KAISER PERMANENTE®

2024 Prior Authorization Criteria

ACTHAR **Drug Products Affected:** Acthar Gel, Cortrophin Gel	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

AIDS RELATED WEIGHT LOSS **Drug Products Affected:** Dronabinol, Syndros	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

ANTICONVULSANTS **Drug Products Affected:** Epidiolex	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

ANTI-INFECTIVES **Drug Products Affected:** Arikayce	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

ANTIMIGRAINE **Drug Products Affected:** Ajovy	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

ANTINEOPLASTICS **Drug Products Affected:** Bexarotene Gel	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

BONE DISORDERS **Drug Products Affected:** Xgeva	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

BOTULINUM TOXINS **Drug Products Affected:** Xeomin	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

COSMETIC INDICATION **Drug Products Affected:** Avita, Retin-A, Retin-A Micro, Tazarotene, Tazorac, Tretinoin Cream, Tretinoin Gel	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

CYSTIC FIBROSIS **Drug Products Affected:** Kalydeco	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

DIABETES **Drug Products Affected:** Korlym, Ozempic, Victoza	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

EOSINOPHILIC PHENOTYPE **Drug Products Affected:** Dupixent, Fasenra, Nucala	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

ERECTILE DYSFUNCTION AGENTS **Drug Products Affected:** Tadalafil Tablets 2.5mg, 5mg	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Stand alone erectile dysfunction
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

FERTILITY TREATMENT **Drug Products Affected:** Chorionic Gonadotropin Injection, Endometrin	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

HEPATITIS DRUGS **Drug Products Affected:** Epclusa, Harvoni, Ledipasvir/Sofosbuvir, Mavyret, Sofosbuvir/Velpatasvir, Sovaldi, Viekira Pak, Vosevi, Zepatier	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	Genotype must be documented
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

HYPERCHOLESTEROLEMIA **Drug Products Affected:** Juxtapid, Repatha Sureclick	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

HYPERPHOSPHATEMIA **Drug Products Affected:** Auryxia	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

LIDOCAINE PATCH **Drug Products Affected:** Lidocaine Patch, Lidocan	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

MULTIPLE SCLEROSIS **Drug Products Affected:** Teriflunomide	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

NARCOLEPSY **Drug Products Affected:** Lumryz, Sodium Oxybate, Xyrem, Xywav	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

NUEDEXTA **Drug Products Affected:** Nuedexta	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

NUVIGIL/PROVIGIL **Drug Products Affected:** Armodafinil, Modafinil	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

PLAQUE PSORIASIS PSORIATIC ARTHRITIS **Drug Products Affected:** Ilumya, Otezla, Stelara	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

PULMONARY ARTERIAL HYPERTENSION **Drug Products Affected**: Adempas, Liqrev, Sildenafil Suspension, Sildenafil Tablets 20mg, Tadalafil Tablets 20mg, Tadliq, Treprostinil	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

PULMONARY FIBROSIS **Drug Products Affected:** Pirfenidone	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

RHEUMATOID ARTHRITIS **Drug Products Affected:** Cimzia, Xeljanz**,** Xeljanz XR	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

SHORT BOWEL SYNDROME **Drug Products Affected:** Gattex	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

SKELETAL MUSCLE RELAXANTS **Drug Products Affected:** Cyclobenzaprine	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

SOMATROPIN PRODUCTS **Drug Products Affected:** Humatrope, Norditropin, Omnitrope, Skytrofa, Sogroya, Zorbtive	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

TASIMELTEON **Drug Products Affected:** Hetlioz LQ, Tasimelteon	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the end of the Plan Contract Year
Other Criteria	N/A

TRANSMUCOSAL IMMEDIATE RELEASE FENTANYL (TIRF) **Drug Products Affected:** **Fentora** (generics only) – Fentanyl Citrate, Buccal Tablets **Lazanda –** Fentanyl, Nasal Spray **Subsys –** Fentanyl, Sublingual Metered Spray	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	Diagnosis of Non-Cancer related pain
Required Medical Information	Diagnosis of Cancer pain. Documentation of tolerance to around-the-clock opioid therapy for their underlying persistent pain.
Age Restrictions	N/A
Prescriber Restrictions	Patient under care of Oncologist, Hospice/Palliative Care Specialist, or Pain Specialist.
Coverage Duration	Through the End of the Plan Contract Year
Other Criteria	N/A

XOLAIR **Drug Products Affected:** Xolair	
Covered Uses	All FDA-approved indications not otherwise excluded from Part D.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Through the End of the Plan Contract Year
Other Criteria	N/A

Notice of Nondiscrimination

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal and Colorado state civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, gender expression, or any other basis protected by applicable federal or state laws.
We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call **1-800-632-9700** (TTY **711)**.

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity or gender expression, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**). You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, (TTY **1-800-537-7697**). Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

KAISER PERMANENTE®

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June 2023

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-800-476-2167** (TTY **711**). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-800-476-2167** (TTY **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-800-476-2167** (TTY **711**)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-800-476-2167** (TTY **711**)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-800-476-2167** (TTY **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-800-476-2167** (TTY **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-800-476-2167** (TTY **711**). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-800-476-2167** (TTY **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

KAISER PERMANENTE®

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-800-476-2167** (TTY **711**). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-800-476-2167** (TTY **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY **711**) **1-800-476-2167**. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-800-476-2167** (TTY **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-800-476-2167** (TTY **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-800-476-2167** (TTY **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-800-476-2167** (TTY **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-800-476-2167** (TTY **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、**1-800-476-2167** (TTY **711**). にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。