deterrent tabs, Xyvona	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria **1** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Brand Prolate tabs and soln	
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has had trial and failure to both of the following:

- Generic oxycodone/acetaminophen
- Generic hydrocodone/acetaminophen

OR

2 - Rationale provided from the prescriber as to why generic alternatives cannot be used (please document)

Product Name:Brand Prolate tabs and soln	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient continues to meet initial criteria

AND

2 - Documentation of positive response to therapy

2 . Revision History

Date	Notes
1/29/2026	Added criteria for Prolate. Updated GPI/drug list.

Short-Acting Bronchodilators

Prior Authorization Guideline

Guideline ID	GL-416246
Guideline Name	Short-Acting Bronchodilators
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Ventolin, generic albuterol sulfate HFA, Brand and generic albuterol sulfate nebulizer, Airsupra, Proair Respiclick	
Approval Length	12 month(s)
Guideline Type	Quantity Limit
Approval Criteria **1** - The patient has a diagnosis of asthma **AND**	

2 - One of the following:

- The patient has been assessed for causes of asthma and external triggers have been removed or reduced where possible
- If the patient is 18 years of age or less, the patient requires an additional inhaler unit for school or equivalent program

Product Name:Brand Ventolin, generic albuterol sulfate HFA, Brand and generic albuterol sulfate nebulizer, Airsupra, Proair Respiclick	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met

Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:levalbuterol nebulizer solution, Xopenex HFA. Levalbuterol aer	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

- The patient is experiencing side effects on one other beta-adrenergic agent of any formulation
- The patient's cardiovascular status is considered to be in severe deteriorating condition

2 . Revision History

Date	Notes
10/7/2025	New guideline

Sickle Cell

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-422484
Guideline Name	Sickle Cell
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Lyfgenia	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is 12 years of age or older

AND

2 - The patient has had genetic testing confirming diagnosis of severe sickle-cell disease (SCD) genotype (βS/βS or βS/βO or βS/β+)

AND

3 - The patient does not have disease with greater than 2 α-globin gene deletions

AND

4 - The patient has symptomatic disease with hydroxyurea or alternative approved agent unless contraindicated

AND

5 - The patient experienced greater than or equal to 4 vaso-occlusive events/crises (VOE/VOC) in the previous 24-months

AND

6 - Prescribed by or in consultation with a Hematologist

AND

7 - Prescriber attestation that the patient is a candidate for autologous hematopoietic stem cell transplant (HSCT)

AND

8 - The patient has not previously received any other SCD gene therapy, including the requested medication* (e.g. Casgevy)

AND

9 - The patient has been counseled and verbalized understanding that hematologic

malignancy (blood cancer) has occurred in clinical studies with Lyfgenia treatment (black box warning)

AND

10 - The patient does not have any of the following conditions:

10.1 Positive for presence of HIV-1 or HIV-2, HBV, HCV

OR

10.2 Clinically significant and active bacterial, viral, fungal, or parasitic infection

OR

10.3 Advanced liver disease

OR

10.4 Inadequate bone marrow function as defined by an absolute neutrophil count of less than 1000/μL (

OR

10.5 Any history of severe cerebral vasculopathy (defined by overt or hemorrhagic stroke; abnormal transcranial Doppler [greater than or equal to 200 cm/sec] needing chronic transfusions, or occlusion or stenosis in the polygon of Willis; or presence of Moyamoya disease

AND

11 - Prescriber attestation that all necessary preparations prior to Lyfgenia administration will be followed per package insert (including scheduled transfusions to target required Hb and HbS levels and management of other concomitant medications

Notes	*Max one treatment course per lifetime

Product Name:Casgevy	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is greater than or equal to 12 years of age

AND

2 - Prescribed by or in consultation with Hematologist

AND

3 - Prescriber attestation that patient is candidate for autologous HSCT

AND

4 - The patient has not previously received an allogeneic transplant

AND

5 - The patient has not received other gene therapy for sickle-cell disease or beta-thalassemia, including the requested medication* (e.g., Lyfgenia®, Zynteglo®)

AND

6 - The patient does not have any of the following conditions:

6.1 Positive for presence of HIV-1 or HIV-2, HBV, or HCV

OR

6.2 Clinically significant and active bacterial, viral, fungal, or parasitic infection

OR

6.3 Advanced liver disease

AND

7 - If the request is for sickle cell disease (SCD) ALL of the following:

7.1 The patient has had genetic testing confirming diagnosis of severe SCD genotype (βS/βS or βS/βO or βS/β+)

AND

7.2 The patient experienced greater than or equal to 2 VOE/VOC per year for the previous two years

AND

7.3 The patient has symptomatic disease despite treatment with hydroxyurea or alternative approved agent (e.g., crizanlizumab, voxelotor), unless contraindicated

AND

7.4 Prescriber attestation that all necessary preparations prior to Casgevy administration will be followed per package insert (including scheduled transfusions to target required Hb and HbS levels and discontinuation of disease modifying therapies)

AND

8 - If the request is for Transfusion-dependent beta-thalassemia (TDT) ALL of the following:

8.1 The patient has had genetic testing confirming diagnosis β-thalassemia

AND **8.2** The patient has transfusion-dependent disease defined as a history of transfusions of greater than or equal to 100 mL/kg/year or greater than or equal to 10 units/year of packed red blood cells (pRBCs) in the previous 2 years **AND** **8.3** The patient does not have severely elevated iron in the heart (i.e., recipients with cardiac T2 less than 10 msec by MRI or LVEF of, less than 45% by echocardiogram) **AND** **8.4** Prescriber attestation that all necessary preparations prior to Casgevy administration will be followed per package insert (including scheduled transfusions to target required Hb levels and discontinuation of disease modifying therapies)	
Notes	*Max 1 treatment course per lifetime

2 . Revision History

Date	Notes
10/20/2025	1/1/2026 Implementation

Signifor

Prior Authorization Guideline

Guideline ID	GL-438189
Guideline Name	Signifor
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Signifor

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

Approval Criteria

1 - Diagnosis of endogenous Cushing's disease (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids)

AND

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
11/5/2025	Combined formularies - added NV, VA, WA, IN, NE, NM. No clinical c hanges.

Skyclarys (omaveloxolone)

Prior Authorization Guideline

Guideline ID	GL-422490
Guideline Name	Skyclarys (omaveloxolone)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is at least 16 years of age

AND

2 - The patient has a diagnosis of Friedreich's ataxia as confirmed by molecular genetic testing and detection of biallelic pathogenic variant in the FXN gene and clinical signs and symptoms (e.g., ataxia, speech disturbance, sensory dysfunction, etc.) that is consistent with Friedreich's ataxia

AND

3 - Prescribed by or in consultation with a neurologist, geneticist, or other specialist with advanced knowledge in treating Friedreich's ataxia

AND

4 - The patient retains meaningful voluntary motor function (e.g., manipulate objects using upper extremities, ambulates)

AND

5 - The patient has baseline Modified Friedreich's Ataxia Rating Scale (mFARS) score greater than 20 and less than 80

AND

6 - The patient's B-Type Natriuretic Peptide (BNP) is less than or equal to 200 pg/mL prior to initiating therapy and will be monitored periodically during treatment

AND

7 - Prescriber will assess both of the following prior to therapy initiation and periodically during therapy as recommended in the product label:

- Liver function (ALT, AST, bilirubin)
- Lipid parameter

AND

8 - The patient does not have severe hepatic impairment (Child-Pugh C)

AND

9 - The patient has the ability to swallow capsules

AND

10 - If the patient has reproductive potential, they have been advised to use non-hormonal contraceptive method (e.g., non-hormonal intrauterine system, condoms) during Skyclarys therapy and for 28 days after discontinuation

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

Approval Criteria

1 - The patient continues to meet the initial authorization criteria

AND

2 - The patient must have disease improvement as defined by stabilization or slowed progression of disease signs and symptoms (e.g., bulbar function, upper/lower limb coordination, upright stability) from pretreatment baseline

AND

3 - The patient has not experienced any treatment-restricting adverse effects (e.g., fluid overload, heart failure; ALT or AST greater than 5 times the Upper Limit of Normal (ULN) or greater than 3 times the ULN with signs of liver dysfunction)

2 . Revision History

Date	Notes
10/20/2025	1/1/2026 Implementation

Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and Combinations

Prior Authorization Guideline

Guideline ID	GL-419220
Guideline Name	Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors and Combinations
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:dapagliflozin (generic for Farxiga), dapagliflozin/metformin ER (generic for Xigduo XR), Inpefa, Invokamet XR, Segluromet, Steglatro, Steglujan, Trijardy XR	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - If the request is non-preferred, ONE of the following:

1.1 Both of the following:

- The patient is using the requested medication for an antidiabetic indication

• The patient has tried and failed ONE preferred medication * **OR** **1.2** The patient has tried and failed TWO preferred medications *
Notes | *PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

2 . Revision History

Date	Notes
10/9/2025	New Implementation 1/1/2026

Sofdra

Prior Authorization Guideline

Guideline ID	GL-435272
Guideline Name	Sofdra
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of primary axillary hyperhidrosis

AND

2 - ONE of the following:

2.1 Failure to Xerac-AC as confirmed by claims history or submission of medical records **OR** **2.2** History of contraindication or intolerance to Xerac-AC (please specify contraindication or intolerance)

2 . Revision History

Date	Notes
11/4/2025	New guideline

Sohonos

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-438190
Guideline Name	Sohonos
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of fibrodysplasia ossificans progressiva (FOP)

AND

2 - Diagnosis has been confirmed by the presence of a mutation in the activin receptor IA (ACVR1) gene

AND

3 - ONE of the following:

3.1 BOTH of the following:

- Patient is female
- Patient is 8 years of age or older

OR

3.2 BOTH of the following:

- Patient is male
- Patient is 10 years of age or older

AND

4 - Sohonos is being used to reduce the volume of new heterotopic ossification (HO)

AND

5 - Prescribed by or in consultation with an FOP expert (e.g., endocrinologist, geneticist, pediatric orthopedist, pediatric rheumatologist)

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

Approval Criteria

1 - Documentation of positive clinical response [e.g., reduction in new HO (heterotopic ossification) volume, improved CAJIS (Cumulative Analogue Joint Involvement Scale) and FOP-PFQ (Fibrodysplasia Ossificans Progressiva-Physical Function Questionnaire) scores, improved quality of life]

AND

2 - Prescribed by or in consultation with an FOP expert (e.g., endocrinologist, geneticist, pediatric orthopedist, pediatric rheumatologist)

2 . Revision History

Date	Notes
11/5/2025	Combined formularies - added NV, VA, IN, NE, NM. No clinical chang es.

Spinal Muscular Atrophy (SMA) Agents

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-380432
Guideline Name	Spinal Muscular Atrophy (SMA) Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of Spinal Muscular Atrophy (SMA) type I, II, or III

AND

2 - Patient has mutation or deletion of genes in chromosome 5q resulting in one of the following:

2.1 Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13)

OR

2.2 Compound heterozygous mutation (e.g., deletion of survival motor neuron 1 (SMN1) exon 7 [allele 1] and mutation of SMN1 [allele 2])

AND

3 - Patient has at least two copies of SMN2

AND

4 - Patient is not dependent on invasive ventilation or tracheostomy and non- invasive ventilation beyond use for naps and nighttime sleep

AND

5 - One of the following:

5.1 Patient is less than 2 months of age requesting Evrysdi proactively to not delay access to initial therapy in recently diagnosed infants*

OR

5.2 At least ONE of the following exams (based on the patient's age and motor ability) have been conducted to establish baseline motor ability:

- Hammersmith Infant Neurological Exam (HINE) (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)

- Motor Function Measure 32 (MFM-32) Scale

AND

6 - Medication is prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA

AND

7 - Patient is not receiving concomitant chronic SMN (survival motor neuron) modifying therapy for the treatment of SMA (e.g. Spinraza)

AND

8 - One of the following:

8.1 Patient has not previously received gene replacement therapy for the treatment of SMA (e.g. Zolgensma)

OR

8.2 Patient has previously received gene therapy for the treatment of SMA (e.g. Zolgensma) and the provider attests that there has been an inadequate response to gene therapy (e.g. sustained decrease in at least one motor test score over a period of six months)

Notes	*Initial assessments shortly post-therapy can serve as baseline with re spect to efficacy reauthorization assessment.

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

Approval Criteria

1 - Patient has documentation of positive clinical response to therapy from pretreatment baseline status as demonstrated by the most recent results from ONE of the following exams:

1.1 One of the following HINE-2 milestones:

1.1.1 Improvement or maintenance of previous improvement of at least a two-point (or maximal score) increase in ability to kick

OR

1.1.2 Improvement or maintenance of previous improvement of at least a one-point increase in any other HINE-2 milestone (e.g., head control, rolling, sitting, crawling, etc.), excluding voluntary grasp

OR

1.1.3 Patient exhibited improvement, or maintenance of previous improvement in more HINE motor milestones than worsening, from pretreatment baseline (net positive improvement)

OR

1.1.4 The patient has achieved and maintained any new motor milestones when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

OR

1.2 One of the following HFMSE milestones:

1.2.1 Improvement or maintenance of a previous improvement of at least a three-point increase in score from pretreatment baseline

OR

1.2.2 Patient has achieved and maintained any new motor milestone from pretreatment baseline when they would otherwise be unexpected to do so (e.g., sit unassisted, stand, walk)

OR

1.3 One of the following ULM test milestones:

1.3.1 Improvement or maintenance of a previous improvement of at least a two-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 (e.g., sit unassisted, stand, walk)

OR

1.4 One of the following CHOP INTEND milestones:

1.4.1 Improvement or maintenance of a previous improvement of at least a four-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 (e.g., sit unassisted, stand, walk)

OR

1.5 One of the following MFM-32 milestones:

1.5.1 Improvement or maintenance of a previous improvement of at least a three-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 (e.g., sit unassisted, stand, walk)

AND

2 - Patient continues to not be dependent on invasive ventilation or tracheostomy and use of non-invasive ventilation beyond use for naps and nighttime sleep

AND

3 - Medication is prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA

AND

4 - Patient is not receiving concomitant chronic SMN modifying therapy for the treatment of SMA (e.g. Spinraza)

AND

5 - One of the following:

5.1 Patient has not previously received gene replacement therapy for the treatment of SMA (e.g. Zolgensma)

OR

5.2 Patient has previously received gene therapy for the treatment of SMA (e.g. Zolgensma) and the provider attests that there has been an inadequate response to gene therapy (e.g. sustained decrease in at least one motor test score over a period of six months)

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

Approval Criteria

1 - Patient has a diagnosis of Spinal Muscular Atrophy (SMA)

AND

2 - Medication is prescribed by or in consultation with a neurologist who has experience treating SMA

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

Approval Criteria

1 - Patient is maintaining neurological status

AND

2 - Patient is tolerating therapy

AND

3 - One of the following:

3.1 The medication is prescribed by or in consultation with a neurologist who has experience treating SMA

OR

3.2 Both of the following:

- Patient has been on therapy for 12 months or more
- Patient has experienced benefit from therapy (e.g., disease amelioration compared to untreated patients)

Product Name:Zolgensma	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is two years of age or younger

AND

2 - Patient has a mutation or deletion of genes in chromosome 5q 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 - ONE of the following

3.1 Patient has a diagnosis of spinal muscular atrophy (SMA), which has been confirmed by a neurologist with expertise in the diagnosis of SMA

OR

3.2 Patient has a diagnosis of SMA based on the results of SMA newborn screening with three copies or less of SMN2

AND

4 - Patient is not dependent on either invasive ventilation or tracheostomy or use of non-invasive ventilation beyond use of naps and nighttime sleep

AND

5 - Submission of medical records (e.g., chart notes, laboratory values) documenting the patient's anti-AAV9 antibody titers are less than or equal to 1:50

AND

6 - Patient is not receiving concomitant SMN (survival motor neuron) modifying therapy (e.g. Spinraza)

AND

7 - Medication is prescribed by a neurologist with expertise in the diagnosis of SMA

AND

8 - Patient has NOT previously received Zolgensma treatment in their lifetime

2 . Revision History

Date	Notes
9/10/2025	New

Spravato

Prior Authorization Guideline

Guideline ID	GL-421296
Guideline Name	Spravato
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Spravato	
Approval Length	4 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 BOTH of the following:

- Diagnosis of treatment-resistant depression

- Diagnosis evidenced by failure of two antidepressants

OR

1.2 BOTH of the following:

- Diagnosis of depressive symptoms in adults with major depressive disorder (MDD) with acute suicidal ideation or behavior
- Treatment must be in conjunction with an oral antidepressant

AND

2 - Patient is at least 18 years of age

AND

3 - Medication must be administered under the direct supervision of a healthcare provider with post-administration observation

AND

4 - Prescribed by or in consultation with a psychiatrist

AND

5 - Patient does NOT have an aneurism or arteriovenous (AV) malformation

AND

6 - Patient is NOT currently pregnant or breastfeeding

Product Name:Spravato	
Approval Length	6 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - Patient continues to meet initial authorization criteria **AND** **2** - Documentation of positive clinical response to treatment	

2 . Revision History

Date	Notes
10/15/2025	New program

Strensiq (asfotase alfa)

Prior Authorization Guideline

Guideline ID	GL-432189
Guideline Name	Strensiq (asfotase alfa)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of perinatal/infantile or juvenile-onset hypophosphatasia (HPP)

AND

2 - Patient was 18 years of age or younger at onset

AND

3 - The patient experienced clinical manifestations of HPP (e.g., vitamin B6-responsive seizures, chest deformity, severe hypercalcemia, bowing of the long bones, failure to thrive)

AND

4 - The patient obtained radiographic imaging to support diagnosis of HPP

AND

5 - Genetic testing has been completed documenting tissue non-specific alkaline phosphatase (ALP) gene mutation

AND

6 - There has been reduced activity of unfractionated serum ALP

AND

7 - Prescribed by or in consultation with an endocrinologist, geneticist, or a metabolic disorder specialist

AND

8 - The requested quantity is within FDA-labeled dosing requirement based on the patient's weight (document weight)

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

Guideline Type	Prior Authorization
Approval Criteria **1** - Prescribed by or in consultation with an endocrinologist, geneticist, or a metabolic disorder specialist **AND** **2** - The requested quantity is within FDA-labeled dosing requirement based on the patient's weight (document weight)	

2 . Revision History

Date	Notes
10/27/2025	New program

Stromectol

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-438197
Guideline Name	Stromectol
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Stromectol, generic ivermectin tabs	
Approval Length	1 month(s)

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of ONE of the following:

- Onchocerciasis due to nematode parasite
- Pediculosis
- Strongyloidiasis
- Ascariasis
- Scabies (including crusted scabies)
- Cutaneous larva migrans (hook worm disease)
- Enterobiasis
- Filariasis
- Trichuriasis
- Gnathostomiasis

2 . Revision History

Date	Notes
11/5/2025	Added NV formulary. No clinical changes.

Sublingual Immunotherapy (SLIT)

Prior Authorization Guideline

Guideline ID	GL-438198
Guideline Name	Sublingual Immunotherapy (SLIT)
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Grastek	
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 defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

AND

2 - Diagnosis confirmed by ONE of the following:

2.1 Positive skin test to Timothy grass or cross-reactive grass pollens (e.g., Sweet Vernal, Orchard/Cocksfoot, Perennial Rye, Kentucky blue/June grass, Meadow Fescue, or Redtop)

OR

2.2 In vitro testing for pollen-specific IgE (immunoglobulin E) 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 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

4.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- 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	
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

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 defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

AND

2 - Diagnosis confirmed by ONE of the following:

2.1 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)]

OR

2.2 In vitro testing for pollen-specific IgE (immunoglobulin E) 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 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

4.2 History of contraindication or intolerance to ALL of the following (please specify contraindication or intolerance):

- 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	
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	
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 defined by symptoms severe enough to interfere with quality of life (e.g., sleep disturbances; impairment of daily, sport, or leisure activities; impairment of school or work performance)

AND

2 - Diagnosis confirmed by ONE of the following:

- Positive skin test to short ragweed pollen
- In vitro testing for pollen-specific IgE (immunoglobulin E) 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 - ONE of the following:

4.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]

- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

4.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- 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	
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	
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 (immunoglobulin E) antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites

AND

3 - ONE of the following:

3.1 Failure to TWO of the following as confirmed by claims history or submission of medical records:

- oral antihistamine [e.g., cetirizine (Zyrtec)]
- intranasal antihistamine [e.g., azelastine (Astelin)]
- intranasal corticosteroid [e.g., fluticasone (Flonase)]
- leukotriene inhibitor [e.g., montelukast (Singulair)]

OR

3.2 History of intolerance or contraindication to ALL of the following (please specify intolerance or contraindication):

- 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

Product Name:Odactra	
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Odactra therapy	

2 . Revision History

Date	Notes
11/5/2025	Added NV formulary. No clinical changes.

Substance Abuse Agents

Prior Authorization Guideline

Guideline ID	GL-404235
Guideline Name	Substance Abuse Agents
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Suboxone, generic buprenorphine SL film, buprenorphine SL tab, Zubsolv, buprenorphine SL tab	
Diagnosis	Exceeding 24 mg of buprenorphine or Equivalent
Approval Length	12 month(s)
Guideline Type	Drug Utilization Review
Approval Criteria **1** - Patient has a diagnosis of opioid dependence	

Product Name:Brand Suboxone, generic buprenorphine SL film, buprenorphine SL tab, Zubsolv, buprenorphine SL tab	
Approval Length	12 month(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	
Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Brand Lucemyra, generic lofexidine	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization
Approval Criteria **1** - Patient has a diagnosis of opioid withdrawal with symptoms due to abrupt opioid discontinuation **AND** **2** - The requested quantity does not exceed 2.88 mg/day (milligrams per day) for up to 14 days **AND** **3** - If the request is for a non-preferred product, the "Non-Preferred Drugs" approval criteria have been met	
Notes	PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Vivitrol

Approval Length	6 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The requested medication is being used for an FDA (Food and Drug Administration) approved indication

AND

2 - The medication will be delivered directly to the prescriber's office

AND

3 - The requested medication will only to be administered once per month

AND

4 - Attestation that routine urine screening and monitoring will be completed

2 . Revision History

Date	Notes
10/2/2025	New guideline

Synagis (palivizumab)

Prior Authorization Guideline

Guideline ID	GL-416255
Guideline Name	Synagis (palivizumab)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Synagis*	
Diagnosis	Patients less than 12 months of age at start of RSV season
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 The patient was born at 28 weeks, six days of gestation or earlier

OR

1.2 The patient has a diagnosis of chronic lung disease (CLD) of prematurity

OR

1.3 The patient has hemodynamically significant congenital heart disease

OR

1.4 The patient has congenital abnormalities of the airways or neuromuscular disease

OR

1.5 Both of the following:

- The patient has a diagnosis of cystic fibrosis
- The patient has clinical evidence of CLD and/or nutritional compromise

AND

2 - The number of doses requested do not exceed a maximum quantity of 5 per RSV (respiratory syncytial virus) season

Notes	*Approval for up to five doses per RSV season

Product Name:Synagis*	
Diagnosis	Patients less than 24 months of age at start of RSV season
Guideline Type	Prior Authorization

Approval Criteria

1 - One of the following:

1.1 Both of the following:

- The patient has a diagnosis of chronic lung disease (CLD) of prematurity

- The patient has required medical therapy (e.g., bronchodilator, diuretics, oxygen, corticosteroids) within six months to the start of RSV (respiratory syncytial virus) season

OR

1.2 The patient has had a cardiac transplant

OR

1.3 The patient is severely immunocompromised (solid organ or hematopoietic stem cell transplant, chemotherapy, or other conditions) during the RSV season

OR

1.4 The patient has had a cardiopulmonary bypass and continues to require prophylaxis after surgery or at the conclusion of extracorporeal membrane oxygenation

OR

1.5 Both of the following:

- The patient has a diagnosis of cystic fibrosis
- The patient has had manifestations of severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persists when stable) or weight for length less than the tenth percentile

AND

2 - The number of doses requested do not exceed a maximum quantity of 5 per RSV (respiratory syncytial virus) season

Notes	*Approval for up to five doses per RSV season

2 . Revision History

Date	Notes
10/7/2025	New guideline

Targretin (bexarotene) 1% gel

Prior Authorization Guideline

Guideline ID	GL-449217
Guideline Name	Targretin (bexarotene) 1% gel
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Targretin 1% gel, generic bexarotene 1% 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 - ONE of the following:

2.1 Failure 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)] as confirmed by claims history or submission of medical records

OR

2.2 History of 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)] (please specify contraindication or intolerance)

Product Name:Brand Targretin 1% gel, generic bexarotene 1% gel	
Diagnosis	Cutaneous T-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 therapy

Product Name:Brand Targretin 1% gel, generic bexarotene 1% gel	
Diagnosis	NCCN Recommended Regimens
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

Product Name:Brand Targretin 1% gel, generic bexarotene 1% 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 therapy

2 . Revision History

Date	Notes
11/13/2025	New NV state specific guideline

Tarpeyo

Prior Authorization Guideline

Guideline ID	GL-438194
Guideline Name	Tarpeyo
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Tarpeyo	
Approval Length	9 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy

AND

2 - Patient is at risk for disease progression

AND

3 - Used to reduce the loss of kidney function

AND

4 - Estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m^2 (milliliters/minute/1.73 square meters)

AND

5 - ONE of the following:

5.1 Patient is on a stabilized dose and receiving concomitant therapy with ONE of the following, as confirmed by claims history or submitted medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

OR

5.2 Patient has an allergy, contraindication, or intolerance to ACE inhibitors and ARBs (please specify allergy, contraindication, or intolerance)

AND

6 - ONE of the following:

6.1 Failure of ONE 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) confirmed by claims history or submitted medical records

OR

6.2 History of intolerance or contraindication to ONE glucocorticoid (please specify intolerance or contraindication)

AND

7 - Prescribed by or in consultation with a nephrologist

2 . Revision History

Date	Notes
11/5/2025	Added NV formulary. No clinical changes.

Tavalisse

Prior Authorization Guideline

Guideline ID	GL-438193
Guideline Name	Tavalisse
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Tavalisse	
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 - ONE of the following:

2.1 BOTH of the following:

2.1.1 ONE of the following:

2.1.1.1 Failure to at least ONE of the following classes confirmed by claims history or submitted medical records:

- Corticosteroids
- Immunoglobulins

OR

2.1.1.2 History of contraindication or intolerance to BOTH of the following classes (please specify intolerance or contraindication):

- Corticosteroids
- Immunoglobulins

AND

2.1.2 ONE of the following:

2.1.2.1 Failure to eltrombopag (generic Promacta) confirmed by claims history or submitted medical records

OR

2.1.2.2 History of contraindication or intolerance to eltrombopag (generic Promacta) (please specify intolerance or contraindication)

OR **2.2** Patient is currently on Tavalisse therapy

Product Name:Tavalisse	
Diagnosis	Chronic immune thrombocytopenia (ITP)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response to Tavalisse therapy	

2 . Revision History

Date	Notes
11/5/2025	Added NV formulary. No clinical changes.

Tavneos (avacopan)

Prior Authorization Guideline

Guideline ID	GL-422487
Guideline Name	Tavneos (avacopan)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is 18 years of age or older

AND

2 - The patient has severe active antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis and BOTH of the following

2.1 Patient has autoantibodies for proteinase 3 (PR3) or myeloperoxidase (MPO), as detected using indirect immunofluorescence (IIF) assay or antigen-specific ELISAs

AND

2.2 Disease is confirmed by tissue biopsy at the site of active disease

AND

3 - Prescribed by or in consultation with a Nephrologist, Pulmonologist, or Rheumatologist

AND

4 - Prescriber has assessed baseline (pre-treatment) disease severity utilizing an objective measure/tool (e.g., Birmingham Vasculitis Activity Score [BVAS]) (initial request only)

AND

5 - Tavneos will be used as adjunctive therapy in combination with standard therapy (e.g., corticosteroids, cyclophosphamide, azathioprine, mycophenolate, rituximab)

AND

6 - Patient does not have an active infection, including localized infections

AND

7 - Patient does not have severe hepatic impairment (e.g., Child-Pugh C) or active, untreated, and/or uncontrolled chronic liver disease (e.g., chronic active hepatitis B, untreated hepatitis C, uncontrolled autoimmune hepatitis, cirrhosis)

AND

8 - Liver panel has been obtained before initiating Tavneos and will be repeated per package insert (every four weeks after start of therapy for first six months then as clinically indicated)

AND

9 - Patient has been evaluated and screened for the presence of HBV prior to initiating treatment (initial criteria only)

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

Approval Criteria

1 - The patient continues to meet the initial authorization criteria

AND

2 - Documentation of positive clinical response to Tavneos therapy

2 . Revision History

Date	Notes
10/20/2025	1/1/2026 Implementation

Testosterone

Prior Authorization Guideline

Guideline ID	GL-435275
Guideline Name	Testosterone
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate	
Diagnosis	Hypogonadism
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 TWO pre-treatment serum total testosterone levels less than 300 ng/dL

(nanograms/deciliter) [less than 10.4 nmol/L (nanomoles/liter)] or less than the reference range for the lab, taken at separate times (This may require treatment to be temporarily held. 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 (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]

AND

1.2.2 ONE pre-treatment calculated free or bioavailable testosterone level less than 50 pg/mL (picograms/milliliter) (< 5 ng/dL or < 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 any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

3 - Patient is NOT taking any aromatase inhibitor [e.g., Arimidex (anastrozole), Femara (letrozole), 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% ideal body weight) [e.g., AIDS (acquired immunodeficiency syndrome) wasting syndrome]
- Osteopenia
- Osteoporosis
- Decreased bone density
- Decreased libido
- Organic cause of testosterone deficiency (e.g., injury, tumor, infection, or genetic defects)

Notes	*Patients that have previously received injectable testosterone open a ccess should be reviewed using reauthorization criteria

Product Name:Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate	
Diagnosis	Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Initial Authorization*
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is using hormones to change physical characteristics to align with gender expression

AND

2 - Patient must be diagnosed with gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

AND

3 - Patient is NOT taking any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

4 - Patient is NOT taking any aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

Notes	*Patients that have previously received injectable testosterone open a ccess should be reviewed using reauthorization criteria

Product Name:Brand Depo-Testosterone, generic testosterone cypionate, testosterone enanthate	
Diagnosis	Hypogonadism, Gender Dysphoria
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - ONE of the following:

1.1 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)

OR

1.2 BOTH of the following:

1.2.1 Patient has a diagnosis of ONE of the following:

- Hypogonadism
- Gender dysphoria, as defined by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)

AND

1.2.2 ONE of the following:

1.2.2.1 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

1.2.2.2 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

1.2.2.3 BOTH of the following:

1.2.2.3.1 Patient has a condition that may cause altered sex-hormone binding globulin (SHBG) [e.g., thyroid disorder, HIV (human immunodeficiency virus) disease, liver disorder, diabetes, obesity]

AND

1.2.2.3.2 ONE of the following:

- 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)
- 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 any of the following growth hormones, unless diagnosed with panhypopituitarism:

- Genotropin
- Humatrope
- Norditropin FlexPro
- Nutropin AQ
- Omnitrope
- Saizen

AND

3 - Patient is NOT taking any aromatase inhibitors [e.g., Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)]

2 . Revision History

Date	Notes
11/4/2025	New guideline

Therapeutic Duplication (Subtype A)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-503398
Guideline Name	Therapeutic Duplication (Subtype A)
Formulary	• Medicaid - Community & State Indiana (ACUIN) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Generic arformoterol nebulizer solution, Brand Brovana nebulizer, generic formoterol nebulizer solution, Brand Perforomist nebulizer, Striverdi Respimat, Serevent Diskus, Incruse Ellipta, Brand Spiriva Handihaler, generic tiotropium, Spiriva Respimat, Tudorza Pressair, generic ipratropium inhalation solution, Atrovent HFA, Anoro Ellipta, Stiolto Respimat, Bevespi Aerosphere, Duaklir Pressair, Breztri Aerosphere, Glyxambi, Steglujan, Qtern, Trijardy XR, Brand Pulmicort suspension, generic budesonide suspension, Victoza, Adlyxin, Trulicity, Bydureon BCise, Byetta, Ozempic, Rybelsus, Januvia, Janumet, Janumet XR, Brand Onglyza, generic saxagliptin, Brand Kombiglyze XR, generic saxagliptin/metformin ER, Tradjenta, Jentadueto, Jentadueto XR, Nesina, alogliptin, Kazano, alogliptin/metformin, Oseni, alogliptin/pioglitazone, Mounjaro, Xultophy, Soliqua, Invokana, brand Farxiga, generic dapagliflozin, Jardiance, Invokamet, Invokamet XR, brand Xigduo XR, generic dapagliflozin/metformin ER, Synjardy, Synjardy XR, Steglatro, Segluromet, Zituvio, Brand Flovent HFA, Fluticasone propionate HFA, Flovent Diskus, Brand Fluticasone propionate Diskus, Brand Pulmicort Flexhaler, Alvesco, ArmonAir Digihaler, Asmanex Twisthaler, Asmanex HFA, Arnuity Ellipta, Qvar RediHaler, Lonhala Magnair, Trelegy Ellipta, Brand Advair Diskus, generic fluticasone propionate/salmeterol diskus (generic Advair Diskus),

generic Wixela Inhub (generic Advair Diskus), AirDuo Respiclick, fluticasone/salmeterol (authorized generic of AirDuo), Brand Advair HFA, Brand Fluticasone/salmeterol HFA, Brand Symbicort, generic budesonide/formoterol, Breyna, AirDuo Digihaler, Dulera, Breo Ellipta, Brand fluticasone/vilanterol Ellipta, Basaglar Tempo pen, Basaglar Kwikpen, Insulin Glargine Solostar, Lantus Solostar, Toujeo Solostar, Toujeo Max Solostar, Semglee Pen Injector, Insulin Glargine-YFGN pen, Lantus vial, Insulin Glargine vial, Semglee vial, Insulin Glargine-YFGN vial, Levemir vial, Levemir Flextouch, Levemir Flexpen, Tresiba vial, Insulin Degludec vial, Tresiba Flextouch, Insulin Degludec Flextouch, Rezvoglar, Baclofen tabs, generic baclofen suspension, Brand Fleqsuvy, Brand Ozobax DS, brand Ozobax, Brand Baclofen solution, brand Lioresal intrathecal, generic baclofen intrathecal, brand Gablofen intrathecal, baclofen intrathecal solution, Lyvispah, generic carisoprodol tab, brand Soma, brand Vanadom tab, generic chlorzoxazone, brand Lorzone, generic cyclobenzaprine, brand Fexmid, generic cyclobenzaprine ER, brand Amrix, metaxalone, methocarbamol, orphenadrine CR/ER, generic tizanidine caps/tabs, brand Zanaflex caps/tabs, brand Dantrium, generic dantrolene, brand Norgesic, generic orphenadrine/aspirin/caffeine, norgesic forte, orphengesic forte, Brand Neurontin caps/tabs/soln, generic gabapentin caps/tabs/soln, gabapentin tinytabs, brand Lyrica caps/soln, generic pregabalin caps/soln, brand Gralise, brand Lyrica CR, generic pregabalin ER, Horizant, Zorvolex, brand Zipsor, generic diclofenac caps, brand Lofena, generic diclofenac tabs, diclofenac DR/ER, brand Cambia, generic diclofenac packet (migraine), etodolac cap, brand Lodine, generic etodolac tab, etodolac ER, brand Nalfon caps/tabs, generic fenoprofen caps/tabs, flurbiprofen, ibuprofen caps/tabs/chewable (includes All Manufactures), Brand Advil, ibuprofen suspension (40 mg/ml & 100 mg/5ml), indomethacin caps, indomethacin ER/SR caps, indocin susp, indocin suppository, indomethacin suppository, ketoprofen cap, ketoprofen ER cap, ketorolac tabs, meclofenamate cap, mefenamic acid, meloxicam cap/tab, brand Relafen DS, generic nabumetone, generic naproxen tab/susp/caps (includes All Manufactures), brand naprosyn tab/susp, brand Aleve, brand Anaprox DS, brand EC-Naprosyn, generic naproxen DR, generic EC-naproxen, brand Naprelan, generic naproxen CR/ER, Brand Daypro, generic oxaprozin, brand Feldene, generic piroxicam, sulindac, tolmetin, brand Celebrex, generic celecoxib, Elyxyb, brand Arthrotec, generic diclofenac sodium/misoprostol, brand Duexis, generic ibuprofen/famotidine, brand Vimovo, generic naproxen/esomeprazole, brand Advil PM, generic ibuprofen/diphenhydramine, brand Aleve PM, generic naproxen/diphenhydramine, hydrocodone/ibuprofen, brand Treximet, generic sumatriptan/naproxen, Motrin Dual Action/Tylenol, Advil Dual Action/acetaminophen, acetaminophen/ibuprofen, Naproxen/capsaicin cream (Naprotin), Inpefa, Saxenda, Wegovy inj/tab, Brand Brenzavvy, Brand Bexagliflozin, Zepbound, Coxanto, Jantoven, warfarin tabs, Pradaxa, generic dabigatran, Eliquis, Savaysa, Xarelto, Zituvimet, Sitagliptin/metformin, Brand Tanlor, Dolobid, generic diflunisal, Zituvimet XR, Tresni, Fenopron, Gabarone, Addaprin, Symbravo, Exenatide, Brynovin, Vyscoxa, Tonmya	
Diagnosis	DUR: Therapeutic Duplication
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria	

1 - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued

OR

2 - All of the following:

2.1 The requested medication combination 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

2.2 The drug combination is being prescribed for a medically accepted indication that is recognized as a covered benefit by the applicable health plan's program

AND

2.3 The provider attests that they are aware that the patient is using duplicate therapy

AND

2.4 Special clinical circumstances exist that necessitate the need for duplicate therapy (document special circumstances)

AND

2.5 Provider attests that the necessity for continued concomitant therapy and safety will be periodically assessed

2 . Revision History

Date	Notes
1/21/2026	Added Wegovy tab, Vyscoxa, Tonmya

Therapeutic Duplication (Subtype B)

Prior Authorization Guideline

Guideline ID	GL-507189
Guideline Name	Therapeutic Duplication (Subtype B)
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Kansas (ACUKS, ACUKSC, ACUKSEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State North Carolina (ACUNC) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Community & State Arizona (ACUAZ, ACUAZEC) • Medicaid - Community & State Texas (ACUTX, ACUTXC, ACUTXEC, ACUTXSK)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:(All formulations/packaging, except for Entyvio) Entyvio Pen, Stelara, Cimzia, Abrilada, Humira, Amjevita, Idacio, Hulio, Cyltezo, Yusimry, Yuflyma, Hadlima, Hyrimoz, Adalimumab (all products), Simponi, Enbrel, Actemra, Cosentyx, Ilaris, Kineret, Kevzara, Taltz, Tremfya, Orencia, Xeljanz, Xeljanz XR, Xeljanz Solution, Siliq, Otezla, Olumiant, Ilumya, Skyrizi, Rinvoq, Sotyktu, Cibinqo, Adbry, Dupixent, brand Copaxone, generic glatiramer acetate, generic glatopa, Mavenclad, Rebif, Avonex, Betaseron, Extavia, brand Aubagio, generic teriflunomide, Plegridy, Lemtrada, Tysabri, Ocrevus, brand Tecfidera, generic dimethyl fumarate, Vumerity, brand Gilenya, generic fingolimod, Tascenso ODT, Zeposia, Mayzent, Bafiertam, Kesimpta, Ponvory, Xolair, Fasenra, Nucala, Cinqair, Tezspire, Velsipity, Bimzelx, Omvoh, Zymfentra, Simlandi, Spevigo, Tyenne, Rinvoq LQ, Nemluvio, Ebglyss, Wezlana, Steqeyma, Yesintek, Pyzchiva, Otulfi, Selarsdi, Imuldosa, Ustekinumab (all products), Leqselvi, Litfulo, Avtozma, Otezla XR, Starjemza, Exdensur	
Diagnosis	DUR: Therapeutic Duplication
Approval Length	12 month(s)
Guideline Type	Administrative
Approval Criteria **1** - The requested medication will be used exclusively, and the previously prescribed medication will be discontinued	

2 . Revision History

Date	Notes
1/22/2026	Added TX

Tolvaptan

Prior Authorization Guideline

Guideline ID	GL-439214
Guideline Name	Tolvaptan
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Jynarque, generic tolvaptan tab, generic tolvaptan pack	
Diagnosis	Autosomal dominant polycystic kidney disease (ADPKD)
Approval Length	12 month(s)

Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of autosomal dominant polycystic kidney disease (ADPKD)

Notes	This criteria comes from the Jynarque policy.

Product Name:Brand Jynarque, generic tolvaptan tab, generic tolvaptan pack	
Diagnosis	Autosomal dominant polycystic kidney disease (ADPKD)
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy

Notes	This criteria comes from the Jynarque policy.

Product Name:Brand Samsca, generic tolvaptan tab	
Diagnosis	Hypervolemic or Euvolemic Hyponatremia
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	
Notes	This criteria comes from the Samsca policy.

2 . Revision History

Date	Notes
11/5/2025	Added Nevada Formulary

Topical Immunomodulators

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-506302
Guideline Name	Topical Immunomodulators
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Brand Elidel, Generic Pimecrolimus, Eucrisa, Tacrolimus Oint 0.03%, Tacrolimus Oint 0.1%	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient meets the appropriate diagnosis for the requested product:

- Brand Elidel, generic pimecrolimus, Eucrisa: Mild to moderate atopic dermatitis
- Tacrolimus Ointment: Moderate to severe atopic dermatitis

AND

2 - The patient meets the appropriate age limit for the requested product:

- Brand Elidel, generic pimecrolimus, Tacrolimus Oint 0.03%: Patient is 2 years of age or older
- Eucrisa: Patient is 3 months of age or older
- Tacrolimus Oint 0.1%: Patient is 16 years of age or older

AND

3 - The medication is not for chronic use

AND

4 - Patient is NOT immunocompromised

AND

5 - If the request is for Elidel (pimecrolimus), patient does not have Netherton's syndrome

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

Approval Criteria

1 - Diagnosis of mild to moderate Atopic Dermatitis

AND

2 - Patient is 2 years of age or older

AND

3 - The medication will not be used chronically

AND

4 - Patient is NOT immunocompromised

AND

5 - Patient has had a trial and failure, contraindication, or intolerance to two or more of the following classes:

- Prescription topical corticosteroids
- Topical calcineurin inhibitor (e.g., Elidel (pimecrolimus) or Protopic (tacrolimus))
- Topical phosphodiesterase-4 inhibitor (e.g.,Eucrisa (crisaborole))

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

Approval Criteria

1 - Patient has had disease improvement and/or stabilization

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

Approval Criteria

1 - Diagnosis of moderate to severe chronic hand eczema (CHE)

AND

2 - Patient is at least 18 years of age

AND

3 - ONE of the following:

- Hand eczema has persisted for more than 3 months
- Hand eczema has returned twice or more within the last 12 months

AND

4 - Patient has had an inadequate response, intolerance, or contraindication to at least 1 moderate to high potency topical corticosteroid

AND

5 - Medication will NOT be used concurrently with Opzelura (ruxolitinib), systemic JAK inhibitors, or potent immunosuppressants

AND

6 - Patient does NOT have an active or serious infection

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

Guideline Type	Prior Authorization
Approval Criteria **1** - Documentation of positive clinical response	

2 . Revision History

Date	Notes
1/26/2026	Added Anzupgo. Updated age criteria for Opzelura

Toradol (ketorolac tromethamine) tablets

Prior Authorization Guideline

Guideline ID	GL-416243
Guideline Name	Toradol (ketorolac tromethamine) tablets
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:ketorolac tablets	
Approval Length	Up to 5 days
Guideline Type	Prior Authorization

Approval Criteria

1 - The requested oral treatment is for continuation therapy to intravenous (IV)/intramuscular (IM) therapy

AND

2 - The requested oral treatment will not exceed 5 days **AND** **3** - The requested oral treatment will not exceed 40 milligrams per day

2 . Revision History

Date	Notes
10/6/2025	New guideline

Tranexamic acid

Prior Authorization Guideline

Guideline ID	GL-443193
Guideline Name	Tranexamic acid
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name: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
11/6/2025	Updated guideline name to Tranexamic acid. Removed Lysteda from guideline (obsolete). Combined formularies - added NV, VA, NE, NM, PA CAID

Tryngolza (olezarsen)

Prior Authorization Guideline

Guideline ID	GL-391198
Guideline Name	Tryngolza (olezarsen)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is greater than 18 years of age

AND

2 - Diagnosis of familial chylomicronemia syndrome (FCS) confirmed by one of the following:

2.1 Genetic confirmation of bi-allelic pathogenic variants in affected genes (e.g., LPL, ApoA5, ApoC2, LMF1, GPIHBPI, G3PDH1)

OR

2.2 ALL of the following:

2.2.1 Fasting triglyceride (TG) levels persistently >880 mg/dL while on conventional lipid lowering therapy, unless contraindicated or not tolerated (e.g., fibrates, omega-3 fatty acids, statins, niacin, ezetimibe)

AND

2.2.2 Secondary causes of hypertriglyceridemia have been ruled out (e.g., alcohol use, chronic kidney disease (CKD), hypothyroidism, uncontrolled diabetes, medications [e.g., atypical antipsychotics, beta-blockers, corticosteroids, oral estrogens])

AND

2.2.3 The patient has a clinical history suggestive of FCS (e.g., pancreatitis, eruptive xanthomas, lipemia retinalis)

AND

3 - The patient has been counseled to follow a low-fat diet

AND

4 - Prescribed by, or in consultation with, an endocrinologist, cardiologist, or lipidologist

Product Name:Tryngolza	
Approval Length	6 month(s)
Therapy Stage	Reauthorization

Guideline Type	Prior Authorization
Approval Criteria **1** - The patient continues to meet initial authorization criteria **AND** **2** - Documentation of positive response to therapy	

2 . Revision History

Date	Notes
9/8/2025	1/1/2026 implementation

Tryvio

Prior Authorization Guideline

Guideline ID	GL-434331
Guideline Name	Tryvio
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Community & State Pennsylvania (ACUPA)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Tryvio

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

Approval Criteria

1 - Diagnosis of resistant hypertension

AND

2 - ONE of the following:

- Systolic blood pressure greater than or equal to 130 mm Hg (millimeters of mercury) on two consecutive measurements despite maximally tolerated antihypertensive treatment
- Diastolic blood pressure greater than or equal to 80 mm Hg on two consecutive measurements despite maximally tolerated antihypertensive treatment

AND

3 - Patient has been previously treated with ALL of the following antihypertensive classes for an adequate duration (minimum 4 weeks each) at a maximally tolerated dose as confirmed by claims history or submission of medical records:

- Maximally tolerated blocker of the renin-angiotensin system [angiotensin-converting enzyme (ACE) inhibitor (e.g., enalapril, lisinopril) or angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)]
- Maximally tolerated calcium channel blocker (e.g., amlodipine, diltiazem, verapamil)
- Maximally tolerated diuretics (e.g., hydrochlorothiazide)
- Maximally tolerated mineralocorticoid receptor antagonist [MRA (e.g., spironolactone, eplerenone)]

AND

4 - Provider attests other causes of hypertension have been excluded (e.g., secondary causes [e.g., primary hyperaldosteronism], white coat effect, medication nonadherence)

AND

5 - Used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program)

AND

6 - Tryvio will be used in combination with at least 3 antihypertensive medications from different classes at maximally tolerated doses

AND

7 - 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 - Documentation the patient is receiving clinical benefit to Tryvio therapy

AND

2 - Tryvio will be used in combination with at least 3 antihypertensive medications from different classes at maximally tolerated doses

2 . Revision History

Date	Notes
11/3/2025	Added NV Formulary

Tzield (teplizumab-mzwv)

Prior Authorization Guideline

Guideline ID	GL-432190
Guideline Name	Tzield (teplizumab-mzwv)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Tzield	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of stage 2 type 1 diabetes

AND

2 - Patient is at least 8 years of age

AND

3 - Documentation of at least two positive pancreatic islet cell autoantibodies (e.g., glutamic acid decarboxylase 65 [GAD65], insulin autoantibody [IAA], insulinoma-associated antigen 2 autoantibody [IA-2A], zinc transporter 8 autoantibody [ZnT8A], islet cell autoantibody [ICA])

AND

4 - Documentation of dysglycemia without overt hyperglycemia using an oral glucose tolerance test (an alternative method of diagnosis may be used if an oral glucose tolerance test is not available)

AND

5 - Prescriber attests to the absence of acute Epstein-Barr virus (EBV) and CMV infection through laboratory or clinical evidence

AND

6 - Prescriber has confirmed the absence of an active serious infection or chronic active infection, excluding localized skin infection

AND

7 - The patient has received all age-appropriate vaccines, with live vaccines administered at least eight weeks before treatment, and inactivated vaccines and mRNA vaccines administered at least two weeks before treatment

AND

8 - The patient is not pregnant or planning to become pregnant during the 14-day treatment course

AND

9 - Prescribed by or in consultation with an adult or pediatric endocrinologist

AND

10 - Request does NOT exceed 24 vials per 14-day course of therapy

AND

11 - Request does NOT exceed one treatment course per lifetime

2 . Revision History

Date	Notes
10/27/2025	New program

Valchlor

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-509218
Guideline Name	Valchlor
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC)

Guideline Note:

Effective Date:	2/1/2026

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	Histiocytic Neoplasms
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Langerhans Cell Histiocytosis (LCH)

AND

2 - Skin disease is unifocal and isolated

Product Name:Valchlor	
Diagnosis	Primary Cutaneous Lymphomas, Histiocytic Neoplasms
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 - Use is supported by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium

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

1/27/2026	Combined formularies. Reorganized WA policy to match CORE since no changes to clinical intent.

Vanrafia

Prior Authorization Guideline

Guideline ID	GL-434329
Guideline Name	Vanrafia
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by renal biopsy

AND

2 - Patient is at risk of disease progression

AND

3 - Medication is used to slow kidney function decline

AND

4 - Medication is used to reduce proteinuria

AND

5 - Estimated glomerular filtration rate (eGFR) is greater than or equal to 30 mL/min/1.73 m2

AND

6 - Both of the following:

6.1 Patient is on a maximized stable dose with ONE of the following prior to initiating therapy confirmed by claims history or submitted medical records:

- Maximally tolerated angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril)
- Maximally tolerated angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan)

AND

6.2 Use of endothelin receptor antagonists [(ERAs) e.g., Letairis, Opsumit, Tracleer)] will be discontinued prior to initiating treatment

AND

7 - One of the following:

7.1 Failure to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) confirmed by claims history or submitted medical records

OR

7.2 History of contraindication or intolerance to a 30-day trial of a glucocorticoid (e.g., methylprednisolone, prednisone) (please specify intolerance or contraindication)

AND

8 - 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 - Documentation of positive clinical response demonstrated by a reduction in proteinuria

2 . Revision History

Date	Notes
11/3/2025	Added NV Formulary

Vemlidy

Prior Authorization Guideline

Guideline ID	GL-434328
Guideline Name	Vemlidy
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of chronic hepatitis B infection

AND

2 - ONE of the following:

- Failure to entecavir (generic Baraclude) as confirmed by claims history or submission of medical records
- History of contraindication or intolerance to entecavir (generic Baraclude) (please specify contraindication or intolerance)
- Patient is not a suitable candidate for entecavir (generic Baraclude)

AND

3 - ONE of the following:

3.1 Failure to tenofovir disoproxil fumarate (generic Viread) as confirmed by claims history or submission of medical records

OR

3.2 History of contraindication or intolerance to tenofovir disoproxil fumarate (generic Viread) (please specify contraindication or intolerance)

OR

3.3 Submission of medical records documenting an estimated glomerular filtration rate below 90 mL/min (milliliters/minute)

OR

3.4 Submission of medical records documenting a diagnosis of osteopenia as defined by a BMD (bone mineral density) 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 one of the following with

evidence of progressive bone loss on serial DEXA (dual-energy X-ray absorptiometry) scan [Provider must submit patient specific BMD T-scores]:

- Lumbar spine (at least two vertebral bodies)
- Hip (femoral neck, total hip)
- Radius (one-third radius site)

OR

3.5 Submission of medical records documenting a diagnosis of osteoporosis as defined by a BMD T-score less than or equal to -2.5 based on BMD measurements from one of the following [Provider must submit patient specific BMD T-score]:

- Lumbar spine (at least two vertebral bodies)
- Hip (femoral neck, total hip)
- Radius (one-third radius site)

OR

3.6 Submission of medical records documenting a prior low-trauma or non-traumatic fracture

OR

3.7 Patient is less than 20 years of age

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

Approval Criteria

1 - Documentation of positive clinical response to Vemlidy therapy

AND

2 - Patient is not a suitable candidate for entecavir (generic Baraclude) or tenofovir disoproxil fumarate (generic Viread)

2 . Revision History

Date	Notes
11/3/2025	Added NV Formulary

Veozah

Prior Authorization Guideline

Guideline ID	GL-507208
Guideline Name	Veozah
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Veozah	
Approval Length	12 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 - ONE of the following:

2.1 Failure (after a 30-day trial) to ONE of the following as confirmed by claims history or submission of medical records:

- Hormonal therapy (e.g., estradiol, Premarin, Prempro)
- Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]

OR

2.2 History of contraindication or intolerance to BOTH of the following (please specify contraindication or intolerance):

- Hormonal therapy (e.g., estradiol, Premarin, Prempro)
- Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]

AND

3 - Patient has received baseline hepatic laboratory tests to rule out the presence of underlying liver disease

Product Name:Veozah	
Approval Length	12 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)

AND

2 - Patient has received periodic evaluation of hepatic laboratory tests to rule out liver injury associated with Veozah use

2 . Revision History

Date	Notes
1/23/2026	Combined formularies. No changes to clinical criteria. Minor cosmetic update.

Verkazia (cyclosporine)

Prior Authorization Guideline

Guideline ID	GL-398251
Guideline Name	Verkazia (cyclosporine)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Patient is greater than or equal to 4 years of age

AND

2 - Patient has a diagnosis of vernal keratoconjunctivitis

AND

3 - Prescriber attestation that disease severity is moderate to severe

AND

4 - Patient has had a disease flare within the past 1 year

AND

5 - Patient is NOT using another immunomodulator via the ophthalmic route (e.g., other formulations of cyclosporine, tacrolimus, pimecrolimus)

AND

6 - Patient will NOT exceed a maximum daily dose of 4 vials

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

Approval Criteria

1 - Patient continues to meet initial authorization criteria

AND

2 - Prescriber attestation that patient has had disease improvement and/or stabilization (e.g.,

improvement on corneal fluorescein staining [CFS], decrease in number of flares, improvement in symptoms) **AND** **3** - Patient has NOT experienced any treatment-restricting adverse effects (e.g., eye pain, infection)

2 . Revision History

Date	Notes
9/18/2025	New program.

Vimovo (naproxen-esomeprazole magnesium), Duexis (ibuprofen-famotidine)

Prior Authorization Guideline

Guideline ID	GL-422493
Guideline Name	Vimovo (naproxen-esomeprazole magnesium), Duexis (ibuprofen-famotidine)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Vimovo, generic naproxen/esomeprazole, ibuprofen/famotidine	
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The requested medication is being used for an FDA (Food and Drug Administration) approved indication

AND

2 - Documentation of one of the following risk factors for developing an NSAID (non-steroidal anti-inflammatory drug)-related ulcer:

- Previous history of a major gastrointestinal bleed, perforation, or obstruction
- Previous history of a peptic ulcer, hemorrhagic gastritis, hemorrhagic gastropathy, or erosive esophagitis
- Concomitant therapy for an anticoagulant or antiplatelet agent (including aspirin) or chronic oral corticosteroids
- The patient has had gastric bypass surgery (Roux-en-Y gastric bypass)

AND

3 - The patient is intolerant to a COX-2 inhibitor or has had a gastric or duodenal ulcer while taking a COX-2 inhibitor

AND

4 - The patient has experienced an NSAID-associated ulcer in the past while taking a single-entity PPI or prostaglandin agent concomitantly with an NSAID or the patient is intolerant to both PPIs and prostaglandin agents

AND

5 - Documentation of an inadequate response or adverse reaction with concurrent therapy of an equivalent dose of the individual components

2 . Revision History

Date	Notes
10/21/2025	New guideline

Voquezna Dual and Triple Pak

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-422544
Guideline Name	Voquezna Dual and Triple Pak
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Voquezna Dual Pak, Voquezna Triple Pak	
Approval Length	14 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is 18 years or age or older

AND

2 - Patient has a confirmed diagnosis of Helicobacter pylori (H. pylori) infection

AND

3 - Patient does NOT have hypersensitivity or cross-hypersensitivity to any component or drug class of the product (e.g., penicillins, cephalosporins, macrolides)

AND

4 - Treatment will not be used concurrently with rilpivirine-containing products

AND

5 - If the request is for Voquezna Triple Pak, both of the following:

5.1 The patient does NOT have a history of hepatic dysfunction or cholestatic jaundice associated with prior use of clarithromycin

AND

5.2 The patient does NOT have ventricular cardiac arrythmia, prolongation of the QT interval, or proarrhythmic condition (e.g., uncorrected hypokalemia or hypomagnesemia)

AND

6 - The patient has an adequate trial and failure of, or relevant medical reason for not using, PPI-based H. pylori treatment regimen

AND

7 - Baseline renal and hepatic function laboratory tests have been obtained

2 . Revision History

Date	Notes
10/22/2025	New guideline

Vowst

Prior Authorization Guideline

Guideline ID	GL-434326
Guideline Name	Vowst
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Diagnosis of recurrent Clostridioides difficile infection (rCDI) as defined by BOTH of the following:

1.1 Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for 2 consecutive days

AND

1.2 A positive stool test for Clostridioides difficile toxin

AND

2 - Patient is 18 years of age or older

AND

3 - Patient has had one or more recurrences of CDI following an initial episode of CDI

AND

4 - Patient has completed at least 10 days of ONE of the following antibiotic therapies for rCDI 2 to 4 days prior to initiating Vowst as confirmed by claims history or submission of medical records:

- Oral vancomycin
- Dificid (fidaxomicin)

AND

5 - 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

6 - Patient will drink magnesium citrate on the day before and at least 8 hours prior to taking the first dose of Vowst

AND

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

- Gastroenterologist
- Infectious disease specialist

2 . Revision History

Date	Notes
11/3/2025	Added NV Formulary

Voxzogo (vosoritide)

Prior Authorization Guideline

Guideline ID	GL-422488
Guideline Name	Voxzogo (vosoritide)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is less than 18 years of age

AND

2 - Patient has diagnosis of confirmed achondroplasia based on ONE of the following:

2.1 Both of the following

2.1.1 Clinical manifestations of achondroplasia (e.g. proximal shortening of arms, large head, narrow chest, short fingers) and radiographic (e.g., ilia and horizontal acetabula, narrow sacrosciatic notch, proximal radiolucency of the femurs, generalized metaphyseal abnormality, decreasing interpedicular distance caudally)

AND

2.1.2 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 metaphysis, and short and narrow chest)

OR

2.2 Genetic testing with an identifiable mutation in the fibroblast growth factor receptor type 3 (FGFR3) gene

AND

3 - Prescribed by or in consultation with endocrinologist, pediatric endocrinologist, clinical geneticist, or other specialist with advanced knowledge in treating achondroplasia

AND

4 - Patient has open epiphyses

AND

5 - Medication dosed per FDA-label based on patient's actual body weight

AND

6 - Prescriber attestation that patient body weight, growth, and physical development will be monitored and assessed every three to six months

AND

7 - Patient has not had (within the previous 18 months) nor will they receive limb lengthening surgery

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

Approval Criteria

1 - Patient continues to meet initial authorization criteria

AND

2 - Documentation of positive clinical response to therapy as demonstrated by improvement in annualized growth velocity compared to pre-treatment baseline

2 . Revision History

Date	Notes
10/20/2025	1/1/2026 Implementation

Voydeya (danicopan)

Prior Authorization Guideline

Guideline ID	GL-421235
Guideline Name	Voydeya (danicopan)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

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) confirmed by flow cytometry testing

AND

2 - Patient is at least 18 years old

AND

3 - Patient has received a stable dose of C5 inhibitor therapy (ravulizumab-cwvz [Ultomiris] or eculizumab [Soliris]) for at least 6 months prior to starting Voydeya

AND

4 - Voydeya will be used as add-on therapy to eculizumab (Soliris) or ravulizumab-cwvz (Ultomiris)

AND

5 - Patient has clinically significant extravascular hemolysis (EVH) while on Soliris or Ultomiris as evidenced by both of the following:

- Hb 9.5 g/dL or less
- Absolute reticulocyte count at least 120 x 109/L

AND

6 - Prescribed by or in consultation with Hematologist

AND

7 - Patient has documented vaccinations for Neisseria meningitidis (N. meningitidis) and Streptococcus pneumoniae (S. pneumoniae) at least 2 weeks prior to initiating therapy

AND

8 - Patient does NOT have any of the following:

- Severe hepatic impairment (Child-Pugh class C)
- Unresolved serious infection caused by encapsulated bacteria (including N. meningitides, S. pneumoniae, or Haemophilus influenzae type b [HIB])

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

Approval Criteria

1 - Voydeya being used as add-on therapy to eculizumab (Soliris) or ravulizumab-cwvz (Ultomiris)

AND

2 - Prescribed by or in consultation with Hematologist

AND

3 - Patient has demonstrated positive response to therapy (e.g., decreased requirement of RBC transfusions, Hb stabilization or improvement LDH reduction, symptom improvement or stabilization, reduction in thrombotic events)

AND

4 - Patient does not have any treatment restricting adverse effects (e.g., encapsulated bacterial infection, clinically significant or symptomatic hepatic enzyme elevations)

2 . Revision History

Date	Notes
10/13/2025	New program

Vuity (pilocarpine)

Prior Authorization Guideline

Guideline ID	GL-392219
Guideline Name	Vuity (pilocarpine)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Brand Vuity, generic pilocarpine 1.25% ophth soln	
Approval Length	1 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient has a diagnosis of presbyopia

AND

2 - Prescribed by or in consultation with an ophthalmologist or optometrist

AND

3 - Patient is unable to use corrective lenses (e.g., eyeglasses or contact lenses) confirmed by medical records (e.g., chart notes)

AND

4 - The requested medication will NOT be prescribed concurrently with any ophthalmic pilocarpine formulations

Product Name:Brand Vuity, generic pilocarpine 1.25% ophth soln	
Approval Length	6 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - Documentation of positive clinical response to therapy (e.g., improvement in near vision in low light conditions without loss of distance vision)

AND

2 - Prescribed by or in consultation with an ophthalmologist or optometrist

2 . Revision History

Date	Notes
9/12/2025	New program.

Vyalev

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-434325
Guideline Name	Vyalev
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Vyalev

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 has inadequately controlled motor fluctuations despite being treated with optimized oral therapies (e.g. levodopa)

AND

3 - Prescribed by or in consultation with a neurologist

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

Approval Criteria

1 - Documentation of positive clinical response to Vyalev therapy demonstrated by an increase in “on” time without troublesome dyskinesia

2 . Revision History

Date	Notes
11/3/2025	Added NV Formulary

Vyjuvek (beremagene geperpavec-svdt)

Prior Authorization Guideline

Guideline ID	GL-398228
Guideline Name	Vyjuvek (beremagene geperpavec-svdt)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Patient is 6 months of age or older

AND

2 - Patient has NOT received a skin graft within the past 3 months

AND

3 - Patient has a genetically confirmed diagnosis of dystrophic epidermolysis bullosa (DEB) with mutation in the collagen type VII alpha 1 chain (COL7A1) gene

AND

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

- Pediatric dermatologist
- Other specialist with advanced knowledge of treating DEB

AND

5 - Patient has cutaneous wound(s) which are clean with adequate granulation tissue, excellent vascularization, and do not appear infected

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

Approval Criteria

1 - Patient continues to meet initial authorization criteria

AND

2 - Patient has NOT experienced any unacceptable toxicity from the drug (e.g., severe medication reaction resulting in discontinuation of therapy)

AND **3** - Patient has disease response as defined by improvement (healing) of treated wound(s) **AND** **4** - Patient requires continued treatment for new and/or existing open wounds

2 . Revision History

Date	Notes
9/17/2025	New program.

Vykat XR

Prior Authorization Guideline

Guideline ID	GL-434324
Guideline Name	Vykat XR
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Washington (ACUWA, ACUWAAHE, ACUWAC) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of hyperphagia associated with Prader-Willi Syndrome

AND

2 - Prader-Willi Syndrome is confirmed by genetic testing

AND

3 - Patient is at least 4 years of age or older

AND

4 - Prescribed by or in consultation with an endocrinologist, geneticist, or a specialist with knowledge 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 - Documentation of positive clinical response to Vykat XR therapy

2 . Revision History

Date	Notes

11/3/2025	Added NV Formulary

Vyndaqel and Vyndamax

Prior Authorization Guideline

Guideline ID	GL-435236
Guideline Name	Vyndaqel and Vyndamax
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Vyndaqel, Vyndamax	
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 - 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 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 light chain amyloidosis

AND

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

AND

4 - Physician attests that the patient has an N-terminal pro-B-type naturetic peptide (NT-proBNP) level that, when combined with signs and symptoms, is considered definitive for a diagnosis of ATTR-CM

AND

5 - ONE of the following:

- History of heart failure, with at least one prior hospitalization for heart failure
- Presence of clinical signs and symptoms of heart failure (e.g., dyspnea, edema)

AND

6 - One of the following:

- Failure to Attruby as confirmed by claims history or submission of medical records
- History of intolerance or contraindication to Attruby (please specify intolerance or contraindication)

AND

7 - Prescribed by, or in consultation, with a cardiologist

AND

8 - Patient is not receiving Vyndaqel/Vyndamax in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Attruby (acoramadis), Onpattro (patisiran), Tegsedi (inotersen), or Wainua (eplontersen)]

Notes	*May require prior authorization and notification

Product Name:Vyndaqel, Vyndamax

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

Approval Criteria

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

AND

3 - Prescribed by or in consultation with a cardiologist

AND

4 - Patient is not receiving Vyndaqel/Vyndamax in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Attruby (acoramadis), Onpattro (patisiran), Tegsedi (inotersen), or Wainua (eplontersen)]

2 . Revision History

Date	Notes
11/3/2025	Added a step through Attruby. Added NV formulary.

Wainua (eplontersen)

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-429197
Guideline Name	Wainua (eplontersen)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - Patient is greater than or equal to 18 years of age

AND

2 - Patient has a diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis confirmed by testing (e.g., genetic testing, biopsy)

AND

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

- Cardiologist
- Geneticist
- Neurologist
- Other specialist with advanced knowledge in treating hereditary transthyretin-mediated amyloidosis

AND

4 - Patient has clinical manifestations of polyneuropathy

AND

5 - Medication will NOT be used in combination with inotersen (Tegsedi), tafamidis (Vyndamax), tafamidis meglumine (Vyndaqel), patisiran (Onpattro), or vutrisiran (Amvuttra)

AND

6 - Patient does NOT have any of the following conditions:

- Severe renal impairment or end-stage renal disease
- Moderate or severe hepatic impairment
- Prior liver transplant

AND

7 - Prescriber will supplement vitamin A at the recommended daily allowance as appropriate and refer to an ophthalmologist if ocular symptoms suggestive of vitamin A deficiency (e.g., night blindness, dry eyes) occur

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

Approval Criteria

1 - Patient continues to meet initial authorization criteria

AND

2 - Patient has demonstrated a clinical benefit based on improvement in clinical manifestations of polyneuropathy from baseline

AND

3 - Patient has NOT experienced any treatment-restricting adverse effects (e.g., severe ocular symptoms related to vitamin A deficiency)

2 . Revision History

Date	Notes
10/27/2025	New program.

Winrevair

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-391208
Guideline Name	Winrevair
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is 18 years of age or older

AND

2 - Prescribed by, or in consultation with, a pulmonologist or cardiologist

AND

3 - Diagnosis of pulmonary arterial hypertension (PAH) World Health Organization (WHO) Group 1

AND

4 - Submission of right heart catheterization results confirming diagnosis

AND

5 - The patient's WHO functional class is II or greater

AND

6 - The patient has been stable on background PAH therapy for greater than or equal to 90 days and will continue background PAH therapy during treatment with Winrevair, unless contraindicated *

AND

7 - The patient does not have a baseline platelet count less than 50 x 10^9/L

AND

8 - The prescriber attests that hemoglobin (Hgb) and platelet levels will be monitored per package insert (e.g., before each dose for at least the first five doses)

AND

9 - If the patient is a female of reproductive potential both of the following:

- They have a negative pregnancy test prior to starting therapy
- They have been counseled on use of effective contraception during treatment

AND

10 - Winrevair will be dosed per FDA-label based on patient's weight

Notes	*Please note: Background therapy refers to combination therapy consisting of drugs from greater than or equal to 2 of the following drug classes: endothelin receptor antagonists (ERA), phosphodiesterase type 5 (PDE5) inhibitor (PDE5i), soluble guanylate cyclase stimulator, and/or prostacyclin analogue or receptor agonist

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

Approval Criteria

1 - Prescribed by, or in consultation with, a pulmonologist, or cardiologist

AND

2 - Winrevair will be dosed per FDA-label based on patient's weight

AND

3 - Documentation of positive clinical response to therapy

AND

4 - The patient continues on background PAH therapy during treatment with Winrevair, unless contraindicated *

Notes	*Please note: Background therapy refers to combination therapy consisting of drugs from greater than or equal to 2 of the following drug classes: endothelin receptor antagonists (ERA), phosphodiesterase type 5 (PDE5) inhibitor (PDE5i), soluble guanylate cyclase stimulator, and/or prostacyclin analogue or receptor agonist

2 . Revision History

Date	Notes
9/10/2025	1/1/2026 Implementation

Xdemvy

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-505195
Guideline Name	Xdemvy
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Michigan (ACUMI) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

Product Name:Xdemvy

Approval Length	6 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Demodex blepharitis

AND

2 - Patient demonstrates ONE of the following signs of Demodex infestation:

- Cylindrical cuff at the root of the eyelashes
- Lid margin erythema
- Eyelash anomalies (e.g., eyelash misdirection, eyelash loss)

AND

3 - Patient demonstrates TWO of the following symptoms of Demodex infestation:

- Itching/Burning
- Foreign body sensation
- Crusting/matted lashes
- Blurry vision
- Discomfort/irritation
- Tearing/lacrimation
- Dryness
- Purulence/discharge

AND

4 - Patient is practicing good eye-lid hygiene (e.g., non-prescription tree-tea oil)

AND

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

- Ophthalmologist

• Optometrist

2 . Revision History

Date	Notes
1/22/2026	Combined formularies. No changes to clinical criteria.

Xiaflex

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-482199
Guideline Name	Xiaflex
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Xiaflex	
Diagnosis	Dupuytren's Contracture
Approval Length	4 Week(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is at least 18 years of age

AND

2 - The patient has a confirmed diagnosis of Dupuytren's contracture with a palpable cord

AND

3 - The patient has not received surgical treatment (e.g., fasciotomy) on the selected primary joint within the last 90 days

AND

4 - Documentation that the flexion deformity is causing functional limitations

AND

5 - Treatment is administered no sooner than a four-week intervals

AND

6 - The patient has not had 3 cycles in total

Product Name:Xiaflex	
Diagnosis	Peyronie's Disease (PD)
Approval Length	6 Week(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient is at least 18 years of age

AND

2 - The patient has a confirmed diagnosis of Peyronie's disease (PD) with a palpable plaque

AND

3 - The patient has curvature deformity of at least 30 degrees and

AND

4 - Xiaflex is not being used for sexual or erectile dysfunction associated with PD

AND

5 - Must be used in conjunction with penile modeling procedure

AND

6 - Treatment is administered no sooner than 6-week intervals

AND

7 - The patient has not had 4 cycles in total

Product Name:Xiaflex	
Diagnosis	Peyronie's Disease (PD)
Approval Length	6 Week(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient continues to meet the initial authorization criteria

AND

2 - Curvature deformity remains greater than 15 degrees (curvature less than 15 degrees does not warrant subsequent treatment cycle)

Xolremdi

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-395221
Guideline Name	Xolremdi
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is greater than or equal to 12 years of age

AND

2 - Diagnosis of warts, hypogammaglobulinemia, infections, and myelokathexis (WHIM) syndrome with genotype-confirmed CXCR4 variant

AND

3 - Prescribed by, or in consultation with, a geneticist, immunologist, or other specialist with advance knowledge in treating WHIM syndrome

AND

4 - Confirmed absolute neutrophil count (ANC) less than or equal to 400 cells/µL (or total white blood cell (WBC) count less than or equal to 400 cells/µL if ANC is below lower limit of detection)

AND

5 - Prescriber attestation to assess QTc at baseline and to monitor QTc periodically during treatment for patients with risk factors for QTc prolongation

AND

6 - The patient is not taking any of the following:

- Another CXCR4 antagonist (e.g., plerixafor [Mozobil]
- Any medication that is highly dependent on cytochrome P450 (CYP) 2D6 for clearance (e.g., amitriptyline, fluoxetine)
- A strong CYP3A4 inducer (e.g., rifampin, phenytoin)

AND

7 - If the request is for a female of reproductive potential BOTH of the following:

- The patient has a confirmed negative pregnancy test prior to initiation
- The patient attests to use effective contraception during treatment and for three weeks after the last dose

AND

8 - Xolremdi will be dosed per FDA label based on patient's body weight with dose when used concomitantly with a strong CYP3A4 inhibitor

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

Approval Criteria

1 - The patient continues to meet the initial authorization criteria

AND

2 - Positive response to therapy (e.g., improvement in ANC and/or absolute lymphocyte counts [ALC], reduction in infections)

AND

3 - The patient has not experienced any treatment restricting adverse effects (e.g., significant QTc prolongation)

2 . Revision History

Date	Notes
9/17/2025	1/1/2026 Implementation

Yorvipath (palopegteriparatide)

Prior Authorization Guideline

Guideline ID	GL-504204
Guideline Name	Yorvipath (palopegteriparatide)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	2/1/2026

1 . Criteria

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

Approval Criteria

1 - The patient is greater than 18 years of age

AND

2 - Diagnosis of hypoparathyroidism that is not acute post-surgical

AND

3 - Within the previous two weeks the patient has both of the following:

- Serum 25(OH) vitamin D within the normal range
- Albumin-corrected serum calcium greater than or equal to 7.8 mg/dL (milligrams per deciliter)

AND

4 - Prescriber attestation that patient's disease cannot be adequately controlled on maximally tolerated active vitamin D (calcitriol) and elemental calcium

AND

5 - Medication is prescribed by, or in consultation with, an endocrinologist or nephrologist

AND

6 - The request does not exceed two pens/28 days for a max dose of 30 mcg daily

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

Approval Criteria

1 - Documentation of positive response to therapy

AND **2** - Medication is prescribed by, or in consultation with, an endocrinologist or nephrologist

2 . Revision History

Date	Notes
1/16/2026	Clarified ≥ and mg/dL. Added prescriber requirement to initial and rea uth. Added patient can't be controlled on vitamin D and calcium to init ial auth. Removed initial auth requirement for reauth.

Zeposia (ozanimod)

Prior Authorization Guideline

Guideline ID	GL-485198
Guideline Name	Zeposia (ozanimod)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Zeposia	
Diagnosis	Ulcerative Colitis
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has as a diagnosis of moderately to severely active UC (ulcerative colitis)

AND

2 - Prescribed by, or in consultation with, a gastroenterologist

AND

3 - Inadequate response after a 90-day trial of one of the following conventional therapies:

- 6-mercaptopurine
- Aminosalicylates (e.g., mesalamine, balsalazide, olsalazine)
- Sulfasalazine
- Azathioprine
- Corticosteroids (e.g., budesonide, high dose steroids, 40-60 mg of prednisone daily)

AND

4 - The patient has tried and failed two preferred immunomodulator therapies indicated for moderately to severely active UC*

Notes	*PDL link: https://www.uhcprovider.com/en/health-plans-by-state/nevada-health-plans/nv-comm-plan-home/nv-cp-pharmacy.html

Product Name:Zeposia	
Diagnosis	Multiple Sclerosis
Approval Length	12 month(s)
Therapy Stage	Initial Authorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has a diagnosis of a relapsing form of MS (multiple sclerosis) [e.g., relapsing-remitting MS (RRMS), secondary-progressive MS (SPMS) with relapses]

AND

2 - One of the following:

2.1 The requested medication is being used for continuation of therapy

OR

2.2 The patient has had failure after a trial of at least four weeks, contraindication, or intolerance to at least one of the following disease-modifying therapies for MS:

- Avonex (interferon beta-1a)
- Betaseron (interferon beta-1b)
- Copaxone/Glatopa (glatiramer acetate)
- Tecfidera (dimethyl fumarate)

AND

3 - Prescribed by, or in consultation with, a neurologist

Product Name:Zeposia	
Diagnosis	Multiple Sclerosis
Approval Length	12 month(s)
Therapy Stage	Reauthorization
Guideline Type	Prior Authorization

Approval Criteria

1 - The patient has documentation of positive clinical response to therapy (e.g., improvement in radiologic disease activity, clinical relapses, disease progression)

AND

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

2 . Revision History

Date	Notes

12/18/2025	Added PDL link to UC criteria

Zilbrysq

Prior Authorization Guideline

Guideline ID	GL-434312
Guideline Name	Zilbrysq
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Indiana (ACUIN) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Zilbrysq	
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.) confirming ALL of the following:

1.1 Diagnosis of generalized myasthenia gravis (gMG)

AND

1.2 Positive serologic test for anti-AChR antibodies

AND

1.3 Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy

AND

1.4 Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score greater than or equal to 6 at initiation of therapy

AND

2 - ONE of the following:

2.1 History of failure of at least two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.) as confirmed by claims history or submission of medical records

OR

2.2 Patient has a history of failure of at least one immunosuppressive therapy (as confirmed by claims history or submission of medical records) and has required four or more courses of

plasmapheresis/ plasma exchanges and/or intravenous immune globulin over the course of at least 12 months without symptom control

OR

2.3 Contraindication or intolerance to at least two immunosuppressive agents (please specify contraindication or intolerance)

AND

3 - Patient is not receiving Zilbrysq in combination with another complement inhibitor [e.g., Soliris (eculizumab), Ultomiris (ravulizumab-cwvz)] or a neonatal Fc receptor blocker [e.g., Rystiggo (rozanolixizumab-noli), Vyvgart (efgartigimod alfa-fcab),Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)]

AND

4 - Prescribed by, or in consultation with, a neurologist

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

Approval Criteria

1 - Submission of medical records (e.g., chart notes, laboratory tests) to demonstrate a positive clinical response from baseline as demonstrated by at least ALL of the following:

1.1 Improvement and/or maintenance of at least a 2-point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline

AND

1.2 Reduction in signs and symptoms of myasthenia gravis

AND **1.3** Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Zilbrysq* **AND** **2** - Patient is not receiving Zilbrysq in combination with another complement inhibitor [e.g., Soliris (eculizumab), Ultomiris (ravulizumab-cwvz)] or a neonatal Fc receptor blocker [e.g., Rystiggo (rozanolixizumab-noli), Vyvgart (efgartigimod alfa-fcab),Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)] **AND** **3** - Prescribed by, or in consultation with, a neurologist	
Notes	*Add on, dose escalation of IST, or additional rescue therapy from bas eline to treat myasthenia gravis or exacerbation of symptoms while on Zilbrysq therapy will be considered as treatment failure

2 . Revision History

Date	Notes
11/3/2025	Added NV formulary.

Zokinvy

Optum Rx®

Prior Authorization Guideline

Guideline ID	GL-434311
Guideline Name	Zokinvy
Formulary	• Medicaid - Community & State Colorado (ACUCO, ACUCOC) • Medicaid - Community & State Hawaii (ACUHI, ACUHIEC) • Medicaid - Community & State Maryland (ACUMD) • Medicaid - Health Plan of Nevada Medicaid (ACUNV) • Medicaid - Community & State New Jersey (PSI2300) • Medicaid - Community & State New York EPP (ACUNYEPP) • Medicaid - Community & State New York (ACUNY, ACUNYM) • Medicaid - Community & State Pennsylvania CHIP (ACUPAC) • Medicaid - Community & State Rhode Island (ACURI) • Medicaid - Community & State Arizona (ACUAZ, ACUAZEC) • Medicaid - Community & State Virginia (ACUVA, ACUVAC, ACUVAEC) • Medicaid - Community & State Pennsylvania (ACUPA) • Medicaid - Community & State Nebraska (ACUNE) • Medicaid - Community & State New Mexico (ACUNM)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Zokinvy	
Diagnosis	Hutchinson-Gilford Progeria Syndrome

Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of Hutchinson-Gilford Progeria Syndrome

Product Name:Zokinvy	
Diagnosis	Progeroid Laminopathies
Approval Length	12 month(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Diagnosis of processing deficient Progeroid laminopathy

AND

2 - Documentation of ONE of the following:

- Heterozygous LMNA (gene) mutation with progerin-like protein accumulation
- Homozygous or compound heterozygous ZMPSTE24 (gene) mutations

2 . Revision History

Date	Notes
11/3/2025	Added NV formulary

Zynteglo (betibeglogene autotemcel)

Prior Authorization Guideline

Guideline ID	GL-395187
Guideline Name	Zynteglo (betibeglogene autotemcel)
Formulary	• Medicaid - Health Plan of Nevada Medicaid (ACUNV)

Guideline Note:

Effective Date:	1/1/2026

1 . Criteria

Product Name:Zynteglo	
Approval Length	30 Day(s)
Guideline Type	Prior Authorization

Approval Criteria

1 - Patient is greater than or equal to 4 years of age

AND

2 - Diagnosis of beta-thalassemia confirmed with genetic testing

AND

3 - Prescribed by, or in consultation with, a hematologist

AND

4 - Prescriber attests that the patient is a candidate for autologous hematopoietic stem-cell transplant (HSCT)

AND

5 - The patient has not previously received an allogeneic transplant

AND

6 - The patient has not previously received other gene therapies (e.g., Casgevy)

AND

7 - The patient has transfusion-dependent disease defined as ONE of the following:

- History of transfusions of at least 100 mL/kg/year of packed red blood cells (pRBCs)
- Greater than or equal to 8 transfusions of pRBCs per year in the previous two years

AND

8 - The patient has been screened for HBV, HCV, human T-lymphotropic virus 1 and 2 (HTLV-1/HTLV-2), and HIV in accordance with clinical guidelines prior to collection of cells (leukapheresis)

AND

9 - If the patient requires anti-retrovirals for HIV prophylaxis, BOTH of the following:

- The patient has not used prophylactic HIV anti-retroviral medication or hydroxyurea within 30 days prior to mobilization (or for the expected duration for elimination of those medications) and until all cycles of apheresis are completed
- Confirmation of a negative test for HIV before beginning mobilization

AND

10 - Iron chelation therapy has been discontinued for at least seven days prior to initiating myeloblative conditioning therapy and myelosuppressive iron chelators will be avoided for six months post-treatment

AND

11 - The patient does not have any of the following:

- Severely elevated iron in the heart (e.g., patients with cardiac T2 <10 msec by MRI
- Advanced liver disease
- MRI of the liver with results demonstrating liver iron content ≥15 mg/g (unless biopsy confirms absence of advanced disease)

AND

12 - The patient has been counseled and verbalized understanding that hematologic malignancies may develop in individuals treated with Zynteglo and lifelong monitoring is warranted

AND

13 - Prescriber attestation that all necessary preparations prior to Zynteglo administration will be followed per package insert (including scheduled transfusions to target required Hb levels)

AND

14 - The patient has not previously received one treatment course of Zynteglo in their lifetime

2 . Revision History

Date	Notes
9/10/2025	1/1/2026 implementation