# 2020

# Prior Authorization Criteria

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# Actimmune

**Products Affected**

- ACTIMMUNE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis, Bone biopsy if osteopetrosis, Antibiotic failure if chronic granulomatous disease |
| **Age Restrictions** | Ages approved in FDA labeling/compendia |
| **Prescriber Restrictions** | Infectious Disease/Hematology-oncology/Orthopedist/rheumatologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Sulfamethoxazole/Trimethoprim and/or itraconazole failure for infections secondary to chronic granulomatous disease. Osteopetrosis must be severe malignant |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Adcirca Tabs

**Products Affected**

- *tadalafil (pah)*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Right Heart catheterization, vasoreactivity test. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Pulmonology, Cardiology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Sildenafil for WHO group 1 PAH |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Adempas

**Products Affected**

- ADEMPAS

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | pulmonologist/cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For PAH must have tried and failed ambrisentan and tadalafil, CTPH requires failure of bosentan (based on compendial support) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Afinitor

**Products Affected**

- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG
- *everolimus oral tablet 2.5 mg, 5 mg, 7.5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/neurology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Alecensa

**Products Affected**

- ALECENSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approved for ALK+ Non Small Cell Lung Cancer |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# alitretinoin (Panretin)

**Products Affected**

- PANRETIN

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Alunbrig

**Products Affected**

- ALUNBRIG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Ambrisentan

**Products Affected**

- *ambrisentan*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, including right heart catheterization, 6 Minute Walk time |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pulmonologist or cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral ,Coverage will be based on medical history/status, vasoreactivity tests, failure of sildenafil. Sildenafil failure does not apply to pediatric patients with congental or ideopathic PAH |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Ampyra

**Products Affected**

- *dalfampridine er*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute). |
| **Required Medical Information** | Diagnosis of multiple sclerosis AND patient is ambulatory (able to walk at least 25 feet) AND patient has walking impairment |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Initial - 3 months. Renewal - 12 months |
| **Other Criteria** | For renewal, walking speed has improved from baseline. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Apokyn

**Products Affected**

- APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, previous treatment history. |
| **Age Restrictions** | Ages approved in FDA labeling/compendia |
| **Prescriber Restrictions** | Neurologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient must have poorly controlled off time episodes and failed dopamine agonist and COMT inhibitor |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Aptiom

**Products Affected**

- APTIOM

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of carbamazepine and Oxcarbazepine |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Arcalyst

**Products Affected**

- ARCALYST

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Coverage will be based on a Diagnosis of CAPS, failure of 1 other treatment used for this condition such as cancakinumab, nsaids |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Immunologist,dermatologist,rheumatologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Aubagio

**Products Affected**

- AUBAGIO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Glatopa and Gilenya |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Avonex

**Products Affected**

- AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT
- AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of glatiramer |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Ayvakit

**Products Affected**

- AYVAKIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | hemaotology/oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | Failure of imatinib AND one other tyrosine kinase inhibitor for unresectable or metastatic GIST with a mutation in PDGFRA exon 18 or failure of imatinib and harboring a PDGFRA D842V mutation. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# aztreonam (Cayston)

**Products Affected**

- CAYSTON

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 Months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Balversa

**Products Affected**

- BALVERSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Urology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Banzel

**Products Affected**

- BANZEL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Baqsimi

**Products Affected**

- BAQSIMI TWO PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Restricted to endocrinology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Benlysta

**Products Affected**

- BENLYSTA SUBCUTANEOUS

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Member receiving other biologic therapy or intravenous cyclophosphamide. |
| **Required Medical Information** | Diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE), and member currently receiving one or more of the following standard SLE therapies: Corticosteroids, Antimalarials, Non-steroidal anti-inflammatory drugs (NSAIDs), Immunosuppressants |
| **Age Restrictions** | Greater or equal to 18 years of age |
| **Prescriber Restrictions** | Rheumatologist or nephrologist |
| **Coverage Duration** | Lifetime |
| **Other Criteria** | None |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Berinert

**Products Affected**

- BERINERT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Must not be taking medications that can exacerbate thefrequency and/or severity of hereditary angioedema (HAE)attacks including estrogens and ACE inhibitors. |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Betaseron

**Products Affected**

- BETASERON SUBCUTANEOUS KIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of glatiramer |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Bosulif

**Products Affected**

- BOSULIF

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months or until disease progression |
| **Other Criteria** | Requires failure of imatinib for low risk CML based on Sokal or Hasford scores. Can be used first line for Ph+ CML with an intermediate to high risk Sokal or Hasford score |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Braftovi

**Products Affected**

- BRAFTOVI ORAL CAPSULE 75 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of BRAF mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progresison |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Briviact

**Products Affected**

- BRIVIACT ORAL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | failed trial or contraindication or intolerance of Levetiracetam |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Brukinsa

**Products Affected**

- BRUKINSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Disease progression on a covalent BTK inhibitor |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | Intolerance to Imbruvica in overlapping indication. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Cabometyx

**Products Affected**

- CABOMETYX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered until disease progression. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Calquence

**Products Affected**

- CALQUENCE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months  or clinical progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Caplyta

**Products Affected**

- CAPLYTA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | written by neurology/psychiatry |
| **Coverage Duration** | 12 months |
| **Other Criteria** | failure of aripiprazole and risperidone |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Caprelsa

**Products Affected**

- CAPRELSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Carbaglu

**Products Affected**

- CARBAGLU

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Cinryze

**Products Affected**

- CINRYZE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient must have two or more angioedema attacks per month and has failed danazol |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Cometriq

**Products Affected**

- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | combination use with other tyrosine Kinase inhibitors. |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | oncology/hematology |
| **Coverage Duration** | 6 months or until disease progression |
| **Other Criteria** | Covered for Metastatic Thyroid Medullary Cancer |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Copiktra

**Products Affected**

- COPIKTRA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Corlanor

**Products Affected**

- CORLANOR ORAL SOLUTION
- CORLANOR ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of the following: 1. Diagnosis of chronic heart failure with left ventricular ejection fraction less than or equal to 35% AND 2. Patient is in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute AND 3. Patient is on maximally tolerated doses of beta-blockers or has a contraindication to beta-blocker use AND 4. Patient is receiving an ACE inhibitor or ARB or has a contraindication to these agents. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Cotellic

**Products Affected**

- COTELLIC

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered for BRAF+ metastatic melanoma for combination use in with Zelboraf |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Cubicin

**Products Affected**

- *daptomycin intravenous solution reconstituted 500 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | daptomycin is contraindicated in patients with known hypersensitivity to daptomycin or any other component of the product. |
| **Required Medical Information** | Documentation of a consultation with an infectious disease specialist. If being used to treat a condition caused by end-stage renal disease(ESRD) and member is on dialysis, please bill to Medicare Part B. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | If all conditions are met, the request will be authorized until the end of the contract year. |
| **Other Criteria** | Physician reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Cuprimine

**Products Affected**

- *penicillamine oral capsule*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | serum ceruloplasmin if used for wilson's disease |
| **Age Restrictions** | |
| **Prescriber Restrictions** | rheumatology/hepatology/neurology/urology/nephrology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Coverage for RA requires failure of a TNF-Agent and JAK inhibitor or abatacept. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Cyclobenzaprine

**Products Affected**

- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | Authorization is required for patients over 64 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 weeks for skeletal muscle spasm, 12 months for fibromyalgia |
| **Other Criteria** | For patients over 64 years of age, Physician attests they have counseled patient on risk benefit of muscle relaxers as a high risk medication and patient has been evaluated for fall risk. |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |

# Daliresp

**Products Affected**

- DALIRESP

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure or intolerance of combination inhaled corticosteroid/Long Acting Beta Agonist and long acting muscarinic antagonist. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Daurismo

**Products Affected**

- DAURISMO ORAL TABLET 100 MG, 25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Dronabinol

**Products Affected**

- *dronabinol*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Previous Treatment History |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Infectious disease/oncologist/gastroenterologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For HIV/Cancer related cachexia patient must fail megestrol, For Chemotherapy induced nausea, patient must fail Emend and Ondansetron. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Emend

**Products Affected**

- *aprepitant*
- EMEND ORAL SUSPENSION RECONSTITUTED

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Previous treatment history |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist/Surgeon |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient must fail treatment with ondansetron (PA not applicable for PONV) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Emsam

**Products Affected**

- EMSAM

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, current assessment and plan, prior medication failures |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient must fail 6 week trial with two formulary anti-depressants |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Enbrel

**Products Affected**

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- ENBREL SUBCUTANEOUS SOLUTION RECONSTITUTED
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications combination with other biologic |
| **Required Medical Information** | Medical notes supporting diagnosis (including imaging, serology when applicable), response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Rheumatology/Dermatology or Specialist trained in management of prescribed condition |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For RA Patient must fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2-nonbiologic DMARDS. For Ankylosing Spondylitis PT must fail 2 NSAIDS within past 6 months. For Plaque Psoriasis patient must fail MTX or Soriatane and Topical Therapy(ie. high potency steroids Vit D analogs). for Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# entrectinib (Rozlytrek)

**Products Affected**

- ROZLYTREK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Rozyltrek is a kinase inhibitor indicated for solid tumorswith NTRK-Fusions and ROS-1 mutated Non-Small Celllung cancer. Medical history, studies, and appropriateconfirmatory tests are reviewed in Referrals and ifapproved will notify pharmacy and the physician. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Entresto

**Products Affected**

- ENTRESTO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of chronic heart failure (NYHA Class II-IV) and reduced ejection fraction (less than or equal to 40%). |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Entresto will be used in place of an ACE inhibitor or other ARB. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Epidiolex

**Products Affected**

- EPIDIOLEX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of both Valproate and Clobazam as combination treatment |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Erivedge

**Products Affected**

- ERIVEDGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematologist/Oncologist |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | Diagnosis of metastatic basal cell carcinoma OR Diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Erleada

**Products Affected**

- ERLEADA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Use for metastatic disease |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Urologist, Oncologist |
| **Coverage Duration** | 12 months or until PSA progression |
| **Other Criteria** | Failure of LHRH agonist and bicalutamide for non-metastatic disease. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Esbriet

**Products Affected**

- ESBRIET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Confirmed Diagnosis of idiopathic pulmonary fibrosis (IPF) through exclusion of other fibrosing conditions/causes and definitive High resolution CT IPF pattern or Biopsy proven IPF. FVC of at least 50% of predicted value DLCO of at least 30% |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Exelon

**Products Affected**

- *rivastigmine*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of memantine and donepezil for Alzheimer's disease. no prequisite medications for dementia due to parkinson's disease |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Exjade

**Products Affected**

- *deferasirox oral tablet soluble*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | previous treatment history, iron indices |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Fanapt

**Products Affected**

- FANAPT
- FANAPT TITRATION PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Neurology/Psychiatry |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Farydak

**Products Affected**

- FARYDAK ORAL CAPSULE 10 MG, 20 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematologist/oncologist |
| **Coverage Duration** | 12months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Fentanyl Lozenge

**Products Affected**

- *fentanyl citrate buccal lozenge on a handle*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Previous treatment history |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pain management physician/oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered for breakthrough pain in patients receiving long acting opioid treatment and are opioid tolerant. Patient must fail two immediate release C-II opioid such as hydromorphone, morphine, oxycodone. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Fentanyl Patch

**Products Affected**

- *fentanyl transdermal patch 72 hour 12 mcg/hr 100 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr*
- *fentanyl transdermal patch 72 hour*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pain management physician/oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Ferriprox

**Products Affected**

- FERRIPROX ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | oncologist/hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Exjade and Desferal |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Fetzima

**Products Affected**

- FETZIMA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Must fail two generically available anti-depressants in past12 months |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Fintepla

**Products Affected**

- FINTEPLA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of epidiolex |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Firazyr

**Products Affected**

- *icatibant acetate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Fosrenol

**Products Affected**

- FOSRENOL ORAL PACKET
- *lanthanum carbonate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Previous treatment history, CA, PO4, IPTH |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Nephrologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient must fail or not be a candidate for calcium based phosphate binders based on KDOQI guidelines for use |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Fycompa

**Products Affected**

- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Gattex

**Products Affected**

- GATTEX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Gastroenterologist |
| **Coverage Duration** | 6 months initially |
| **Other Criteria** | Diagnosis of Short Bowel Syndrome Dependent on Parenteral Support Baseline Records of parenteral hydration After 6 month trial of Gattex, patient must demonstrate clinical improvement and or reduction in weekly parenteral fluid volume for continuation. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Gavreto

**Products Affected**

- GAVRETO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Gilenya

**Products Affected**

- GILENYA ORAL CAPSULE 0.5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Gilotrif

**Products Affected**

- GILOTRIF

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Off label use must be supported by NCCN criteria with evidence rating of 2a or 1 |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Glyburide

**Products Affected**

- *glyburide micronized*
- *glyburide oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | failure or contraindication to preferred glipizide and glimeperide |
| **Age Restrictions** | Prior authorization required for members 65 years or older. Automatic approval for members less than 65 years of age. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Through benefit year |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Hetlioz

**Products Affected**

- HETLIOZ

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Confirmed Diagnosis of non-24 hour sleep-Wake disorder Sleep study to rule out Sleep/apnea or other contributory sleep disorders Patient must be totally Blind |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Humira

**Products Affected**

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA PEN-CD/UC/HS STARTER
- HUMIRA PEN-PS/UV/ADOL HS START
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications combination with other biologic |
| **Required Medical Information** | Medical notes supporting diagnosis (including imaging, serology when applicable), response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Dermatologist/rheumatologist/ Gastroenterologist/Ophthalmologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For RA or psoriatic arthritis patient must fail infliximab and a preferred Part D specialty agent either Enbrel, Simponi, r Xeljanz. For Ankylosing spondylitis Patient must fail infiximab and Enbrel or Simponi. For ulcerative colitis patient must fail infliximab and Simponi or Xeljanz. For Crohn's disease patient must fail infliximab and 6-mp. For plaque psoriasis patients must fail infliximab and Enbrel |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Humulin U-500

**Products Affected**

- HUMULIN R U-500 KWIKPEN SUBCUTANEOUS SOLUTION PEN-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Insulin requirements of greater than 200 units/day |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Ibrance

**Products Affected**

- IBRANCE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Iclusig

**Products Affected**

- ICLUSIG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Idhifa

**Products Affected**

- IDHIFA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of IDH-1 mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Imbruvica

**Products Affected**

- IMBRUVICA ORAL CAPSULE
- IMBRUVICA ORAL TABLET 420 MG, 560 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology/ transplant specialist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Off Label and combination use must be supported by NCCN guidelines with evidence rating of 2a or 1 |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |

# Increlex

**Products Affected**

- INCRELEX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Endocrinologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Inlyta

**Products Affected**

- INLYTA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Inqovi

**Products Affected**

- INQOVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/oncology |
| **Coverage Duration** | up to 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Inrebic

**Products Affected**

- INREBIC

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | Failure of Jakafi |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Iressa

**Products Affected**

- IRESSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Iressa is contraindicated in patients with severe hypersensitivity to gefitinib or other components. |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Patient must be at least 18 years old or older. |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approved for Non Small Cell Lung Cancer with Egfr exon 19 deletion or Exon 21 substitution. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Isotretinoin

**Products Affected**

- *isotretinoin oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 5 months |
| **Other Criteria** | For cystic, nodular or scarring acne, must be refractory to oral antibiotics and topical retinoids. Trial of combination oral teracycline and topical retinoid most have been tried in most recent 6 months. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Itraconazole

**Products Affected**

- *itraconazole oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Previous treatment history, fungal culture and sensitivity |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | minimum of 12 week up to 12 months |
| **Other Criteria** | Failure of terbinafine for onychomycosis |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# IVIG

**Products Affected**

- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis, immunoglobulin studies |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For ITP Must fail corticosteroids and Anti-D immunoglobulin (if indicated). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Jakafi

**Products Affected**

- JAKAFI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications, Low risk Disease |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematology-oncology |
| **Coverage Duration** | 3 months |
| **Other Criteria** | Continuation will be based on reduction in spleen size from baseline or symptomatic improvement. Not covered when used in combination with antiproliferative drugs (i.e lenalidomide), or other JAK or Tyrosine Kinase inhibitors. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Januvia

**Products Affected**

- JANUVIA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications, Non FDA approved combinations |
| **Required Medical Information** | HA1c, previous treatment history |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Onglyza |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Juxtapid

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months initially, 12 months for continuation |
| **Other Criteria** | Clinical confirmation that patient has HoFH and failure of Statin and PCSK-9 therapy. Continuation of Juxtapid after 3 month trial based on LDL reduction while on therapy. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Kalydeco

**Products Affected**

- KALYDECO ORAL PACKET 25 MG
- KALYDECO ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Genotyping supportive of mutation status in the FDA label |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Kevzara

**Products Affected**

- KEVZARA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Coverage is limited to Rheumatoid arthritis. Must fail a preferred specialty agent (Enbrel, Xeljanz, Simponi). Must have clear documentation of moderate to severe rheumatoid arthritis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Kevzara is a injectible Il-6 antagonist indicated for rheumatoid arthritis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Kineret

**Products Affected**

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications combination with other biologic |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For RA failure of Enbrel and Humira |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Kisqali

**Products Affected**

- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KISQALI FEMARA (400 MG DOSE)
- KISQALI FEMARA (600 MG DOSE)
- KISQALI FEMARA(200 MG DOSE)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Korlym

**Products Affected**

- KORLYM

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | endocrinologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Diagnosis of Cushings syndrome , Type 2 diabetes mellitus , Failed surgery OR not a candidate for surgery , Failure of ketoconazole |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Koselugo

**Products Affected**

- KOSELUGO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | neurology/hematology/oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Diagnosis of Type 1 neurofibromatosis with symptomatic or inoperable plexiform neurofibromas |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Kuvan

**Products Affected**

- KUVAN

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to dietary changes, current assessment and plan, serum phenylalanine. |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Medical Geneticist, neurologist, hepatologist,Metabolic specialist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Latuda

**Products Affected**

- LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG, 80 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Lenvima

**Products Affected**

- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Lidoderm

**Products Affected**

- *lidocaine external patch 5 %*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered for PHN, patient must fail gabapentin |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# liraglutide (Victoza)

**Products Affected**

- VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Victoza is a medication indicated for treatment of type 2 diabetes mellitus. Criteria for coverage as follows: Covered after failure of metformin and Bydureon. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Lobrena

**Products Affected**

- LORBRENA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of ALK+ mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Lokelma

**Products Affected**

- LOKELMA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 month |
| **Other Criteria** | Two elevated serum potassium levels in absence of potassium sparing medications. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Long Acting Anti-Psychotics Injections

**Products Affected**

- ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE
- GEODON INTRAMUSCULAR
- INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE
- RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER
- *ziprasidone mesylate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Neurology Psychiatry |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of two generic anti-psychotics in the past 12 months |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Lonsurf

**Products Affected**

- LONSURF

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Lotronex

**Products Affected**

- *alosetron hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Gastroenterologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of loperimide and cholestyramine. Approved initially for 3 months continuation up to 12 months if patient has improvement in symptoms. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Lynparza

**Products Affected**

- LYNPARZA ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Mavyret

**Products Affected**

- MAVYRET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Gastroenterology, infectious disease, Hepatology |
| **Coverage Duration** | 8  weeks to 16 weeks |
| **Other Criteria** | Information supporting diagnosis,genotype,and Metavir score. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Mekinist

**Products Affected**

- MEKINIST

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | Mutation analysis showing BRAF V600E or V600K positive, not covered for combination use with other anti-neoplastics unless FDA indication or NCCN recommended with a class 2A or greater evidence rating. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Mektovi

**Products Affected**

- MEKTOVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of BRAF mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Menest

**Products Affected**

- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered for palliative treatment of breast cancer. Coverage for Hormone replacement therapy would required failure of formulary estrogens which do not have utilization management (ie. premarin, estradiol, estropipate) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Movantik

**Products Affected**

- MOVANTIK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12months |
| **Other Criteria** | Failure of Lactulose and polyethylele glycol 3350 (Miralax) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Multaq

**Products Affected**

- MULTAQ

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of sotalol and amiodarone |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Myrbetriq

**Products Affected**

- MYRBETRIQ

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Toviaz and Oxybutynin |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Natpara

**Products Affected**

- NATPARA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | iPTH, Calcium |
| **Age Restrictions** | |
| **Prescriber Restrictions** | endocrinologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Hypocalcemia despite  using maximal doses of calcitriol |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Nerlynx

**Products Affected**

- NERLYNX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematologist/Oncologist |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Neupro

**Products Affected**

- NEUPRO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Ropinirole and Pramipexole |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Nexavar

**Products Affected**

- NEXAVAR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Ninlaro

**Products Affected**

- NINLARO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Velcade  and Revlimid required for coverage |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Northera

**Products Affected**

- NORTHERA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Documented orthostatic hypotension, failure of midodrine or Fludrocortisone. No perquisite drugs required for Dopamine-Beta-Hydroxylase deficiency |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Noxafil

**Products Affected**

- NOXAFIL ORAL SUSPENSION
- *posaconazole*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months |
| **Other Criteria** | Failure, resistance or contraindication to itraconazole,voriconazole |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Nubeqa

**Products Affected**

- NUBEQA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Patient has failed Xtandi for premetastatic castrate resistant prostate cancer. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months or until Disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Nucala

**Products Affected**

- NUCALA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | The following criteria must be met for coverage for severe eosinophilic asthma: Prescriber must be a pulmonologist or allergist. Patient must fail 3 months of therapy on maximal indicated doses of ICS (inhaled corticosteroid) + LABA (long acting beta agonist) and a LAMA (long acting muscarinic agonist). Patient must have failed leukotriene receptor antagonist |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Prescriber must be a pulmonologist or allergist. |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Nucala is an interleukin 5 antagonist indicated for eosinophillic asthma  and eosophilic granulomatosis with polyangiitis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Nuedexta

**Products Affected**

- NUEDEXTA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Nuplazid

**Products Affected**

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology Psychiatry |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Notes supporting dementia with hallucinations or delusions secondary to parkinsons dementia. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Odomzo

**Products Affected**

- ODOMZO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 3 - 12 months |
| **Other Criteria** | Approval will initially be for three months, if patient has a response to therapy will be renewed for 12 months |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Ofev

**Products Affected**

- OFEV

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | pulmonologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Confirmed Diagnosis of idiopathic pulmonary fibrosis (IPF) through exclusion of other fibrosing conditions/causes and definitive High resolution CT IPF pattern or Biopsy proven IPF. FVC of at least 50% of predicted value DLCO of at least 30% |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Omnitrope

**Products Affected**

- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | studies establishing diagnosis of indication. |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Endocrinologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Onfi

**Products Affected**

- *clobazam*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | FDA approved Ages |
| **Prescriber Restrictions** | Restricted to Neurology |
| **Coverage Duration** | 12 Months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Opsumit

**Products Affected**

- OPSUMIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | pulmonologist/cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Ambrisentan and tadalafil |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Orenitram

**Products Affected**

- ORENITRAM

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Right Heart catheterization to confirm the diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Pulmonologist or Cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of combination Ambrisentan and tadalafil |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Orilissa

**Products Affected**

- ORILISSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | OB/GYN |
| **Coverage Duration** | 6 months |
| **Other Criteria** | Covered for endometriosis, failure of NSAID and combinedestrogen-progestin contraceptive or progestin. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Orkambi

**Products Affected**

- ORKAMBI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | CFTR mutation analysis, spirometry |
| **Age Restrictions** | Ages approved in FDA label |
| **Prescriber Restrictions** | pulmonologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | CFTR mutation must be supported by FDA approved label such as homozygous F508-deletion |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Otezla

**Products Affected**

- OTEZLA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of active psoriatic arthritis or moderate-to-severe plaque psoriasis or Bechet's disease. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Rheumatologist, Dermatologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Plaque Psoriasis patient must Enbrel and Simponi) or have a contraindication to TNF inhibitors and failed MTX and acitretin. For Psoriatic Arthritis patient must fail a preferred TNF inhibitor (simponi/xeljanz) and Xeljanz or have a contraindication to TNF inhibitors or Xeljanz and failed MTX and Leflunomide. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Oxandrolone

**Products Affected**

- *oxandrolone oral tablet 2.5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# oxymetholone (Anadrol-50)

**Products Affected**

- ANADROL-50

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling/compendia |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Pemazyre

**Products Affected**

- PEMAZYRE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Phenoxybenzamine

**Products Affected**

- *phenoxybenzamine hcl oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Piqray

**Products Affected**

- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months or until progression, |
| **Other Criteria** | HR+ ER- with PIK3CA mutation advanced/metastatic breast cancer and failure of a CDK 4/6 inhibitor. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Pomalyst

**Products Affected**

- POMALYST

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approve for patients with multiple myeloma who have received at least two prior therapies including lenalidomide and bortezomib and have demonstrated disease progression on or within 60 days of completion of the last therapy |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Prolastin-C

**Products Affected**

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 1 Year |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Prolia

**Products Affected**

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Intolerance or contraindication to injectable bisphosphonate required for coverage of prolia |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Promacta

**Products Affected**

- PROMACTA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, CBC ,Platelet count less than 50,000/ml for ITP, Platelet count of less than 75,000/ml for HCV |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist, Hepatologist/gastroenterologist, Infectious Disease |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Chronic ITP Refractory to IVIG, corticosteroids or splenectomy as per FDA approval studies not applicable to HCV related thrombocytopenia |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Pulmozyme

**Products Affected**

- PULMOZYME

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, Spirometry |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pulmonologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Patients with Cystic Fibrosis who have had recurrent pulmonary infections |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# pyrimethamine (Daraprim)

**Products Affected**

- *pyrimethamine oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 Months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Qinlock

**Products Affected**

- QINLOCK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | hematology/oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Quinine

**Products Affected**

- *quinine sulfate oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Notes supporting diagnosis of malaria |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Ravicti

**Products Affected**

- RAVICTI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | hepatologist or metabolic specialist such as a endocrinologist or geneticist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Clinical Failure of Buphenyl |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Rebif

**Products Affected**

- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of glatiramer |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Repatha

**Products Affected**

- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For patients with HoFH, HeFH, or with established atherosclerotic cardiovascular disease and Primary hyperlipidemia who require additional LDL lowering: Failure of rosuvastatin 40mg or Atorvastatin 80 combined with ezetimibe 10mg. Diagnosis of must be HeFH supported by Dutch Lipid Clinic Network criteria. Diagnosis of HOFH must be confirmed by genetic testing. Patients who are intolerant to rosuvastatin/ atorvastatin can use an alternative statin + Ezetimibe 10mg.For statin intolerant patients who required additional LDL lowering and have established cardiovascular disease, HoFH, or HeFH: History of statin intolerance to a hydrophillic statin such as fluvastatin, pravastatin, rosuvastatin in the absence of fibrates or other combinations which can increase risk of myopathy or myalgia when used in combination with a statin. |
| **Indications** | All FDA-approved Indications. |

| PA Criteria | Criteria Details |
| --- | --- |
| **Off Label Uses** | |

# Retacrit

**Products Affected**

- RETACRIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Scr, HGB, T-sat, Ferritin |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months |
| **Other Criteria** | Hemoglobin must be within FDA approved ranges for initiation and maintenance. Patient must have adequate iron stores to initiate and continue treatment. ESRD will be covered under Medicare Part B |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Retevmo

**Products Affected**

- RETEVMO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or disease progression |
| **Other Criteria** | Diagnosis of metastatic non-small cell lung cancer or metastatic or advanced medullary thyroid carcinoma with RET alterations |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Revatio

**Products Affected**

- *sildenafil citrate oral tablet 20 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, 6 min walk, diffusion studies,Rt Heart Cath |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pulmonologist/Cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral ,Coverage will be based on medical history/status, vasoreactivity tests. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Revlimid

**Products Affected**

- REVLIMID

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, CBC, Bone Marrow Biopsy, Karyotype |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Rexulti

**Products Affected**

- REXULTI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12months |
| **Other Criteria** | Failure of aripiprazole and risperidone for schizophrenia or failure of combination SSRI and aripiprazole for major depressive disorder. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Rilutek

**Products Affected**

- *riluzole*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan. |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Neurologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Diagnosis is definite or probable ALS by Neurology, symptoms present for less than 5 years, Vital Capacity is 60% or more of predicted, patient does not have a tracheotomy |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Rubraca

**Products Affected**

- RUBRACA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Rydapt

**Products Affected**

- RYDAPT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | Labs supporting FLT3 mutation if being used for AML, not required for systemic mastocytosis |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Sabril

**Products Affected**

- *vigabatrin*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Neurologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient must fail treat with adjunctive treatment combination (applies to Refractory Partial Complex only) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Saphris

**Products Affected**

- SAPHRIS

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Psychiatry/ Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Secuado

**Products Affected**

- SECUADO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Restricted to Neurology/Psychiatry |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of two generic formulary medications for the same indication. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Sensipar

**Products Affected**

- *cinacalcet hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, previous treatment history, associated studies iPTH, calcium, phosphate |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Nephrologist/endocrinologist/oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For secondary hyperparathyroidism related to CKD, patient must fail active vit-D therapy/phosphate binders. ESRD use is excluded from medicare Part D and this authorization will include a determination of Part D vs Part B coverage based indication |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Signifor

**Products Affected**

- SIGNIFOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Endocrinologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Cushings Disease failed or poor surgical candidate for pituitary resection |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Simponi

**Products Affected**

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR MG/0.5ML
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 50

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For RA Patient must fail 3 month trial of MTX in combination with a DMARD in past 6 months. If MTX contraindicated, must try combination of 2-nonbiologic DMARDS. For Ankylosing Spondylitis PT must fail 2 NSAIDS within past 6 months. For Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. For ulcerative colitis patient must fail Azathioprine/6MP in combination with a 5-ASA compound. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Solaraze

**Products Affected**

- *diclofenac sodium transdermal gel 3 %*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Dermatologist, oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Somatuline

**Products Affected**

- SOMATULINE DEPOT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | endocrinologist, oncologist , medical geneticist |
| **Coverage Duration** | 12 Months |
| **Other Criteria** | Need clinical notes and labs supporting diagnosis of Acromegaly GH, IGF-1 |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Somavert

**Products Affected**

- SOMAVERT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Endocrinologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Sprycel

**Products Affected**

- SPRYCEL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | Requires failure of imatinib for low risk CML based on Sokal or Hasford scores. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Stelara

**Products Affected**

- STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML
- STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | gastroenterologist/rheumatologist/dermatologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Crohns, patient must fail Entyvio and Renflexis. For plaque psoriasis, patient must fail Enbrel and Renflexis. For psoriatic arthritis, patient must fail Enbrel, Simponi, and Xeljanz. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Stivarga

**Products Affected**

- STIVARGA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Sutent

**Products Affected**

- SUTENT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Symlin

**Products Affected**

- SYMLINPEN 120 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- SYMLINPEN 60 SUBCUTANEOUS SOLUTION PEN-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, HA1c BG |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Endocrinologist, Internist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient BG must be non-controlled on optimal doses of insulin |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Sympazan

**Products Affected**

- SYMPAZAN

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Synarel

**Products Affected**

- SYNAREL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis, Notes, Previous treatment history |
| **Age Restrictions** | Ages approved in FDA Label |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered after patient fails treatment with Lupron for endometriosis or precocious puberty |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tabrecta

**Products Affected**

- TABRECTA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tafinlar

**Products Affected**

- TAFINLAR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | Mutation analysis showing BRAF V600E or V600K positive, not covered for combination use with other anti-neoplastics unless FDA indication or NCCN recommended with a class 2A or greater evidence rating. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tagrisso

**Products Affected**

- TAGRISSO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Coverage requires Diagnosis of Non Small Cell Lung cancer EGFR mutations including T790m, exon 19 deletions. For first line use in patients with exon 21 (L858R) EGFR mutation erlotinib failure may be required if NCCN guidelines support use of either drug based on results of Flaura trial. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Talzenna

**Products Affected**

- TALZENNA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of germline BRCA mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tarceva

**Products Affected**

- *erlotinib hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Targretin

**Products Affected**

- *bexarotene*
- TARGRETIN EXTERNAL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | Must have failed one prior systemic therapy |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tasigna

**Products Affected**

- TASIGNA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered for failure or relapse of CML when previously treated with imatinib.  Covered for newly diagnosed CML patients who are Philadelphia chromosome +. Will also be covered for intolerance or adverse reaction to imatinib. Combination therapy with other tyrosine kinase inhibitors or MTOR inhibitors for CML is not supported. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tazorac

**Products Affected**

- *tazarotene external*
- TAZORAC EXTERNAL CREAM 0.05 %
- TAZORAC EXTERNAL GEL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Previous treatment history |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Psoriasis patient must have failed medium to high potency topical corticosteroid, For acne patient must have failed Tretinoin and oral antibiotic |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# tazverik

**Products Affected**

- TAZVERIK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tecfidara

**Products Affected**

- *dimethyl fumarate oral*
- TECFIDERA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Gilenya |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tetrabenazine

**Products Affected**

- *tetrabenazine*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology or Psychiatry |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For tardive dyskinesia causative drug must be discontinued or tried at a lower dose |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Thalomid

**Products Affected**

- THALOMID

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist/infectious disease |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tibsovo

**Products Affected**

- TIBSOVO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of IDH-1 Mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tobi Podhaler

**Products Affected**

- TOBI PODHALER

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Medical notes describing indication for the management of cystic fibrosis patients with Pseudomonas aeruginosa and with forced expiratory volume in 1 second (FEV1) greater than 25% or less than 80%. |
| **Age Restrictions** | 6 years and older |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Through benefit year |
| **Other Criteria** | Safety and efficacy have not been demonstrated in patients with forced expiratory volume in 1 second (FEV1) less than 25% or greater than 80%, or patients colonized with Burkholderia cepacia |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tracleer

**Products Affected**

- *bosentan*
- TRACLEER ORAL TABLET SOLUBLE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, right heart catheterization, 6 Minute Walk time |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pulmonologist or cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral ,Coverage will be based on medical history/status, vasoreactivity tests, failure of sildenafil. Sildenafil failure does not apply to pediatric patients with congental or ideopathic PAH |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tretinoin Topical

**Products Affected**

- *tretinoin external cream*
- *tretinoin external gel 0.01 %, 0.025 %*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications, treatment of photoaging, wrinkles |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Trintellix

**Products Affected**

- TRINTELLIX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of two generically available anti-depressants within past 6 months |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tukysa

**Products Affected**

- TUKYSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | hematology/oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Turalio

**Products Affected**

- TURALIO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/hematology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | Patient is not a surgical candidate and has a Tenosynovial giant cell tumor. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tykerb

**Products Affected**

- TYKERB

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan associated studies |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Oncologist/hematologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient is using in combination with capecitabine for HER/NEU + Metastatic breast CA, having failed an anthracycline, Herceptin and a taxane, or Patient must be using in combination with an aromatase inhibitor and have HER/NEU+ HR+ metastatic breast CA |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Tymlos

**Products Affected**

- TYMLOS

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications/ cumulative tx more than 24month |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, BMD, PTH, VITD |
| **Age Restrictions** | Late adolescents and Adults only |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient must fail or have contraindication to bisphosphonates,  Vitamin D (25,OH), PTH must be WNL |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Udenyca

**Products Affected**

- UDENYCA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Uptravi

**Products Affected**

- UPTRAVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Right heart catheterization supporting diagnosis of PAH |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Pulmonology or Cardiology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | diagnosis of WHO group 1 PAH, failure of Ambrisentan and tadalafil |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Valchor

**Products Affected**

- VALCHLOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Valtoco

**Products Affected**

- VALTOCO 10 MG DOSE
- VALTOCO 15 MG DOSE
- VALTOCO 20 MG DOSE
- VALTOCO 5 MG DOSE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of diazepam rectal gel and history of cluster seizures or acute repetitive seizures. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Vancomycin Capsules

**Products Affected**

- *vancomycin hcl oral capsule*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnostic confirmation of clostridium difficile diarrhea or staphylcoccal enterocolitis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Gastroenterology, infectious disease, oncology |
| **Coverage Duration** | 10 days |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Venclexta

**Products Affected**

- VENCLEXTA
- VENCLEXTA STARTING PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Verzenio

**Products Affected**

- VERZENIO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or clinical progresion |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Vimpat

**Products Affected**

- VIMPAT ORAL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Vitrakvi

**Products Affected**

- VITRAKVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of a NTRK fusion |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Vizimpro

**Products Affected**

- VIZIMPRO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of EGFR mutated non-small cell lung cancer |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until Disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Voriconazole

**Products Affected**

- *voriconazole intravenous*
- *voriconazole oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months |
| **Other Criteria** | Covered when two of the following medications have been tried, unless resistance or contraindication precludes use, Itraconazole, fluconazole, ketoconazole. Exclusions to prerequisite medications are Invasive pulmonary aspergillosis, Scedosporium apiospermum, Fusarium |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Votrient

**Products Affected**

- VOTRIENT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Vraylar

**Products Affected**

- VRAYLAR ORAL CAPSULE
- VRAYLAR ORAL CAPSULE THERAPY PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Psychiatry or Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Requires failure of aripiprazole and risperidone. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Xalkori

**Products Affected**

- XALKORI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis, documentation support ALK+ NSLC or ROS1 Positive |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematology-oncology |
| **Coverage Duration** | 6 months |
| **Other Criteria** | Continuation will be based on lack of disease progression |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Xcopri

**Products Affected**

- XCOPRI
- XCOPRI (250 MG DAILY DOSE)
- XCOPRI (350 MG DAILY DOSE)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Medication history |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Recent failure (past 6 months) of two generically available medications used to treat partial onset seizures. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Xeljanz

**Products Affected**

- XELJANZ
- XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HOUR 11 MG, 22 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Rheumatology/Gastroenterologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Rheumatoid arthritis- 3 month trial of Combination DMARD therapy in past 6 months, For Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. For ulcerative colitis patient must fail Azathioprine/6MP in combination with a 5-ASA compound. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Xgeva

**Products Affected**

- XGEVA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | oncology/endocrinology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure or contraindication to bisphosphonate for osteolytic cancer indications other than giant cell tumor of the bone. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Xolair

**Products Affected**

- XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan. For asthma please submit RAST, aeroallergens results, IgE values |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pulmonologist, allergist, Dermatologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Asthma patient Must Fail Combination LABA/ICS. For chronic ideopathic urticaria failure of hydroxyzine and H-2 antagonist. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Xospata

**Products Affected**

- XOSPATA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Xpovio

**Products Affected**

- XPOVIO (100 MG ONCE WEEKLY)
- XPOVIO (40 MG ONCE WEEKLY)
- XPOVIO (40 MG TWICE WEEKLY)
- XPOVIO (60 MG ONCE WEEKLY)
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY)
- XPOVIO (80 MG TWICE WEEKLY)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Xtandi

**Products Affected**

- XTANDI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months or until disease progression |
| **Other Criteria** | Failure of Abiraterone for metastatic prostate cancer |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Xyrem

**Products Affected**

- XYREM

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Physician Board certified in Sleep Medicine or neurologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Modafanil/Armodafinil and amphetamine/dextroamphetamine or failure of fluoxetine for narcolepsy with cataplexy |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Zavesca

**Products Affected**

- *miglustat*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Oncologist/Hematologist, Neurologist, Medical Geneticist, Metabolic Specialist. |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Zejula

**Products Affected**

- ZEJULA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Zelboraf

**Products Affected**

- ZELBORAF

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 3 months |
| **Other Criteria** | Authorization for continuation past 90 days will be based on absence of disease progression. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Zemplar

**Products Affected**

- *paricalcitol oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, CA PO4, iPTH |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Nephrologist/endocrinologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient must fail or have contraindication to Calcitriol or phosphate binder if appropriate |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Zepatier

**Products Affected**

- ZEPATIER

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Gentotype, Viral Load, Fibroscan/Fibrosure or liver biopsy, RAV NS5A panel |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Infectious disease, Gastroenterology/Hepatology |
| **Coverage Duration** | 12 or 16 weeks depending on RAV profile as supported by current AASLD guidelines |
| **Other Criteria** | Contraindication to GLECAPREVIR/PIBRENTASVIR |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# zileuton (Zyflo)

**Products Affected**

- *zileuton er*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Pulmonology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Uncontrolled Asthma while on maximal doses of long acting bronchodilators and inhaled corticosteroids AND montelukast. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Zolinza

**Products Affected**

- ZOLINZA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Oncologist/hematologist/dermatologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failed minimum of two systemic treatments, one of which must be Targretin, unless contraindicated |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Zydelig

**Products Affected**

- ZYDELIG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Zykadia

**Products Affected**

- ZYKADIA ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | Restricted to use in ALK+ Non Small Cell Lung Cancer |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Zyprexa Injection

**Products Affected**

- *olanzapine intramuscular*
- ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION RECONSTITUTED 210 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of two generic anti-psychotics in the past 12 months |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

# Zytiga

**Products Affected**

- *abiraterone acetate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Oncology/urology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |

**Index**

FHCP Medicare
An Affiliate of Florida Blue

# Section 1557 Notification: Discrimination is Against the Law

FHCP Medicare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. FHCP Medicare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

FHCP Medicare:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified Interpreters
  - Information written in other languages

If you need these services, contact:

- FHCP Medicare : 1-833-866-6559

If you believe that FHCP Medicare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

FHCP Medicare
Civil Rights Coordinator
1340 Ridgewood Avenue,
Holly Hill, FL 32117.
Phone: 1-844-219-6137,
TTY: 1-800-955-8770
Fax: 386-676-7149,
Email: rights@fhcp.com.

You can file grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

FHCP Medicare

An Affiliate of Florida Blue

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-833-866-6559. (TTY: 1-800-955-8770)**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-833-866-6559** (TTY: **1-800-955-8770**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-833-866-6559 (TTY: 1-800-955-8770).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-866-6559 (TTY: 1-800-955-8770).

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ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-833-866-6559 (TTY: 1-800-955-8770).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-833-866-6559 (TTY: 1-800-955-8770).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-833-866-6559 (TTY: 1-800-955-8770)번으로 전화해 주십시오.

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