

2026 Prior Authorization Criteria

ACTHAR	
Drug Products Affected: 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	
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

ANTIINFECTIVES	
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: Bomynta, Osenvelt, Wyost	
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: Retin-A, 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, Liraglutide, Mifepristone Tablet 300mg, Ozempic	
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 Solution Prefilled Syringe 30mg/mL, Fasenra Pen Solution Auto-injector 30mg/mL, Nucala Solution Auto-injector 100mg/mL, Nucala Solution Prefilled Syringe 40mg/0.4mL, 100mg/mL

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 Tablet 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 Solution Reconstituted, 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, Vosevi

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:** 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

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: Sodium Oxybate	
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: Otezla, Stelara Solution 130mg/26mL, Yesintek	
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, Opsumvi, Sildenafil Citrate Suspension Reconstituted, Sildenafil Citrate Tablet 20mg, Tadalafil (PAH) Tablet 20mg, 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 Tablet	
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: 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: Norditropin Flexpro Solution Pen-Injector 5mg/1.5mL, 10mg/1.5mL, 15mg/1.5mL, Omnitrope	
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: 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 Tablet 100mcg, 200mcg	
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	N/A
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

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Georgia, Inc. (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate, exclude people or treat them less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

Kaiser Health Plan:

- Provides 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, braille, and accessible electronic formats
- Provides 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 **1-888-865-5813** (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, or sex, you can file a grievance by mail at: Member Relations Unit (MRU), Attn: Kaiser Civil Rights Coordinator, Nine Piedmont Center, 3495 Piedmont Road, NE Atlanta, GA 30305-1736. Telephone Number: 1-888-865-5813.

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, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at <https://healthy.kaiserpermanente.org/georgia/language-assistance/nondiscrimination-notice>

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-888-865-5813** (TTY: **711**).

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-888-865-5813** ይደውሉ (TTY: 711)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-888-865-5813** (TTY: 711).

中文 (Chinese) 注意事項: 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-888-865-5813** (TTY: 711)。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-888-865-5813** (TTY: 711) (تلفن متنی) تماس بگیرید.

Français (French) ATTENTION: si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-888-865-5813** (TTY: 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistentz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-888-865-5813** an (TTY: 711).

ગુજરાતી (Gujarati) ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો યોગ્ય સહાયક સહાય અને સેવાઓ સહિતની ભાષા સહાય સેવાઓ, તમારા માટે મફત ઉપલબ્ધ છે. **1-888-865-5813** (TTY: 711) પર કોલ કરો.

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale kreyòl, w ap jwenn sèvis asistans lang tankou èd ak sèvis konplemantè adapte gratis. Rele **1-888-865-5813** (TTY: 711).

हिन्दी (Hindi) ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए उपयुक्त सहायक उपकरण और सेवाओं सहित भाषा सहायता सेवाएँ मुफ्त उपलब्ध हैं। **1-888-865-5813** (TTY: 711) पर कॉल करें।

日本語 (Japanese) 注意: 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。 **1-888-865-5813** までお電話ください (TTY: 711)。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-888-865-5813** 로 전화해 주세요 (TTY: 711).

Naabeehó (Navajo) DÍÍ BAA AKÓ NÍNÍZIN: Díí saad bee yánítí'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'I bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiiik'eh, éí ná hóló, koji' hódíílnih **1-888-865-5813** (TTY: 711).

Português (Portuguese) ATENÇÃO: Se fala português, temos à sua disposição serviços gratuitos de assistência linguística, incluindo serviços e materiais de apoio adequados. Ligue para **1-888-865-5813** (TTY: 711).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-888-865-5813** (TTY: 711).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-888-865-5813** (TTY: 711).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-888-865-5813** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-888-865-5813** (TTY: **711**).