ACTEMRA IV

Products Affected

- ACTEMRA INTRAVENOUS

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: RA, PJIA, SJIA, GCA: 6 MONTHS. CRS: 1 MONTH. REAUTH: RA, PJIA, SJIA, GCA: 12 MONTHS.
Other Criteria	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. SJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). REAUTH: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ACTEMRA SC

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST. SYSTEMIC SCLEROSIS-ASSOCIATED INTERSTITIAL LUNG DISEASE (SSC-ILD): PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, REAUTH: 12 MONTHS.
Other Criteria	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. SJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). SSC-ILD: DOES NOT HAVE OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS). REAUTH: RA, PJIA, SJIA: CONTINUES TO BENEFIT FROM THE MEDICATION. SSC-ILD:

PA Criteria	Criteria Details
	CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of one of the following: 1) Chronic granulomatous disease (CGD), or 2) severe malignant osteopetrosis (SMO).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ADAPALENE

Products Affected

- *adapalene topical cream*
- *adapalene topical gel*
- *adapalene topical solution*
- *adapalene-benzoyl peroxide topical gel with pump 0.3-2.5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of acne.
Age Restrictions	PA applies to members 26 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ADCIRCA

Products Affected

- *alyq*
- *tadalafil (pulm. hypertension)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ADDERALL XR

Products Affected

- *dextroamphetamine-amphetamine oral capsule,extended release 24hr 10 mg, 15 mg, 20 mg, 25 mg, 30 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following: a) diagnosis of attention deficit hyperactivity disorder (ADHD), OR b) diagnosis of attention deficit disorder (ADD)
Age Restrictions	PA applies to members 19 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Chronic thomboembolic pulmonary hypertension (CTEPH) (Initial): One of the following: A) Both of the following: 1) Diagnosis of inoperable or persistent/recurrent CTEPH and 2) CTEPH is symptomatic OR B) Patient is currently on any therapy for the diagnosis of CTEPH.
Age Restrictions	
Prescriber Restrictions	PAH, CTEPH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH, CTEPH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH, CTEPH (Reauth): Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AFINITOR

Products Affected

- *everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention but patient is not a candidate for curative surgical resection. Renal cell carcinoma: Diagnosis of advanced or metastatic renal cell carcinoma AND trial and failure, contraindication, or intolerance to SUTENT (sunitinib) or NEXAVAR (sorafenib). Neuroendocrine tumors of pancreatic origin (pNET): Diagnosis of progressive pNET that are unresectable, locally advanced, or metastatic. Renal angiomyolipoma: Diagnosis of renal angiomyolipoma and TSC AND Patient does not require immediate surgery. Breast Cancer: Patient is a postmenopausal woman AND Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer AND trial and failure, contraindication, or intolerance to FEMARA (letrozole) or ARIMIDEX (anastrozole) AND AFINITOR (EVEROLIMUS) will be used in combination with AROMASIN (exemestane). Neuroendocrine tumors of gastrointestinal (GI) or lung origin: Diagnosis of progressive, well-differentiated, non-functional NET of GI or lung origin AND patient has unresectable, locally advanced or metastatic disease.
Age Restrictions	
Prescriber Restrictions	All Indications: Prescribed by or in consultation with an oncologist and or a neurologist.
Coverage Duration	All Indications: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AFINITOR DISPERZ

Products Affected

- *everolimus (antineoplastic) oral tablet for suspension*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA): Diagnosis of SEGA associated with tuberous sclerosis complex (TSC) that requires therapeutic intervention but patient is not a candidate for curative surgical resection.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist OR a neurologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AKEEGA

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) AND will be used in combination with prednisone AND patient will also receive a gonadotropin-releasing hormone (GnRH) analog concurrently OR should have had bilateral orchiectomy. Selection for treatment must be based on an FDA-approved test showing presence of a BRCA gene alteration and must be provided in chart notes. Patient has Trial and Failure and/or Contraindication to treatment with Lynparza + abiraterone + corticosteroid.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Initial: 6 months. Reauth: 6 months
Other Criteria	Reauth: Patient has not experienced disease progression nor has experienced unacceptable toxicity per physician chart notes.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of anaplastic lymphoma kinase (ALK)-positive, metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ALPHA-1 PROTEINASE INHIBITOR, NON-PREFERRED

Products Affected

- ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG
- GLASSIA
- ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Alpha1-proteinase inhibitor deficiency for the long-term augmentation and maintenance therapy in adults with severe hereditary??deficiency of alpha1-antitrypsin??(AAT) with clinically evident??emphysema AND Patient has had trial and failure or intolerance to Prolastin-C.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ALPHA-1 PROTEINASE INHIBITOR, PROLASTIN

Products Affected

- PROLASTIN C 1,000 MG/20 ML VL PRICE/ONE MG,SUV
- PROLASTIN-C INTRAVENOUS RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Alpha1-proteinase inhibitor deficiency for the long-term augmentation and maintenance therapy in adults with severe hereditary??deficiency of alpha1-antitrypsin??(AAT) with clinically evident??emphysema.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ALUNBRIG

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of anaplastic lymphoma kinase (ALK)-positive metastatic non-small cell lung cancer (NSCLC) as detected by an FDA-approved test
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AMPYRA

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis (MS) (initial): Diagnosis of MS. Physician confirmation that patient has difficulty walking (eg, timed 25 foot walk test). One of the following: expanded disability status scale (EDSS) score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).
Age Restrictions	
Prescriber Restrictions	MS (Initial): Prescribed by or in consultation with a neurologist.
Coverage Duration	MS (Initial): 6 months. (Reauth): 12 months.
Other Criteria	MS (Reauth): Physician confirmation that the patient's walking improved with DALFAMPRIDINE ER therapy. One of the following: EDSS score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

APOKYN

Products Affected

- *apomorphine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Parkinson's disease (PD) (Initial): Diagnosis of advanced PD. Patient is experiencing acute intermittent hypomobility (defined as off episodes characterized by muscle stiffness, slow movements, or difficulty starting movements). Patient is receiving apomorphine in combination with other medications for the treatment of PD (e.g., carbidopa/levodopa, pramipexole, ropinirole, benztropine, etc.).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PD (Initial, reauth): 12 months
Other Criteria	PD (Reauth): Patient is benefiting from therapy (eg, patient had an improvement in motor function).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cryopyrin-Associated Periodic Syndromes (CAPS) (Initial): Diagnosis of CAPS, including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS). The medication will not be used in combination with another biologic.
Age Restrictions	
Prescriber Restrictions	CAPS (Initial): Prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist or other medical specialist.
Coverage Duration	CAPS, Def. of IL-1 receptor antagonist (DIRA), Recurrent Pericarditis: (initial/reauth): 12 months
Other Criteria	CAPS (Reauth): Patient has experienced disease stability or improvement in clinical symptoms while on therapy as evidence by one of the following: A) improvement in rash, fever, joint pain, headache, conjunctivitis, B) decreased number of disease flare days, C) normalization of inflammatory markers (CRP, ESR, SAA), D) corticosteroid dose reduction, OR E) improvement in MD global score or active joint count.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ARIKAYCE

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	Patients with non-refractory MAC lung disease.
Required Medical Information	Treatment of Mycobacterium avium complex (MAC) lung disease in adults who have not achieved negative sputum cultures after treatment with a multidrug regimen that includes: 1) azithromycin or clarithromycin and 2) ethambutol and 3) rifampin or rifabutin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Subject to Part B vs. Part D review
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ASPRUZYO SPRINKLE

Products Affected

- ASPRUZYO SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of chronic angina and patient cannot swallow or is currently on a feeding tube.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a Cardiologist.
Coverage Duration	Initial:6 months Reauth: 6 months.
Other Criteria	Reauth: Patient still meets initial criteria.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AUBAGIO

Products Affected

- AUBAGIO
- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease with evidence of new brain lesions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AUGTYRO

Products Affected

- AUGTYRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Non-small Cell Lung Cancer (NSCLC): Diagnosis of locally advanced or metastatic ROS1-positive non-small cell lung cancer (NSCLC). Patient has tried and failed or has a contraindication to therapy with Xalkori (crizotinib) or Rozlytrek (entrectinib).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Initial/Reauth: 12 months
Other Criteria	Reauth: The patient has been tolerating and benefitting from therapy per provider
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AURYXIA

Products Affected

- AURYXIA

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of iron deficiency anemia in patients with CKD not on dialysis
Required Medical Information	Patient must have a diagnosis of Hyerphosphatemia: For the control of serum phosphorus levels in patients with chronic kidney disease (CKD) receiving dialysis. This drug is excluded from Medical Part D Coverage when used for the treatment of iron deficiency anemia.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a Nephrologist
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AUSTEDO

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 24 MG, 6 MG
- AUSTEDO XR TITRATION KT(WK1-4)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the treatment of chorea associated with Huntington disease AND the patient has tried and failed tetrabenazine. For the treatment of tardive dyskinesia (TD) AND If TD is related to drug use, and if appropriate for this patient, the causative drug must be discontinued or tried at a lower dose AND Baseline evaluation of TD using one of the following: Abnormal Involuntary Movement Scale (AIMS) greater than or equal to 10 or Clinical Global Impression of Severity (CGI-S) score greater than or equal to 4.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	Initial: 3 mths. Reauth: 6 months
Other Criteria	Reauth Criteria: Patient's therapy has been re-evaluated within the last 3mths AND patient is tolerating treatment AND patient has disease stabilization or improvement in disease.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AYVAKIT

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of one of the following: 1) unresectable or metastatic gastrointestinal stromal tumor harboring a PDGFRA exon 18 mutation, including PDGFRA D842V mutations in adults or 2) advanced systemic mastocytosis. 3) Systemic mastocytosis, indolent: Diagnosis of indolent systemic mastocytosis (ISM) in adults
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist, allergist or immunologist
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BENLYSTA

Products Affected

- BENLYSTA INTRAVENOUS
- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Systemic lupus erythematosus (SLE) (init): Diagnosis of active SLE. Autoantibody positive (ie, anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL). Currently receiving at least one standard of care treatment for active SLE (eg, antimalarials [eg, Plaquenil (hydroxychloroquine)], corticosteroids [eg, prednisone], or immunosuppressants [eg, methotrexate, Imuran (azathioprine), CellCept (mycophenolate mofetil)]).
Age Restrictions	
Prescriber Restrictions	SLE (init): Prescribed by or in consultation with a rheumatologist
Coverage Duration	SLE and lupus nephritis (init, reauth): 6 months
Other Criteria	SLE (reauth): Documentation of positive clinical response to Benlysta therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BERINERT

Products Affected

- BERINERT INTRAVENOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks: Diagnosis of HAE. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks (eg, Firazyr, Kalbitor, or Ruconest).
Age Restrictions	
Prescriber Restrictions	HAE: Prescribed by an immunologist, allergist, or rheumatologist
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BESREMI

Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	Hypersensitivity to interferons, including interferon alfa-2b, or any component of the formulation, existence of, or history of severe psychiatric disorders, particularly severe depression, suicidal ideation, or suicide attempt, moderate (Child-Pugh class B) or severe (Child-Pugh class C) hepatic impairment, history or presence of active serious or untreated autoimmune disease, immunosuppressed transplant recipients.
Required Medical Information	Diagnosis is Polycethemia Vera. Patient has a documented failure, contraindication, or ineffective response to maximum tolerated doses of hydroxyurea for a minimum 3-month trial.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	Initial: 6 months Reauth: 12 months
Other Criteria	Reauth Criteria: Patient is responding well to treatment (has maintained hematological stability).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BOSULIF

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of newly-diagnosed chronic phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML) or treatment of chronic, accelerated, or blast phase Ph+ CML with resistance or intolerance to prior therapy with one of the following tyrosine kinase inhibitors (TKI): Gleevec [imatinib], Tasigna [nilotinib], Sprycel [dasatinib].
Age Restrictions	CHRONIC PHASE PH+ CML: 1 year of age or older. ACCELERATED/BLAST PHASE PH+ CML: 18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BOTOX

Products Affected

- BOTOX INJECTION RECON SOLN 100 UNIT, 200 UNIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Neuromuscular Disorders (init): Strabismus, blepharospasm associated with dystonia (eg, benign essential blepharospasm), treatment of upper or lower limb spasticity, VII cranial nerve disorders (hemifacial spasms), cervical dystonia Hyperhidrosis(HH): (Init) Dx of primary axillary HH. Score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS) or skin maceration with secondary infection. Trial and failure, contraindication, or intolerance (TF/C/I) to topical prescription strength drying agents [eg, Drysol, Hypercare, Xerac AC (aluminum chloride hexahydrate)]. Migraine:(Init) Dx of chronic migraines (greater than or equal to 15 migraine headache days per month with headache lasting 4 hours a day or longer). TF/C/I to prophylactic therapy with at least two of the following agents, each given for a trial of at least two months: antidepressants [ie, Effexor (venlafaxine)], antiepileptics [ie, Depakote/Depakote ER (divalproex sodium), Topamax (topiramate)], beta-blockers [eg, atenolol, Inderal (propranolol), nadolol, timolol, Toprol XL (metoprolol)] Achalasia:(Init) High risk of complication from or failure to pneumatic dilation or myotomy, or prior dilation caused esophageal perforation, or patient has an epiphrenic diverticulum or hiatal hernia. Anal Fissure (AF)(Init): Dx of chronic AF. At least 2 months of either nocturnal pain and bleeding or postdefecation pain. Chronic Back Pain (CBP):(Init) Dx of low back pain lasting greater than or equal to six months. Urinary incont (UI):(init) Neurogenic detrusor overactivity associated with a neurologic condition (eg, spinal cord injury [SCI], multiple sclerosis) or detrusor sphincter dyssynergia with SCI. Overactive bladder (OAB): (init) Dx of OAB. One of the following symptoms: urge urinary incontinence, urgency, frequency.
Age Restrictions	
Prescriber Restrictions	Migraine (Initial): Prescribed by a neurologist or pain specialist. CBP (Initial): Prescribed by a neurologist, neurosurgeon, orthopedist, or pain specialist. UI, OAB (initial): Prescribed by a neurologist, neurosurgeon, or urologist.

PA Criteria	Criteria Details
Coverage Duration	Achalasia: 6moCBP:1 tx(series of injxs)UI:3mo(1 dose,200units)Other:3mo
Other Criteria	UI, OAB, CBP, Neuromuscular Disorders:(Reauth) Confirmed improvement in symptoms with initial Botox treatment. At least 3 months have or will have elapsed since the last treatment with Botox HH:(Reauth) At least a 2-point improvement in HDSS. Migraine:(Reauth) Reduction in headache frequency or intensity. Confirmation of decreased utilization of pain medications (eg, narcotic analgesics, NSAIDs) or triptans, or a reduction in the number of ER visits. Achalasia:(Reauth) Documentation of improvement or reduction in symptoms of achalasia (ie, dysphagia, regurgitation, chest pain). At least 6 months have or will have elapsed since last series of injections AF: (Reauth) Incomplete healing of fissure or recurrence of fissure. Improved symptoms with prior treatment with Botox.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BRAFTOVI

Products Affected

- BRAFTOVI ORAL CAPSULE 50 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	Encorafenib is not indicated for treatment of wild-type BRAF melanoma, wild-type BRAF colorectal cancer (CRC), or wild-type BRAF non-small cell lung cancer (NSCLC).
Required Medical Information	1) Unresectable or metastatic melanoma: Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test AND therapy will be used in combination with binimetinib. 2) Metastatic colorectal cancer (mCRC): Diagosis of metastatic colorectal cancer (mCRC) with a BRAF V600E mutation, as detected by an FDA-approved test, after prior therapy AND therapy will be used in combination with cetuximab. 3) Metastatic non-small cell lung cancer (NSCLC): Diagosis of metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation, as detected by an FDA-approved test AND therapy will be used in combination with binimetinib.
Age Restrictions	mCRC: 18 years of age or older. NSCLC: 18 years of age or older
Prescriber Restrictions	CRC, NSCLC: Prescribed by or in consultation with an oncologist. Melanoma: Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	Initial 6 months. Reauth 12 months
Other Criteria	REAUTH: The patient continues to meet initial approval criteria
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BRONCHITOL

Products Affected

- BRONCHITOL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of Cystic Fibrosis AND will be used as add-on maintenance to improve pulmonary function AND patient has passed the Bronchitol Tolerance Test (BTT).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a pulmonologist.
Coverage Duration	Initial and Reauth 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BRUKINSA

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the treatment of mantle cell lymphoma (relapsed or refractory) in adults who have received at least 1 prior therapy. For the treatment of relapsed or refractory marginal zone lymphoma in adults who have received at least 1 anti CD20 based regimen. For the treatment of Waldenstrom macroglobulinemia. For the treatment of adult patients with chronic lymphocytic leukemia or small lymphocytic lymphoma.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial 6 months, Reauth 6 months.
Other Criteria	Reauth: Mantle cell lymphoma and Marginal zone lymphoma: patient must demonstrate disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread. Waldenstrom's macroglobulinemia, Chronic lymphocytic leukemia, small lymphocytic lymphoma: patient must demonstrate disease response with treatment as determined by the provider.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CABLIVI

Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Treatment of acquired thrombotic thrombocytopenic purpura (aTTP) in adults, in combination with plasma exchange and immunosuppressive therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CABOMETYX

Products Affected

- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1)Renal cell carcinoma (RCC): Diagnosis of RCC. RCC is advanced. Trial and failure, contraindication, or intolerance to at least one prior anti-angiogenic therapy [e.g., Nexavar (sorafenib), Sutent (sunitinib)]. 2)Treatment of hepatocellular carcinoma (HCC) in patients who have previously been treated with Nexavar (sorafenib). 3) First-line treatment (in combination with nivolumab) of advanced renal cell carcinoma (RCC). Dx locally advanced or metastatic differentiated thyroid cancer that has progressed following VEGFR-targeted therapy and who are radioactive iodine-refractory or ineligible.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CAPRELSA

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Thyroid Cancer: Diagnosis of medullary thyroid cancer (MTC)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with oncologist or endocrinologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CAYSTON

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystic fibrosis (CF) (Initial, Reauth): Diagnosis of CF AND Patient has evidence of Pseudomonas aeruginosa in the lungs
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CF (Initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CERDELGA

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Gaucher disease (Initial): Diagnosis of Gaucher disease type 1. Patient is an extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) of cytochrome P450 enzyme (CYP) 2D6 as detected by an FDA-cleared test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Gaucher disease (initial, reauth): 12 months
Other Criteria	Gaucher disease (Reauth): Patient has experienced improvement or disease progression has slowed.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CGRP RECEPTOR ANTAGONISTS FOR MIGRAINE PROPHYLAXIS

Products Affected

- AIMOVIG AUTOINJECTOR MG/ML, 300 MG/3 ML (100 MG/ML X 3)
- EMGALITY PEN
- EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For migraine PROPHYLAXIS to be approved if: Patient must have at least 4 migraine days per month or one or more severe migraines lasting for greater than 12 hours despite use of abortive therapy (e.g. triptan or NSAIDs) AND there is documentation of trial and failure, intolerance, contraindication (i.e., drug interaction, allergy, adverse reaction, etc.) to at least one agent in any two of the following classes below for at least 4 weeks EACH: (a)antidepressants: amitriptyline, venlafaxine or (b) beta blockers: Metoprolol, propranolol, timolol (oral), nadolol, atenolol, nebivolol or (c) calcium channel blocker: verapamil or (d) antiepileptic agents: valproate sodium, divalproex sodium, topiramate, gabapentin or (e) Botox (for chronic migraine).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist, headache specialist or pain specialist.
Coverage Duration	Initial: 6 mths Reauth 12mths: positive response to tx (reduction in h/a frequency/intensity).
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CHOLBAM

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Bile acid synthesis disorders due to single enzyme defects (BAS) (initial): diagnosis of a bile acid synthesis disorder due to a single enzyme defect. Peroxisomal disorders (PD) (initial): All of the following: 1) diagnosis of peroxisomal disorder, 2) patient exhibits at least one of the following: a) liver disease (eg, jaundice, elevated serum transaminases), OR b) steatorrhea, OR c) complications from decreased fat-soluble vitamin absorption (eg, poor growth), AND 3) Cholbam will be used as an adjunctive treatment.
Age Restrictions	
Prescriber Restrictions	All uses (initial): Prescribed by a hepatologist, medical geneticist, pediatric gastroenterologist, OR other specialist that treats inborn errors of metabolism.
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	All uses (reauth): documentation of positive clinical response to Cholbam therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CHORIONIC GONADOTROPIN

Products Affected

- CHORIONIC GONADOTROPIN, HUMAN INTRAMUSCULAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prepubertal Cryptorchidism: Diagnosis of prepubertal cryptorchidism not due to anatomical obstruction. Male Hypogonadotropic Hypogonadism (MHH) (initial): Diagnosis of male hypogonadism secondary to pituitary deficiency, and low testosterone (below normal reference value provided by the physician's laboratory) and one of the following: a) low LH (below normal reference value provided by the physician's laboratory) or b) low FSH (below normal reference value provided by the physician's laboratory).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Prepubertal Cryptorchidism: 6 wks. MHH (initial, reauth): 12 months.
Other Criteria	Excluded if used to promote fertility. MHH (Reauth): Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CIMZIA

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other TNF antagonists, non-TNF immunomodulatory drugs: abatacept, anakinra, natalizumab, tofacitinib or rituximab.
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. REAUTH: 12 MONTHS.
Other Criteria	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ, SKYRIZI. PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, SKYRIZI. AS: TRIAL OF OR

PA Criteria	Criteria Details
	CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ. CD: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, SKYRIZI OR RINVOQ. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO: COSENTYX AND RINVOQ. PATIENTS WHO ARE PREGNANT, BREASTFEEDING, OR TRYING TO BECOME PREGNANT ARE EXCLUDED FROM STEP CRITERIA FOR ALL INDICATIONS. REAUTH: RA, PSA, AS, PSO, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CINRYZE

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis: Hereditary Angioedema, for the routine prophylaxis against angioedema attacks.
Age Restrictions	
Prescriber Restrictions	HAE (prophylaxis, treatment): Prescribed by an immunologist, allergist, or rheumatologist
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CLOVIQUE

Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Not recommended in cystinuria or rheumatoid arthritis, not indicated for biliary cirrhosis.
Required Medical Information	Treatment of patients with Wilson disease who are intolerant of penicillamine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial 6 months Reauth 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

COMETRIQ

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medullary thyroid cancer (MTC): Diagnosis of Metastatic MTC. Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC and positive for RET gene rearrangements.
Age Restrictions	
Prescriber Restrictions	MTC: Prescribed by or in consultation with an oncologist/hematologist or endocrinologist. NSCLC: Prescribed by or in consultation with an oncologist/hematologist.
Coverage Duration	All uses: 12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

COPIKTRA

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic lymphocytic leukemia/small lymphocytic lymphoma, relapsed or refractory Treatment of relapsed or refractory chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) in adult patients after at least two prior therapies.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CORLANOR

Products Affected

- CORLANOR ORAL SOLUTION
- CORLANOR ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	BP less than 90/50, severe hepatic impairment, a. fib.
Required Medical Information	Chronic heart failure (CHF): Diagnosis of CHF with NYHA Class II, III, or IV symptoms. Left ventricular ejection fraction less than or equal to 35%. Patient is in sinus rhythm with a resting heart rate of greater than or equal to 70 BPM and has been hospitalized for worsening HF in the previous 12 months. Trial and failure, intolerance, or contraindication to maximally tolerated doses of at least one beta-blocker with proven mortality benefit (i.e., carvedilol, bisoprolol, sustained-release metoprolol) AND trial and failure, intolerance, or contraindication to maximally tolerated doses of an ACE inhibitor or ARB OR Treatment of stable symptomatic heart failure due to dilated cardiomyopathy in pediatric patients ages 6 months and older.
Age Restrictions	
Prescriber Restrictions	CHF (initial): Prescribed by or in consultation with a cardiologist
Coverage Duration	Initial, reauth: 12 months
Other Criteria	CHF (reauth): patient does not have contraindications/exclusions to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

COSENTYX

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)
- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML
- COSENTYX UNOREADY PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: 1) Plaque psoriasis (PsO): Psoriasis covering 3 percent or more of body surface area (BSA) OR psoriatic lesions affecting the hands, feet, genital area, or face. Trial of or contraindication to ONE conventional therapy such as PUVA, UVB, topical corticosteroids, calcipotriene, acitretin, methotrexate, or cyclosporine. 2) Psoriatic arthritis (PsA): trial of or contraindication to ONE DMARD such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine 3) Ankylosing spondylitis (AS): trial of or contraindication to an NSAID 4) Non-radiographic axial spondyloarthritis (nr-axSpA): A trial of or contraindication to an NSAID AND the patient meets ONE of the following objective signs of inflammation: C-reactive protein (CRP) levels above the upper limit of normal OR Sacroiliitis on MRI. 5) Enthesitis-related arthritis (ERA): trial of or contraindication to ONE NSAID, sulfasalazine, OR methotrexate 6) Hidradenitis suppurativa (HS): Cosentyx will NOT be used concurrently with other systemic biologics (e.g., Humira [adalimumab]) for the treatment of HS or other IL-17 inhibitors (e.g., Taltz [ixekizumab]) for any indication
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA, ENTHESITIS-RELATED ARTHRITIS (ERA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. HIDRADENITIS SUPPURATIVA (HS): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST
Coverage Duration	INITIAL PSO, PSA, AS, NR-AXSPA, ERA: 6 MONTHS. HS: 4 MONTHS. ALL INDICATIONS REAUTH: 12 MONTHS
Other Criteria	REAUTH: PSO, PSA, AS, NR-AXSPA, ERA: Patient continues to benefit from the medication. HS: Cosentyx will NOT be used

PA Criteria	Criteria Details
	concurrently with other systemic biologics (e.g., Humira [adalimumab]) for the treatment of HS or other IL-17 inhibitors (e.g., Taltz [ixekizumab]) for any indication and patient continues to benefit from the medication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Melanoma: Diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation as detected by an FDA-approved test (e.g., cobas 4800 BRAF V600 Mutation Test) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with vemurafenib. Diagnosis of histiocytic neoplasms in adults as a single agent.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CRESEMBA

Products Affected

- CRESEMBA ORAL CAPSULE 186 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Aspergillosis: Treatment of invasive aspergillosis. Mucormycosis: Treatment of invasive mucormycosis.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	3 months
Other Criteria	For Invasive Aspergillosis, patient has T/F or has CI to voriconazole or posaconazole.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CRINONE

Products Affected

- CRINONE

PA Criteria	Criteria Details
Exclusion Criteria	All indications: Excluded if for fertility uses.
Required Medical Information	Secondary amenorrhea: Diagnosis of secondary amenorrhea (the absence of menses in women who have already started menstruation who are not pregnant, breastfeeding, or in menopause).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CYSTADROPS

Products Affected

- CYSTADROPS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a diagnosis of cystinosis confirmed by one of the following: Genetic analysis of the cystinosin (CTNS) gene, OR elevated cystine concentrations in polymorphonuclear (PMN) leukocytes OR Increase cystine content in cultured fibroblasts from amniotic fluid or in the placenta at the time of birth OR cystine crystals in the cornea on slit lamp examination AND Corneal cystine crystals are observed on slit lamp examination.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist.
Coverage Duration	Initial Auth: 6 mths Reauth: 12 months.
Other Criteria	Reauth: Patient has received a beneficial reponse to therapy including but not limited to the following: stability or reduction in the photorated corneal cystine crystal score (CCCS), reduction of crystals upon slit lamp examination, and/or improvement in symptoms (i.e. photophobia) compared to pretreatment baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DALIRESP

Products Affected

- *roflumilast*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD): (Initial) Diagnosis of severe COPD. Patient has chronic bronchitis. Trial and failure, intolerance, or contraindication to two prior therapies for COPD.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	COPD (init, reauth): 12 months
Other Criteria	COPD (reauth): Documentation of positive clinical response to roflumilast therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DARAPRIM

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Toxoplasmosis: 1) Patient is using pyrimethamine for the treatment of toxoplasmic encephalitis, secondary prophylaxis of toxoplasmic encephalitis, or treatment of congenital toxoplasmosis OR 2) Patient is using pyrimethamine for the primary prophylaxis of toxoplasmic encephalitis, patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX), and one of the following: patient has been re-challenged with TMP-SMX using a desensitization protocol and is still unable to tolerate, or evidence of life-threatening reaction to TMP-SMX in the past (eg, toxic epidermal necrolysis, Stevens-Johnson syndrome).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist
Coverage Duration	12 months
Other Criteria	Toxoplasmosis only: Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DARBEPOETIN-ALFA (ARANESP)

Products Affected

- ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML
- ARANESP (IN POLYSORBATE) INJECTION SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Patient with a Dx of ESRD and on dialysis, OR the patient is identified as a Part D ESRD member. This medication is included in the bundled ESRD dialysis facility payment which is paid under Medicare Part B and is not a Part D eligible drug.
Required Medical Information	Initial: 1. Dx of Anemia due to CKD and ALL of the following: a. Hg level less than 10g/dL AND b. T/F, CI to Retacrit 2. Dx of anemia due to Cancer Chemo and meets ALL of the following criteria: a. Hg level less than 10g/dL AND b. T/F, CI to Retacrit. Reauth: 1. Dx of Anemia due to CKD and ALL of the following: a. The patient is NOT receiving dialysis treatment AND b. Hg level is less than 10g/dL OR has reached 10g/dL and dose reduction/interruption is required to reduce the need for blood transfusions. 2. Dx of Anemia due to Cancer Chemo and meets ONE of the following a. Hg level of less than 10g/dL b. patient's Hg level does not exceed a level needed to avoid RBC transfusion.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, oncologist or nephrologist.
Coverage Duration	6 months
Other Criteria	Initial: Retacrit is the preferred epoetin-alfa product. Requests for Aranesp will require T/F, CI to Retacrit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DAURISMO

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Acute myeloid leukemia. Treatment of newly diagnosed acute myeloid leukemia (in combination with low-dose cytarabine) in adult patients who are greater than or equal to 75 years of age or who have comorbidities that preclude use of intensive induction chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DEFERASIROX

Products Affected

- *deferasirox oral tablet*
- *deferasirox oral tablet, dispersible*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic Iron Overload Due to Blood Transfusions (Initial): Diagnosis of chronic iron overload due to blood transfusions (transfusional hemosiderosis). Patient has a baseline ferritin level more than 1,000 mcg/L. Patient has required the transfusion of at least 100 mL/kg packed red blood cells. Myelodysplastic Syndrome (MDS) (Initial): Diagnosis of MDS. Patient has Low or Intermediate-1 disease or is a potential transplant patient. Patient has received more than 20 red blood cell transfusions. Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT) (Initial): Diagnosis of chronic iron overload due to NTDT. Liver iron concentration (LIC) 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw) or higher. Serum ferritin level greater than 300 mcg/L.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Iron Overload Due to Blood Transfusions, MDS (initial, reauth):12 mo. NTDT (initial, reauth): 6mo.
Other Criteria	Iron Overload Due to Blood Transfusions, MDS (Reauth): Patient experienced a reduction from baseline in serum ferritin level or LIC. NTDT (Reauth): Patient has LIC 3 mg Fe/g dw or higher. Patient experienced a reduction from baseline in serum ferritin level or LIC.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DIACOMIT

Products Affected

- DIACOMIT ORAL CAPSULE 250 MG, 500 MG
- DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the adjunctive treatment of refractory generalized tonic-clonic seizures AND to be used in conjunction with clobazam in patients with Dravet syndrome (previously known as severe myoclonic epilepsy in infancy).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by a neurologist or epileptologist.
Coverage Duration	Initial and Reauth: 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DICLOFENAC 3% GEL

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dx of Actinic Keratosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DIFICID

Products Affected

- DIFICID ORAL SUSPENSION FOR RECONSTITUTION
- DIFICID ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Treatment of Clostridioides (formerly Clostridium) difficile infection (CDI) and patient has had T/F or CI to vancomycin.
Age Restrictions	
Prescriber Restrictions	Prescibed by or in consultation with an infectious disease specialist.
Coverage Duration	10 days.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DISPOSABLE EXTERNAL INSULIN PUMP

Products Affected

- OMNIPOD 5 G6 INTRO KIT (GEN 5)
- OMNIPOD 5 G6 PODS (GEN 5)
- OMNIPOD CLASSIC PODS (GEN 3)
- OMNIPOD DASH INTRO KIT (GEN 4)
- OMNIPOD DASH PDM KIT (GEN 4)
- OMNIPOD DASH PODS (GEN 4)
- V-GO 20
- V-GO 30
- V-GO 40

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Patient must be diagnosed with Type I or Type II Diabetes AND 2. Documentation is submitted stating that patient has utilized one of the following insulin administration methods for at least the last 6 months (a or b): a. Use of an insulin pump OR b. Multiple daily insulin injections (meets i and ii): i. administration of at least 3 injections per day AND ii. History of suboptimal blood sugar control despite appropriate management: one of the following (a-f): a) Repeated hypoglycemic events (BG less than 70 mg/dL) b) Repeated episodes of diabetic ketoacidosis c) Wide fluctuations in blood glucose before mealtime (e.g., pre-prandial blood glucose levels commonly exceed 140 mg/dL d) Hypoglycemia unawareness e) Glycosylated hemoglobin level (HbA1c) greater than or equal to 7.0 f) "Dawn phenomenon" with fasting blood sugars repeatedly greater than 200 g/dL AND 3. Patient has monitored blood glucose at least 4 times a day for at least the last 2 months.
Age Restrictions	Patient age is within the manufacturer recommendations for the requested indication for the requested product
Prescriber Restrictions	Must be prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial and Reauth 6 months
Other Criteria	Reauth: Documentation of satisfactory patient response (including current HbA1C).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DOJOLVI

Products Affected

- DOJOLVI

PA Criteria	Criteria Details
Exclusion Criteria	Patient is NOT taking a pancreatic lipase inhibitor (e.g. orlistat) AND Patient will NOT receive an additional medium chain triglyceride while taking triheptanoin.
Required Medical Information	Dx of Long-chain fatty acid oxidation disorders: As a source of calories and fatty acids for the treatment of molecularly confirmed long-chain fatty acid oxidation disorders in adults and pediatric patients.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by clinical specialist knowledgeable in appropriate disease-related dietary management (e.g., medical geneticist, genetic metabolic disorders, or a physician with a board certification in nutrition.
Coverage Duration	Initial 6 mths. Reauth 6 mths. -improvement of sxs and reduction in events (e.g. hospitaliz).
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DOXEPIN, TOPICAL

Products Affected

- *doxepin topical*

PA Criteria	Criteria Details
Exclusion Criteria	Patients with untreated narrow angle glaucoma or a tendency to urinary retention
Required Medical Information	Diagnosis of Pruritis: Short-term (up to 8 days) management of moderate pruritus in adults with atopic dermatitis or lichen simplex chronicus. Medication history includes the use of at least 2 topical corticosteroids, unless contraindicated or clinically significant adverse effects are experienced.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a dermatologist and or allergist.
Coverage Duration	30 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DUOBRII

Products Affected

- DUOBRII

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Plaque Psoriasis. Patient has tried and failed or had contraindications to at least two of the following topical medications: halobetasol, tazarotene, calcipotriene, calcipotriene-betamethasone.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	Initial Auth: 6 months
Other Criteria	Reauth: Documentation of positive clinical response to therapy. 12 months.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DUPIXENT

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ASTHMA: Add-on maintenance treatment of moderate to severe asthma in adults and pediatric patients equal to or greater than 6 years of age with an eosinophilic phenotype or with corticosteroid dependent asthma. Limitations of use: Not indicated for the relief of acute bronchospasm or status asthmaticus. ATOPIC DERMATITIS (AD): Treatment of moderate to severe atopic dermatitis in adults and pediatric patients 6 months of age and older whose disease is not adequately controlled with topical prescription therapies. T/F, CI to a topical corticosteroid or a topical immunomodulating agent (e.g., pimecrolimus, tacrolimus)]. RHINOSINUSITIS (chronic) with NASAL POLYPOSIS: Add-on maintenance treatment (T/F, CI to ONE Intranasal corticosteroid) in adults with inadequately controlled chronic rhinosinusitis with nasal polyposis. Eosinophilic esophagitis: Treatment of adults and pediatric patients 12 years and older weighing at least 40 kg with eosinophilic esophagitis. Prurigo Nodularis (PD): treatment of adult patients with prurigo nodularis who have T/F or have CI to ONE of the following agents: topical corticosteroid, topical calcineurin inhibitor, topical calcipotriene, naltrexone.
Age Restrictions	
Prescriber Restrictions	Asthma: Prescribed by or in consultation with a Pulmonologist, Allergist, or Immunologist. Atopic Dermatitis (AD), Prurigo Nodularis (PD): Prescribed by or in consultation with a Dermatologist, Allergist, Or Immunologist. RHINOSINUSITIS (chronic) with NASAL POLYPOSIS: Prescribed by or in consultation with an ENT, Allergist, or Immunologist. Eosinophilic Esophagitis: Prescribed by or in consultation with an Allergist, Immunologist, Gastroenterologist, or ENT.
Coverage Duration	Initial 6 months and Reauth (Patient is responding well to treatment): 12 months
Other Criteria	
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

EGRIFTA

Products Affected

- EGRIFTA SV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HIV-associated lipodystrophy (initial): All of the following: 1) diagnosis of HIV-associated lipodystrophy, 2) one of the following: a) waist-circumference of greater than or equal to 95 cm (37.4 inches) in men, OR b) waist-circumference of greater than or equal to 94 cm (37 inches) for women, 3) one of the following: a) Waist-to-hip ratio of greater than or equal to 0.94 for men, OR b) waist-to-hip ratio of greater than or equal to 0.88 for women, 4) body mass index (BMI) greater than 20 kg/m^2, AND 5) fasting blood glucose (FBG) levels less than or equal to 150 mg/dL (8.33 mmol/L), AND 6) patient has been on a stable regimen of antiretrovirals (eg, NRTIs, NNRTI, Protease Inhibitors, Integrase Inhibitors) for at least 8 weeks.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	(initial, reauth): 6 months
Other Criteria	(reauth): documentation of clinical improvement (eg, improvement in visceral adipose tissue [VAT], decrease in waist circumference, belly appearance, etc) while on Egrifta therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ELIGARD

Products Affected

- ELIGARD
- ELIGARD (3 MONTH)
- ELIGARD (4 MONTH)
- ELIGARD (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Prescriber provides chart notes to support diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ENBREL

Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.
Age Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), PSORIATIC ARTHRITIS (PSA): 18 YEARS OR OLDER.
Prescriber Restrictions	INITIAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), AS: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSA: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, REAUTH: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE: IS REQUIRED. PJIA, PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. REAUTH: RA, PJIA, PSA, AS, PSO: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has the diagnosis of sickle cell disease, identified by any genotype (e.g. HbSS, HbSC, HbS/beta0-thalassemia, or HbS/beta pos/neg minus thalassemia). Patient has had an insufficient response to a minimum 3-month trial of hydroxyurea (unless contraindicated or intolerant)
Age Restrictions	Patient is 5 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with a hematologist.
Coverage Duration	Initial/Reauth: 6 months
Other Criteria	Reauth: Patient has benefitted from treatment per the provider.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EPCLUSA (SOFOSBUVIR-VELPATASVIR)

Products Affected

- EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG, 200-50 MG
- EPCLUSA ORAL TABLET 200-50 MG
- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR OR TOPOTECAN. PATIENTS WITH DECOMPENSATED CIRRHOSIS REQUIRE CONCURRENT RIBAVIRIN UNLESS RIBAVIRIN INELIGIBLE. REQUESTS FOR EPCLUSA 200MG-50MG PELLETS: PATIENT IS UNABLE TO SWALLOW TABLETS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EPIDIOLEX

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Treatment of seizures associated with Lennox-Gastaut syndrome (LGS), Dravet syndrome (DS) or tuberous sclerosis complex in patients equal to or greater than 1 year of age. Patient has failed or has developed intolerable side effects to conventional treatment. Conventional treatment includes medications from the following Anticonvulsant Therapeutic Classes: Calcium Channel Modifying Agents, Gamma-aminobutyric Acid (GABA) Augmenting Agents, Glutamate Reducing Agents, Sodium Channel Agents, Anticonvulsants, Other. Dravet syndrome -patient is taking at least 1 concomitant antiepileptic medication AND The patient is refractory on current therapy (i.e. patient has experienced a convulsive seizure [i.e. tonic, atonic, tonic clonic] in the past 28 days). Lennox Gastaut Syndrome -patient has an EEG which has shown a pattern of slow (greater than 2.5 Hz) spike and wave complexes AND The member is taking at least 1 concomitant antiepileptic medication AND The member is refractory on current therapy (e.g. has experienced a drop seizure in the past 28 days, i.e. tonic, atonic, tonic clonic, that led to or could have led to a fall or injury)
Age Restrictions	
Prescriber Restrictions	Prescribed by a neurologist.
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EPOETIN-ALFA

Products Affected

- PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML
- RETACRIT

PA Criteria	Criteria Details
Exclusion Criteria	Patient with a Dx of ESRD and on dialysis, OR the patient is identified as a Part D ESRD member. This medication is included in the bundled ESRD dialysis facility payment which is paid under Medicare Part B and is not a Part D eligible drug.
Required Medical Information	Initial: 1. Dx of Anemia due to CKD and ALL of the following: a. Hg level less than 10g/dL AND b. For all Procrit requests, T/F, CI to Retacrit 2. Dx of anemia due to Cancer Chemo and meets ALL of the following criteria: a. Hg level less than 10g/dL AND b. For all Procrit requests, T/F, CI to Retacrit. 3. Dx of anemia related to zidovudine therapy and meets ALL of the following criteria a. Hg level less than 10g/dL AND b. For all Procrit requests, T/F, CI to Retacrit. 4. Patient is undergoing elective, noncardiac, or nonvascular surgery and meets ALL of the following criteria: a. Hg level less than 13g/dL AND b. For all Procrit requests, T/F, CI to Retacrit.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, oncologist, nephrologist or infectious disease specialist.
Coverage Duration	Anemia from chemo/CKD without dialysis/zidovudine: 6 months. Surgery: 1 month.
Other Criteria	Initial: CKD, Anemia related to zidovudine therapy or cancer chemotherapy, or elective non-cardiac or non-vascular surgery: For all Procrit requests, T/F, CI to the preferred agent Retacrit
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EPRONTIA

Products Affected

- EPRONTIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following diagnoses: Initial monotherapy for the treatment of partial-onset or primary generalized tonic- clonic seizures in patients 2 years of age and older. Adjunctive therapy for the treatment of partial-onset seizures, primary generalized tonic-clonic seizures, or seizures associated with Lennox-Gastaut syndrome in patients 2 years of age and older. Preventive treatment of migraine in patients 12 years of age and older. For all indications, patient must have tried and failed one of the following: topiramate ER CAP SPRINKLE 24 hr, topiramate CAP SPRINKLE IR, topiramate tab IR (adult or adolescent able to swallow tablets).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an neurologist, epileptologist, headache specialist or pain specialist for migraine.
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Reauth Criteria: Patient is stable on medication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Basal cell carcinoma: One of the following: A) Diagnosis of metastatic basal cell carcinoma OR B) Both of the following: 1) Diagnosis of locally advanced basal cell carcinoma AND 2) One of the following: a) Disease recurred following surgery or b) Patient is not a candidate for surgery and radiation.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ERLEADA

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	Patient has experienced disease progression while on Erleada (apalutamide). Concomitant use with an androgen receptor inhibitor or androgen synthesis inhibitor (e.g., enzulutamide, abiraterone, nilutamide, flutamide, bicalutamide) due to lack of evidence supporting efficacy and safety
Required Medical Information	Prostate Cancer (non-metastatic castration resistant): The patient has a diagnosis of non-metastatic castration resistant prostate cancer AND the patient will use Erleada (apalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchioectomy or GnRH analog). Prostate Cancer (metastatic castration-sensitive): The patient has a diagnosis of metastatic castration-sensitive prostate cancer AND the member will use Erleada (apalutamide) in combination with androgen deprivation therapy (e.g. previous bilateral orchioectomy or GnRH analog).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ESBRIET

Products Affected

- *pirfenidone oral capsule*
- *pirfenidone oral tablet 267 mg, 801 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Idiopathic pulmonary fibrosis (IPF) (initial): Both of the following: 1) diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity), AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF.
Age Restrictions	
Prescriber Restrictions	IPF (initial): Prescribed by a pulmonologist
Coverage Duration	initial, reauth: 12 months
Other Criteria	IPF (reauth): Documentation of positive clinical response to pirfenidone (generic) or Esbriet (brand) therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ETHACRYNIC ACID

Products Affected

- *ethacrynic acid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months and REAUTH: 12 MONTHS.
Other Criteria	Patient has had T/F to TWO generic formulary diuretics (e.g. torsemide, bumetanide, furosemide) or patient has a documented sulfonamide hypersensitivity.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EXKIVITY

Products Affected

- EXKIVITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis is non-small cell lung cancer (NSCLC) AND the patient has locally advanced or metastatic (NSCLC) AND patient disease epidermal growth factor receptor (EGFR) exon 20 insertion mutations, as detected by an FDA-approved test AND patient has disease progression on or subsequent to platinum-based chemotherapy
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 6 months. Reauth: 6 months
Other Criteria	Reauth Criteria: Patient continues to meet initial criteria and patient must have disease stabilization and/or decrease in size of tumor or tumor spread.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FASENRA

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ASTHMA: INITIAL: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	INITIAL: 4 MONTHS, REAUTH: 12 MONTHS.
Other Criteria	ASTHMA: INITIAL: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID (ICS) AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. REAUTH: 1) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL

PA Criteria	Criteria Details
	RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FERRIPROX

Products Affected

- *deferiprone*
- FERRIPROX (2 TIMES A DAY)
- FERRIPROX ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Treatment of transfusional iron overload in adults and pediatric patients 8 years of age or older (tablets) or adults and pediatric patients 3 years of age or older (oral solution) with thalassemia syndromes, sickle cell disease, or other anemias.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	All uses (initial, reauth): 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FILGRASTIM

Products Affected

- GRANIX
- NEUPOGEN
- NIVESTYM INJECTION SOLUTION 300 MCG/ML, 480 MCG/1.6 ML
- NIVESTYM SUBCUTANEOUS SYRINGE 300 MCG/0.5 ML, 480 MCG/0.8 ML
- RELEUKO
- ZARXIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Neupogen (filgrastim): ONE of the following: 1. Acute exposure to myelosupp doses of radiation (e.g. Hematopoietic Syndrome of Acute Radiation) or 2. ONE of the following AND T/F, CI to Nivestym: a. NMM and receiving myelosupp chemo assoc with a signif incidence of severe neutropenia with fever b. AML and undergoing induction or consolidation chemo tx, c. NMM, undergoing myeloablative chemo followed by BMT, and neutropenia and/or neutropenia-related sequelae (e.g., febrile neutropenia) expected, d. Mobilization of autologous hematopoietic progenitor cells into the peripheral blood for leukapheresis, e. Congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. Zarxio (filgrastim-sndz) and Releuko (filgrastim-ayow): ONE of the following AND T/F, CI to Nivestym: a. NMM and receiving myelosupp chemo assoc with signif incidence of severe neutropenia with fever b. Acute myeloid leukemia (AML) and induction or consolidation chemo tx, c. Pt. NMM, undergoing myeloablative chemo followed by BMT, and neutropenia and/or neutropenia-related clinical sequelae (e.g., febrile neutropenia) expected, d. Mobilization of autologous hematopoietic progenitor cells into peripheral blood for leukapheresis, e. Congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. Nivestym (filgrastim-aafi): ONE of the following a. NMM and receiving myelosupp chemo assoc with a signif incidence of severe neutropenia with fever b. AML and undergoing induction or consolidation chemo c. NMM, undergoing myeloablative chemo followed by BMT, and neutropenia and/or neutropenia-related clinical sequelae (e.g., febrile neutropenia) are expected, d. Mobilization of autologous hematopoietic progenitor cells into the peripheral blood for leukapheresis, e. Congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia. Granix (tbo-filgrastim): 1 mth of age or older AND receiving myelosupp chemo assoc with a signif incidence of severe neutropenia with fever AND T/F, CI to Nivestym.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	6 months
Other Criteria	Initial: Nivestym is the preferred filgrastim product. Requests for Nivestym does not require prior use of other filgrastims. Other formulary versions of filgrastim products (Neupogen, Zarxio, Granix, Releuko) will require a T/F, CI to Nivestym, where indications align.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FINTEPLA

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dravet syndrome (DS). Fenfluramine (Fintepla) will be added to background antiepileptic therapy. Patient has refractory epilepsy and has had Trial/Failure of one of the following drugs: stiripentol or Epidiolex. Lennox-Gastaut syndrome. Fenfluramine (Fintepla) will be added to background antiepileptic therapy. Patient has refractory epilepsy and has had Trial/Failure of Epidiolex.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by a pediatric neurologist, pediatric epiliptologist, neurologist or epileptologist.
Coverage Duration	Initial: 6 mths Reauth 6 mths-documented response to tx (dec seizures/stabilization from baseline).
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FIRAZYR

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks: Diagnosis of HAE. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks (eg, Berinert, Kalbitor, or Ruconest).
Age Restrictions	
Prescriber Restrictions	HAE: Prescribed by an immunologist, allergist, or rheumatologist
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FIRMAGON

Products Affected

- FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FLECTOR PATCH

Products Affected

- *diclofenac epolamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of acute mild pain or moderate pain due to minor strains, sprains, and contusions (initial auth): (Reauthorization): Documentation of clinical benefit from ongoing therapy with generic Flector Patch (diclofenac epolamine topical).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

FOTIVDA

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of renal cell carcinoma (RCC) AND Patient has relapsed or refractory advanced disease with clear cell histology AND Patient has progressed after 2 or more prior systemic therapies. Tivozanib will be used as a single agent.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Initial and Reauth 6 months.
Other Criteria	Reauth: Patient has disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FRUZAQLA

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Metastatic colorectal cancer (mCRC): Diagnosis of metastatic colorectal cancer. Patient has been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, AND (if RAS wild-type and medically appropriate) an anti-EGFR therapy. Patient has tried and failed therapy with Stivarga (regorafenib) OR Lonsurf (trifluridine plus tipiracil) with or without bevacizumab unless the patient has a contraindication/intolerance or the prescriber indicates why the member cannot try the alternative(s) listed.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Initial/Reauth: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GAMASTAN S/D

Products Affected

- GAMASTAN

PA Criteria	Criteria Details
Exclusion Criteria	Contraindications to immune globulin therapy (i.e., IgA deficiency with antibodies to IgA and a history of hypersensitivity or product specific contraindication).
Required Medical Information	Immune globulin is being used intramuscularly. The immune globulin will be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis. Patient requires immunization for hepatitis A, measles, rubella, or varicella.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months (Approve one dose only)
Other Criteria	Subject to Part B vs D review.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GATTEX

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Short Bowel Syndrome (SBS) (Initial) Diagnosis of SBS. Patient is dependent on parenteral nutrition/intravenous (PN/IV) support.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	SBS (Init): 6 months. SBS (Reauth): 12 months.
Other Criteria	SBS (Reauth): Documentation of positive clinical response to Gattex therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GAVRETO

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis: Metastatic rearranged during transfection (RET) fusion-positive non-small cell lung cancer (NSCLC) as detected by an FDA approved test AND being used as a single agent. Advanced or metastatic RET-mutant medullary thyroid cancer (MTC) who require systemic therapy. Advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy and who are radioactive iodine-refractory (if radioactive iodine is appropriate).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 6 mths Reauth 6 mths
Other Criteria	Reauth: Patient has experienced disease response with treatment as defined by stabilization of disease or decrease in size of tumor or tumor spread.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GILENYA

Products Affected

- *fingolimod*
- GILENYA ORAL CAPSULE 0.25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease with evidence of new brain lesions. Patient has had a trial and inadequate response or intolerance to one of the following: Avonex (interferon beta-1a), Betaseron (interferon beta-1b) OR II. Patient has high disease activity despite treatment with one of the following disease modifying drugs: GLATIRAMER or GLATOPA. High disease activity is defined as the following: At least 1 relapse in the previous year while on therapy AND At least 9 T2-hyperintense lesions in cranial MRI OR At least 1 Gadolinium-enhancing lesion. OR III. Patient is treatment naive (no previous history of use of disease modifying drugs) AND IV. Pt. has rapidly evolving severe relapsing multiple sclerosis defined as the following: Two or more disabling relapses in 1 year AND ONE or more Gadolinium-enhancing lesions on brain MRI. OR V. Patient is between 10-17 years of age and has a diagnosis of relapsing MS (RMS).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of 1) First-line treatment of metastatic non-small cell lung cancer (NSCLC) whose tumor has nonresistant epidermal growth factor receptor (EGFR) mutations as detected by a Food and Drug Administration-approved test. OR 2) Treatment of previously treated metastatic squamous cell NSCLC that has progressed following platinum-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GLATIRAMER ACETATE

Products Affected

- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- *glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (eg, clinically-isolated syndrome, relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses, active secondary progressive disease).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GLEEVEC

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For adults 18 years of age or older, One of the following: A) Diagnosis of Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia (CML) AND Patient is found to be Ph+ or BCR-ABL positive as detected by bone marrow cytogenetics, FISH or PCR OR B) Ph+ acute lymphoblastic leukemia (ALL) OR C) Gastrointestinal stromal tumor (GIST) AND one of the following: 1) Patient has documented c-KIT (CD117) positive unresectable or metastatic malignant GIST, OR 2) Patient had resection of c-KIT (CD117) positive GIST and imatinib will be used as adjuvant therapy OR D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic OR E) Hypereosinophilic syndrome or chronic eosinophilic leukemia OR F) Myelodysplastic syndrome (MDS) or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements OR G) Aggressive systemic mastocytosis without the D816V c-KIT mutation or with c-KIT mutational status unknown. For Pediatric patients younger than 18 years of age, One of the following: A) Diagnosis of Ph+ CML that is newly diagnosed in the chronic phase OR B) Diagnosis of newly diagnosed Ph+ALL.
Age Restrictions	
Prescriber Restrictions	All uses: Prescribed by or in consultation with an oncologist, hematologist, allergist, immunologist or dermatologist.
Coverage Duration	All uses: 12 months
Other Criteria	All uses: Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GLEOSTINE

Products Affected

- GLEOSTINE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Brain Tumors: treatment of primary and metastatic brain tumors (after appropriate surgical and/or radiotherapeutic procedures). Hodgkin's Lymphoma: As a component of combination chemotherapy for the treatment of patients with Hodgkin's Lymphoma whose disease has progressed following initial chemotherapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	Initial: 6 months Reauth: 6 months
Other Criteria	Reauth: Pt. responding to tx
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GLP1 AGONISTS

Products Affected

- MOUNJARO
- OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 0.25 MG OR 0.5 MG(2 MG/1.5 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)
- RYBELSUS
- TRULICITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of type 2 diabetes mellitus. Clinical notes are provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GOCOVRI (AMANTADINE ER CAPSULES)

Products Affected

- GOCOVRI ORAL
  CAPSULE,EXTENDED RELEASE
  24HR 137 MG, 68.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Patient has a diagnosis of Parkinson Disease and is being treated for dyskinesia AND patient is currently receiving levodopa-based therapy (e.g., carbidopa/levodopa). 2. Patient has a diagnosis of Parkinson Disease and is experiencing "off episodes" and will be used as adjunctive treatment to levodopa/carbidopa.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	Initial Auth: 12 mths Reauth: Documentation submitted with positive clinical response: 12 mths
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

HARVONI (LEDIPASVIR-SOFOSBUVIR)

Products Affected

- HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG
- HARVONI ORAL TABLET 45-200 MG
- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist.
Coverage Duration	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), OR TIPRANAVIR/RITONAVIR. REQUESTS FOR HARVONI 45MG-200MG PELLETS: PATIENT IS UNABLE TO SWALLOW TABLETS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

HETLIOZ

Products Affected

- *tasimelteon*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Non-24-Hour Sleep-Wake Disorder (Non-24) (initial): Diagnosis of non-24-hour sleep-wake disorder AND Dx is confirmed by meeting one of the following conditions: i. Assessment of a least one physiologic circadian phase marker (e.g. measurement of urinary melatonin levels, dim light melatonin onset, as measured in blood or saliva), assessment of core body temperature OR ii. If assessment of at least on physiologic circadian phase marker cannot be done, the dx must be confirmed by actigraphy performed for one week or greater plus evaluation of sleep logs recorded for one month or greater AND patient is totally blind (has no light perception).
Age Restrictions	
Prescriber Restrictions	Non-24 (initial): Prescribed by or in consultation with a specialist in sleep disorders or a neurologist.
Coverage Duration	Non-24 and Smith-Magenis syndrome (initial): 6 mo. (reauth): 12 mo.
Other Criteria	Non-24 (reauth): Documentation of positive clinical response to tasimelteon therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

HUMIRA

Products Affected

- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PEDIATRIC UC
- HUMIRA(CF) PEN PSOR-UV-ADOL HS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST. UVEITIS: PRESCRIBED BY OR IN CONSULTATION WITH AN OPTHALMOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, REAUTH: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PJIA, PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL

PA Criteria	Criteria Details
	THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIEN E, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. UVEITIS: NO ISOLATED ANTERIOR UVEITIS. REAUTH: RA, PJIA, PSA, AS, PSO, HIDRADENITIS SUPPURATIVA, UVEITIS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1)Breast cancer, advanced (initial endocrine-based therapy): Treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER-2)-negative advanced or metastatic breast cancer (in combination with an aromatase inhibitor [e.g., anastrozole, letrozole, exemestane]) in adult patients as initial endocrine-based therapy. 2)Breast cancer, advanced (with disease progression following endocrine therapy): Treatment of HR-positive, HER-2-negative advanced or metastatic breast cancer (in combination with fulvestrant) in adult patients with disease progression following endocrine therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ICLUSIG

Products Affected

- ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic myelogenous leukemia: Diagnosis of chronic myelogenous leukemia AND One of the following: A) Trial and failure, resistance, relapse, contraindication, or intolerance to at least TWO other tyrosine kinase inhibitors (i.e., Gleevec [imatinib], Sprycel, Tasigna, and Bosulif) or B) Patient has the T315I mutation. Acute Lymphoblastic Leukemia: Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) AND One of the following: A) Trial and failure, resistance relapse, contraindication, or intolerance to at least TWO other FDA-approved tyrosine kinase inhibitors (i.e., Gleevec [imatinib], Sprycel), or B) Patient has the T315I mutation.
Age Restrictions	
Prescriber Restrictions	All Uses: Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	All uses: 12 months
Other Criteria	All uses: Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IMBRUVICA

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Waldenstrom's macroglobulinemia: Diagnosis of Waldenstroms macroglobulinemia/lymphoplasmacytic lymphoma. Small lymphocytic lymphoma (SLL): Diagnosis of SLL. Chronic graft-versus-host disease (cGVHD) (refractory): Diagnosis of cGVHD (refractory).
Age Restrictions	
Prescriber Restrictions	All uses: Prescribed by or in consultation with an oncologist, hematologist or transplant specialist.
Coverage Duration	All Uses: 12 months
Other Criteria	All Uses: Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IMLYGIC

Products Affected

- IMLYGIC INJECTION SUSPENSION 10EXP6 (1 MILLION) PFU/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Treatment (local) of unresectable cutaneous, subcutaneous, and nodal lesions in patients with melanoma recurrent after initial surgery.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a dermatologist or oncologist.
Coverage Duration	Initial and Reauth 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IMPAVIDO

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have one of the following diagnoses: 1. visceral Leishmaniasis (caused by Leishmania donovani) AND patient has tried and failed or has a contraindication to Amphoterecin B liposomal (Ambisome), 2. cutaneous Leishmaniasis (caused by L. braziliensis, L. guyanensis, and L. panamensis), 3. mucosal leishmaniasis (caused by L. braziliensis). Patient must weigh at least 30 kg.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	28 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INBRIJA

Products Affected

- INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has developed OFF periods due to disease progression despite treatment with oral doses of carbidopa/levodopa.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INGREZZA

Products Affected

- INGREZZA
- INGREZZA INITIATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	Must not be taken with other VMAT2 inhibitors, such as Xenazine (tetrabenazine).
Required Medical Information	For the treatment of tardive dyskinesia (TD) AND If TD is related to drug use, and if appropriate for this patient, the causative drug must be discontinued or tried at a lower dose. For the treatment of Chorea associated with Huntington disease. Patient has had T/F or CI to Austedo.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist or psychiatrist
Coverage Duration	3 months, Reauth 12 months
Other Criteria	REAUTH: TD: Pt has experienced improvement in symptoms deemed to be clinically significant by the provider based on stabilization or improvement in Abnormal Involuntary Movement Scale (AIMS) score. Chorea associated with Huntington disease: Pt has experienced improvement in symptoms deemed to be clinically significant by the provider based on stabilization or improvement in Unified Huntington's Disease Rating Scale-Total Motor Score (UHDRS-TMS) or AIMS score.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INLYTA

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	First-line treatment (in combination with avelumab??or??pembrolizumab) of advanced renal cell carcinoma OR Treatment (as a single-agent) of advanced renal cell carcinoma after failure of 1 prior systemic therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INQOVI

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dx: myelodysplastic syndromes (MDS), including previously treated and untreated, de novo and secondary MDS with the following FrenchAmerican-British subtypes (refractory anemia, refractory anemia with ringed sideroblasts, refractory anemia with excess blasts, and chronic myelomonocytic leukemia [CMML]) and intermediate-1, intermediate-2, and high-risk International Prognostic Scoring System (IPSS) groups
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist/hematologist.
Coverage Duration	Initial and Reauth: 6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INREBIC

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	Duration: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IRESSA

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ISOTRETINOIN

Products Affected

- *claravis*
- *isotretinoin*
- *zenatane*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acne (initial): Diagnosis of acne. Trial and failure, contraindication or intolerance to an adequate trial (at least 30 days) of ONE of the following conventional therapy regimens: a) topical retinoid or retinoid-like agent [eg, Retin-A/Retin-A Micro (tretinoin)] OR b) one of the following: 1) oral antibiotic (eg, erythromycin), minocycline) OR 2) topical antibiotic (eg, clindamycin, erythromycin).
Age Restrictions	
Prescriber Restrictions	Acne (Initial): Prescribed by a dermatologist
Coverage Duration	Acne (initial, reauth): 5 months
Other Criteria	Acne (reauth): One of the following: A) After more than 2 months off therapy, persistent or recurring severe recalcitrant nodular acne is still present, OR B) the total cumulative dose is less than 150 mg/kg (will be approved up to a total of 150 mg/kg).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ISTURISA

Products Affected

- ISTURISA ORAL TABLET 1 MG, 10 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Cushing??s disease AND Pituitary surgery was not curative or patient is not a candidate for surgery.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an endocrinologist.
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IVIG

Products Affected

- BIVIGAM
- FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %
- GAMMAGARD LIQUID
- GAMMAGARD S-D (IGA < 1 MCG/ML)
- GAMMAKED
- GAMMAPLEX (WITH SORBITOL)
- GAMUNEX-C
- OCTAGAM
- PANZYGA
- PRIVIGEN

PA Criteria	Criteria Details
Exclusion Criteria	All uses (initial, reauth): Contraindications to immune globulin therapy (i.e., IgA deficiency with antibodies to IgA and a history of hypersensitivity or product specific contraindication). Privigen only: Hyperprolinemia. Octagam only: Allergy to corn. Gammaplex only: Hereditary intolerance to fructose. Infants for whom sucrose or fructose tolerance has not been established.
Required Medical Information	Initial: Immune globulin (Ig) will be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis. For IVIG: Ig is being used intravenously (IV) AND One of the following diagnoses: [A] Primary Immunodeficiency 1) Common variable immunodeficiency. 2) Congenital agammaglobulinemia (X-linked or autosomal recessive). 3) Severe combined immunodeficiencies. 4) Wiskott-Aldrich syndrome. OR 5) Other PI with an immunologic evaluation including IgG levels below the normal laboratory value for the patient age at the time of diagnosis and the patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine). [B] Secondary Acquired Antibody Deficiency 1) B-cell chronic lymphocytic leukemia with an Ig level less than 500 mg/dL OR history of recurrent bacterial infections. 2) HIV infection with an Ig level less than 400 mg/dL OR Patient has active bleeding or a platelet count less than 10 x 109/L. 3) Multiple myeloma in plateau phase and patient has hypogammaglobulinemia. [C] Hematological Autoimmune Disorders 1) Acquired (pure) red cell aplasia (PRCA) that is immunologic and patient had a trial and failure, contraindication, or intolerance (TF/C/I) to a corticosteroid and an immunosuppressant (i.e., cyclophosphamide, cyclosporine) OR patient has viral PRCA caused by parvovirus B19. 2) Fetal alloimmune thrombocytopenia. 3) Hemolytic disease of the newborn and the patient has established hyperbilirubinemia. 4) Idiopathic thrombocytopenic purpura and patient had a TF/C/I to a corticosteroid OR a platelet count less than 30,000 cells/mm3. Continued in Other Criteria Section.

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	All uses (initial, reauth): Prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g., immunologist, hematologist, neurologist, etc.).
Coverage Duration	4 months: Solid organ transplant. 12 months: all other diagnoses.
Other Criteria	[D] Neuromuscular Autoimmune Disorders 1) Chronic inflammatory demyelinating polyneuropathy. 2) Guillain-Barr syndrome. 3) Inflammatory myopathies (dermatomyositis and polymyositis) AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., azathioprine, methotrexate, cyclosporine A, cyclophosphamide, or tacrolimus). 4) Lambert-Eaton myasthenic syndrome AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (e.g., azathioprine). 5) Multifocal motor neuropathy. 6) Myasthenia gravis with severe exacerbations or myasthenic crises AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., azathioprine, cyclosporine, cyclophosphamide, or mycophenolate mofetil). 7) Stiff person syndrome AND Patient had a TF/C/I to at least 2 standard therapies (i.e., bzds, muscle relaxants, or anti-convulsants). [E] Other Disorders 1) Autoimmune blistering disease AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., cyclophosphamide, dapsone, methotrexate, azathioprine, or mycophenolate mofetil). 2) Kawasaki syndrome. 3) Solid organ transplant and IVIG is being used for CMV prophylaxis, or patient is a kidney transplant recipient and has donor specific antibodies, or patient has steroid-resistant rejection and had a TF/C/I to standard therapies. For SCIG (Gamunex-C, Gammagard Liquid, Gammaked only)- Immune globulin is being used subcutaneously AND One of the following PI diagnoses: 1) Common variable immunodeficiency. 2) Congenital agammaglobulinemia (X-linked or autosomal recessive). 3) Severe combined immunodeficiencies. 4) Wiskott-Aldrich syndrome. OR 5) Other PI with an immunologic evaluation including IgG levels below the normal laboratory value for the patients age at the time of diagnosis and patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine). All products: Subject to Part B vs. Part D review. For non-oncology renewal, the patient has experienced an objective improvement on immune globulin therapy and the immune globulin will be administered at the minimum effective dose (by decreasing the dose, increasing the frequency, or implementing both strategies) for maintenance therapy.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

IWILFIN

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Neuroblastoma, high-risk: Diagnosis is High-Risk Neuroblastoma. High-Risk is defined as an unresectable tumor that has spread to at least one of the following: 1. lymph node involvement near the tumor 2. distant lymph node involvement in other parts of the body such as bones, bone marrow, liver or skin 3. other areas near the tumor, but not to other parts of the body. Drug is being used to reduce the risk of relapse of high-risk neuroblastoma. Patient has demonstrated at least a partial response to prior multiagent, multimodality therapy including anti-GD2 immunotherapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Myelofibrosis: Diagnosis of primary myelofibrosis, OR post-polycythemia vera myelofibrosis, OR post-essential thrombocythemia myelofibrosis. Polycythemia vera: Diagnosis of polycythemia vera, AND trial and failure, contraindication, or intolerance to hydroxyurea. Dx Treatment of steroid-refractory acute graft-versus-host disease (aGVHD) in adult and pediatric patients 12 years of age or greater. Dx of chronic graft-versus-host disease (cGVHD) after failure of one or two lines of systemic therapy in adult and pediatric patients 12 years of age or greater.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist or transplant specialist.
Coverage Duration	Myelofibrosis, Polycythemia vera, graft-versus-host disease: 12 months.
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

JAYPRICA

Products Affected

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Mantle Cell Lymphoma: Treatment of relapsed or refractory mantle cell lymphoma after at least two lines of systemic therapy, including a Bruton tyrosine kinase (BTK) inhibitor, in adults. 2) Chronic lymphocytic leukemia or small lymphocytic lymphoma (CLL/SLL): Treatment of chronic lymphocytic leukemia or small lymphocytic lymphoma (CLL/SLL) after at least two prior lines of therapy, including a BTK inhibitor and a BCL-2 inhibitor.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial/Reauth: 6 months
Other Criteria	Reauth: Patient has benefitted from treatment per the provider.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

JUXTAPID

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Homozygous familial hypercholesterolemia (HoFH) (initial): Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH), or b) both of the following: 1) either untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. Patient has had trial and failure or intolerance to ONE LDL-C lowering prescription therapy. Patient has had trial and failure or intolerance to Repatha therapy. One of the following LDL-C values while on maximally tolerated lipid-lowering regimen within the last 30 days: LDL-C greater than or equal to 70 mg/dL with ASCVD OR LDL-C greater than or equal to 130 mg/dL without ASCVD. Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor. Patient is not pregnant. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests. Patient is not concomitantly on moderate or strong CYP 3A4 inhibitors (eg, clarithromycin).
Age Restrictions	
Prescriber Restrictions	HoFH (initial, reauth): Prescribed by a cardiologist, endocrinologist, or lipid specialist.
Coverage Duration	HoFH (initial): 6 months. (reauth): 12 months
Other Criteria	HoFH (reauthorization): Patient continues to receive statin at the maximally tolerated dose (or other LDL-C lowering prescription therapy if patient is unable to take a statin). Submission of medical records (eg, laboratory values) documenting a sustained LDL-C reduction from pre-treatment baseline (ie, prior Juxtapid therapy) while on Juxtapid therapy. Not used in combination with a proprotein convertase subtilisin/kexin type

PA Criteria	Criteria Details
	9 (PCSK9) inhibitor. Patient is not pregnant. Patient does not have moderate or severe hepatic impairment (ie, Child-Pugh category B or C) or active liver disease including unexplained persistent abnormal liver function tests. Patient is not concomitantly on moderate or strong CYP 3A4 inhibitors (eg, clarithromycin).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KALYDECO

Products Affected

- KALYDECO ORAL GRANULES IN PACKET 25 MG, 50 MG, 75 MG
- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Cystic Fibrosis (CF) in patients 4 months of age or older who have 1 mutation in the CF transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bidirectional sequencing when recommended by the mutation test instructions for use
Age Restrictions	
Prescriber Restrictions	CF (Initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or a pulmonologist.
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KERENDIA

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All of the following: Patient has a diagnosis of type 2 diabetes AND chronic kidney disease. Patient is currently receiving a maximally tolerated labeled dosage of an ACE Inhibitor or ARB OR patient has a CI to ACEI and ARB therapy. Serum potassium level is less than or equal to 5 mEQ/L prior to initiating treatment. Drug is being used to reduce the risk of any of the following: 1. Sustained eGFR decline, 2. ESRD, 3. Cardiovascular death, 4. Non-fatal MI, 5. Hospitalization for Heart Failure.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a Cardiologist, Endocrinologist or Nephrologist.
Coverage Duration	Initial: 6 months Reauth: 12 months
Other Criteria	Reauth: Disease response with treatment
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KEVEYIS

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Exclusion Criteria	All Uses (Initial and Reauth): Hepatic insufficiency (e.g., Child-Pugh class A). Severe pulmonary disease [e.g., severe chronic obstructive pulmonary disease]. Concomitant use with high dose aspirin (i.e., greater than 100 mg per day).
Required Medical Information	Periodic paralysis (Initial): Diagnosis of one of the following: Primary hyperkalemic periodic paralysis, Primary hypokalemic periodic paralysis, or Paramyotonia Congenita with periodic paralysis
Age Restrictions	
Prescriber Restrictions	All uses (Initial): Prescribed by or in consultation with a neurologist
Coverage Duration	All uses (Initial): 3 months. (Reauth): 12 months
Other Criteria	All uses (Reauth): Documentation of positive clinical response to Keveyis therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KEVZARA

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, REAUTH: 12 MONTHS.
Other Criteria	RA: INITIAL: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. REAUTH: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KINERET

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	RA: INITIAL: 6 MONTHS, REAUTH: 12 MONTHS. ALL OTHERS: 12 MONTHS.
Other Criteria	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, RINVOQ, ENBREL, XELJANZ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. REAUTH: RA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KISQALI

Products Affected

- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Breast cancer, advanced or metastatic: Treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer (in combination with an aromatase inhibitor [e.g., anastrozole, letrozole, exemestane]) in adults as initial endocrine-based therapy AND T/F, CI to Ibrance. Treatment of HR-positive, HER2-negative advanced or metastatic breast cancer (in combination with fulvestrant) in postmenopausal females and in males as initial endocrine-based therapy or following disease progression on endocrine therapy AND T/F, CI to Ibrance.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KISQALI-FEMARA PACK

Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Breast cancer, advanced or metastatic as initial endocrine-based therapy for the treatment of adults with hormone receptor-positive, human epidermal growth factor receptor 2-negative breast cancer AND T/F, CI to Ibrance. Males and pre-/perimenopausal females receiving ribociclib and letrozole will also receive a luteinizing hormone-releasing hormone agonist.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KORLYM

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cushing's syndrome (Initial): Diagnosis of endogenous Cushings syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Diagnosis of either type 2 diabetes mellitus or diagnosis of glucose intolerance. Patient has either failed surgery or patient is not a candidate for surgery. Patient is not pregnant.
Age Restrictions	
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial, reauth: 6 months
Other Criteria	Reauthorization: Documentation of one of the following: patient has improved glucose tolerance while on Korlym therapy or patient has stable glucose tolerance while on Korlym therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KOSELUGO

Products Affected

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pediatric patient has diagnosis of neurofibromatosis type 1. Patient is symptomatic and has inoperable plexiform neurofibromas.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist or a neurologist.
Coverage Duration	Initial: 6 months Reauth: 12 months with positive response.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KRAZATI

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Non-small cell lung cancer, locally advanced or metastatic, KRAS G12C-mutated: Treatment of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer, as determined by an approved test, in adults who have received at least 1 prior systemic therapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial and Reauth: 6 mths
Other Criteria	Reauth: Pt is benefitting from treatment
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KUVAN

Products Affected

- *sapropterin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient is a new start to sapropterin dihydrochloride. Patient will have blood Phe levels measured after 1 week of therapy and periodically for up to 2 months of therapy to determine response.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PKU (Init): 2 months (Reauth): 12 months
Other Criteria	PKU (reauth): Patient is currently on therapy with sapropterin dihydrochloride. Prescriber submits chart notes indicating that the the patient has experienced improvement.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LENVIMA

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Differentiated thyroid cancer (DTC): Diagnosis of DTC. Disease is locally recurrent or metastatic. Patient has symptomatic or progressive disease. Disease is refractory to radioactive iodine treatment. Renal Cell Carcinoma (RCC): Diagnosis of advanced RCC in combination with pembrolizumab as first-line treatment. In combination with everolimus, for the treatment of adult patients with advanced RCC following one prior anti-angiogenic therapy. Hepatocellular carcinoma (HCC): Diagnosis of unresectable (HCC). Endometrial carcinoma, advanced: Diagnosis of advanced endometrial carcinoma (in combination with pembrolizumab) that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (pMMR), as determined by an FDA-approved test, in patients who have disease progression following prior systemic therapy and are not candidates for curative surgery or radiation.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LETAIRIS

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. PAH (Reauth): 12 months
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LEUKINE

Products Affected

- LEUKINE INJECTION RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Bone marrow/stem cell transplant (BMSCT): One of the following: 1) patients with non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT, OR 2) for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis, OR 3) for peripheral stem cell transplant (PSCT) patients who have received myeloablative chemotherapy. Acute myeloid leukemia (AML): patients with AML following induction or consolidation chemotherapy, AND age greater than or equal to 55 years. Primary prophylaxis of chemotherapy-induced febrile neutropenia (CFN): One of the following: 1) patient is receiving chemotherapy regimens associated with a greater than 20% incidence of FN, OR 2) both of the following: a) patient receiving chemotherapy regimen associated with 10-20% incidence of FN, AND b) one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia. Secondary prophylaxis of FN: Both of the following: 1) patients receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm^3), AND 2) patients with a history of FN during a previous course of chemotherapy. Neutropenia associated with dose-dense chemotherapy (NDDC): One of the following: 1) Patient is receiving National Cancer Institutes Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, OR 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown. Treatment of FN (off-label): Both of the following: 1) patients receiving myelosuppressive anticancer drugs associated with neutropenia (ANC less than or equal to 500 cells/mm^3), AND 2) patients with FN at high risk for infection-associated complications.
Age Restrictions	
Prescriber Restrictions	(Initial): Prescribed by hematologist/oncologist except HIVN: Prescribed by hematologist/oncologist or infectious disease specialist
Coverage Duration	BMSCT, AML, CFN, FN (prophylaxis), NDDC:3mo or duration of tx. HIVN:6mo. FN (tx):1 mo. H-ARS:3 mths.

PA Criteria	Criteria Details
Other Criteria	HIV-related neutropenia (HIVN)(off-label): Patients infected with HIV, and ANC less than or equal to 1000 (cells/mm^3).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LIDOCAINE

Products Affected

- *lidocaine topical ointment*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 Months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LIDODERM

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of post-herpetic neuralgia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LINEZOLID

Products Affected

- *linezolid oral suspension for reconstitution*
- *linezolid oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed vancomycin-resistant enterococcus faecium (VRE) infection. Confirmed methicillin-resistant S. aureus (MRSA), methicillin-susceptible Staphylococcus aureus, Streptococcus pneumoniae, Streptococcus agalactiae, or Streptococcus pyogenes infection AND individual has had a trial and inadequate response or intolerance to or has contraindications to an alternative antibiotic that the organism is susceptible to (depending on manifestation, severity of infection and culture or local sensitivity patterns, examples of alternative antibiotics may include, but are not limited to: vancomycin, TMP-SMX, clindamycin, doxycycline, tetracycline (Based on 2011 IDSA MRSA guideline recommendations)). Individual started treatment with LINEZOLID in the hospital and requires continued outpatient therapy. Isolates of MRSA have a vancomycin minimum inhibitory concentration (MIC) of greater than 2.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LIVTENCITY

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis is Cytomegalovirus AND it is refractory to treatment (with or without genotypic resistance) with ganciclovir, valganciclovir, cidofovir or foscarnet AND patient is posttransplant.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Initial: 3 months Reauth: 3 months
Other Criteria	Reauth Criteria: Patient has responded to treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LONSURF

Products Affected

- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Colorectal Cancer: Diagnosis of metastatic colorectal cancer AND trial and failure, contraindication, or intolerance to at least one component in the following: fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI) AND trial and failure, contraindication, or intolerance to at least one anti-VEGF therapy (e.g., Avastin) AND One of the following: A) patient has KRAS wild-type tumors and trial and failure, contraindication, or intolerance to at least one anti-EGFR therapy (e.g., Vectibix, Erbitux) OR Patient has KRAS mutant tumors. 2) Gastric Cancer: Diagnosis of Metastatic gastric or gastroesophageal junction adenocarcinoma previously treated with at least two prior lines of chemotherapy that included a fluoropyrimidine, a platinum, either a taxane or irinotecan, and if appropriate, HER2/NEU-targeted therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LORBRENA

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Non-small cell lung cancer, metastatic: Treatment of metastatic non-small cell lung cancer in adults whose tumors are ALK-positive (as detected by an approved test).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LOTRONEX

Products Affected

- *alosetron*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Severe Diarrhea-Predominant Irritable Bowel Syndrome (IBS) in Women (initial): All of the following: 1) diagnosis of severe diarrhea-predominant IBS, 2) symptoms for at least 6 months, 3) female patient, AND 4) trial and failure, contraindication, or intolerance to an antidiarrheal agent [eg, loperamide].
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	IBS (initial): 12 weeks. IBS (reauth): 6 mo.
Other Criteria	IBS (reauthorization): Symptoms of IBS continue to persist, AND documentation of positive clinical response to alosetron therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LUCEMYRA

Products Affected

- LUCEMYRA

PA Criteria	Criteria Details
Exclusion Criteria	Congenital long QT syndrome, severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, chronic renal failure.
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LUMAKRAS

Products Affected

- LUMAKRAS ORAL TABLET 120 MG, 320 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Non-small cell lung cancer, locally advanced or metastatic, KRAS G12C-mutated: Treatment of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), as determined by an FDA-approved test, in patients who have received at least 1 prior systemic therapy
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 6mths. Reauth: 6 months
Other Criteria	Reauth Criteria: Patient must continue to meet the above criteria AND Disease response with treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LUPKYNIS

Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has active lupus nephritis and will be used in combination with a background immunosuppressive therapy regimen AND patient has had trial and failure or contraindication to belimumab (BENLYSTA).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an immunologist, rheumatologist or nephrologist.
Coverage Duration	Initial Auth and Reauth: 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LUPRON

Products Affected

- *leuprolide subcutaneous kit*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer.
Age Restrictions	
Prescriber Restrictions	Prostate Cancer:(initial, reauth): Prescribed by or in consultation with an oncologist.
Coverage Duration	Prostate CA (initial, reauth): 12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LUPRON DEPOT

Products Affected

- *leuprolide (3 month)*
- LUPRON DEPOT
- LUPRON DEPOT (3 MONTH)
- LUPRON DEPOT (4 MONTH)
- LUPRON DEPOT (6 MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prostate Cancer (7.5 mg, 22.5 mg, 30 mg, 45 mg): Diagnosis of advanced or metastatic prostate cancer. Where there are aligning indications and strengths, must have T/F or CI to generic Leuprolide Depot or Eligard or Trelstar. Endometriosis (3.75 mg, 11.25 mg) (initial): Diagnosis of endometriosis. One of the following: Patient has had surgical ablation to prevent recurrence, or trial and failure, contraindication, or intolerance to one NSAID and one oral contraceptive. Uterine Leiomyomata (UL) (3.75 mg, 11.25 mg): a) For use prior to surgery to reduce size of fibroids to facilitate a surgical procedure (eg, myomectomy, hysterectomy) OR b) all of the following: treatment of anemia, anemia is caused by uterine leiomyomata (fibroids), and for use prior to surgery. For all indications, Prescriber provides chart notes to support diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Prostate CA: 12 mo. Endomet (init, reauth):6mo. UL (anemia):3 mo (fibroids):4 mo
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LUPRON DEPOT PED

Products Affected

- LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, 30 MG
- LUPRON DEPOT-PED INTRAMUSCULAR KIT
- LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Central Precocious Puberty (CPP) (initial): Diagnosis of CPP (idiopathic or neurogenic). Early onset of secondary sexual characteristics in females less than age 8 or males less than age 9. Advanced bone age of at least one year compared with chronologic age. One of the following: a) patient has undergone gonadotropin-releasing hormone agonist (GnRHa) testing AND Peak luteinizing hormone (LH) level above pre-pubertal range, or b) patient has a random LH level in the pubertal range.
Age Restrictions	
Prescriber Restrictions	CPP (initial, reauth): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	CPP (init, reauth): 12 months
Other Criteria	CPP (reauthorization): LH levels have been suppressed to pre-pubertal levels.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LYBALVI

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	Patient is not currently using opioids AND Patient is not undergoing acute opioid withdrawal.
Required Medical Information	Diagnosis is Schizophrenia or Bipolar I Disorder. If used for Bipolar I Disorder, will be used for either: Acute Treatment of manic or mixed episodes as monotherapy OR as adjunct to lithium or valproate OR maintenance monotherapy treatment. Patient has had Trial and Failure of at least one second-generation (atypical) antipsychotic (e.g. risperidone, olanzapine).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with a psychiatrist.
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Reauth: Patient must continue to meet the above criteria AND patient must have disease improvement and/or stabilization AND patient has been reassessed for the need for continued therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LYNPARZA

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1st Line Maint BRCAm Adv Ovarian CA (AOCA): maint tx of delet or susp delet germline/somatic BRCA-mutated (gBRCAm or sBRCAm) adv epithelial ovarian, fallopian tube, or primary peritoneal CA in complete or PR to 1st line platinum-based chemo. 1st Line Maint HRD Positive AOCA in comb w/ Bevacizumab: In comb. w/ bevacizumab for the maint tx of adv Epith ovarian, fallopian tube or prim. peritoneal CA in complete or PR to 1st line platinum-based chemo and CA is assoc w/ homolog recomb def (HRD) pos status defined by either: a delet or susp delet BRCA mutation, and/or genomic instability. Maint Recurr OCA: For the maint tx of recurrent epithelial ovarian, fallopian tube, or primary peritoneal CA, in complete or PR to platinum-based chemo. Adv gBRCAm OCA: For the tx of delet or susp delet germline BRCA mutated (gBRCAm) AOCA who have been tx w/ 3 or more prior lines of chemo (Per NCCN Guidelines in Oncology for Ovarian Cancer). gBRCAm, HER2-Neg Metastatic Breast CA: For the tx of delet or susp delet gBRCAm, human epidermal growth factor receptor 2 (HER2)-negative metastatic breast CA who have been tx w/ chemo in the neoadj, adj, or metastatic setting. Pts w/ hormone receptor (HR)-pos breast CA should have been tx w/ a prior endocrine tx or considered inapprop for endocrine tx. gBRCAm, early, high-risk, HER2-Neg, Breast CA: Adj tx of delet or susp delet gBRCAm, HER2-neg, high-risk, early breast CA who have been tx with neoadj or adj chemo. 1st Line Maint gBRCAm Metastatic Pancreatic CA: For the maint tx of delet or susp delet gBRCAm metastatic pancreatic adenoCA whose disease has not progressed on at least 16 wks of a 1st line platinum-based chemo regimen. HRR Gene-mutated mCRPC: For the tx of delet or susp delet germline/somatic HRR gene-mutated mCRPC who have progressed after tx w/ enzalutamide or abiraterone. Delet or susp delet BRCA-mutated mCRPC in comb w/ abiraterone and prednisone or prednisolone and tx selection is based on an FDA approved dx test for Lynparza.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist

PA Criteria	Criteria Details
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LYTGOBI

Products Affected

- LYTGOBI ORAL TABLET 4 MG, 4 MG (4X 4 MG TB), 4 MG (5X 4 MG TB)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cholangiocarcinoma, intrahepatic, previously treated, unresectable locally advanced or metastatic, with FGFR2 gene fusion or rearrangement: Treatment of previously treated, unresectable, locally advanced or metastatic intrahepatic cholangiocarcinoma (CCA) harboring fibroblast growth factor receptor 2 (FGFR2) gene fusions or other rearrangements in adults. Presence of FGFR2 gene fusion or rearrangement must be provided in the clinical notes.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 6 months. Reauth: 6 months.
Other Criteria	Reauth: Patient is responding well to treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MARINOL

Products Affected

- *dronabinol*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. Trial and failure, contraindication, or intolerance to one 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). Trial and failure, contraindication, or intolerance to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine). AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CINV: 6 months. AIDS anorexia: 3 months.
Other Criteria	Subject to Part B vs. Part D review.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MAYZENT

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG
- MAYZENT STARTER(FOR 1MG MAINT)
- MAYZENT STARTER(FOR 2MG MAINT)

PA Criteria	Criteria Details
Exclusion Criteria	A CYP2C9*3/*3 genotype?? Patient must not have experienced in the last 6 months experienced myocardial infarction, unstable angina, stroke, transient ischemia attack, decompensated heart failure requiring hospitalization, or Class III or IV heart failure ?? Patient must not have presence of Mobitz type II second-degree, third-degree AV block, or sick sinus syndrome, unless patient has a functioning pacemaker
Required Medical Information	Inadequate response, or intolerance, to first-line agents such as fingolimod (GILENYA) and dimethyl fumarate (TECFIDERA).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by a neurologist or in consultation with a neurologist.
Coverage Duration	Initial Auth: 12 months
Other Criteria	Reauth: Documentation of positive clinical response to therapy. 12 months.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MEGESTROL

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All Medically Accepted indications not otherwise excluded by Part D.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MEKINIST

Products Affected

- MEKINIST ORAL RECON SOLN
- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1.As a single agent for the tx of BRAF V600E or V600K mutations as detected by an FDA-approved test. 2. in combination with dabrafenib for the tx of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations as detected by an FDA-approved test 3. adjuvant treatment of patients with melanoma with BRAF V600E or V600K mutations, as detected by an FDA-approved test, and involvement of lymph node(s), following complete resection 4. metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test 5. locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation with no satisfactory locoregional treatment options. 6. adult and pediatric patients 1 years of age and older with unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior tx and have no satisfactory alternative tx options.7. pediatric patients 1 year of age and older with low-grade glioma (LGG) with a BRAF V600E mutation who require systemic therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MEKTOVI

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Unresectable or metastatic melanoma: Diagnosis of unresectable or metastatic melanoma with a BRAF V600E or V600K mutation, as detected by an FDA-approved test AND therapy will be used in combination with encorafenib. 2) Metastatic non-small cell lung cancer (NSCLC): Diagosis of metastatic non-small cell lung cancer (NSCLC) with a BRAF V600E mutation, as detected by an FDA-approved test AND therapy will be used in combination with encorafenib.
Age Restrictions	NSCLC: 18 years of age or older
Prescriber Restrictions	NSCLC: Prescribed by or in consultation with an oncologist. Melanoma: Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

METADATE ER-RITALIN SR

Products Affected

- *methylphenidate hcl oral tablet extended release*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following: a) diagnosis of attention deficit hyperactivity disorder (ADHD), OR b) diagnosis of attention deficit disorder (ADD), OR c) diagnosis of narcolepsy as confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)
Age Restrictions	PA applies to members 19 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

METHYLIN CHEW

Products Affected

- *methylphenidate hcl oral tablet,chewable*
  10 mg, 2.5 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following: a) diagnosis of attention deficit hyperactivity disorder (ADHD), OR b) diagnosis of attention deficit disorder (ADD), OR c) diagnosis of narcolepsy as confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)
Age Restrictions	PA applies to members 19 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

METHYLPHENIDATE

Products Affected

- *methylphenidate hcl oral solution*
- *methylphenidate hcl oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following: a) diagnosis of attention deficit hyperactivity disorder (ADHD), OR b) diagnosis of attention deficit disorder (ADD), OR c) diagnosis of narcolepsy as confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible)
Age Restrictions	PA applies to members 19 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

METHYLPHENIDATE ER

Products Affected

- *methylphenidate hcl oral cap,er sprinkle,biphasic 40-60*
- *methylphenidate hcl oral capsule, er biphasic 30-70 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg*
- *methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 60 mg*
- *methylphenidate hcl oral tablet extended release 24hr 18 mg, 18 mg (bx rating), 27 mg, 27 mg (bx rating), 36 mg, 36 mg (bx rating), 54 mg, 54 mg (bx rating)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following: a) diagnosis of attention deficit hyperactivity disorder (ADHD), OR b) diagnosis of attention deficit disorder (ADD)
Age Restrictions	PA applies to members 19 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MOTEGRITY

Products Affected

- MOTEGRITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a diagnosis of chronic idiopathic constipation, Patient must have experienced an inadequate response after a 14-day trial of lactulose or polyethylene glycol (PEG-3350) at a maximum tolerated dose, OR have a documented intolerance or contraindication to both lactulose and polyethylene glycol (PEG-3350), Patient must not have a known or suspected mechanical gastrointestinal obstruction.
Age Restrictions	
Prescriber Restrictions	Precribed by or in consultation with a gastroenerologist.
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MS INTERFERONS

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT
- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease with evidence of new brain lesions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MYALEPT

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Lipodystrophy (initial): Diagnosis of congenital or acquired generalized lipodystrophy AND one of the following: a) Patient has hypertriglyceridemia and is refractory or intolerant to at least two formulary triglyceride lowering agents at highest tolerated doses (i.e. atorvastatin, simvastatin, pravastatin, rosuvastatin, fenofibrate, ezetimibe, gemfibrozil) OR b) Patient has Diabetes Mellitus or insulin resistance with persistent hyperglycemia despite insulin therapy.
Age Restrictions	
Prescriber Restrictions	Initial: Prescribed by or in consultation with an endocrinologist
Coverage Duration	Initial and reauth: 12 months
Other Criteria	Lipodystrophy (reauth): Patient has experienced an objective response to therapy, such as A) Sustained reduction in hemoglobin A1c (HbA1c) level from baseline OR B) Sustained reduction in triglyceride (TG) levels from baseline
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NAMENDA XR (INCLUDING TITRATION PACK), MEMANTINE (TABLETS, SOLUTION AND TITRATION PACK)

Products Affected

- *memantine oral capsule,sprinkle,er 24hr*
- *memantine oral solution*
- *memantine oral tablet*
- *memantine oral tablets,dose pack*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Member has a diagnosis of moderate to severe dementia of the Alzheimers type.
Age Restrictions	PA applies to members that are 49 years of age or younger.
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NATESTO

Products Affected

- NATESTO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dx: Hypogonadism (hypogonadotropic) or hypogonadism (primary) (males) AND labwork within the past 12 months of low testosterone level measured on at least two occasions is provided AND patient has tried and failed at least 1 formulary generic alternative testosterone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial and Reauth 6 mths
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Hypocalcemia (Initial): Diagnosis of hypocalcemia due to chronic hypoparathyroidism. NATPARA is not being used in the setting of acute post-surgical hypoparathyroidism. Patient does not have a known calcium-sensing receptor mutation. Patient is not at an increased risk for osteosarcoma.
Age Restrictions	
Prescriber Restrictions	Hypocalcemia (Initial): Prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial: 4 months. Reauth: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NAYZILAM

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the acute treatment of intermittent, stereotypic episodes of frequent seizure activity (e.g., seizure clusters, acute repetitive seizures) that are distinct from a patient??s usual seizure pattern in patients with epilepsy 12 years of age and greater.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by a neurologist or in consultation with a neurologist.
Coverage Duration	3 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NEXAVAR

Products Affected

- *sorafenib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of RCC. One of the following: Relapsed disease OR both medically/surgically unresectable tumor and dx of Stage IV disease. Hepatocellular carcinoma (HCC): Diagnosis of HCC. One of the following: patient has metastatic disease, or patient has extensive liver tumor burden, or patient is inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only), or both of the following: patient is not a transplant candidate and disease is unresectable. Differentiated thyroid carcinoma (DTC): Diagnosis of DTC (ie, follicular carcinoma, Hurthle cell carcinoma, or papillary carcinoma). One of the following: locally recurrent disease or metastatic disease. One of the following: patient has symptomatic disease or patient has progressive disease. Disease is refractory to radioactive iodine (RAI) treatment. Medullary thyroid carcinoma (MTC): Diagnosis of MTC. Patient has symptomatic disease. Trial and failure, contraindication, or intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib).
Age Restrictions	
Prescriber Restrictions	RCC, DTC, MTC: Prescribed by or in consultation with an oncologist. HCC: Prescribed by or in consultation with an oncologist, hepatologist, or gastroenterologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NEXLETOL

Products Affected

- NEXLETOL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis: 1) ASCVD, established: Treatment of established ASCVD (as confirmed by e.g. acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA or PAD, all of presumed atherosclerotic origin), as an adjunct to maximally tolerated statin therapy (OR The member is determined to have statin-associated muscle symptoms or myalgias that have included rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of statin-associated muscle symptoms or myalgias despite both lowering of statin strength AND attempting a different statin), in adult patients who require additional lowering of LDL-C. 2) Heterozygous familial hypercholesterolemia (HeFH): Treatment of HeFH, as an adjunct to maximally tolerated statin therapy (OR The member is determined to have statin-associated muscle symptoms or myalgias that have included rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of statin-associated muscle symptoms or myalgias despite both lowering of statin strength AND attempting a different statin), in adult patients who require additional lowering of LDL-C.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 mths. Reauth: 12 mths.
Other Criteria	Reauth: Submission of LDL-C labs demonstrating improvement from baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NEXLIZET

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis: 1) ASCVD, established: Treatment of established ASCVD (as confirmed by e.g. acute coronary syndromes, history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA or PAD, all of presumed atherosclerotic origin), as an adjunct to maximally tolerated statin therapy (OR The member is determined to have statin-associated muscle symptoms or myalgias that have included rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of statin-associated muscle symptoms or myalgias despite both lowering of statin strength AND attempting a different statin), in adult patients who require additional lowering of LDL-C. 2) Heterozygous familial hypercholesterolemia (HeFH): Treatment of HeFH, as an adjunct to maximally tolerated statin therapy (OR The member is determined to have statin-associated muscle symptoms or myalgias that have included rhabdomyolysis OR Member has failed to achieve goal LDL-C reduction because of statin-associated muscle symptoms or myalgias despite both lowering of statin strength AND attempting a different statin), in adult patients who require additional lowering of LDL-C. OR Patient has a dx of ASCVD, established or HeFH and has tried and failed tx with NEXLETOL (bempedoic acid).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 mths. Reauth: 12 mths. Lab values show sustained LDL-C reduction from pre-tx baseline.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple myeloma: Diagnosis of multiple myeloma. Used in combination with Revlimid (lenalidomide) and dexamethasone. Patient has received at least one prior therapy for multiple myeloma [eg, Revlimid (lenalidomide), Thalomid (thalidomide), Velcade (bortezomib)].
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NORTHERA

Products Affected

- *droxidopa*
- NORTHERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Neurogenic orthostatic hypotension (NOH) (init): Diagnosis of symptomatic NOH. NOH is caused by one of the following conditions: primary autonomic failure (eg, Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, non-diabetic autonomic neuropathy. Trial and failure, contraindication, or intolerance to one of the following agents: fludrocortisone acetate, midodrine.
Age Restrictions	
Prescriber Restrictions	NOH (init): Prescribed by or in consultation with a cardiologist, neurologist, or nephrologist
Coverage Duration	NOH (init): 1 month (reauth): 12 months
Other Criteria	NOH (reauth): Documentation of positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NOVANTRONE

Products Affected

- *mitoxantrone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis (MS) (init): Diagnosis (dx) of one of the following: secondary progressive MS: gradually worsening disability with or without superimposed relapses, progressive relapsing MS: progression of disability from the onset with superimposed relapses, or worsening relapsing-remitting MS: neurological status remains significantly abnormal in between MS relapses. Disease progression despite one of the following therapies: Avonex, Aubagio, Betaseron, Copaxone, Glatopa, Extavia, Gilenya, Lemtrada, Rebif, Tecfidera, Tysabri. Left ventricular ejection fraction (LVEF) greater than or equal to 50%. Neutrophil count greater than or equal to 1500 cell/mm^3. Lifetime cumulative dose less than 140 mg/m^2. Prostate Cancer (PC) (init): Dx of advanced hormone-refractory (castration-resistant) PC. Used in combination with corticosteroids (eg, prednisone, methylprednisolone). LVEF greater than or equal to 50%. Neutrophil count greater than or equal to 1500 cell/mm^3. Acute Non-Lymphocytic Leukemia (ANLL) (init): Dx of ANLL (eg, myelogenous, promyelocytic, monocytic, and erythroid). Used in combination with other medications used for the treatment of ANLL. LVEF greater than or equal to 50%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	All Uses: 12 weeks
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NOXAFIL DR 100MG TABLET

Products Affected

- *posaconazole oral tablet,delayed release (dr/ec)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NUBEQA

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following diagnoses: 1. Treatment of nonmetastatic castration-resistant prostate cancer. 2. Treatment of metastatic hormone-sensitive prostate cancer in combination with docetaxel.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NUCALA (MEPOLIZUMAB)

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE. NASAL POLYPS: PRESCRIBED BY OR IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL: ASTHMA: 4 MO. NASAL POLYPS: 6 MO. OTHERS: 12 MO. REAUTH: NASAL POLYPS, ASTHMA: 12 MO.
Other Criteria	INITIAL: ASTHMA: 1) CONCURRENT THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 2) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE/WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE/WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 3) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA. NASAL POLYPS: PREVIOUS 8 WEEK TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID. REAUTH: ASTHMA: 1) NOT CONCURRENTLY RECEIVING XOLAIR,

PA Criteria	Criteria Details
	DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 2) CONTINUED USE OF ICS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, AND 3) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR D) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. NASAL POLYPS: CLINICAL BENEFIT COMPARED TO BASELINE.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pseudobulbar affect (PBA) (initial): Diagnosis of PBA. (Reauthorization): Documentation of clinical benefit from ongoing therapy with Nuedexta.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NUPLAZID

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Parkinson's disease psychosis: Diagnosis of Parkinson's disease. Patient has at least one of the following: hallucinations or delusions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NURTEC ODT

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acute Treatment of Migraine (initial): Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Patient has fewer than 15 headache days per month. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Medication will not be used in combination with another oral CGRP inhibitor. Preventive Treatment of Episodic Migraine (EM) (initial): Diagnosis of EM. Patient has greater than or equal to 4 or less than 15 migraine headache days per month (prior to initiating a migraine-preventative medication). Trial and failure (after a trial of at least two months), contraindication, or intolerance to two of the following prophylactic therapies: a) Amitriptyline (Elavil), b) One of the following beta-blockers: atenolol, metoprolol, nadolol, propranolol, or timolol, c) Divalproex sodium (Depakote/Depakote ER), d) Topiramate (Topamax), e) Venlafaxine (Effexor), f) Candesartan (Atacand). Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Age Restrictions	
Prescriber Restrictions	Acute Treatment of Migraine (initial): Prescribed by or in consultation with one of the following specialists with expertise in the treatment of migraine: neurologist, pain specialist, headache specialist. Preventive Treatment of EM (initial): Prescribed by or in consultation with one of the following specialists with expertise in the treatment of episodic migraine: neurologist, pain specialist, headache specialist.
Coverage Duration	ALL INDICATIONS: INITIAL: 6 MONTHS, REAUTH: 12 MONTHS.
Other Criteria	Reauth: Acute Treatment of Migraine (reauth): Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea). Medication will not be used in combination with another oral CGRP inhibitor. Preventive Treatment of EM (reauth): Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity. Medication will not be

PA Criteria	Criteria Details
	used in combination with another CGRP inhibitor for the preventive treatment of migraines.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NUVIGIL

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Obstructive sleep apnea/hypopnea syndrome (OSAHS) (Initial): Diagnosis (dx) of OSAHS defined by one of the following: a) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or b) both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), AND 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work sleep disorder (SWSD) (Initial):Dx of SWSD confirmed by symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, or sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). No other medical condition or medication accounts for the symptoms. Narcolepsy (initial): Dx of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming that a sleep study is not feasible).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OSAHS (Initial): 3 months (Reauth): 12 months. SWSD (Initial, Reauth): 3 months. Other:12 months
Other Criteria	OSAHS (Reauth): Documentation of positive clinical response to prior therapy. SWSD (Reauth): Documentation of positive clinical response to prior therapy. Patient still requires treatment for SWSD. Narcolepsy (reauth): Documentation of positive clinical response to prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

NUZYRA

Products Affected

- NUZYRA INTRAVENOUS
- NUZYRA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Nuzyra tablets: Community-Acquired Bacterial Pneumonia (CABP) Diagnosis: CABP caused by designated susceptible microorganisms, AND patient has had T/F or CI or is not a good candidate for at least two of the following available treatment options 1. appropriate beta-lactam (i.e. ceftriaxone, cefotaxime, ertapenem, ampicillin/sulbactam) in combination with a macrolide (i.e. azithromycin, clarithromycin) or doxycycline, or 2. monotherapy with a respiratory fluoroquinolone (i.e. levofloxacin). Acute Bacterial Skin and Skin Structure Infections (ABSSSI) Diagnosis: ABSSSI caused by designated susceptible microorganisms, AND patient has had T/F or CI or is not a good candidate for at least two of the following treatment options: vancomycin, linezolid, doxycycline, trimethoprim/sulfamethoxazole. Nuzyra vials: Patient-specific, clinically significant reason why the member cannot use the oral tablet formulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OCALIVA

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual has a diagnosis of primary biliary cholangitis (PBC) as confirmed by TWO of the following (Lindor, 2009): a) Elevated alkaline phosphatase. b) Positive antimitochondrial antibodies (AMA) titer. C) Liver biopsy with findings consistent with PBC.
Age Restrictions	
Prescriber Restrictions	PBC (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist.
Coverage Duration	PBC (initial): 6 months, (reauth): 12 months
Other Criteria	PBC (reauthorization): Submission of medical records (eg, laboratory values) documenting a reduction in ALP level from pre-treatment baseline (ie, prior Ocaliva therapy) while on Ocaliva therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Basal cell carcinoma: Diagnosis of locally advanced basal cell carcinoma AND One of the following: 1) Cancer has recurred following surgery or radiation therapy or 2) Patient is not a candidate for surgery or radiation therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Idiopathic pulmonary fibrosis (IPF): diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity) AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF. Chronic fibrosing interstitial lung diseases with a progressive phenotype: Diagnosis of chronic fibrosing interstitial lung diseases (ILD) with a progressive phenotype. Systemic sclerosis-associated interstitial lung disease: Diagnosis of systemic sclerosis-associated ILD to slow the rate of decline in pulmonary function.
Age Restrictions	
Prescriber Restrictions	IPF (initial): Prescribed by a pulmonologist
Coverage Duration	Initial, reauth: 12 months
Other Criteria	IPF (reauth): Documentation of positive clinical response to Ofev therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OGSIVEO

Products Affected

- OGSIVEO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Desmoid tumor: Diagnosis of progressing desmoid tumors in adult patients who require systemic treatment.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist
Coverage Duration	Initial/Reauth: 6 months
Other Criteria	Reauth: Prescriber provides notes documenting that patient is benefitting from treatment
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OJJAARA

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of MF with anemia: Treatment of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF [postpolycythemia vera (PV) and post-essential thrombocythemia (ET)], in adults with anemia. Documentation of diagnosis is required. The patient meets the following criteria: anemia associated with disease is symptomatic (as defined as hemoglobin level less than 10 g/dL or symptomatic splenomegaly) AND the patient has previously received treatment with a JAK inhibitor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Must be prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	INITIAL/REAUTH: 6 months
Other Criteria	REAUTH: The patient meets initial criteria and continues to benefit from treatment per provider. Clinical chart notes are provided.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OLUMIANT

Products Affected

- OLUMIANT

PA Criteria	Criteria Details
Exclusion Criteria	CORONAVIRUS DISEASE 2019 (COVID-19) IN HOSPITALIZED ADULTS
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	RA: INITIAL: 6 MONTHS, REAUTH: 12 MONTHS. AA: INITIAL and REAUTH: 3 MONTHS.
Other Criteria	RA: INITIAL: TRIAL OF OR CONTRAINDICATION TO ANY TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ. REAUTH: CONTINUES TO BENEFIT FROM THE MEDICATION. AA: INITIAL: TREATMENT OF ADULT PATIENTS WITH SEVERE ALOPECIA AREATA AS CONFIRMED BY PRESCRIBER CHART NOTES. APPROVAL OF THE 4 MG TABLET ONCE DAILY REQUIRES DOCUMENTATION OF NEARLY COMPLETE OR COMPLETE SCALP HAIR LOSS, WITH OR WITHOUT SUBSTANTIAL EYELASH OR EYEBROW HAIR LOSS. REAUTH: CONTINUES TO BENEFIT FROM MEDICATION PER PROVIDER CHART NOTES AND FOR PATIENTS ON THE 4 MG TABLETS ONCE DAILY WHERE AN ADEQUATE RESPONSE HAS BEEN ACHIEVED, THE DOSE WILL BE REDUCED TO 2 MG ONCE DAILY.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ONGENTYS

Products Affected

- ONGENTYS ORAL CAPSULE 25 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis is Parkinsons disease. Patient is experiencing off episodes. Drug will be given as adjunctive treatment to levodopa/carbidopa. Patient has tried and failed entacapone tablet.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	Initial and Reauth: 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ONUREG

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the continued treatment of adult patients with acute myeloid leukemia (AML) who achieved first complete remission (CR) or CR with incomplete blood count recovery (CRi) following intensive induction chemotherapy and who are not able to complete intensive curative therapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by an oncologist.
Coverage Duration	Initial: 6mths. Reauth: 6 months
Other Criteria	For Reauth: Patient demonstrates disease response with treatment as defined by stabilization of disease or improvement as evidenced by a complete response (CR) (e.g. morphologic, cytogenic, or molecular CR), complete hematologic response or a partial response by CBC, bone marrow cytogenic analysis, quantitative polymerase chain reaction (QPCR), or fluorescence in situ hybridization (FISH).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
Age Restrictions	
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ORENCIA IV

Products Affected

- ORENCIA (WITH MALTOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	RA: 18 years of age or older. PJIA, PsA, aGVHD: 2 years of age or older
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	RA, PJIA, PSA: INITIAL: 6 MONTHS, REAUTH: 12 MONTHS. AGVHD: 12 MONTHS.
Other Criteria	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ, SKYRIZI. AGVHD: ORENCIA WILL BE USED IN COMBINATION WITH A CALCINEURIN INHIBITOR AND METHOTREXATE AND THE PATIENT IS UNDERGOING HEMATOPOIETIC STEM CELL TRANSPLANTATION (HSCT) FROM A MATCHED OR 1 ALLELE-MISMATCHED UNRELATED DONOR. REAUTH: RA, PJIA, PSA, AGVHD: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

ORENCIA SC

Products Affected

- ORENCIA
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	RA: 18 years of age or older. PJIA, PsA, aGVHD: 2 years of age or older
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	RA, PJIA, PSA: INITIAL: 6 MONTHS, REAUTH: 12 MONTHS. AGVHD: 12 MONTHS.
Other Criteria	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ IR. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ, SKYRIZI. AGVHD: ORENCIA WILL BE USED IN COMBINATION WITH A CALCINEURIN INHIBITOR AND METHOTREXATE AND THE PATIENT IS UNDERGOING HEMATOPOIETIC STEM CELL TRANSPLANTATION (HSCT) FROM A MATCHED OR 1 ALLELE-MISMATCHED UNRELATED DONOR. REAUTH: RA, PJIA, PSA, AGVHD: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

ORGOVYX

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has androgen-sensitive advanced prostate cancer AND patient must have T/F and or have a CI to one GnRH antagonist (degarelix, Firmagon) or one GnRH agonist (leuprolide, Lupron, Eligard, triptorelin, Trelstar).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an urologist or an oncologist.
Coverage Duration	Initial and Reauth: 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ORKAMBI

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene. The presence of the mutation was documented by an FDA-cleared cystic fibrosis mutation test or Clinical Laboratory Improvement Amendments-approved facility.
Age Restrictions	
Prescriber Restrictions	CF (Initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or a pulmonologist.
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ORSERDU

Products Affected

- ORSERDU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Breast cancer, advanced or metastatic, ER-positive, HER2-negative, ESR1-mutated: Treatment of estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative, ESR1-mutated advanced or metastatic breast cancer in postmenopausal patients or adult males with disease progression following at least 1 line of endocrine therapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial/Reauth: 6 months
Other Criteria	Reauth: Patient has benefitted from treatment per the provider.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OSMOLEX ER

Products Affected

- OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG, 193 MG, 258 MG, 322 MG/DAY(129 MG X1-193MG X1)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Drug-Induced Parkinsonism and patient has tried and failed at least ONE generically available immediate-release formulations of amantadine (e..g. AMANTADINE 100 MG CAPSULE, AMANTADINE 100 MG TABLET, AMANTADINE 50 MG/5 ML SOLUTION, AMANTADINE 100 MG/10 ML SOLN). 2. Diagnosis of Parkinson Disease and patient must have trial and failure of use of at least ONE generically available immediate-release formulations of amantadine (e..g. AMANTADINE 100 MG CAPSULE, AMANTADINE 100 MG TABLET, AMANTADINE 50 MG/5 ML SOLUTION, AMANTADINE 100 MG/10 ML SOLN).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OTEZLA

Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MILD PLAQUE PSORIASIS (PSO): ONE OF THE FOLLOWING: 1) PSORIASIS COVERING 2 PERCENT OF BODY SURFACE AREA (BSA), 2) STATIC PHYSICIAN GLOBAL ASSESSMENT (SPGA) SCORE OF 2, OR 3) PSORIASIS AREA AND SEVERITY INDEX (PASI) SCORE OF 2 TO 9. MODERATE TO SEVERE PSO: 1) PSORIASIS COVERING 3 PERCENT OR MORE OF BSA, OR 2) PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. BEHCETS DISEASE: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. REAUTH: 12 MONTHS.
Other Criteria	INITIAL: PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ, SKYRIZI. MILD PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL SYSTEMIC AGENT (E.G., METHOTREXATE, ACITRETIN, CYCLOSPORINE) AND ONE CONVENTIONAL TOPICAL AGENT (E.G., PUVA, UVB, TOPICAL CORTICOSTEROIDS). MODERATE TO SEVERE PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, SKYRIZI. BEHCETS DISEASE: 1) PATIENT HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OR MORE CONSERVATIVE TREATMENTS (E.G., COLCHICINE, TOPICAL CORTICOSTEROID,

PA Criteria	Criteria Details
	ORAL CORTICOSTEROID). REAUTH: PSA, PSO, BEHCETS DISEASE: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OXANDRIN

Products Affected

- *oxandrolone oral tablet 10 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Promote weight gain (initial): Medication will be used as an adjunct therapy to promote weight gain AND One of the following: Extensive surgery, Chronic infections, Severe trauma, Failure to gain or maintain at least 90% of ideal body weight without definite pathophysiologic reasons. Counterbalance protein catabolism (initial): oxandrolone will be used to counterbalance protein catabolism associated with chronic corticosteroid administration. Bone pain (initial): Diagnosis of bone pain associated with osteoporosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	bone pain (initial, reauth): 1 month. Others (initial, reauth): 3 months
Other Criteria	All diagnoses (reauth): patient has experienced an objective improvement (i.e. weight gain, increase in lead body mass, or reduction in muscle pain/weakness)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PALYNZIK

Products Affected

- PALYNZIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Labs showing uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on existing management
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 YEAR
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PEGASYS

Products Affected

- PEGASYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic hepatitis B: Diagnosis of chronic hepatitis B infection, and patient is without decompensated liver disease. Chronic Hepatitis C: Criteria will be applied consistent with current AASLD-IDSA guidance
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HepB: 48 wks. HepC: Initial: 28 wks. Reauth: 20 wks.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PEGFILGRASTIM

Products Affected

- FULPHILA
- FYLNETRA
- NEULASTA
- NYVEPRIA
- UDENYCA
- UDENYCA AUTOINJECTOR
- ZIEXTENZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Neulasta (pegfilgrastim): ONE of the following: 1. To increase survival in patients acutely exposed to myelosuppressive doses of radiation (e.g. Hematopoietic Syndrome of Acute Radiation Syndrome) or 2. Patient has Non-Myeloid Malignancy and is receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of neutropenia with fever AND patient has had T/F or CI to Nyvepria (pegfilgrastim-apgf). For Formulary Neulasta biosimilars except Nyvepria (e.g. Fulphila (pegfilgrastim-jmdb), Udenyca (pegfilgrastim-cbqv), Ziextenzo (pegfilgrastim-bmez)): Patient has Non-Myeloid Malignancy and is receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of neutropenia with fever AND patient has had T/F or CI to Nyvepria (pegfilgrastim-apgf). For Nyvepria (pegfilgrastim-apgf): Patient has Non-Myeloid Malignancy and is receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of neutropenia with fever.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	6 months
Other Criteria	Initial: Neulasta and Formulary Biosimilars except Nyvepria (e.g. Udenyca, Ziextenzo, Fulphila) will be approved after T/F or CI to biosimilar Nyvepria for aligned indication (Patient has Non-Myeloid Malignancy and is receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of neutropenia with fever).
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

PEMAZYRE

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the treatment of previously treated, unresectable locally advanced or metastatic cholangiocarcinoma in adults with a fibroblast growth factor receptor 2 fusion or other rearrangement. Must provide documentation of detection by an FDA-approved test. For the treatment of relapsed or refractory myeloid/lymphoid neoplasms with FGFR1 rearrangement.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 6 months Reauth: 12 months with positive response.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple Myeloma (MM): Diagnosis of MM. Used in combination with dexamethasone. Patient has received two prior therapies, including Revlimid (lenalidomide) and a proteasome inhibitor [eg, Velcade (bortezomib) or Kyprolis (carfilzomib)] or has a contraindication or intolerance to Revlimid and proteasome inhibitors. Patient has experienced disease progression on or within 60 days of completion of last therapy. Kaposi sarcoma (KS): Diagnosis of KS. Treatment of AIDS-related Kaposi sarcoma in adults after failure of highly active antiretroviral therapy (HAART). Treatment of Kaposi sarcoma in HIV-negative adults.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist/hematologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PRETOMANID

Products Affected

- PRETOMANID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Not indicated for drug-sensitive tuberculosis, latent infection due to Mycobacterium tuberculosis, or multidrug-resistant TB that is not treatment-intolerant or nonresponsive to standard therapy. Must be used in combination with bedaquiline and linezolid.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PREVYMIS

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant administration with pimozide or ergot alkaloids: concomitant administration with pitavastatin and simvastatin when coadministered with cyclosporine.
Required Medical Information	Cytomegalovirus (prophylaxis): Prophylaxis of cytomegalovirus (CMV) infection and disease in adult CMV-seropositive recipients [R+] of an allogeneic hematopoietic stem cell transplant (HSCT). Cytomegalovirus (prophylaxis): Prophylaxis of cytomegalopvirus (CMV) disease in adult kidney transplant recipients at high risk. High Risk is denoted as: donor CMV seropositive/recipient CMV seronegative [D+/R-].
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PROCYSBI

Products Affected

- PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Nephropathic cystinosis: Diagnosis of nephropathic cystinosis, confirmed by elevated leukocyte cystine levels (LCL) or genetic analysis of the CTNS gene AND Trial and failure or intolerance to therapy with Cystagon (immediate-release cysteamine bitartrate).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PROMACTA

Products Affected

- PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic immune (idiopathic) thrombocytopenic purpura (ITP) (initial): Diagnosis of relapsed/refractory chronic ITP for greater than 6 months. Baseline platelet count is less than 50,000/mcL. Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding. One of the following: A) Trial and failure, intolerance, contraindication to corticosteroids or immune globulin OR B) Trial and failure or contraindication to splenectomy. Chronic hepatitis C (initial): Diagnosis of chronic hepatitis C. Patient has thrombocytopenia defined as platelets less than 90,000/mcL for initiation (pre-treatment) of interferon therapy. Diagnosis of Severe aplastic anemia (initial): Patient has a platelet count less than 30,000/mcL. 1. First-line treatment (in combination with standard immunosuppressive therapy) of severe aplastic anemia in patients greater than or equal to 2 years of age, or 2. treatment of severe (refractory) aplastic anemia in patients who have had an insufficient response to immunosuppressive therapy. Trial and failure, intolerance, or contraindication to immunosuppressive therapy with antithymocyte globulin and cyclosporine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ITP (init, reauth): 12mo. HepC: 9wks (init), 24wks (reauth). Aplas anemia (init, reauth): 16wks.
Other Criteria	ITP (reauth): After at least 4 weeks of therapy, patient has experienced improvement. Hepatitis C (reauth): patient has experienced improvement. Aplastic anemia (reauth): patient has experienced improvement.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

PROVIGIL

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Obstructive sleep apnea/hypopnea syndrome (OSAHS) (Initial): Diagnosis (dx) of OSAHS defined by one of the following: 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), and 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work sleep disorder (SWSD) (Initial):Dx of SWSD confirmed by symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, or sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). No other medical condition or medication accounts for the symptoms. Narcolepsy (initial): Dx of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming that a sleep study is not feasible). MS Fatigue (initial): Dx of multiple sclerosis (MS). Patient is experiencing fatigue. Depression (initial): Treatment-resistant depression defined as diagnosis of major depressive disorder (MDD) or bipolar depression, AND trial and failure, contraindication, or intolerance to at least two antidepressants from different classes (eg, SSRIs, SNRIs, bupropion). Used as adjunctive therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OSAHS/MS/dep(init), SWSD (init,reauth): 3 mo.OSAHS/dep(reauth): 12mo. MS (reauth): 6mo. Other: 12mo
Other Criteria	OSAHS (Reauth): Documentation of positive clinical response to prior therapy. SWSD (Reauth): Documentation of positive clinical response to

PA Criteria	Criteria Details
	prior therapy. Patient still requires treatment for SWSD. Narcolepsy (reauth): Documentation of positive clinical response to prior therapy. MS Fatigue (reauth): Patient is experiencing relief of fatigue with modafinil therapy. Depression (reauth): Documentation of positive clinical response to modafinil therapy. Used as adjunctive therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PULMOZYME

Products Affected

- PULMOZYME

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis (CF) (Initial, Reauth): Diagnosis of CF
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	CF (initial, reauth): 12 months
Other Criteria	Part B vs D determination applies. CF (reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PYRUKYND

Products Affected

- PYRUKYND 5 MG TAPER PACK INNER
- PYRUKYND ORAL TABLET 20 MG, 5 MG, 5 MG (4-WEEK PACK), 50 MG
- PYRUKYND ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis is pyruvate kinase deficiency and patient is being treated for hemolytic anemia.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a hematologist, hepatologist or gastroenterologist.
Coverage Duration	Initial: 6 months Reauth: 12 months
Other Criteria	Reauth Criteria: Patient has benefitted from treatment based on Hgb and hemolysis values and transfusion requirements.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

QINLOCK

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Gastrointestinal stromal tumor, advanced. Treatment of advanced GIST in adults who have previously received treatment with 3 or more kinase inhibitors, including imatinib.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	12 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

QUALAQUIN

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Malaria: Diagnosis of uncomplicated malaria. One of the following: 1) Treatment in areas of chloroquine-sensitive malaria, and trial and failure, contraindication, or intolerance to chloroquine or hydroxychloroquine, OR 2) Treatment in areas of chloroquine-resistant malaria. Not used for the treatment or prevention of nocturnal leg cramps.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	7 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RASUVO- METHOTREXATE SC AUTOINJECTOR

Products Affected

- RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Severe, active rheumatoid arthritis (RA) and polyarticular juvenile idiopathic arthritis (pJIA) and have had T/F or CI to methotrexate oral tablets AND intramuscular methotrexate injectable vial. 2. Symptomatic control of severe, recalcitrant, disabling psoriasis in adults who are intolerant of/have a contraindication to or have had T/F or CI to methotrexate oral tablets AND methotrexate injectable prefilled syringe (pf) (REDITREX) OR for continuation of Rasuvo therapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a rheumatologist or dermatologist.
Coverage Duration	Initial and Reauth 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Urea cycle disorders (UCDs) (Initial): Diagnosis of UCDs.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	UCDs (Initial, reauth): 12 months
Other Criteria	UCDs (reauth): Documentation of positive clinical response to Ravicti therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RECORLEV

Products Affected

- RECORLEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the treatment of endogenous hypercortisolemia in adult patient with Cushing's syndrome for whom surgery is not an option or surgery has not been curative. If surgery is not an option and surgery or surgery has not been curative, T/F or CI to Signifor/LAR.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an endocrinologist.
Coverage Duration	Initial: 6 months Reauth: 12 months
Other Criteria	Reauth Criteria: Patient continues to benefit from medication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REDITREX- METHOTREXATE INJ PREFILLED SYR (PF)

Products Affected

- REDITREX (PF) SUBCUTANEOUS SYRINGE 10 MG/0.4 ML, 12.5 MG/0.5 ML, 15 MG/0.6 ML, 17.5 MG/0.7 ML, 20 MG/0.8 ML, 22.5 MG/0.9 ML, 25 MG/ML, 7.5 MG/0.3 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1. Severe, active rheumatoid arthritis (RA) and polyarticular juvenile idiopathic arthritis (pJIA) and have had T/F or CI to methotrexate oral tablets AND intramuscular methotrexate injectable vial. 2. Symptomatic control of severe, recalcitrant, disabling psoriasis in adults who are intolerant of/have a contraindication to or have had T/F or CI to methotrexate oral tablets AND intramuscular methotrexate injectable vial OR for continuation of Reditrex therapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a rheumatologist or dermatologist.
Coverage Duration	Initial and Reauth 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REGRANEX

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diabetic neuropathic ulcers: Patient has a lower extremity diabetic neuropathic ulcer. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	5 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RELISTOR INJ

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Opioid-induced constipation (OIC) (Initial): Diagnosis of OIC. Patient has used opioid medication for a minimum of 4 weeks. Patient is experiencing fewer than 3 bowel movements in a week or no bowel movement for longer than 2 days. One of the following: A) Patient is an adult with a diagnosis of chronic non-cancer pain AND patient had a trial and failure, contraindication, or intolerance to lubiprostone AND Movantik, OR B) Patient is receiving palliative care for an advanced illness.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OIC (initial, reauth): 4 months
Other Criteria	OIC (Reauth): Diagnosis of OIC. One of the following: A) Patient is an adult with a diagnosis of chronic non-cancer pain, OR B) Both of the following: Patient is receiving palliative care for an advanced illness AND Patient has responded to therapy (e.g., increase in bowel movements).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RELISTOR TABLET

Products Affected

- RELISTOR ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Opioid-induced constipation (OIC) (Initial): Diagnosis of OIC. Patient has used opioid medication for a minimum of 4 weeks. Patient is experiencing fewer than 3 bowel movements in a week or no bowel movement for longer than 2 days AND Patient is an adult with a diagnosis of chronic non-cancer pain AND patient had a trial and failure, contraindication, or intolerance to lubiprostone AND Movantik.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	OIC (initial, reauth): 4 months
Other Criteria	OIC (Reauth): Patient has responded to therapy (e.g., increase in bowel movements).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RETEVMO

Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following Diagnoses:1) Non-small cell lung cancer (NSCLC), metastatic, advanced or metastatic RET fusion-positive, 2) advanced or metastatic RET-mutant medullary thyroid cancer (MTC) in patients who require systemic therapy, 3) advanced or metastatic RET fusion-positive thyroid cancer in patients who require systemic therapy and who are refractory to radioactive iodine (if radioactive iodine is appropriate). 3) treatment of adult patients with locally advanced or metastatic solid tumors with a RET gene fusion that have progressed on or following prior systemic treatment or who have no satisfactory alternative treatment options.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	12 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REVATIO

Products Affected

- *sildenafil (pulm.hypertension) oral suspension for reconstitution*
- *sildenafil (pulm.hypertension) oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. For sildenafil oral suspension only (initial, reauth): One of the following: A) Intolerance to sildenafil tablets, OR B) 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, or dysphagia.
Age Restrictions	
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth: 12 months.
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REVLIMID

Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Either used as 1) combination therapy with dexamethasone, or 2) maintenance therapy following autologous hematopoietic stem cell transplantation (auto-HSCT). Myelodysplastic syndromes (MDS): Patient has transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with a deletion 5q (del 5q) cytogenetic abnormality with or without additional cytogenetic abnormalities. Mantle cell lymphoma (MCL): Diagnosis of MCL. Disease has relapsed, refractory, or progressed after at least one prior therapy (eg, bortezomib, bendamustine, cladribine, rituximab). Follicular lymphoma (previously treated): Treatment of previously treated follicular lymphoma (in combination with a rituximab product) in adults. Marginal zone lymphoma (previously treated): Treatment of previously treated marginal zone lymphoma (in combination with a rituximab product).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist/hematologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REZLIDHIA

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acute myeloid leukemia, relapsed or refractory: Treatment of relapsed or refractory acute myeloid leukemia in adults with a susceptible isocitrate dehydrogenase-1 mutation as detected by an FDA-approved test.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 6 months. Reauth: 6 months.
Other Criteria	Reauth: Patient is responding well to treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REZUROCK

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has diagnosis of chronic graft-versus-host disease (cGVHD) AND Patient has failed at least 2 previous lines of systemic therapy for the treatment of cGVHD (e.g., corticosteroids and immunosuppressants such as prednisone, cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months Reauth: 6 months
Other Criteria	Reauth: Patient continues to meet the initial criteria AND Patient has a response to therapy with an improvement in one or more of the following: Clinician assessments (e.g., NIH Skin Score, Upper GI Response Score, NIH Lung Symptom Score) AND/OR Patient-reported symptoms (e.g., Lee Symptom Scale).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RILUTEK

Products Affected

- *riluzole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Amyotrophic lateral sclerosis (ALS): Diagnosis of amyotrophic lateral sclerosis (ALS)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ALS: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RINVOQ

Products Affected

- RINVOQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: RA, AS, NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. AD: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST. UC, CD: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. REAUTH: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. The patient had an inadequate response or intolerance to one or more tumor necrosis factor (TNF) blockers (e.g., Humira [adalimumab]). PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. The patient had an inadequate response or intolerance to one or more tumor necrosis factor (TNF) blockers (e.g., Humira [adalimumab]). ATOPIC DERMATITIS: 1) ATOPIC DERMATITIS COVERING AT LEAST 10 PERCENT OF BODY SURFACE AREA OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS, 2) INTRACTABLE PRURITUS OR CRACKING/OOZING/BLEEDING OF AFFECTED SKIN, 3) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING: TOPICAL CORTICOSTEROID, TOPICAL CALCINEURIN INHIBITOR, TOPICAL PDE4 INHIBITOR,

PA Criteria	Criteria Details
	OR TOPICAL JAK INHIBITOR, AND 4) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR THE TREATMENT OF ATOPIC DERMATITIS. CD, UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. The patient had an inadequate response or intolerance to one or more tumor necrosis factor (TNF) blockers (e.g., Humira [adalimumab]). NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). The patient had an inadequate response or intolerance to one or more tumor necrosis factor (TNF) blockers (e.g., Humira [adalimumab]). REAUTH: RA, PSA, AS, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION. ATOPIC DERMATITIS: 1) IMPROVEMENT WHILE ON THERAPY, AND 2) NO CONCURRENT USE WITH OTHER SYSTEMIC BIOLOGIC/JAK INHIBITOR FOR THE TREATMENT OF ATOPIC DERMATITIS.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ROZLYTREK

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are ROS1 positive. Adult and pediatric patients 1 month of age and older with solid tumors that: have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, and have either progressed following treatment or have no satisfactory alternative therapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ROZLYTREK PELLETS

Products Affected

- ROZLYTREK ORAL PELLETS IN PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are ROS1 positive. Adult and pediatric patients 1 month of age and older with solid tumors that: have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity, and have either progressed following treatment or have no satisfactory alternative therapy. Chart notes documenting that the patient is not a candidate for capsule formulation due to age or inability to swallow due to documented diagnosis of dysphagia.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	Chart notes documenting that the patient is not a candidate for capsule formulation due to age or inability to swallow due to documented diagnosis of dysphagia.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Ovarian, Fallopian Tube, or Primary Peritoneal Cancer: for the maintenance treatment of adult patients with a deleterious BRCA mutation (germline and/or somatic)-associated recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. Prostate cancer, metastatic, castration-resistant (BRCA-mutated): Treatment of deleterious BRCA mutation (germline and/or somatic)-associated metastatic castration-resistant prostate cancer in adults who have been treated with androgen receptor-directed therapy and a taxane-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RUCONEST

Products Affected

- RUCONEST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Treatment of hereditary angioedema (HAE) attacks: Diagnosis of HAE. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks (eg, Berinert, Firazyr, or Kalbitor).
Age Restrictions	
Prescriber Restrictions	HAE: Prescribed by an immunologist, allergist, or rheumatologist
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acute Myeloid Leukemia (AML): Newly diagnosed acute myeloid leukemia (AML), FMS-like tyrosine kinase 3 (FLT3) mutation-positive as detected by a U.S. Food and Drug Administration (FDA)-approved test, used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. Aggressive Systemic Mastocytosis (ASM), Systemic Mastocytosis with Associated Hematological Neoplasm (SM-AHN), Mast Cell Leukemia (MCL): Diagnosis of one of the following: aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).
Age Restrictions	
Prescriber Restrictions	All indications: Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SABRIL

Products Affected

- *vigabatrin*
- *vigadrone oral powder in packet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Complex Partial Seizures (CPS): For use as adjunctive therapy. Failure, contraindication, or intolerance to two formulary anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)]. Infantile Spasms (IS): Diagnosis of infantile spasms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SANDOSTATIN

Products Affected

- *octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml, 500 mcg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly AND One of the following: A) History of failure to surgical resection and/or pituitary irradiation OR B) patient is not a candidate for surgical resection or pituitary irradiation AND Trial and failure or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses. Carcinoid tumor (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea and flushing episodes. Vasoactive intestinal peptide tumor (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	All Uses (Initial and reauth): 12 months
Other Criteria	Acromegaly (reauth): Patient has had a clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size). Carcinoid tumor (reauth): patient has improvement in number of diarrhea and flushing episodes. Vasoactive intestinal peptide tumor (reauth): patient has improvement in number of diarrhea episodes.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SCEMBLIX

Products Affected

- SCEMBLIX ORAL TABLET 20 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis is one of the following: Chronic myeloid leukemia, Philadelphia chromosome-positive (Ph+), chronic phase, previously treated with greater than or equal to 2 tyrosine kinase inhibitors or Chronic myeloid leukemia, Ph+, chronic phase, with T315I mutation.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Reauth Criteria: Patient has experienced clinical improvement (no treatment failure or unacceptable toxicity).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cushing's disease (initial): Diagnosis of Cushings disease AND failure to or patient is not a candidate for pituitary surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months. Reauth: 12 months.
Other Criteria	Cushing's disease (reauth): a clinically meaningful reduction in 24-hour urinary free cortisol levels or improvement in signs or symptoms of the disease
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SILIQ

Products Affected

- SILIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): INITIAL: PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	PSO: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, REAUTH: 12 MONTHS.
Other Criteria	PSO: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, SKYRIZI, AND 2) HAS BEEN COUNSELED ON AND EXPRESSES UNDERSTANDING OF THE RISK OF SUICIDAL IDEATION AND BEHAVIOR. REAUTH: 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) HAS NOT DEVELOPED OR REPORTED WORSENING DEPRESSIVE SYMPTOMS OR SUICIDAL IDEATION AND BEHAVIORS WHILE ON TREATMENT WITH SILIQ.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SIMPONI (SC)

Products Affected

- SIMPONI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. REAUTH: 12 MONTHS.
Other Criteria	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ, SKYRIZI. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ. UC: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, XELJANZ, RINVOQ. REAUTH: RA, PSA, AS: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

SIMPONI ARIA (IV)

Products Affected

- SIMPONI ARIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. REAUTH: 12 MONTHS.
Other Criteria	INITIAL: RA: ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, ENBREL, XELJANZ, RINVOQ, OR 2) TRIAL OF A TNF INHIBITOR AND PHYSICIAN HAS INDICATED THE PATIENT CANNOT USE A JAK INHIBITOR DUE TO THE BLACK BOX WARNING FOR INCREASED RISK OF MORTALITY, MALIGNANCIES, AND SERIOUS CARDIOVASCULAR EVENTS. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ, SKYRIZI. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ. PJIA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, XELJANZ IR. REAUTH: RA, PSA, AS, PJIA: CONTINUES TO BENEFIT FROM THE MEDICATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SKYRIZI

Products Affected

- SKYRIZI INTRAVENOUS
- SKYRIZI SUBCUTANEOUS PEN INJECTOR
- SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.83 ML
- SKYRIZI SUBCUTANEOUS SYRINGE KIT
- SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PLAQUE PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. CROHNS DISEASE (CD): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. REAUTH: 12 MONTHS.
Other Criteria	INITIAL: PSO: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). CD: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. REAUTH: PSO, PSA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

SODIUM OXYBATE

Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (e.g. polysomnography, multiple sleep latency test) , AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy according to ICSD-3 or DSM-5 criteria and as confirmed by sleep study (e.g. polysomnography, multiple sleep latency test), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND trial and failure, contraindication, or intolerance to at least one CNS stimulant (e.g. methylphenidate, amphetamine salt combination immediate release, or dextroamphetamine) AND modafinil or armodafinil.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a sleep specialist.
Coverage Duration	All uses initial: 3 months, reauth: 6 months
Other Criteria	Narcolepsy Type 1 (reauth): Documentation demonstrating a reduction in the frequency of cataplexy attacks associated with sodium oxybate (Xyrem) therapy, OR documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with sodium oxybate (Xyrem) therapy. Narcolepsy Type 2 (reauth): Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with sodium oxybate (Xyrem) therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SOMATROPIN - GROWTH HORMONE

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE
- OMNITROPE
- SAIZEN
- ZOMACTON

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.
Required Medical Information	PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), SHOX DEFICIENCY: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS AND REAUTH: 12 MONTHS.
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. PEDIATRIC GHD, ISS, SGA, TS, SHOX DEFICIENCY: OPEN EPIPHYSES. ADULT GHD, PEDIATRIC GHD, ISS, SGA, TS, PWS: TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT: NORDITROPIN. REAUTH: PEDIATRIC GHD, ISS, SGA, TS, SHOX DEFICIENCY: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES. PWS: IMPROVEMENT IN BODY COMPOSITION.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

SOMATROPIN - NORDITROPIN

Products Affected

- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.
Required Medical Information	PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS AND REAUTH: 12 MONTHS.
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: OPEN EPIPHYSES. REAUTH: PEDIATRIC GHD, ISS, SGA, TS, NOONAN SYNDROME: 1) IMPROVEMENT WHILE ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES. PWS: IMPROVEMENT IN BODY COMPOSITION. HEIGHT OR INCREASED GROWTH VELOCITY). PWS: IMPROVEMENT IN BODY COMPOSITION.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SOMATROPIN - NUTROPIN AQ

Products Affected

- NUTROPIN AQ NUSPIN

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE DUE TO CKD: PATIENT HAD A RENAL TRANSPLANT.
Required Medical Information	PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), TURNER SYNDROME (TS): HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. CKD: HEIGHT OR GROWTH VELOCITY AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER.
Age Restrictions	
Prescriber Restrictions	PEDIATRIC GHD, ISS, TS, ADULT GHD: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST. GROWTH HORMONE FAILURE DUE TO CKD: PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS AND REAUTH: 12 MONTHS.
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. PEDIATRIC GHD, ISS, TS: OPEN EPIPHYSES. ADULT GHD, PEDIATRIC GHD, ISS, TS: TRIAL OF OR CONTRAINDICATION TO the PREFERRED AGENT: NORDITROPIN. REAUTH: PEDIATRIC GHD, ISS, TS: 1) IMPROVEMENT while on therapy (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY), AND 2) OPEN EPIPHYSES. CKD: IMPROVEMENT while on therapy (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY).
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

SOMATROPIN - SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	HIV/WASTING: MEETS ONE OF THE FOLLOWING CRITERIA FOR WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5% OVER 6 MONTHS, OR 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 18.5 KG PER METER SQUARED.
Age Restrictions	
Prescriber Restrictions	HIV/WASTING: PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	INITIAL AND REAUTH: 3 MONTHS.
Other Criteria	HIV/WASTING: INITIAL: INADEQUATE RESPONSE TO ONE PREVIOUS THERAPY (E.G., MEGACE, APPETITE STIMULANTS, ANABOLIC STEROIDS), REAUTH: CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT. INITIAL AND REAUTH: CURRENTLY ON HIV ANTIRETROVIRAL THERAPY.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acromegaly (initial): Diagnosis of acromegaly AND Failure to surgery and/or radiation therapy and/or other medical therapies (such as dopamine agonists [e.g., bromocriptine, cabergoline]) unless patient is not a candidate for these treatment options AND trial and failure or intolerance to generic octreotide (a somatostatin analogue)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial and reauth: 12 months
Other Criteria	Acromegaly (reauth): Patient has experienced an objective response to therapy (biochemical control, decrease or normalization of IGF-1 levels).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SOVALDI

Products Affected

- SOVALDI ORAL PELLETS IN PACKET 150 MG, 200 MG
- SOVALDI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT WITH END STAGE RENAL DISEASE OR REQUIRES DIALYSIS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist.
Coverage Duration	12 to 48 wks. Criteria will be applied consistent with current AASLD/IDSA guideline
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SPORANOX

Products Affected

- *itraconazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following: 1) patient has a systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis), OR 2) patient is resistant to topical antifungal treatment and has one of the following diagnoses: a) tinea corporis (ringworm), OR b) tinea cruris (jock itch), OR c) tinea pedis (athletes foot), OR d) tinea capitis (scalp ringworm), OR e) pityriasis versicolor, OR 3) all of the following: a) patient has a diagnosis of onychomycosis confirmed by one of the following (CAPSULE ONLY): i) positive potassium hydroxide (KOH) preparation, OR ii) culture, OR iii) histology, AND b) patient has had a trial and inadequate response, intolerance or hypersensitivity to oral terbinafine, OR 4) patient has a diagnosis of candidiasis (esophageal or oropharyngeal) that is refractory to treatment with fluconazole (ORAL SOLUTION ONLY).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Systemic fungal fxn:6mo, candidiasis:1 mo., fingernail onycho: 5 weeks, toenail onycho, other:3mo.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SPRYCEL

Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Philadelphia chromosome positive (Ph+) chronic myelogenous leukemia (CML): Diagnosis of Ph+ CML. Ph+ acute lymphoblastic leukemia (ALL): Diagnosis of Ph+ ALL.
Age Restrictions	
Prescriber Restrictions	All Uses: Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	All Uses: 12 months
Other Criteria	All Uses: Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

STELARA

Products Affected

- STELARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): (Initial - 45mg/0.5mL): Dx of moderate to severe plaque psoriasis. (PSO): (Initial - 90mg/1mL): Dx of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). PSO (Initial regardless of dose): One of the following: at least 3% body surface area involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Minimum duration of a 4-week T/F, CI to ONE of the following conventional therapy such as topical corticosteroids, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), tazarotene, vitamin d analogs (eg, calcitriol, calcipotriene), acitretin, methotrexate, cyclosporine. T/F, CI to TWO of the following: Humira, Enbrel, Cosentyx, Skyrizi. PSORIATIC ARTHRITIS (PsA) (Initial - 45mg/0.5mL): Dx of active PsA. PsA (Initial - 90mg/1mL): Dx of active PsA. Patient's weight is greater than 100 kg (220 lbs). Dx of co-existent moderate to severe psoriasis. PsA (Initial regardless of dose): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. T/F, CI to TWO of the following: Humira, Enbrel, Cosentyx, Skyrizi, Rinvoq, Xeljanz IR. CROHN'S DISEASE (CD) (initial): Dx of moderately to severely active Crohn's disease. SC will be used as a maintenance dose following the intravenous induction dose. T/F, CI to one conventional therapy such as a corticosteroid (e.g., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine. T/F, CI to two of the following: Humira, Rinvoq, Skyrizi. ULCERATIVE COLITIS (UC) (initial): Dx of moderately to severely active UC. SC will be used as a maintenance dose following the intravenous induction dose. T/F, CI to one conventional therapy such as a corticosteroid (e.g., budesonide, methylprednisolone), azathioprine, mercaptopurine, methotrexate, or mesalamine. T/F, CI to TWO of the following: Humira, Xeljanz IR/XR, Rinvoq.
Age Restrictions	
Prescriber Restrictions	INITIAL: PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSO: PRESCRIBED BY OR IN

PA Criteria	Criteria Details
	CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. REAUTH: 12 MONTHS.
Other Criteria	PSO (reauth): Documentation of positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline. PsA (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. CD (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (reauth): Documentation of positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Colorectal cancer, metastatic- Treatment of metastatic colorectal cancer in patients previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, antivascular endothelial growth factor (VEGF) therapy (e.g. Avastin [bevacizumab]) and antiepidermal growth factor receptor (EGFR) therapy [e.g. Vectibix (panitumumab), Erbitux (cetuximab)] (if RAS gene [HRAS, KRAS, NRAS] wild type) Gastrointestinal stromal tumors- Treatment of locally advanced, unresectable or metastatic gastrointestinal stromal tumors (GIST) in patients previously treated with imatinib and sunitinib. Liver Carcinoma- Treatment of Hepatocellular carcinoma in patients previously treated with sorafenib.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SUTENT

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Renal cell carcinoma: Adjuvant treatment of adults at high risk of recurrent renal cell carcinoma (RCC) following nephrectomy or treatment of advanced RCC. Gastrointestinal stromal tumor (GIST): Diagnosis of GIST after disease progression on or intolerance to imatinib. Pancreatic neuroendocrine tumors: Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumor that is unresectable locally advanced or metastatic disease.
Age Restrictions	
Prescriber Restrictions	All Indications: Prescribed by or in consultation with an oncologist
Coverage Duration	All Indications: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SYMLIN

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Exclusion Criteria	Gastroparesis.
Required Medical Information	One of the following diagnoses: A) Type 1 diabetes OR B) Type 2 diabetes.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SYNRIBO

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic myelogenous leukemia (CML): Diagnosis of CML in the chronic or accelerated phase AND Patient has tried and has had resistance, relapse, inadequate response, intolerance or is contraindicated to TWO tyrosine kinase inhibitors (i.e., Gleevec [imatinib], Sprycel, Tasigna, and Bosulif, Iclusig)
Age Restrictions	
Prescriber Restrictions	CML: Prescribed by or in consultation with a hematologist/oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TABRECTA

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dx: Non-small cell lung cancer, metastatic (with documented mesenchymal-epithelial transition [MET] exon 14 skipping mutation) and is being used as monotherapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	12 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TACROLIMUS OINTMENT

Products Affected

- *tacrolimus topical*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis is Atopic dermatitis (moderate to severe). If the patient is 2 to 15 years of age, only the 0.03% ointment will be used. Patient is no immunocompromised.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patient had a trial of and inadequate response or intolerance to one topical prescription strength corticosteroid.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TADALAFIL 5 MG FOR BPH

Products Affected

- *tadalafil oral tablet 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of Benign Prostatic Hypertrophy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAFINLAR

Products Affected

- TAFINLAR ORAL CAPSULE
- TAFINLAR ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following: 1. Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT) as detected by an FDA-approved test (THxID-BRAF Kit) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). 2. Treatment of adult and pediatric patients 1 year of age and older with unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options and will be used in combination with Mekinist (trametinib) oral tablets. 3. Melanoma: Adjuvant treatment of melanoma (in combination with trametinib) and cancer is positive for BRAF V600E or V600K mutations and lymph node involvement and patient has had a complete resection. 4. Thyroid cancer, anaplastic, locally advanced or metastatic: Treatment of locally advanced or metastatic anaplastic thyroid cancer (ATC) (in combination with trametinib) and cancer is positive for BRAF V600E mutation and there are no satisfactory locoregional treatment options. 5. BRAF V600E Mutation-Positive Metastatic NSCLC: in combination with trametinib, for the treatment of patients with metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation as detected by an FDA-approved test 6. BRAF V600E or V600K Mutation-Positive Unresectable or Metastatic Melanoma:in combination with trametinib, for the treatment of patients with unresectable or metastatic melanoma with BRAF V600E or V600K mutations, as detected by an FDA-approved test. 7. Glioma, low-grade, with BRAF V600E mutation: Treatment of low-grade glioma with a BRAF V600E mutation (in combination with trametinib) in pediatric patients 1 year of age or greater who require systemic therapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	12 months

PA Criteria	Criteria Details
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1)Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Tumors are positive for epidermal growth factor receptor (EGFR) T790M mutation. The patient has experienced disease progression on or after one of the following EGFR Tyrosine Kinase Inhibitors (TKIs): Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib). 2)First-line treatment of patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations 3) Non-small cell lung cancer, adjuvant treatment: Adjuvant therapy following tumor resection for non-small cell lung cancer (NSCLC) in adults whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected in tumor specimen by an approved test.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TALTZ

Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS (PSO): PSORIASIS COVERING 3 PERCENT OR MORE OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): 1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR 2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
Age Restrictions	
Prescriber Restrictions	INITIAL: PSO: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS), NR-AXSPA: PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. REAUTH: 12 MONTHS.
Other Criteria	INITIAL: PSO: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS, WHERE AGES ALIGN: HUMIRA, COSENTYX, ENBREL, SKYRIZI. PSA: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: HUMIRA, COSENTYX, ENBREL, XELJANZ, RINVOQ, SKYRIZI. AS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING PREFERRED AGENTS: ENBREL, HUMIRA, COSENTYX, XELJANZ, RINVOQ. NR-AXSPA: TRIAL OF OR CONTRAINDICATION TO: COSENTYX AND RINVOQ. REAUTH: PSO, PSA, AS, NR-AXSPA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

TALZENNA

Products Affected

- TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CRITERIA: 1. Breast cancer, locally advanced or metastatic (BRCA-mutated, HER2-negative) Treatment of deleterious or suspected deleterious germline BRCA-mutated, HER2-negative locally advanced or metastatic breast cancer in adults (as detected by an approved test) 2. in combination with enzalutamide for the treatment of adult patients with HRR gene-mutated metastatic castration resistant prostate cancer
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Reauth Criteria: Patient is responding well to the medication.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TARCEVA

Products Affected

- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Non-small cell lung cancer (NSCLC): Diagnosis of locally advanced or metastatic (Stage III or IV) NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. 2) Pancreatic Cancer: Diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer AND erlotinib will be used in combination with gemcitabine.
Age Restrictions	
Prescriber Restrictions	All Indications: Prescribed by or in consultation with an oncologist
Coverage Duration	All Indications: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TARGRETIN

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cutaneous T-Cell Lymphoma (CTCL): Diagnosis of stage IA and IB cutaneous T-cell lymphoma (CTCL). Trial and failure, contraindication, or intolerance to at least one prior therapy (including skin-directed therapies [eg, corticosteroids {ie, clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate}] or systemic therapies [eg, interferons]). AIDS-related Kaposi's sarcoma. Mycosis fungoides. Sezary syndrome. Lymphomatoid papulosis. Adult T-cell leukemia/lymphoma. Peripheral T-cell lymphoma. Primary cutaneous B-cell lymphomas. Primary cutaneous CD-30-positive T-cell proliferations. Psoriasis.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, hematologist, dermatologist, infectious disease specialist, or HIV/AIDS specialist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TASIGNA

Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic myelogenous leukemia (CML): Diagnosis of Ph+ CML
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAVNEOS

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis is Severe Antineutrophil cytoplasmic autoantibody-associated vasculitis (granulomatosis with polyangiitis and microscopic polyangiitis) AND patient has tried and failed cyclophosphamide in combination with glucocorticoids AND avacopan will be used in combination with glucocorticoids.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist in joint and autoimmune diseases (e.g. rheumatologists) and or Brain and nervous system (e.g. neurologists)
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Reauth Criteria: Patient continues to meet initial criteria and treatment has resulted in disease response.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAZORAC

Products Affected

- *tazarotene topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acne vulgaris (initial): Diagnosis of acne vulgaris AND History of failure or intolerance to at least two topical acne products (e.g., tretinoin, adapalene, benzoyl peroxide, clindamycin, erythromycin, or azelaic acid). Plaque psoriasis (initial): Diagnosis of stable moderate to severe plaque psoriasis AND Patient has body surface area (BSA) involvement of less than 20 percent AND History of failure or intolerance to at least two topical psoriasis product (e.g., medium to high potency corticosteroids and/or vitamin D analogs).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	All uses (Initial and reauth): 12 months
Other Criteria	Acne, Plaque psoriasis (reauth): Documentation of positive clinical response to therapy .
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAZVERIK

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Epithelioid sarcoma, metastatic or locally advanced: Treatment of metastatic or locally advanced epithelioid sarcoma not eligible for complete resection in adults and adolescents 16 years of age or older. Follicular lymphoma, relapsed/refractory: Treatment of relapsed or refractory follicular lymphoma in adults whose tumors are positive for an EZH2 mutation (as detected by an approved test) and who have received at least 2 prior systemic therapies. Treatment of relapsed or refractory follicular lymphoma in adults who have no satisfactory alternative treatment options.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial and Reauth: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TECFIDERA

Products Affected

- *dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease with evidence of new brain lesions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TEGSEDI

Products Affected

- TEGSEDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of hereditary transthyretin (hATTR) amyloidosis or familial amyloid polyneuropathy (FAP) AND has a TTR mutation confirmed by genotyping AND has associated mild to moderate polyneuropathy AND has a baseline platelet count greater than or equal to 100 x 109/L AND has a urinary protein to creatinine ratio (UPCR) greater than or equal to 1000 mg/g.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TEPMETKO

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has metastatic non-small cell lung cancer harboring mesenchymal-epithelial transition (MET) exon 14 skipping alterations. Medical chart information is provided by the prescriber.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	Initial and Reauth: 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TERIPARATIDE

Products Affected

- *teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)*

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not use teriparatide in combination with any of the following: Prolia (denosumab), Bisphosphonates, Evista (raloxifene), Miacalcin/Fortical (calcitonin nasal spray), Recalst (zolendronic acid), or Tymlos (abalaoparatide).
Required Medical Information	Medication is being used for ONE of the following diagnoses: 1.Postmenopausal osteoporosis 2. Primary or hypogonadal osteoporosis in a male patient 3. Glucocorticoid-induced osteoporosis. ONE of the following: 1 The patient is at high risk for fractures defined as ONE of the following: a. History of osteoporotic (i.e., fragility, low trauma) fracture(s) b. 2 or more risk factors for fracture (e.g., history of multiple recent low trauma fractures, BMD T-score less than or equal to -2.5 in the spine, femoral neck, total hip or distal 1/3 of the radius, corticosteroid use, or use of GnRH analogs such as nafarelin, etc.) c. No prior treatment for osteoporosis AND FRAX score greater than or equal to 20 percent for any major fracture OR greater than or equal to 3 percent for hip fracture. 2. The patient is unable to use oral therapy (i.e., Pre-existing gastrointestinal disorders such as Barrett's esophagus, hypersecretory disorders, delayed esophageal emptying, etc.). 3. The patient had a trial of, intolerance to, or a contraindication to ONE bisphosphonate (e.g., alendronate, risedronate, ibandronate). Patient has received a total of 24 months of cumulative treatment with teriparatide (Forteo) AND remains at or has returned to having a high risk for fracture OR Patient has received less than 24 months of cumulative treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial and REAUTH: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

THALOMID

Products Affected

- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Used in combination with dexamethasone, unless the patient has an intolerance to steroids. Erythema nodosum leprosum (ENL): Diagnosis of moderate to severe ENL with cutaneous manifestations. Thalomid is not used as monotherapy if moderate to severe neuritis is present.
Age Restrictions	
Prescriber Restrictions	MM: Prescribed by or in consultation with an oncologist/hematologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

THIOLA

Products Affected

- THIOLA EC
- *tiopronin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Initial Authorization: Patient has a diagnosis of cystinuria, AND Diagnosis is confirmed by nephrolithiasis and 1 of the following: family history of cystinuria, stone analysis confirming cystine stone, or elevated cystine output, AND Patient is greater than 20 kg, Reauthorization Criteria: Patient continues to meet criteria identified above, AND Patient has an improvement in cystinuria, documented by prescriber based on laboratory analysis (e.g., urine cystine) or lack of stone formation, AND Patient has not experienced any treatment-restricting adverse effects (e.g., hypersensitivity, proteinuria), AND Prescriber monitors cystine levels every 3 months to maintain a urinary cystine concentration less than 250 mg/L, AND Prescriber assesses for proteinuria every 3 to 6 months during treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial auth: 6 months. Reauth: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TIBSOVO

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an approved test.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or an hematologist.
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TOPICAL RETINOID

Products Affected

- *tretinoin*
- *tretinoin microspheres topical gel*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following: Acne: Diagnosis of acne.
Age Restrictions	PA applies to members 26 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRACLEER

Products Affected

- *bosentan*

PA Criteria	Criteria Details
Exclusion Criteria	Bosentan is contraindicated in pregnancy, use with cyclosporine A, use with glyburide, and hypersensitivity to bosentan or any of its components.
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient had prior therapy, intolerance to, or contraindication to ONE Phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (sildenafil or tadalafil).
Age Restrictions	
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH: Initial: 6 months. Reauth:12 months.
Other Criteria	PAH (Reauth): Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRANSMUCOSAL FENTANYL CITRATE

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the management of breakthrough cancer pain. Patient is currently taking a long-acting opioid around the clock for cancer pain. Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids: Morphine sulfate at doses of greater than or equal to 60 mg/day, Fentanyl transdermal patch at doses greater than or equal to 25 g/hr, Oxycodone at a dose of greater than or equal to 30 mg/day, Oral hydromorphone at a dose of greater than or equal to 8 mg/day, Oral oxymorphone at a dose of greater than or equal to 25 mg/day, or an alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Pain specialist, Oncologist, Hematologist, Hospice care specialist, or Palliative care specialist.
Coverage Duration	12 months
Other Criteria	This drug also requires payment determination.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRELSTAR

Products Affected

- TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG, 22.5 MG, 3.75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Prescriber provides chart notes to support diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRETINOIN/CLINDAMYCIN

Products Affected

- *clindamycin-tretinoin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acne: Diagnosis of acne.
Age Restrictions	PA applies to members 26 years of age or older
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRIKAFTA

Products Affected

- TRIKAFTA ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have diagnosis of Cystic fibrosis (CF) and have at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene. If the patient??s genotype is unknown, an FDA-cleared CF mutation test should be used to confirm the presence of at least one F508del mutation.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a Pulmonologist.
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRUQAP

Products Affected

- TRUQAP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Locally advanced or metastatic breast cancer: Diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer with one or more PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test following progression on at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Initial/Reauth: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TUKYSA

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a diagnosis of advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive breast cancer, including if the patient has brain metastasis. It will be used in combination with trastuzumab and capecitabine. Patient has received 1 or more prior anti-HER2-based regimens in the metastatic setting. Unresectable or Metastatic Colorectal Cancer: In combination with trastuzumab for the treatment of adult patients with RAS wild-type, HER2-positive unresectable or metastatic colorectal cancer that has progressed following treatment with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 6 months Reauth: 12 months with positive response.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TURALIO

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Treatment of symptomatic tenosynovial giant cell tumor associated with severe morbidity or functional limitations and not amenable to improvement with surgery in adults.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Auth: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TYKERB

Products Affected

- *lapatinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Breast Cancer: Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive metastatic or recurrent breast cancer. Used in combination with one of the following: Herceptin (trastuzumab), Xeloda (capecitabine), or aromatase inhibitors [eg, Aromasin (exemestane), Femara (letrozole), Arimidex (anastrazole)].
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	Patient has utilized abaloparatide and a parathyroid hormone analog (e.g., teriparatide [Forteo]) for a combined total lifetime duration of 2 years or longer. Patient is using Tymlos in combination with any of the following: (1) Prolia (denosumab) OR (2) Bisphosphonate OR (3) Evista (raloxifene) OR (4) Miacalcin/Fortical (calcitonin nasal spray) OR (5) Reclast (zoledronic acid) OR (6) Forteo (teriparatide).
Required Medical Information	Patient is a postmenopausal female with one of the following: (A) dx of osteoporosis (defined as a bone mineral density [BMD] T-score in the spine, femoral neck, total hip or distal 1/3 of the radius of less than or equal to -2.5 OR (B) dx of osteoporosis based on history of an osteoporotic low trauma fracture (fragility fracture) and considered at high risk for additional fracture AND patient has had a trial and failure or has a contraindication to an oral or IV bisphosphonate AND denosumab. Duration has not exceeded a total of 24 months during the patient's lifetime. Patient is a male with dx of osteoporosis at high risk for fracture (defined as a history of osteoporotic fracture or multiple risk factors for fracture), AND patient has had trial and failure or has a contraindication to an oral or IV bisphosphonate AND denosumab. Duration has not exceeded a total of 24 months during the patient's lifetime.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months with one reauth only for a total of 2 years of lifetime treatment
Other Criteria	Reauth: patient is responding positively to treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

UBRELVY

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	Patient must NOT be concurrently using a strong CYP3A4 inhibitor AND Patient must NOT have end-stage renal disease (creatinine clearance [CrCl] less than 15 mL/min). Patient is not being treated for prevention of migraine.
Required Medical Information	Diagnosis of migraine, with or without aura. Patient must have tried and failed 1 or more of the following: NSAID, non-opioid analgesic, OR caffeinated analgesic combination, AND Patient must have tried and failed, or have contraindication to at least 1 formulary triptan (eg. rizatriptan, sumatriptan, zolmitriptan, naratriptan, frovatriptan, almotriptan). REAUTH: patient continues to meet the above criteria and demonstrates resolution in headache pain or reduction in headache severity, as assessed by prescriber.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist, headache specialist or pain specialist.
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Mycosis fungoides-type cutaneous T-cell lymphoma (MF-CTCL) (initial): All of the following: 1) diagnosis of Stage IA MF-CTCL, OR diagnosis of Stage IB MF-CTCL, AND 2) patient has received at least one prior skin-directed therapy [e.g., topical corticosteroids, bexarotene topical gel (Targretin topical gel), topical nitrogen mustard, etc.].
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VANCOMYCIN CAPSULE

Products Affected

- *vancomycin oral capsule 125 mg, 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Individual is being treated for enterocolitis caused by Staphylococcal aureus including methicillin-resistant strains. Individual is being treated for Clostridium difficile-associated diarrhea.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VANFLYTA

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	Maintenance monotherapy following allogeneic hematopoietic cell transplantation.
Required Medical Information	Diagnosis is acute myeloid leukemia (AML) AND patient meets all of the following: 1. The patient's cancer is FLT3 internal tandem duplication (ITD) positive as detected by a FDA-approved test. 2. The patient meets ONE of the following criteria: a. Vanflyta will be used in combination with standard cytarabine and anthracycline (e.g., daunorubicin, idarubicin) as induction therapy b. Vanflyta will be used with cytarabine as consolidation therapy c. Vanflyta will be used as maintenance monotherapy following consolidation chemotherapy.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist / hematologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Reauth: Patient still meets initial criteria and is benefiting from treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VELCADE

Products Affected

- *bortezomib injection recon soln 1 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multiple myeloma (MM): Diagnosis of MM. Mantle cell lymphoma (MCL): Diagnosis of MCL.
Age Restrictions	
Prescriber Restrictions	MM, MCL: Prescribed by or in consultation with an oncologist/hematologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VENCLEXTA

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL): Diagnosis of CLL or SLL, 2) Acute Myeloid Leukemia (AML): Newly-diagnosed acute myeloid leukemia (in combination with azacitidine, decitabine, or low-dose cytarabine) in patients 75 years of age or older, or in patients with comorbidities that preclude use of intensive induction chemotherapy.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VENTAVIS

Products Affected

- VENTAVIS INHALATION SOLUTION FOR NEBULIZATION 10 MCG/ML, 20 MCG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient had prior therapy, intolerance to, or contraindication to ONE Phosphodiesterase type 5 (PDE-5) inhibitor approved for use in PAH (sildenafil or tadalafil) or Adempas (riociguat) AND ONE Endothelin receptor antagonist [e.g.,ambrisentan, bosentan, Opsumit [macitentan]) approved for use in PAH.
Age Restrictions	
Prescriber Restrictions	PAH (Initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
Coverage Duration	PAH (Initial): 6 months. (Reauth): 12 months
Other Criteria	Subject to Part B vs D review. PAH (Reauth): Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VERQUVO

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Patient has a diagnosis of symptomatic chronic heart failure AND ejection fraction is less than 45 percent AND patient meets 1 or more of the following criteria: patient has required the use of at least one IV diuretic (e.g. furosemide, bumetanide) as an outpatient in the past 3 months OR patient was recently hospitalized for heart failure within the las 6 months AND patient is on at least ONE drug for heart failure from any of the following classes, unless contraindicated (beta-blocker {e.g. metoprolol, carvedilol, bisoprolol}, ACE inhibitor {e.g. captopril, enalapril, lisinopril}, ARB {e.g. valsartan, olmesartan, telmisartan, irbesartan, losartan}, aldosterone receptor antagonist {e.g. eplerenone}) AND patient is NOT taking another soluble guanylate cyclase (sGC) stimulator or PDE-5 inhibitor.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a cardiologist.
Coverage Duration	Initial and Reauth 6 months
Other Criteria	Reauth: patient is responding positively to treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1)Breast Cancer, advanced or metastatic: As initial endocrine-based therapy (in combination with an aromatase inhibitor [e.g., anastrozole, letrozole, exemestane]) for the treatment of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative advanced or metastatic breast cancer in adults. In combination with fulvestrant for the treatment of HR-positive, HER2-negative advanced or metastatic breast cancer in adults with disease progression following endocrine therapy. As monotherapy for the treatment of HR-positive, HER2-negative advanced or metastatic breast cancer in patients with disease progression following endocrine therapy and prior chemotherapy in the metastatic setting. 2) Breast cancer, early, high risk: Adjuvant treatment of HR-positive, HER2-negative, node-positive early breast cancer (in combination with endocrine therapy [eg, an aromatase inhibitor or tamoxifen]) in adults at high risk of recurrence
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	12 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VITRAKVI

Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Solid tumors. Treatment of solid tumors (in adult and pediatric patients) that have a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity and have no satisfactory alternative treatments or that have progressed following treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VIZIMPRO

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	First-line treatment of metastatic non-small cell lung cancer (NSCLC) in patients with epidermal growth factor receptor (EGFR) exon 19 deletion or exon 21 L858R substitution mutations as detected by an approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VONJO

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis is intermediate or high-risk primary or secondary (postpolycythemia vera or postessential thrombocythemia) myelofibrosis and platelet count is less than 50,000/mm3.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist/hematologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Reauth: patient has responded well to treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VORICONAZOLE

Products Affected

- *voriconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Aspergillosis, invasive: Treatment of invasive aspergillosis. Candidemia and other Candida infections: Treatment of candidemia in nonneutropenic patients and the following Candida infections: disseminated infections in the skin and infections in the abdomen, bladder wall, kidney, and wounds. Candidiasis, esophageal: Treatment of esophageal candidiasis. Fungal infections, serious: Treatment of serious fungal infections caused by Scedosporium apiospermum and Fusarium spp., including Fusarium solani, in patients intolerant of, or refractory to, other therapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	3 months
Other Criteria	For Candidiasis infections, where indications align, patient has T/F or has CI to fluconazole. For Esophageal Candidiasis, patient has T/F or has CI to itraconazole.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VOSEVI

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with rifampin.
Required Medical Information	Documentation is provided for a diagnosis of chronic hepatitis C (CHC) infection, which includes a genotype and positive HCV RNA result (AASLD/IDSA 2017, CDC 2013) AND patient has received baseline evaluation for liver fibrosis to guide appropriate therapy AND patient does not have a short life expectancy (less than 12 months owing to non-liver related comorbid conditions) that cannot be remediated by treating HCV, by transplantation or other directed therapy (AASLD/IDSA 2016). Trial and failure, contraindication, or intolerance to Epclusa (Sofosbuvir-Velpatasvir) AND Harvoni (Ledipasvir/Sofosbuvir) if patient has a genotype of 1, 4, 5, or 6.
Age Restrictions	
Prescriber Restrictions	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
Coverage Duration	12 weeks. Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VOTRIENT

Products Affected

- *pazopanib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of advanced/metastatic RCC. Soft tissue sarcoma: Diagnosis of advanced soft tissue sarcoma and patient received at least one prior chemotherapy (e.g., ifosfamide, doxorubicin, cisplatin, dacarbazine, docetaxel, oxaliplatin, etc.)
Age Restrictions	
Prescriber Restrictions	All Uses: Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VUMERITY

Products Affected

- VUMERITY

PA Criteria	Criteria Details
Exclusion Criteria	Moderate to severe impairment of kidney function, pregnancy
Required Medical Information	Treatment of relapsing forms of multiple sclerosis (confirmed diagnosis of MS as documented by lab report such as an MRI), including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a Neurologist.
Coverage Duration	Initial and Reauth 12 months
Other Criteria	For Reauth, patient continues to meet initial approval criteria AND absence of toxicities from the drug AND chart notes indicating monitoring of response to therapy has been positive.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VYNDAQEL/VYNDAMAX

Products Affected

- VYNDAMAX
- VYNDAQEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chart notes indicate diagnosis of Cardiomyopathy of Transthyretin-Mediated Amyloidosis (ATTR-CM): Member has a history of NYHA Class I through III Heart Failure AND Significant cardiac involvement (e.g. substantial ventricular wall thickening or elevated intra cardiac filling pressures) on echocardiography or cardiac MRI AND Member has a diagnosis of ATTR-CM as confirmed by one of the following: A.) Cardiac biopsy with positive congo red staining indicating the presence of amyloid deposits on analysis of biopsy specimens AND Medical records indicate the presence of transthyretin precursor protein confirmed on immunohistochemical analysis, scintigraphy, or mass spectrometry using Technescan PYP (PYP Screening) OR B.) The member meets all of the following: i) Serum kappa/lambda free light chain ratio 0.26 to 1.65 AND ii) Absence of monoclonal protein via serum protein immunofixation AND iii) Absence of monoclonal protein via urine protein immunofixation AND iv) Myocardial uptake of 99m Tc-PYP demonstrated by a greater than 1.5 heart-to-contralateral ratio or grade 2 or greater visual evidence. The member does not have a history of any of the following: Liver Transplant, Heart Transplant without evidence of further amyloid deposits post-transplant, Left Ventricular Assist Device (LVAD), Current Pregnancy. Reauthorization: Member has evidence of slowing of clinical decline (e.g., decrease in number of hospitalizations, improvement or stabilization of the 6-minute walk test, stable or improvement in KCCQ-OS).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by a cardiologist or in consultation with a cardiologist.
Coverage Duration	Initial Auth: 12 months
Other Criteria	Reauth: Documentation of positive clinical response to therapy. 12 months.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

WELIREG

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	Immediate need for surgical intervention for tumor treatment or evidence of metastatic disease. Use in combination with erythropoiesis stimulating agents (ESAs). Pregnancy.
Required Medical Information	Diagnosis is von Hippel-Lindau disease and patient requires therapy for associated 1 or more of the following: 1. renal cell carcinoma (RCC), 2. CNS hemangioblastomas, or 3. pancreatic neuroendocrine tumors not requiring immediate surgery. Women of child-bearing age must have a confirmed negative pregnancy test prior to treatment.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 6 months. Reauth: 6 months
Other Criteria	Reauth Criteria: Patient continues to meet initial criteria and treatment has resulted in disease response as defined by stabilization of disease or decrease in tumor size or spread.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XALKORI

Products Affected

- XALKORI ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following: 1. Non-small cell lung cancer (NSCLC): Diagnosis of locally advanced or metastatic (stage IIIB or IV) NSCLC AND One of the following: A) Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility or B) Patient has MET amplification- or ROS1 rearrangements-positive tumor as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. 2. Adult and pediatric patients 1 year and older with unresectable, recurrent, or refractory inflammatory myofibroblastic tumors that are ALK-positive. 3. Relapsed or Refractory, Systemic ALK-Positive Anaplastic Large Cell Lymphoma: Pediatric patients 1 year of age and older and young adults with relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive.
Age Restrictions	
Prescriber Restrictions	NSCLC: Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XALKORI PELLETS

Products Affected

- XALKORI ORAL PELLET 150 MG, 20 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following: 1. Non-small cell lung cancer (NSCLC): Diagnosis of locally advanced or metastatic (stage IIIB or IV) NSCLC AND One of the following: A) Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility or B) Patient has MET amplification- or ROS1 rearrangements-positive tumor as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. 2. Adult and pediatric patients 1 year and older with unresectable, recurrent, or refractory inflammatory myofibroblastic tumors that are ALK-positive. 3. Relapsed or Refractory, Systemic ALK-Positive Anaplastic Large Cell Lymphoma: Pediatric patients 1 year of age and older and young adults with relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive. Chart notes documenting that the patient is not a candidate for capsule formulation due to age or inability to swallow due to documented diagnosis of dysphagia.
Age Restrictions	
Prescriber Restrictions	NSCLC: Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy. Chart notes documenting that the patient is not a candidate for capsule formulation due to age or inability to swallow due to documented diagnosis of dysphagia.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XCOPRI

Products Affected

- XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG
- XCOPRI TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the treatment of partial-onset seizures in adult patients.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	Initial: 6 mths. Reauth: 12 mths.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XELJANZ

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: RHEUMATOID ARTHRITIS (RA), ANKYLOSING SPONDYLITIS (AS), POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. REAUTH: 12 MONTHS.
Other Criteria	INITIAL: RA: TRIAL OF OR CONTRAINDICATION TO 3 MONTHS OF TREATMENT WITH ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSA, PCJIA: TRIAL OF OR CONTRAINDICATION TO ONE DMARD. AS: TRIAL OF OR CONTRAINDICATION TO AN NSAID. UC: TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. REAUTH: RA, PSA, AS, PCJIA: CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

XENAZINE

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chorea associated with Huntington's Disease (HD) (Initial): Diagnosis of chorea in patients with Huntington's disease. Tardive dyskinesia (Initial): Patient has stereotypies associated with tardive dyskinesia. Tourette's syndrome (Initial): Patient has tics associated with Tourette's syndrome. Failure, contraindication, or intolerance to Haldol (haloperidol).
Age Restrictions	
Prescriber Restrictions	HD (Initial): Prescribed by or in consultation with a neurologist. Tardive dyskinesia, Tourette's syndrome (Initial): Prescribed by or in consultation with neurologist or psychiatrist.
Coverage Duration	All indications: (Initial) 3 months, (Reauth) 12 months.
Other Criteria	All indications (Reauth): Documentation of clinical response and benefit from therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XERMELO

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Carcinoid syndrome diarrhea: Treatment of carcinoid syndrome diarrhea (in combination with somatostatin analog therapy) AND diarrhea is inadequately controlled by somatostatin analog (SSA) therapy (e.g., octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot]) for at least 3 months.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist
Coverage Duration	Initial and Reauth 6 months.
Other Criteria	Reauthorization: Documentation of positive clinical response to therapy (e.g., reduction in bowel movement frequency, improvement in stool consistency, improvement in quality of life, etc.) AND will continue to be used in combination with SSA therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Bone metastasis from solid tumors (BMST): Both of the following: 1) diagnosis of solid tumors (eg, breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer), AND 2) documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Both of the following: 1) diagnosis of giant cell tumor of bone AND 2) One of the following: a) tumor is unresectable, OR b) surgical resection is likely to result in severe morbidity. Hypercalcemia of malignancy (HCM): Both of the following: 1) diagnosis of hypercalcemia of malignancy, AND 2) Trial and failure, contraindication, or intolerance to one intravenous bisphosphonate (eg, Zometa (zoledronic acid)).
Age Restrictions	
Prescriber Restrictions	GCTB, HCM: Prescribed by or in consultation with an oncologist
Coverage Duration	BMST, GCTB: 12 mo. HCM: 2 mo.
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XIFAXAN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Travelers' diarrhea (TD) (200 mg strength only): Diagnosis of travelers' diarrhea, AND one of the following: a) Trial and failure, contraindication, or intolerance to one of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin) OR b) resistance to all of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin). Prophylaxis of hepatic encephalopathy (HE) recurrence (550mg strength only): Used for the prophylaxis of hepatic encephalopathy recurrence, AND trial and failure, contraindication or intolerance to lactulose. Irritable bowel syndrome with diarrhea (IBS-D) (550mg strength only) (initial): Diagnosis of IBS-D, AND trial and failure, contraindication or intolerance to an antidiarrheal agent [loperamide] AND an antispasmodic [dicyclomine].
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TD: 1 month HE: 6 months. IBS-D (initial, reauth): 2 weeks.
Other Criteria	IBS-D (reauth): Patient experiences IBS-D symptom recurrence AND patient has not already received 3 treatment courses of Xifaxan for IBS-D in their lifetime.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has Moderate Persistent to Severe Persistent Asthma AND has a positive skin test or in vitro reactivity to a perennial aeroallergen, AND Mbr has an FEV1 less than 80% predicted AND Mbr IgE level is equal to or greater than 30 IU/ml. Severe asthma as defined by the National Heart, Lung, and Blood Institute: Severe Persistent Asthma: symptoms throughout the day, extremely limited normal activity. Nocturnal symptoms are frequent, FEV1 or PEF is less than or equal to 60% predicted. Moderate Persistent Asthma as defined by the National Heart, Lung, and Blood Institute: Daily symptoms, daily use of inhaled short-acting beta2-agonist, somewhat limited activity, Nocturnal symptoms occur greater than 1 time per week, FEV1 or PEF is greater than 60% and less then 80% predicted, FEV1 FVC is reduced 5 percent or exacerbations requiring oral systemic corticosteroids use for more than or equal to 2 times per year, Treatment of chronic idiopathic urticaria in adults and adolescents 12 years and older who remain symptomatic despite H1 antihistamine treatment. Treatment of nasal polyps in adults with inadequate response to nasal corticosteroids.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	For moderate to severe persistent asthma, patient symptoms are inadequately controlled after a trial of combination controller therapy (inhaled corticosteroids plus long acting beta-2 agonists or Leukotriene modifiers), unless patient is intolerant to or has a contraindication to any of these medications. Continued treatment beyond 12 months is allowed when treatment has resulted in clinical improvement as documented by one or more of the following: Decreased utilization of rescue medications OR Decreased frequency of exacerbations (defined as worsening of asthma that requires increase in inhaled corticosteroid dose or treatment with systemic corticosteroids) OR Increase in percent predicted FEV1

PA Criteria	Criteria Details
	from pretreatment baseline OR Reduction in reported asthma-related symptoms, such as, but not limited to, wheezing, shortness of breath, coughing, fatigue, sleep disturbance, or asthmatic symptoms upon awakening. For chronic idiopathic urticaria, patient is refractory to prior treatment with an antihistamine, unless the patient is intolerant to or has a contraindication to an anthistamine.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XOSPATA

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Acute myeloid leukemia, relapsed or refractory. Treatment of relapsed or refractory acute myeloid leukemia (AML) in adult patients with an FMS-like tyrosine kinase 3 (FLT3) mutation as detected by an approved test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	FMS-like tyrosine kinase 3 (FLT3) mutation
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XPOVIO

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	One of the following Diagnoses 1) Multiple myeloma, relapsed or refractory: Treatment of relapsed or refractory multiple myeloma (in combination with dexamethasone) in adults who have received 4 or more prior therapies and whose disease is refractory to 2 or more proteasome inhibitors, 2 or more immunomodulatory agents, and an anti-CD38 monoclonal antibody OR Treatment of multiple myeloma (in combination with bortezomib and dexamethasone) in adults who have received at least 1 prior therapy. 2) Diffuse large B-cell lymphoma, relapsed or refractory: Treatment of relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma, in adults after at least 2 lines of systemic therapy. treatment of multiple myeloma in combination with bortezomib and dexamethasone
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist/hematologist.
Coverage Duration	Authorization: 12 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XTANDI

Products Affected

- XTANDI ORAL CAPSULE
- XTANDI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Castration-resistant prostate cancer (CRPC): Diagnosis of castration-resistant prostate cancer (CRPC). 2) Metastatic castration-sensitive prostate cancer: Diagnosis of metastatic castration-sensitive prostate cancer. 3) Nonmetastatic castration-sensitive prostate cancer: Diagnosis of nonmetastatic castration-sensitive prostate cancer AND the cancer has biochemical recurrence at high risk for metastasis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

YONSA

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	Females who are or may become pregnant
Required Medical Information	Diagnosis of covered use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZAVESCA

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Gaucher disease: Diagnosis of mild to moderate type 1 Gaucher disease. 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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Gaucher disease: 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZEJULA

Products Affected

- ZEJULA ORAL CAPSULE
- ZEJULA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Ovarian, fallopian tube, or primary peritoneal cancer: First-line maintenance treatment of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer in adults who are in a complete or partial response to first-line platinum-based chemotherapy. Recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer: Maintenance treatment in adult patients with deleterious or suspected deleterious germline BRCA-mutated recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. Select patients for therapy based on an FDA-approved companion diagnostic for Zejula (niraparib).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT) as detected by an FDA-approved test (eg, cobas 4600 BRAFV600 Mutation Test) or performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). 2) Erdheim-Chester disease (ECD): Diagnosis of ECD with a BRAF V600 mutation
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZOKINVY

Products Affected

- ZOKINVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has a body surface area (BSA) of 0.39 m2 and above. Patient has a diagnosis of one of the following: 1. Hutchinson-Gilford progeria syndrome (HGPS) AND patient has had a confirmatory mutational analysis with a G608G mutation in the lamin A gene (LMNA gene) (e.g., c.1824C greater than T) OR 2. Processing-deficient progeroid laminopathies AND Heterozygous LMNA mutation with progerin-like protein accumulation (e.g., pathogenic variant in either the exon 11 splice junction or intron 11 of LMNA gene) OR Homozygous or compound heterozygous ZMPSTE24 mutations.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a hematologist, oncologist or geneticist.
Coverage Duration	Initial and Reauth: 6 months.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZOLEDRONIC ACID 5MG/100ML

Products Affected

- *zoledronic acid-mannitol-water intravenous piggyback 5 mg/100 ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Paget's disease of bone in men and women, treatment is indicated with elevations in serum alkaline phosphatase of two times or higher than the upper limit of the age-specific normal reference range, or those who are symptomatic, or those at risk for complications from their disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	This drug also requires payment determination and may be covered under Medicare Part B or D.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cutaneous T-cell lymphoma (CTCL): Diagnosis of CTCL. Progressive, persistent or recurrent disease on or contraindication or intolerance to two systemic therapies (e.g., bexarotene, romidepsin, etc.).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZONISAMIDE SUSPENSION

Products Affected

- ZONISADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medication will be used as adjunctive therapy for the treatment of partial-onset seizures. Patient must have swallowing difficulties as documented in physician's chart notes OR patient is currently on a feeding tube.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by a neurologist or epileptologist.
Coverage Duration	Initial: 6 months. Reauth: 6 months.
Other Criteria	Reauth: Patient still meets initial criteria and is responding well to treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZORTRESS

Products Affected

- *everolimus (immunosuppressive)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prevention of kidney transplant organ rejection: Prophylaxis of organ rejection in renal transplant recipients at low to moderate immunologic risk. Prevention of liver transplant organ rejection: Prophylaxis of allograft rejection in liver transplantation. Everolimus will not be administered earlier than 30 days post-transplant.
Age Restrictions	
Prescriber Restrictions	All indications: Prescriber is experienced in immunosuppressive therapy and management of transplant patients.
Coverage Duration	12 months
Other Criteria	Subject to Part B vs. Part D review. Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZTALMY

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Seizures and Seizures are associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder and patient is 2 years of age and older. Chart notes or medical record documentation of enzyme assay or genetic testing demonstrating pathogenic or likely pathogenic mutation in the CDKL5 gene.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or epileptologist.
Coverage Duration	Initial: 6 months. Reauth: 12 months
Other Criteria	Reauth criteria: Pt is responding to tx.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZURZUVAE

Products Affected

- ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Post partum depression (PPD): Diagnosis of postpartum depression in adults. Patient is postpartum for 1 year or less. Documentation provided qualifies DSM-5 criteria for diagnosis of post partum depression. Trial and failure of at least two formulary generic selective serotonin reuptake inhibitors (SSRI).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a psychiatrist or an obstetrician.
Coverage Duration	14 days
Other Criteria	Reauth not applicable
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Used in combination with Rituxan (rituximab). The patient has relapsed on at least one prior therapy (eg, purine analogues [fludarabine, pentostatin, cladribine], alkylating agents [chlorambucil, cyclophosphamide], or monoclonal antibodies [rituximab]). Patient is a candidate for Rituxan (rituximab) monotherapy due to presence of other comorbidities (eg, coronary artery disease, peripheral vascular disease, diabetes mellitus, pulmonary disease [COPD]).
Age Restrictions	
Prescriber Restrictions	All uses: Prescribed by or in consultation with an oncologist/hematologist.
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZYKADIA

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC that is metastatic or recurrent. Tumor is anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. Trial and failure or intolerance to Xalkori (crizotinib).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZYTIGA

Products Affected

- *abiraterone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prostate Cancer: Diagnosis of metastatic, castration-resistant (chemical or surgical) prostate cancer AND used in combination with prednisone. Diagnosis of metastatic, high-risk castration-sensitive prostate cancer AND used in combination with prednisone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Prostate Cancer: 12 months
Other Criteria	Approve for continuation of prior therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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