PRIOR AUTHORIZATION CRITERIA

This list is current as of December 1, 2021, and pertains to the following formularies:

2021 Pharmacy Benefit Dimensions PDP offered by Niagara County Formulary D0457 - 0464	Version 29
2021 Pharmacy Benefit Dimensions PDP offered by Niagara County Formulary D0465	Version 29

Pharmacy Benefit Dimensions requires you (or your physician) to get prior authorization for certain drugs listed on the formularies above. This means that you will need to get approval from us before you fill your prescriptions. If you do not get approval, we may not cover the drug. These drugs are listed with a "PA" in the Requirements/Notes column on the formularies. This document contains the Prior Authorization requirements that are associated with the formularies listed above.

If you have any questions, please contact our Medicare Member Services Department at 1-800-667-5936 or, for TTY users 711, October 1st – March 31st: Monday through Sunday from 8 a.m. to 8 p.m. ET, April 1st – September 30th: Monday through Friday from 8 a.m. to 8 p.m. ET.

Pharmacy Benefit Dimensions is a subsidiary of Independent Health. Independent Health is a PDP with a Medicare contract. Enrollment in Pharmacy Benefit Dimensions PDP depends on contract renewal between Independent Health and CMS.

The formulary may change at any time. You will receive notice when necessary.

ABILIFY MYCITE (aripiprazole with sensor)

Products Affected

- ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG
- ABILIFY MYCITE ORAL TABLET 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG
- ABILIFY MYCITE STARTER KIT ORAL TABLET 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis
Required Medical Information	Diagnosis of covered use, documentation of previous aripiprazole use (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. For approval, the patient must have documentation of at least a one-month trial of generic aripiprazole solution, tablets, or orally-disintegrating tablets.
Indications	All Medically-accepted Indications.
Off Label Uses	

ACTHAR (corticotropin)

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	Request for IV administration, treatment of patients under 2 years of age in whom congenital infections are suspected, patients with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, a history of or presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction, or sensitivity to proteins of porcine origin
Required Medical Information	Diagnosis of covered use, submission of blood pressure reading and baseline serum sodium and potassium levels.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

ACTIMMUNE (interferon gamma-1b)

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

ADEMPAS (riociguat)

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, severe (Child-Pugh class C) hepatic impairment, creatinine clearance below 15 mL/min or on dialysis, concurrent use with nitrates or nitric oxide donors in any form, concurrent use with phosphodiesterase inhibitors
Required Medical Information	Diagnosis of covered use, submission of negative pregnancy test result for female patients of childbearing age, submission of patient weight and serum creatinine (to calculate estimated creatinine clearance).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to cardiology and pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ADENOSINE DEAMINASE DEFICIENCY

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	Severe thrombocytopenia
Required Medical Information	Diagnosis of covered use, submission of plasma ADA activity and platelet count.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All FDA-approved Indications.
Off Label Uses	

AKYNZEO (netupitant/palonosetron)

Products Affected

- AKYNZEO ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, confirmation patient will receive concurrent dexamethasone therapy as indicated based on level of chemotherapy regimen emetogenicity.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. If the medication is being administered related to cancer treatment and is a full replacement for intravenous administration of antiemetic therapy within 48 hours of cancer treatment, it is covered as a Part B benefit. To be eligible for Part B coverage, the prescribing physician must indicate this on the prescription. Otherwise it may be covered as a Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	

ALECENSA (alectinib)

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of ALK-positive tumor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ALPHA-1-PROTEINASE INHIBITORS

Products Affected

- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG, 500 MG
- GLASSIA
- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED
- ZEMAIRA

PA Criteria	Criteria Details
Exclusion Criteria	Individuals with immunoglobulin A (IgA) deficiency who have known antibodies against IgA
Required Medical Information	Diagnosis of covered use, confirmation that patient has clinically evident emphysema secondary to congenital alpha-1-PI deficiency by submission of pulmonary function testing (e.g., spirometry or body plethysmography), X-ray radiography, or diffusing capacity of the lung for carbon monoxide (DLCO).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. Continuation of therapy requests require objective documentation from the prescriber that the patient's symptoms have improved. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

ALUNBRIG (brigatinib)

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of ALK-positive tumor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

AMANTADINE EXTENDED-RELEASE PRODUCTS

Products Affected

- GOCOVRI HOUR 129 MG, 193 MG, 258 MG
- OSMOLEX ER ORAL TABLET ER 24 HOUR THERAPY PACK
- OSMOLEX ER ORAL TABLET EXTENDED RELEASE 24

PA Criteria	Criteria Details
Exclusion Criteria	End stage renal disease (creatinine clearance below 15 mL/min)
Required Medical Information	Diagnosis of covered use, documentation patient tried and failed immediate-release amantadine.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

AMBISOME (amphotericin B liposomal injection)

Products Affected

- ABELCET
- AMBISOME
- AMPHOTERICIN B INTRAVENOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	Restricted to infectious diseases
Coverage Duration	1 year
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

ANADROL-50 (oxymetholone)

Products Affected

- ANADROL-50

PA Criteria	Criteria Details
Exclusion Criteria	Carcinoma of the prostate or breast in male patients, carcinoma of the breast in females with hypercalcemia, women who are or may become pregnant, nephrosis or the nephrotic phase of nephritis, severe hepatic dysfunction
Required Medical Information	Diagnosis of covered use, submission of CBC and liver function tests.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ARANESP (darbepoetin alfa)

Products Affected

- ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 300 MCG/ML, 40 MCG/ML, 60 MCG/ML PREFILLED SYRINGE
- ARANESP (ALBUMIN FREE) INJECTION SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of hemoglobin or hematocrit level, serum iron, total iron-binding capacity (TIBC), and transferrin within 30 days of request date, documentation that the patient does not have uncontrolled hypertension.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For non-ESRD-related conditions: 90 days. For ESRD-related conditions: 1 year.
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

ARCALYST (rilonacept)

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	Active or chronic infection
Required Medical Information	Diagnosis of covered use, TB skin test result obtained within the past 12 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

ARIKAYCE (amikacin inhalation)

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	Non-refractory Mycobacterium avium complex (MAC) lung disease
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	This medication is covered as a Part B benefit except for enrollees residing in a long-term care facility. PA applies to all when covered as a Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	

AURYXIA (ferric citrate)

Products Affected

- AURYXIA

PA Criteria	Criteria Details
Exclusion Criteria	Iron overload syndrome
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

AYVAKIT (avapritinib)

Products Affected

- AYVAKIT ORAL TABLET 100 MG, 200 MG, 25 MG, 300 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with moderate or strong CYP3A inhibitors or inducers. For advanced systemic mastocytosis indication only, platelet count below 50 x 10^9/L.
Required Medical Information	Diagnosis of covered use. For gastrointestinal stromal tumor indication only, submission of test result confirming presence of PDGFRA exon 18 mutation. For advanced systemic mastocytosis indication only, submission of platelet count.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to allergy, hematology, immunology, and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

BAFIERTAM (monomethyl fumarate)

Products Affected

- BAFIERTAM

PA Criteria	Criteria Details
Exclusion Criteria	Hypersensitivity to dimethyl fumarate or diroximel fumarate, co-administration with dimethyl fumarate or diroximel fumarate
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to all. For approval of Bafiertam, the patient must have tried and failed to have an adequate response to or had an intolerance to dimethyl fumarate.
Indications	All Medically-accepted Indications.
Off Label Uses	

BALVERSA (erdafitinib)

Products Affected

- BALVERSA

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with strong CYP2C9 or CYP3A4 inducers
Required Medical Information	Diagnosis of covered use, submission of FDA-approved companion test showing susceptible FGFR2 or FGFR3 genetic alterations, prior chemotherapy regimen(s) used.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

BEMPEDOIC ACID

Products Affected

- NEXLETOL
- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant pravastatin utilization with doses above 40 mg/day, concomitant simvastatin utilization with doses above 20 mg/day
Required Medical Information	Diagnosis of covered use, submission of current or previous lipid-lowering therapies.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. For approval, the patient must currently be using a statin plus ezetimibe or the patient must have tried and failed to have an adequate response to or had an intolerance to at least two statins or one statin and ezetimibe.
Indications	All Medically-accepted Indications.
Off Label Uses	

BENLYSTA (belimumab)

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Severe active central nervous system lupus, patients using other biologic medications or intravenous cyclophosphamide
Required Medical Information	Diagnosis of covered use, confirmation that the patient is taking standard therapy defined as at least one of the following: corticosteroids, NSAIDs, antimalarials, or immunosuppressants.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

BENZNIDAZOLE

Products Affected

- BENZNIDAZOLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	2 years of age through 12 years of age
Prescriber Restrictions	Restricted to infectious diseases
Coverage Duration	60 days
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

BIOLOGIC RESPONSE MODIFIERS

Products Affected

- ACTEMRA ACTPEN
- ACTEMRA SUBCUTANEOUS
- CIMZIA PREFILLED
- CIMZIA STARTER KIT
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG
- KEVZARA
- OTEZLA
- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- TALTZ
- TREMFYA
- ZEPOSIA
- ZEPOSIA 7-DAY STARTER PACK
- ZEPOSIA STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Zeposia for the treatment of multiple sclerosis, only diagnosis of covered use is required. For all other drugs managed by this policy and for Zeposia for indications other than multiple sclerosis, diagnosis of covered use, submission of previous therapies. For all drugs managed by this policy except Otezla and Zeposia, submission of baseline latent tuberculosis screening test (Mantoux tuberculin skin test [a.k.a. PPD test] or interferon-gamma release assay [IGRA]).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. With the exception of Zeposia for the treatment of multiple sclerosis only, for approval of a drug managed by this policy, the patient must have tried and failed to have an adequate response to or had an intolerance to at least two preferred agents (Cosentyx, Enbrel, Humira, Rinvoq, Skyrizi, Stelara, and Xeljanz/Xeljanz XR) for the indication submitted, where possible. For all drugs managed by this policy except Otezla and Zeposia, if TB screening test returns a positive result, coverage will be delayed until latent TB is treated. For re-authorization, yearly TB screening test or chest X-ray required for patients who live in, work in, or travel to areas where TB exposure is likely while on treatment or for those who have previously had a positive TB screening test.
Indications	All Medically-accepted Indications.
Off Label Uses	

BOSULIF (bosutinib)

Products Affected

- BOSULIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of renal function testing. For accelerated or blast phase Ph+ CML, documentation of resistance or intolerance to at least one of the following prior therapies: imatinib, dasatinib, or nilotinib.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

BRAFTOVI/MEKTOVI (encorafenib/binimetinib)

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG
- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of BRAF V600E or V600K mutation, serum potassium, and serum magnesium. For metastatic melanoma, confirmation that encorafenib and binimetinib will be co-administered. For metastatic colorectal cancer, confirmation that encorafenib and cetuximab will be co-administered.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

BRIVIACT (brivaracetam)

Products Affected

- BRIVIACT ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	4 years of age or older
Prescriber Restrictions	PA not required for neurology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

BRONCHITOL (mannitol powder for inhalation)

Products Affected

- BRONCHITOL

PA Criteria	Criteria Details
Exclusion Criteria	Documented Bronchitol Tolerance Test failure
Required Medical Information	Diagnosis of covered use, documentation patient has passed the Bronchitol Tolerance Test, attestation patient will not be using in combination with hypertonic (7%) sodium chloride nebulized solution.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. For approval, the patient must must have tried and failed to have an adequate response to or had an intolerance to hypertonic (7%) sodium chloride nebulized solution.
Indications	All Medically-accepted Indications.
Off Label Uses	

BRUKINSA (zanubrutinib)

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with moderate or strong CYP3A inducers
Required Medical Information	Diagnosis of covered use, submission of prior chemotherapy regimen(s) used.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

BUTALBITAL-CONTAINING PRODUCTS IN OLDER PATIENTS

Products Affected

- ASCOMP-CODEINE
- BUPAP ORAL TABLET 50-300 MG
- BUTALBITAL-ACETAMINOPHEN ORAL TABLET 50-300 MG, 50-325 MG
- BUTALBITAL-APAP-CAFF-COD
- BUTALBITAL-APAP-CAFFEINE ORAL CAPSULE
- BUTALBITAL-APAP-CAFFEINE ORAL TABLET 50-325-40 MG
- BUTALBITAL-ASA-CAFF-CODEINE
- *butalbital-aspirin-caffeine oral capsule*
- TENCON ORAL TABLET 50-325 MG
- VANATOL LQ
- VTOL LQ
- ZEBUTAL ORAL CAPSULE 50-325-40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All 4 of the following criteria must be met: (1) diagnosis of covered use, (2) documentation provider is aware medication is considered a high-risk medication for elderly patients according to the Centers for Medicare and Medicaid Services, (3) documentation that the benefits of the drug outweigh the potential risks to the patient, and (4) documentation patient has tried and failed or have a contraindication to a preferred alternative such as ibuprofen or rizatriptan.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

BYLVAY (odevixibat)

Products Affected

- BYLVAY
- BYLVAY (PELLETS)

PA Criteria	Criteria Details
Exclusion Criteria	History of liver transplant, clinical evidence of decompensated cirrhosis
Required Medical Information	Diagnosis of covered use confirmed by molecular genetic testing, attestation drug-induced pruritus has been ruled out.
Age Restrictions	
Prescriber Restrictions	Restricted to gastroenterology and hepatology
Coverage Duration	1 year
Other Criteria	PA applies to all. Attestation of improvement in pruritus symptoms and submission of liver function testing, including serum bilirubin, since the previous authorization will be required for subsequent reauthorizations.
Indications	All Medically-accepted Indications.
Off Label Uses	

C1 ESTERASE INHIBITORS (for hereditary angioedema)

Products Affected

- HAEGARDA
- RUCONEST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of documentation that epinephrine will be immediately available in the event of an acute severe hypersensitivity reaction.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

CABLIVI (caplacizumab-yhdp)

Products Affected

- CABLIVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to cardiology, hematology, and immunology
Coverage Duration	3 months
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

CABOMETYX (cabozantinib)

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

CALQUENCE (acalabrutinib)

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	Patients on proton pump inhibitors
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

CAPLYTA (lumateperone)

Products Affected

- CAPLYTA

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis
Required Medical Information	Diagnosis of covered use, submission of previous therapies used for indication and liver function testing or Child-Pugh score.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to psychiatry
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. For approval, the patient must have tried and failed to have an adequate response to or had an intolerance to aripiprazole and at least one other generic second-generation atypical antipsychotic (e.g., paliperidone, quetiapine, risperidone, etc.) or Latuda.
Indications	All Medically-accepted Indications.
Off Label Uses	

CAPRELSA (vandetanib)

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Exclusion Criteria	Congenital long QT syndrome, moderate or severe hepatic impairment, QTcF interval greater than 450 msec
Required Medical Information	Diagnosis of covered use, submission of baseline serum potassium, calcium, magnesium, ALT, AST, bilirubin, TSH, creatinine clearance (or serum creatinine plus current patient weight), and ECG.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

CARBAGLU (carglumic acid)

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of plasma ammonia level.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

CERDELGA (eliglustat)

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	Patients who are extensive or intermediate CYP2D6 metabolizers taking a strong CYP2D6 inhibitor with a strong or moderate CYP3A inhibitor, intermediate and poor CYP2D6 metabolizers taking a strong CYP3A inhibitor
Required Medical Information	Diagnosis of covered use, submission of CYP2D6 metabolizer status as detected by an FDA-cleared test for determining CYP2D6 genotype.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

CGRP INHIBITORS

Products Affected

- AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML
- AJOVY
- EMGALITY
- EMGALITY (300 MG DOSE)
- NURTEC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For treatment of migraine headache prevention, submission of migraine days per month from medical chart, documentation patient has tried and failed or has a contraindication to at least two preferred FDA-approved alternatives for migraine prophylaxis (propranolol, timolol, topiramate, valproic acid). For Nurtec for the treatment of acute migraine, documentation of prior use of at least one triptan.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initially 3 months, then 1 year
Other Criteria	PA applies to all. Continuation requires documentation of clinically relevant response to therapy. For approval of Nurtec for migraine headache prevention, the patient must have a diagnosis of episodic migraine, defined as fewer than 15 migraine days per month, and the patient must have tried and failed to have an adequate response to or had an intolerance to Aimovig and Ajovy. For approval of Emgality for migraine headache prevention, the patient must have tried and failed to have an adequate response to or had an intolerance to Aimovig and Ajovy. For Ajovy, a description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

CHENODAL (chenodiol)

Products Affected

- CHENODAL

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, known hepatocyte dysfunction, bile duct abnormalities such as intrahepatic cholestasis, primary biliary cirrhosis, or sclerosing cholangitis, radiopaque stones, nonvisualizing gallbladder confirmed as nonvisualizing after 2 consecutive single doses of dye, compelling reasons for gallbladder surgery
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	24 months
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

CHOLBAM (cholic acid)

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	Restricted to hepatology, gastroenterology, and pediatric gastroenterology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

COMETRIQ (cabozantinib)

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	Severe hepatic impairment (Child-Pugh class C)
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

COPIKTRA (duvelisib)

Products Affected

- COPIKTRA ORAL CAPSULE 15 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with strong CYP3A inducers
Required Medical Information	Diagnosis of covered use, submission of at least two prior therapies tried and failed, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology or oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

CORLANOR (ivabradine)

Products Affected

- CORLANOR

PA Criteria	Criteria Details
Exclusion Criteria	Acute decompensated heart failure, clinically significant hypotension, clinically significant bradycardia, severe hepatic impairment, pacemaker dependence (heart rate maintained exclusively by the pacemaker), or sick sinus syndrome, sinoatrial block, or 3rd degree AV block unless a functioning demand pacemaker is present
Required Medical Information	Diagnosis of covered use described as is indicated (1) to reduce the risk of hospitalization for worsening heart failure in patients with stable, symptomatic chronic heart failure with left ventricular ejection fraction less than or equal to 35%, who are in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute and either are on maximally tolerated doses of beta-blockers or have a contraindication to beta-blocker use or (2) for stable symptomatic heart failure due to dilated cardiomyopathy in patients who are in sinus rhythm with an elevated heart rate. Submission of current baseline blood pressure reading, confirmation that patient does not have any of the following: (1) acute decompensated heart failure, (2) sick sinus syndrome, sinoatrial block, or 3rd degree AV block, unless a functioning demand pacemaker is present, (3) resting heart rate less than 60 bpm prior to treatment, (4) severe hepatic impairment, (5) pacemaker dependence (heart rate maintained exclusively by the pacemaker). For patients under 18 years old, (1) left ventricular ejection fraction less than or equal to 45% and (2) resting heart rate greater than or equal to the following age-stratified requirements: (a) 105 beats per minute in ages 6 to 12 months old, (b) 95 beats per minute in ages 1 to 3 years old, (c) 75 beats per minute in ages 3 to 5 years old, and (d) 70 beats per minute in ages 5 to 18 years old.
Age Restrictions	
Prescriber Restrictions	Restricted to cardiology
Coverage Duration	1 year
Other Criteria	PA applies to all. Continuation requires documentation of clinically relevant response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

COTELLIC (cobimetinib)

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of BRAF V600E or V600K mutation, submission of left ventricular ejection fraction.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

CYSTADROPS (cysteamine)

Products Affected

- CYSTADROPS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

CYSTARAN (cysteamine)

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

DALFAMPRIDINE

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	History of seizure, moderate or severe renal impairment (CrCl less than or equal to 50 mL/min)
Required Medical Information	Diagnosis of covered use, submission of serum creatinine, patient weight, and objective measurement of walking speed, confirmation that patient is able to walk.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	Initially 3 months, then 1 year
Other Criteria	PA applies to all. Re-authorization contingent upon documentation the patient has demonstrated an improvement in walking speed from baseline measure (or maintenance of improvement if patient has been on long-term therapy) since starting medication.
Indications	All Medically-accepted Indications.
Off Label Uses	

DAURISMO (glasdegib)

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, confirmation patient will also be receiving cytarabine as part of chemotherapeutic regimen. If patient is under 75 years of age, documentation of comorbidities that preclude use of intensive induction chemotherapy, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

DAYVIGO (lemborexant)

Products Affected

- DAYVIGO ORAL TABLET 10 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Narcolepsy
Required Medical Information	Diagnosis of covered use. Patient must have tried and failed to tolerate or had an inadequate response to two covered alternative therapies recommended by the American Academy of Sleep Medicine (doxepin, ramelteon, suvorexant, temazepam, triazolam, zolpidem) including one non-suvorexant therapy for sleep maintenance (doxepin, temazepam) if that is the diagnosis of covered use.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

DEFERASIROX

Products Affected

- *deferasirox granules*
- *deferasirox oral tablet*
- *deferasirox oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	Creatinine clearance less than 40 mL per min or serum creatinine more than 2 times the age-adjusted upper limit of normal, platelet count below 50 x 10^9/L
Required Medical Information	Diagnosis of covered use, submission of CBC, LFTs, serum creatinine, ferritin, and urine protein values, submission of patient weight, documentation that member has had yearly ophthalmic and auditory testing.
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	PA applies to all. For continuation, documentation of ferritin level within last 3 months and CBC, LFT, serum creatinine, urine protein value, patient weight, and ophthalmic and auditory testing have been performed within the last year.
Indications	All Medically-accepted Indications.
Off Label Uses	

DIACOMIT (stiripentol)

Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe renal impairment, moderate or severe hepatic impairment
Required Medical Information	Diagnosis of covered use, confirmation patient is also receiving clobazam.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. Monotherapy requests for Dravet syndrome will not be approved as there are no clinical data to support using stiripentol in this manner.
Indications	All Medically-accepted Indications.
Off Label Uses	

DICLOFENAC 1% GEL

Products Affected

- *diclofenac sodium external gel*

PA Criteria	Criteria Details
Exclusion Criteria	Use during the peri-operative period in the setting of coronary artery bypass graft (CABG) surgery
Required Medical Information	Diagnosis of covered use, including the relief of pain of osteoarthritis of joints amenable to topical treatment, such as the knees and hands.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. Not evaluated for use on joints of the spine, hip, or shoulder and therefore requests for use on these areas will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

DICLOFENAC 1.5% TOPICAL SOLUTION

Products Affected

- *diclofenac sodium external solution*

PA Criteria	Criteria Details
Exclusion Criteria	Use during the peri-operative period in the setting of coronary artery bypass graft (CABG) surgery
Required Medical Information	Diagnosis of covered use, including the relief of pain of osteoarthritis of the knees.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. Not FDA-approved for use on joints of the hands, spine, hip, or shoulder and therefore requests for use on these areas will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

DICLOFENAC 3% GEL

Products Affected

- *diclofenac sodium external gel*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to dermatology
Coverage Duration	90 days
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

DICLOFENAC PATCH

Products Affected

- *diclofenac epolamine external*

PA Criteria	Criteria Details
Exclusion Criteria	Treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery, use on non-intact or damaged skin resulting from any etiology including exudative dermatitis, eczema, infection lesions, burns, or wounds, pregnancy after 30 weeks gestation
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	PA applies to all. Product is approved for acute pain, defined as short-term pain not lasting longer than a 3-month period.
Indications	All FDA-approved Indications.
Off Label Uses	

DIFICID (fidaxomicin)

Products Affected

- DIFICID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	10 days
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

DIGOXIN IN OLDER PATIENTS

Products Affected

- *digitek oral tablet 250 mcg*
- *digox oral tablet 250 mcg*
- *digoxin oral tablet 250 mcg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Current diagnosis of atrial fibrillation or congestive heart failure, submission of patient's current CrCl (mL/min) or current weight and serum creatinine level for the purposes of calculating CrCl with result greater than or equal to 30 mL/min. Patient must have tried and failed to respond adequately to 0.125 mg of digoxin.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. PA not required for doses less than or equal to 0.125 mg per day.
Indications	All Medically-accepted Indications.
Off Label Uses	

DRONABINOL

Products Affected

- *dronabinol*
- SYNDROS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. If authorization is requested for treatment of nausea and vomiting associated with cancer therapy, documentation of previous conventional antiemetic therapies utilized is required.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. If the medication is being administered related to cancer treatment and is a full replacement for intravenous administration of antiemetic therapy within 48 hours of cancer treatment, it is covered as a Part B benefit. To be eligible for Part B coverage, the prescribing physician must indicate this on the prescription. If the medication is being requested for the use of anorexia associated with weight loss in patients with AIDS, approval may be covered under Part D.
Indications	All Medically-accepted Indications.
Off Label Uses	

DUOBRII (halobetasol/tazarotene)

Products Affected

- DUOBRII

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, submission of negative pregnancy test result for female patients of childbearing age, documentation patient tried and failed augmented betamethasone dipropionate, clobetasol, fluocinonide 0.1%, halobetasol, or another Class I ultra-high potency topical steroid.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to dermatology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

DUOPA (carbidopa/levodopa enteral suspension)

Products Affected

- DUOPA ENTERAL

PA Criteria	Criteria Details
Exclusion Criteria	Patients taking non-selective monoamine oxidase inhibitors
Required Medical Information	Diagnosis of covered use, confirmation patient has a naso-jejunal tube for short-term administration or a PEG-J for long-term administration.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

DUPIXENT (dupilumab)

Products Affected

- DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR
- DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For atopic dermatitis, documentation of treatment with at least a moderate strength topical corticosteroid for at four weeks or have a contraindication to their use or therapy is not otherwise advisable. For moderate-to-severe asthma, either (1) documentation of eosinophilic subtype via serum or sputum eosinophil count or lung biopsy or (2) documentation asthma is moderate or severe and requires daily oral corticosteroid for control.
Age Restrictions	
Prescriber Restrictions	Restricted to allergy, dermatology, immunology, otorhinolaryngology, and pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to all. Continuation requires documentation of a positive response to therapy. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

EGRIFTA (tesamorelin)

Products Affected

- EGRIFTA SUBCUTANEOUS SOLUTION RECONSTITUTED 1 MG
- EGRIFTA SV

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, active malignancy, disruption of HPA axis due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, head irradiation, or head trauma, use for weight loss
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. Continuation of therapy requests require confirmation that the patient has demonstrated a clinical improvement (or maintenance of improvement once achieved) from baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	

EMFLAZA (deflazacort)

Products Affected

- EMFLAZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation of treatment failure with or intolerance to prednisone.
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

EMPAVELI (pegcetacoplan)

Products Affected

- EMPAVELI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use confirmed by high-sensitivity flow cytometry, proof of vaccination against Streptococcus pneumoniae, Neisseria meningitidis, and Haemophilus influenzae type B or 2 weeks of antibacterial drug prophylaxis if the vaccines were administered within the last 2 weeks and therapy is required immediately, submission of lactate dehydrogenase level.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology, immunology, and nephrology
Coverage Duration	1 year
Other Criteria	Because this medication is delivered subcutaneously through an infusion pump, it covered as a Part B benefit except for enrollees residing in a long-term care facility. PA applies to all when covered as a Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	

EMSAM (selegiline transdermal)

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	Pheochromocytoma
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ENDOTHELIN RECEPTOR ANTAGONISTS

Products Affected

- *ambrisentan*
- *bosentan*
- OPSUMIT
- TRACLEER ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy. For ambrisentan, idiopathic pulmonary fibrosis and moderate or severe hepatic impairment.
Required Medical Information	Diagnosis of covered use, pregnancy status for female patients of childbearing potential, submission of baseline AST, ALT, and bilirubin. For ambrisentan and Opsumit, submission of baseline hemoglobin level.
Age Restrictions	For ambrisentan and Opsumit, 18 years of age or older. For bosentan, 3 years of age or older.
Prescriber Restrictions	Restricted to cardiology and pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ENSPRYNG (satralizumab-mwge)

Products Affected

- ENSPRYNG

PA Criteria	Criteria Details
Exclusion Criteria	Active hepatitis B infection, active or untreated latent tuberculosis (TB)
Required Medical Information	Diagnosis of covered use, submission of confirmation patient has anti-aquaporin-4 (AQP4) antibody-positive NMOSD, submission of baseline latent TB screening test (Mantoux tuberculin skin test [a.k.a. PPD test] or interferon-gamma release assay [IGRA]), attestation patient does not have any active infection.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology and ophthalmology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

EPCLUSA (sofosbuvir/velpatasvir)

Products Affected

- EPCLUSA ORAL TABLET 200-50 MG, 400-100 MG
- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, laboratory confirmation of hepatitis C virus (HCV) infection, submission of baseline HCV RNA level, documentation of whether cirrhosis is present or not and whether it is compensated or decompensated, confirmation that patients with decompensated cirrhosis will receive concomitant ribavirin therapy unless ribavirin therapy is otherwise clinically not indicated, submission of eGFR (safety and efficacy of sofosbuvir/velpatasvir has not been established in patients with eGFR less than 30 mL/min/1.73 m2), confirmation a test for HBV infection (HBsAg and anti-HBc) was completed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

EPIDIOLEX (cannabidiol)

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	1 year of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ERIVEDGE (vismodegib)

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ERLOTINIB

Products Affected

- *erlotinib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For non-small cell lung cancer, submission of FDA-approved test confirming presence of EGFR exon 19 deletion or exon 21 L858R substitution mutation and prior treatments used.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ESTROGENS IN OLDER PATIENTS

Products Affected

- ALORA
- *amabelz*
- ANGELIQ
- CLIMARA PRO
- COMBIPATCH
- DIVIGEL
- *dotti*
- DUAVEE
- ELESTRIN
- *estradiol oral*
- *estradiol transdermal*
- *estradiol-norethindrone acet*
- EVAMIST
- *fyavolv*
- JINTELI
- *lopreeza*
- *lyllana*
- MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG
- MENOSTAR
- *mimvey*
- *mimvey lo*
- MINIVELLE
- *norethindrone-eth estradiol*
- PREFEST
- PREMARIN ORAL
- PREMPHASE
- PREMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All 5 of the following criteria must be met: (1) diagnosis of covered use, (2) documentation the provider is aware of the associated risks including breast and endometrial cancer and an increased risk of clot formation, (3) documentation provider is aware medication is considered a high-risk medication for elderly patients according to the Centers for Medicare and Medicaid Services, (4) documentation that the benefits of the drug outweigh the potential risks to the patient, and (5) for all indications except treatment of vasomotor symptoms of menopause, documentation of a trial and failure or contraindication to two preferred alternatives is required (for vulvar/vaginal atrophy, topical estradiol and conjugated estrogens, for osteoporosis, alendronate, ibandronate, and raloxifene).
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	PA not required for gynecology
Coverage Duration	1 year
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

EVEROLIMUS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For renal cell carcinoma, documented prior use of sunitinib or sorafenib. For postmenopausal women with advanced hormone receptor-positive, HER-2 negative breast cancer, documentation of treatment failure with letrozole or anastrozole and confirmation drug is being used in combination with exemestane.
Age Restrictions	1 year of age or older
Prescriber Restrictions	Restricted to hematology, neurology, and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

EVRYSDI (risdiplam)

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	Hepatic impairment
Required Medical Information	Diagnosis of covered use confirmed by genetic testing including either (a) homozygous deletion of SMN1 exon 7 or (b) compound heterozygosity for SMN1 exon 7 deletion and small mutation, documentation of two or more copies of the SMN2 gene by genetic testing, attestation patient does not have hepatic impairment, submission of pregnancy status for female patients of childbearing potential.
Age Restrictions	
Prescriber Restrictions	Restricted to neurology
Coverage Duration	Initially 6 months, then 1 year
Other Criteria	PA applies to all. Maintenance of or improvement in any motor score or function compared to baseline will be required for reauthorization.
Indications	All Medically-accepted Indications.
Off Label Uses	

FARYDAK (panobinostat)

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment, recent myocardial infarction or unstable angina
Required Medical Information	Diagnosis of covered use, documentation that the patient has received at least 2 prior regimens including bortezomib and an immunomodulatory agent, submission of baseline ECG documenting QTcF is less than 450 msec prior to initiation, submission of baseline serum electrolytes including potassium and magnesium, submission of baseline CBC documenting platelet count is at least 100 x 10^9/L and absolute neutrophil count is at least 1.5 x 10^9/L, submission of baseline liver function tests including AST, ALT, and total bilirubin. For multiple myeloma, confirmation drug will be given with dexamethasone and bortezomib.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	Initially 8 cycles. An additional 8 cycles if clinical benefit seen.
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

FENTANYL TRANSMUCOSAL

Products Affected

- *fentanyl citrate buccal lozenge on a handle*
- *fentanyl citrate buccal tablet 100 mcg, 200 mcg, 400 mcg, 600 mcg, 800 mcg*

PA Criteria	Criteria Details
Exclusion Criteria	Patients not tolerant to the effects of a chronic opioid, treatment of acute or postoperative pain including headache, migraines, or dental pain
Required Medical Information	Diagnosis of covered use, verified claim or documentation of patient's morphine-equivalent opioid dose.
Age Restrictions	For the buccal tablet, 18 years of age or older. For the lozenge, 16 years of age or older.
Prescriber Restrictions	PA not required for oncology
Coverage Duration	1 Year
Other Criteria	PA applies to all except oncology.
Indications	All Medically-accepted Indications.
Off Label Uses	

FERRIPROX (deferiprone)

Products Affected

- *deferiprone*
- FERRIPROX ORAL SOLUTION
- FERRIPROX ORAL TABLET 1000 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of serum ferritin levels, CBC, ANC, platelet count, and serum ALT.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

FINTEPLA (fenfluramine)

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	Hepatic impairment, moderate or severe renal impairment, administration of monoamine oxidase inhibitors within 14 days of initiation
Required Medical Information	Diagnosis of covered use, submission of patient weight and serum creatinine (to calculate estimated creatinine clearance) and liver function testing or Child-Pugh score.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

FIRDAPSE (amifampridine)

Products Affected

- FIRDAPSE

PA Criteria	Criteria Details
Exclusion Criteria	History of seizure
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

FOTIVDA (tivozanib)

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	Uncontrolled hypertension, severe hepatic impairment, coadministration with strong CYP3A inducers
Required Medical Information	Diagnosis of covered use, submission of previous systemic therapies used to treat renal cell carcinoma including the failure of at least one prior VEGFR inhibitor, pregnancy status for female patients of childbearing potential, confirmation patient has not had episodes of symptomatic heart failure or unstable angina, a myocardial infarction, an arterial thrombotic event, or a significant bleeding event in the 6 months preceding the prior authorization request.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

GALAFOLD (migalastat)

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	Severe renal impairment (eGFR less than 30 mL/min/1.73 m2) or end stage renal disease requiring dialysis
Required Medical Information	Diagnosis of covered use, documentation that the patient has an amenable galactosidase alpha gene variant (see section 12.1, table 2 of package insert for full list) based on in vitro assay data as interpreted by a clinical genetics professional.
Age Restrictions	16 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

GATTEX (teduglutide)

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of baseline laboratory values including bilirubin, alkaline phosphatase, lipase, and amylase obtained within 6 months prior to starting therapy. For adults 18 years of age or older only, submission of documentation that a colonoscopy (or alternate imaging) of the entire colon with polyp removal was performed within 6 months prior to starting treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. Continuation of therapy requires a colonoscopy result within 6 months of PA expiration.
Indications	All Medically-accepted Indications.
Off Label Uses	

GAVRETO (pralsetinib)

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of RET gene fusion or mutation, attestation patient does not have uncontrolled hypertension, pregnancy status for female patients of childbearing potential.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

GILOTRIF (afatinib)

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For non-small cell lung cancer, submission of positive FDA-approved test for non-resistant epidermal growth factor receptor mutations. For metastatic, squamous NSCLC, documentation of progression after platinum-based chemotherapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

GnRH ANTAGONISTS

Products Affected

- ELIGARD
- FIRMAGON (240 MG DOSE)
- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG
- *leuprolide acetate injection*
- LUPANETA PACK
- LUPRON DEPOT (1-MONTH)
- LUPRON DEPOT (3-MONTH)
- LUPRON DEPOT (4-MONTH)
- LUPRON DEPOT (6-MONTH)
- LUPRON DEPOT-PED (1-MONTH) INTRAMUSCULAR KIT 11.25 MG, 15 MG
- LUPRON DEPOT-PED (3-MONTH) INTRAMUSCULAR KIT 30 MG (PED)
- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, pregnancy status for female patients of childbearing potential. For prostate cancer, documentation of baseline prostate-specific antigen and serum testosterone level.
Age Restrictions	
Prescriber Restrictions	Restricted to hematology, oncology, endocrinology, gynecology, and urology
Coverage Duration	For endometriosis and uterine fibroids, 6 months. For all other indications, 1 year.
Other Criteria	PA applies to new starts only. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

GROWTH HORMONE

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- HUMATROPE
- NORDITROPIN FLEXPRO
- NUTROPIN AQ NUSPIN 10
- NUTROPIN AQ NUSPIN 20
- NUTROPIN AQ NUSPIN 5
- NUTROPIN AQ PEN
- OMNITROPE
- SAIZEN
- SAIZENPREP
- ZOMACTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation of growth failure, submission of IGF-1 levels, height, weight, creatinine clearance (or serum creatinine), fasting blood glucose, and bone age if applicable based on patient age and diagnosis.
Age Restrictions	
Prescriber Restrictions	Restricted to endocrinology and nephrology
Coverage Duration	1 year
Other Criteria	PA applies to all. Requests for continuation of therapy require annual submission of updated IGF-1 level, bone age if applicable based on patient age and diagnosis, height, weight, creatinine clearance (or serum creatinine), and fasting glucose.
Indications	All Medically-accepted Indications.
Off Label Uses	

HARVONI (ledipasvir/sofosbuvir)

Products Affected

- HARVONI ORAL PACKET
- HARVONI ORAL TABLET 45-200 MG, 90-400 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, laboratory confirmation of hepatitis C virus (HCV) genotype 1a, 1b, 4, 5, or 6 infection, submission of baseline HCV RNA level, documentation of whether cirrhosis is present or not and whether or not it is compensated or decompensated, confirmation of whether patient is treatment-naive or treatment-experienced, submission of eGFR, confirmation a test for HBV infection (HBsAg and anti-HBc) was completed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Treatment-experienced pts w/genotype 1 and compensated cirrhosis, 24 weeks. All others, 12 weeks.
Other Criteria	PA applies to all. For treatment-naive patients without cirrhosis who have pre-treatment HCV RNA less than 6 million IU/mL, 8 weeks of therapy may be considered by the provider.
Indications	All Medically-accepted Indications.
Off Label Uses	

HEMANGEOL (propranolol oral solution)

Products Affected

- HEMANGEOL

PA Criteria	Criteria Details
Exclusion Criteria	Premature infant with corrected age less than 5 weeks, body weight less than 2 kg, asthma or history of bronchospasm, bradycardia (less than 80 beats per minute), greater than first degree heart block, decompensated heart failure, blood pressure less than 50/30 mmHg, pheochromocytoma
Required Medical Information	Diagnosis of covered use, submission of current weight.
Age Restrictions	5 weeks of age up to 1 year of age
Prescriber Restrictions	Restricted to otolaryngology, pediatric otolaryngology, and pediatric ophthalmology
Coverage Duration	6 months
Other Criteria	PA applies to all. Treatment must be initiated between the ages of 5 weeks and 5 months.
Indications	All Medically-accepted Indications.
Off Label Uses	

HETLIOZ (tasimelteon)

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	Restricted to neurology and sleep specialty
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

HIGH-RISK DRUGS IN OLDER PATIENTS

Products Affected

- *benztropine mesylate oral*
- *chlordiazepoxide hcl*
- *chlorpropamide oral tablet 100 mg*
- *dipyridamole oral*
- *disopyramide phosphate oral*
- *glyburide oral*
- *guanfacine hcl er*
- *guanfacine hcl oral*
- *indomethacin er*
- *indomethacin oral capsule 25 mg, 50 mg*
- *ketorolac tromethamine oral*
- *meprobamate*
- *methyldopa oral*
- *methyldopa-hydrochlorothiazide*
- *nifedipine oral*
- NORPACE CR
- *phenobarbital oral elixir*
- *phenobarbital oral tablet*
- *thioridazine hcl oral*
- *trihexyphenidyl hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All 3 of the following criteria must be met: (1) diagnosis of covered use, (2) documentation provider is aware medication is considered a high-risk medication for elderly patients according to the Centers for Medicare and Medicaid Services, and (3) documentation that the benefits of the drug outweigh the potential risks to the patient.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

HYALURONATES

Products Affected

- EUFLEXXA INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE
- GEL-ONE INTRA-ARTICULAR PREFILLED SYRINGE
- GELSYN-3
- GENVISC 850
- HYALGAN
- HYMOVIS
- MONOVISC
- ORTHOVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE
- SUPARTZ FX
- SYNVISC INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE
- SYNVISC ONE INTRA-ARTICULAR SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient diagnosed with osteoarthritis of the knee joint and has tried and failed to respond to conservative non-pharmacologic therapy (exercise, physical therapy, weight loss) and simple analgesics (oral salicylates, non-steroidal anti-inflammatory drugs, and acetaminophen) within the previous 18 months.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Injection is being administered by an orthopedic surgeon, rheumatologist, physiatrist, or physician who has completed a formal sports medicine fellowship and is fully knowledgeable about the differential diagnosis of knee pain, is able to perform microscopic analysis of synovial fluid, and can recognize conditions such as pseudogout.
Coverage Duration	1 treatment cycle
Other Criteria	A maximum of 1 injection of Synvisc-One, Gel-One, or Monovisc, 3 injections of Euflexxa or Synvisc, 4 injections of Orthovisc, or 5 injections of Hyalgan per knee joint may be authorized per treatment cycle. Retreatment may be authorized, provided (1) previous treatment cycle was administered at least 6 months ago, (2) treating physician submits documentation of a favorable patient response including pain relief derived of more than 3 months in duration, (3) patient has demonstrated a reduction in analgesic use or increase in functional capacity, and (4) patient's progress and results of hyaluronate therapy is fully documented in the patient's record.
Indications	All FDA-approved Indications.
Off Label Uses	

HYDROXYZINE IN OLDER PATIENTS

Products Affected

- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All 3 of the following criteria must be met: (1) diagnosis of anxiety or pruritus, (2) documentation provider is aware medication is considered a high-risk medication for elderly patients according to the Centers for Medicare and Medicaid Services, and (3) documentation that the benefits of the drug outweigh the potential risks to the patient. For pruritus, documentation patient has tried and had an inadequate response to a second-generation antihistamine. For anxiety, documentation patient has tried and failed or had an inadequate response to at least 2 other FDA-approved products for the management of anxiety OR documentation medication is being used as a sedative before and after general anesthesia.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

IBRANCE (palbociclib)

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of genetic tumor testing showing that the primary tumor type is HR-positive, HER2-negative, confirmation that the treatment regimen will include concomitant use of an aromatase inhibitor or fulvestrant, submission of baseline CBC.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ICATIBANT

Products Affected

- *icatibant acetate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

ICLUSIG (ponatinib)

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	Newly diagnosed chronic phase CML
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

IDHIFA (enasidenib)

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of IDH2 mutation.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

IDIOPATHIC PULMONARY FIBROSIS TREATMENTS

Products Affected

- ESBRIET
- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	For Esbriet, patients with end stage renal disease on dialysis
Required Medical Information	Diagnosis of covered use. Submission of baseline AST, ALT, and bilirubin. For Esbriet, submission of patient's current weight and serum creatinine level for the purposes of calculating creatinine clearance.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

ILARIS

Products Affected

- ILARIS SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	Positive TB test
Required Medical Information	Diagnosis of covered use, submission of TB skin test result obtained within past 12 months, documentation that patient has received all recommended vaccinations as appropriate including pneumococcal vaccine and inactivated influenza vaccine prior to initiation of therapy. For CAPS, confirmed diagnosis including genetic testing for variant FCAS or MWS and documentation patient is not receiving concomitant TNF inhibitor therapy. For SJIA, submission of CBC including platelet count and confirmed diagnosis defined by prominence of systemic and inflammatory features including spiking fevers, rash, swelling and inflammation of lymph nodes, liver, and spleen, and high white blood cell and platelet counts.
Age Restrictions	2 years of age or older
Prescriber Restrictions	For SJIA, restricted to rheumatology
Coverage Duration	1 year
Other Criteria	PA applies to all. Continuation of therapy requires submission of updated TB skin test result obtained within the past 12 months and objective documentation of positive patient response or maintenance of response. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

IMBRUVICA (ibrutinib)

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment (Child-Pugh class C)
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology, oncology, and transplant specialty
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

IMCIVREE (setmelanotide)

Products Affected

- IMCIVREE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, including submission of genetic testing showing homozygous or compound heterozygous gene variants in POMC, PCSK1, or LEPR genes interpreted as pathogenic, likely pathogenic, or of uncertain clinical significance and body mass index (BMI) greater than 30 kg/m2 in adults or greater than the 97th percentile in children.
Age Restrictions	6 years of age or older
Prescriber Restrictions	
Coverage Duration	Initially 16 weeks, then 1 year
Other Criteria	PA applies to all. For re-authorization at the 16-week point, submission of clinical documentation attesting to at least 5% weight loss from baseline (or at least 5% BMI from baseline in patients with continued growth potential) is required. Not FDA-approved for other types or causes of obesity, and therefore requests for these uses will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

IMMUNE GLOBULIN

Products Affected

- BIVIGAM INTRAVENOUS SOLUTION 5 GM/50ML
- CARIMUNE NF INTRAVENOUS SOLUTION RECONSTITUTED 12 GM, 6 GM
- FLEBOGAMMA DIF
- GAMASTAN S/D
- GAMMAGARD
- GAMMAGARD S/D LESS IGA
- GAMMAKED INJECTION SOLUTION 1 GM/10ML, 10 GM/100ML, 20 GM/200ML, 5 GM/50ML
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 20 GM/400ML, 5 GM/100ML, 5 GM/50ML
- GAMUNEX-C
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 10 GM/100ML, 10 GM/200ML, 2 GM/20ML, 2.5 GM/50ML, 20 GM/200ML, 25 GM/500ML, 5 GM/100ML, 5 GM/50ML
- PRIVIGEN

PA Criteria	Criteria Details
Exclusion Criteria	IgA-deficient patients with antibodies against IgA and a history of hypersensitivity. For IM forms, severe thrombocytopenia or coagulation disorder that would contraindicate an IM injection.
Required Medical Information	Diagnosis of covered use. For ITP, submission of platelet count. For CLL, IgG level less than 600 mg/dL and recent history of serious bacterial infection requiring either oral or IV antibiotic therapy. For CIDP, unequivocal diagnosis and documentation patient is refractory or intolerant to prednisone or azathioprine given in therapeutic doses over at least 3 months. For passive immunization against varicella, confirmation that the patient is immunosuppressed and cannot receive varicella-zoster immune globulin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For acute conditions/new starts, 3 months. For renewal of chronic conditions, 1 year.
Other Criteria	PA applies to all. For continuation of any diagnosis, documentation of the clinical response to therapy must be submitted. For IV formulations, covered as a Part B benefit if administered in the home for the treatment of primary immune deficiency. For any other combination of treatment site and indication, additional information may need to be submitted to determine if the immune globulin will be covered as a Part B or Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	

INBRIJA (levodopa inhalation)

Products Affected

- INBRIJA

PA Criteria	Criteria Details
Exclusion Criteria	Currently on nonselective monoamine oxidase inhibitor or has taken one within last 2 weeks, asthma, COPD, or other chronic underlying lung disease
Required Medical Information	Diagnosis of covered use, prescription claim or documentation from physician showing patient is currently taking carbidopa/levodopa, documentation of at least one other medication used for "off" episodes (see Other Criteria).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. For approval, the patient must have documentation of a trial of at least one other medication for the treatment of "off" episodes including a dopamine agonist (e.g., pramipexole, ropinirole), a COMT inhibitor (e.g., entacapone), or a monoamine oxidase B inhibitor (e.g., rasagiline, selegiline).
Indications	All Medically-accepted Indications.
Off Label Uses	

INJECTABLE TESTOSTERONE

Products Affected

- *testosterone cypionate injection solution 200 mg/ml*
- *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml*
- *testosterone enanthate intramuscular solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of serum testosterone level, documentation that patient has been evaluated for the presence of breast and prostate cancer prior to initiation of therapy.
Age Restrictions	
Prescriber Restrictions	PA not required for urology or endocrinology
Coverage Duration	1 year
Other Criteria	PA applies to all except when prescribed by urology or endocrinology. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

INLYTA (axitinib)

Products Affected

- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment (Child-Pugh class C), uncontrolled hypertension
Required Medical Information	Diagnosis of covered use, submission of laboratory values including baseline ALT, AST, bilirubin, submission of baseline blood pressure reading.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

INQOVI (decitabine/cedazuridine)

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of complete blood count, submission of pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	Initially 6 months, then 1 year
Other Criteria	PA applies to new starts only. Continuation of initial therapy beyond 6 months requires (a) confirmation of no disease progression and (b) attestation the patient is having no serious adverse events from treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	

INREBIC (fedratinib)

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment, unavoidable concomitant use of moderate or strong CYP3A4 inducers or dual CYP3A4/CYP2C19 inhibitors
Required Medical Information	Diagnosis of covered use, submission of thiamine level and platelet count.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. For approval, the patient must have tried and failed to have an adequate response to or had an intolerance to ruxolitinib.
Indications	All Medically-accepted Indications.
Off Label Uses	

INTERLEUKIN-5 ANTAGONISTS (severe eosinophilic asthma)

Products Affected

- FASENRA
- FASENRA PEN
- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For eosinophilic asthma, documentation that patient's symptoms are poorly controlled with inhaled corticosteroids, submission of pulmonary function test results including FEV1, frequency of inhaled short-acting beta2-agonist therapy, frequency of daily and nighttime symptoms and exacerbations, and effect of exacerbations on activity. For Nucala (eosinophilic asthma diagnosis only), submission of blood eosinophil count documenting 150 cells/mcL obtained within 6 weeks of therapy initiation or 300 cells/mcL within 12 months of therapy initiation. For Fasenra, submission of laboratory confirmation of eosinophilic asthma diagnosis (serum eosinophil count, sputum eosinophil count, or lung biopsy).
Age Restrictions	
Prescriber Restrictions	Restricted to allergy, pulmonology, rheumatology, and immunology
Coverage Duration	1 year
Other Criteria	PA applies to all. Continuation of therapy requests require objective documentation from the prescriber that the patient's symptoms have improved. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

INTRANASAL SEIZURE MEDICATIONS

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Acute narrow-angle glaucoma
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

INTRON A (interferon alfa-2b)

Products Affected

- INTRON A

PA Criteria	Criteria Details
Exclusion Criteria	Autoimmune hepatitis, decompensated liver disease
Required Medical Information	Diagnosis of covered use, submission of triglyceride levels, hemoglobin, complete and differential white blood cell counts, platelet count, serum electrolytes, ALT, serum bilirubin level, serum albumin level, and TSH. For malignant melanoma, submission of the date of surgical treatment. For AIDS-related Kaposi's sarcoma, submission of total CD4 count. For chronic hepatitis C, submission of HCV RNA, prothrombin time, baseline serum creatinine level, and laboratory confirmation of hepatitis C virus, and documentation of previous response to therapy if applicable. For chronic hepatitis B, submission of prothrombin time and documentation patient has been serum HBsAG positive for at least 6 months with evidence of HBV replication.
Age Restrictions	For hairy cell leukemia, malignant melanoma, follicular lymphoma, condylomata acuminata, or AIDS-related Kaposi's sarcoma, 18 years of age or older. For chronic hepatitis C, 3 years of age or older. For chronic hepatitis B, 1 year of age or older.
Prescriber Restrictions	
Coverage Duration	Depends on covered use. See "Other Criteria" section.
Other Criteria	PA applies to new starts only. For hairy cell leukemia, the coverage duration is 6 months. For condylomata acuminata, 3 weeks per course, and at least 12 weeks must pass in between multiple courses in order to be reauthorized. For Kaposi's sarcoma, 16 weeks. For hepatitis B infection, 24 weeks. For all other indications/uses, 1 year. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

INVEGA HAFYERA (paliperidone 6-month injectable suspension)

Products Affected

- INVEGA HAFYERA

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis
Required Medical Information	Diagnosis of covered use, documentation of at least 4 months' treatment with 1-month paliperidone palmitate extended-release injectable suspension or at least one 3-month injection of 3-month paliperidone palmitate extended-release injectable suspension.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

INVEGA TRINZA (paliperidone 3-month injectable suspension)

Products Affected

- INVEGA TRINZA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis
Required Medical Information	Diagnosis of covered use, documentation of at least 4 months' treatment with 1-month paliperidone palmitate extended-release injectable suspension.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

IRESSA (gefitinib)

Products Affected

- IRESSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, confirmation of EGFR exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ISTURISA (osilodrostat)

Products Affected

- ISTURISA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, attestation pituitary gland surgery is not an option for the patient or has not been curative, submission of baseline serum potassium and magnesium levels.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to endocrinology
Coverage Duration	Initially 6 months, then 1 year
Other Criteria	PA applies to all. Continuation requires documentation of clinically relevant response to therapy, including, but not limited to urine free cortisol level.
Indications	All Medically-accepted Indications.
Off Label Uses	

ITRACONAZOLE

Products Affected

- *itraconazole oral*
- TOLSURA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, fungal culture result identifying causative organism or positive KOH result.
Age Restrictions	
Prescriber Restrictions	PA not required for infectious diseases
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

JAKAFI (ruxolitinib)

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	For myelofibrosis, a platelet count less than 50 x 10^9/L with either concomitant estimated creatinine clearance between 15 and 59 mL/min, end stage renal disease not on dialysis, or any degree of hepatic impairment
Required Medical Information	Diagnosis of covered use, submission of baseline platelet count, ALT, AST, and bilirubin, submission of creatinine clearance or current body weight with serum creatinine for calculation of estimated creatinine clearance. For polycythemia vera, documented intolerance or inadequate response to hydroxyurea.
Age Restrictions	
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

JUXTAPID (lomitapide)

Products Affected

- JUXTAPID

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, moderate or severe hepatic impairment (Child-Pugh class B or C), active liver disease
Required Medical Information	Diagnosis of covered use, submission of baseline lab values including ALT, AST, alkaline phosphatase, total bilirubin, baseline LDL-C, total cholesterol (TC), apoB, and non-HDL-C, pregnancy status for female patients of childbearing potential, submission of renal indices, documentation of contraindication to or treatment failure with evolocumab.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to cardiology, lipidology, and endocrinology with experience in and a focus on lipid management
Coverage Duration	Initially 6 months, then 1 year
Other Criteria	PA applies to all. Submission of LDL level documenting clinically significant response to therapy will be required for reauthorization. For approval, the patient must have tried and failed to have an adequate response to, had an intolerance to, or have a contraindication to therapy with evolocumab.
Indications	All Medically-accepted Indications.
Off Label Uses	

JYNARQUE (tolvaptan)

Products Affected

- JYNARQUE

PA Criteria	Criteria Details
Exclusion Criteria	History of signs or symptoms of significant liver impairment or injury (not including uncomplicated polycystic liver disease), uncorrected abnormal blood sodium concentrations, inability to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to nephrology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

KALYDECO (ivacaftor)

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of cystic fibrosis mutation test result and baseline ALT and AST.
Age Restrictions	
Prescriber Restrictions	Restricted to pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

KERENDIA (finerenone)

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	Adrenal insufficiency, estimated glomerular filtration rate (eGFR) less than 25 mL/min/1.73 m2, severe (Child-Pugh class C) hepatic impairment, coadministration with strong CYP3A4 inhibitors
Required Medical Information	Diagnosis of covered use, submission of estimated glomerular filtration rate (eGFR) and baseline serum potassium level.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. For approval, the patient must have documentation of a trial of Farxiga.
Indications	All Medically-accepted Indications.
Off Label Uses	

KETOCONAZOLE ORAL

Products Affected

- *ketoconazole oral*

PA Criteria	Criteria Details
Exclusion Criteria	Acute or chronic liver disease, treatment of fungal meningitis or fungal infections of the skin or nails
Required Medical Information	Ketoconazole is being requested for the treatment of culture-proven systemic blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis, submission of baseline ALT, AST, total bilirubin, alkaline phosphatase, prothrombin time and INR, confirmation from the prescriber that the potential benefits of therapy outweigh the risks.
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

KEVEYIS (dichlorphenamide)

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of high dose aspirin, severe pulmonary disease limiting compensation to metabolic acidosis, hepatic insufficiency
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initially 2 months, then 1 year
Other Criteria	PA applies to all. Documentation of patient's response at 2 months is required for continuation of approval.
Indications	All Medically-accepted Indications.
Off Label Uses	

KISQALI (ribociclib)

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	Congenital long QT syndrome, moderate or severe hepatic impairment, QTcF interval greater than 450 msec, uncorrected hypokalemia or hypomagnesemia, patients on rifampin, phenytoin, or carbamazepine
Required Medical Information	Diagnosis of covered use, submission of genetic tumor testing showing that the primary tumor type is HR-positive, HER2-negative, confirmation that the treatment regimen will include concomitant use of an aromatase inhibitor or fulvestrant, submission of baseline liver function tests, ECG, serum electrolytes, and CBC.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

KORLYM (mifepristone)

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, female patient with a history of unexplained vaginal bleeding, endometrial hyperplasia with atypia, or endometrial carcinoma, patients on concurrent long-term corticosteroid therapy, simvastatin, lovastatin, or CYP3A substrates with narrow therapeutic ranges
Required Medical Information	Diagnosis of covered use, submission of baseline serum potassium, serum creatinine, patient weight, AST, ALT, and alkaline phosphatase, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to endocrinology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

KOSELUGO (selumetinib)

Products Affected

- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of left ventricular ejection fraction, Child-Pugh score or liver function testing results, and pregnancy status for female patients of childbearing potential.
Age Restrictions	Initiation: 2-17 years of age. Continuation: 2 years of age or older.
Prescriber Restrictions	Restricted to oncology
Coverage Duration	Initially 6 months, then 1 year
Other Criteria	PA applies to new starts only. Selumetinib is indicated in pediatric patients and will not be approved for adults unless the patient started on the medication prior to 18 years of age. Continuation of initial therapy beyond 6 months requires (a) documentation of any positive clinical response and (b) attestation the patient is having no serious adverse events to treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	

KUVAN (sapropterin)

Products Affected

- *sapropterin dihydrochloride*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of blood phenylalanine level.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initially 6 months, then 1 year
Other Criteria	PA applies to all. Submission of blood phenylalanine level required for reauthorization.
Indications	All Medically-accepted Indications.
Off Label Uses	

KYNMOBI (apomorphine film)

Products Affected

- KYNMOBI
- KYNMOBI TITRATION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, attestation patient is experiencing "off" episodes despite carbidopa/levodopa therapy.
Age Restrictions	
Prescriber Restrictions	PA not required for neurology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

LAMPIT (nifurtimox)

Products Affected

- LAMPIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	17 years of age or younger
Prescriber Restrictions	Restricted to infectious diseases
Coverage Duration	60 days
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

LENVIMA (lenvatinib)

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	Diagnosis of covered use, submission of baseline blood pressure showing blood pressure is controlled.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

LEUKINE (sargramostim, GM-CSF)

Products Affected

- LEUKINE INJECTION SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of WBC count and ANC.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

LIDOCAINE TRANSDERMAL PATCHES

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. FDA-approved only for postherpetic neuralgia. Requests for other indications will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

LONG-ACTING SOMATOSTATIN ANALOGS

Products Affected

- SOMATULINE DEPOT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation of baseline serum GH, IGF-1, TSH, and blood glucose levels. For acromegaly, degree of control of clinical acromegaly symptoms.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to endocrinology and oncology
Coverage Duration	Initially 3 months, then up to 1 year
Other Criteria	PA applies to new starts only. Continuation of therapy requires documentation of a positive clinical response. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

LONSURF (trifluridine/tipiracil)

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe hepatic impairment
Required Medical Information	Diagnosis of covered use, submission of baseline CBC, absolute neutrophil count, ALT, AST, and bilirubin, documentation of KRAS status.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

LORBRENA (lorlatinib)

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with strong CYP3A inducers
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of ALK-positive tumor, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

LUCEMYRA (lofexidine)

Products Affected

- LUCEMYRA

PA Criteria	Criteria Details
Exclusion Criteria	Congenital long QT syndrome, severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease, chronic renal failure
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

LUMAKRAS (sotorasib)

Products Affected

- LUMAKRAS

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with strong CYP3A inducers, coadministration with proton pump inhibitors or H2 receptor antagonists
Required Medical Information	Diagnosis of covered use, submission of test result confirming presence of KRAS G12C mutations, submission of previous systemic treatment(s) tried.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

LUPKYNIS (voclosporin)

Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment, unavoidable concomitant use of strong CYP3A4 inhibitors, concomitant use of cyclophosphamide
Required Medical Information	Diagnosis of covered use, attestation patient will be taking concurrently with mycophenolate mofetil and corticosteroids, submission of estimated glomerular filtration rate (eGFR), pregnancy status for female patients of childbearing potential. If the patients eGFR is less than or equal to 45 mL/min/1.73 m2, attestation that prescriber believes benefits of therapy outweigh the potential risks to the patient.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. For approval, the patient must have tried and failed to have an adequate response to or had an intolerance/contraindication to Benlysta (belimumab). Continuation at the 1-year mark requires documentation of clinically relevant response to therapy and attestation that prescriber believes benefits of continuing therapy outweigh the potential risks to the patient.
Indications	All Medically-accepted Indications.
Off Label Uses	

LYBALVI (olanzapine/samidorphan)

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis, coadministration with opioids or strong CYP3A inducers, acute opioid withdrawal, end-stage renal disease
Required Medical Information	Diagnosis of covered use, confirmation patient has previously tried and failed, had an intolerance to, or had a contraindication to at least one generic second-generation antipsychotic with low incidence of metabolic side effects (e.g., aripiprazole, ziprasidone), attestation patient has had a trial of generic olanzapine with documentation showing a positive therapeutic benefit but unacceptable weight gain (greater than or equal to a 7% gain from baseline body weight) while using olanzapine.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. Reduction in or stabilization of body weight since the previous authorization will be required for subsequent reauthorizations.
Indications	All Medically-accepted Indications.
Off Label Uses	

LYNPARZA (olaparib)

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of applicable mutations depending on cancer type as necessary, submission of baseline CBC.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology, oncology, and urology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

MAVENCLAD (cladribine)

Products Affected

- MAVENCLAD (10 TABS)
- MAVENCLAD (4 TABS)
- MAVENCLAD (5 TABS)
- MAVENCLAD (6 TABS)
- MAVENCLAD (7 TABS)
- MAVENCLAD (8 TABS)
- MAVENCLAD (9 TABS)

PA Criteria	Criteria Details
Exclusion Criteria	Current malignancy, pregnancy, HIV or other active chronic infection (e.g., hepatitis or tuberculosis), lymphocyte count below normal limit before first course or less than 800 cells/microliter before second course, creatinine clearance below 60 mL/min, Child-Pugh score greater than 6
Required Medical Information	Diagnosis of covered use, pregnancy status for female patients of childbearing potential, submission of lymphocyte count, submission of patient weight and serum creatinine (to calculate estimated creatinine clearance).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to all. After the completion of 2 treatment courses (2 years' treatment), additional treatment courses are not recommended over the following 2 years because of malignancy risk. Re-initiating treatment after those 2 years have passed has not been studied. Requests for therapy for a combined total of greater than 2 years will not be approved.
Indications	All Medically-accepted Indications.
Off Label Uses	

MAVYRET (glecaprevir/pibrentasvir)

Products Affected

- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment (Child-Pugh class C), patients on rifampin or atazanavir
Required Medical Information	Diagnosis of covered use, laboratory confirmation of hepatitis C virus (HCV), documentation of whether cirrhosis is present or not and whether or not it is compensated or decompensated, confirmation a test for HBV infection (HBsAg and anti-HBc) was completed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria for coverage duration will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

MECASERMIN

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation of primary insulin-like growth factor (IGF-1) deficiency or growth hormone gene deletion in patients who have developed neutralizing antibodies to growth hormone, submission of IGF-1 level and growth hormone level.
Age Restrictions	
Prescriber Restrictions	Restricted to endocrinology and nephrology
Coverage Duration	6 months
Other Criteria	PA applies to all. Requests for continuation of therapy require annual submission of updated IGF-1 and growth hormone levels.
Indications	All Medically-accepted Indications.
Off Label Uses	

MEGESTROL IN OLDER PATIENTS

Products Affected

- *megestrol acetate oral suspension 40 mg/ml, 400 mg/10ml, 625 mg/5ml*

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	All 4 of the following criteria must be met: (1) diagnosis of covered use, (2) documentation the provider is aware of the associated risks of megestrol including an increased risk of thrombotic events and death, (3) documentation provider is aware medication is considered a high-risk medication for elderly patients according to the Centers for Medicare and Medicaid Services, (4) documentation that the benefits of the drug outweigh the potential risks to the patient.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

MEKINIST (trametinib)

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Exclusion Criteria	Progression of disease on prior BRAF-inhibitor therapy
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of BRAF V600E or V600K mutation, submission of baseline LVEF, submission of blood pressure reading. For non-small cell lung cancer, attestation that therapy will be used in combination with dabrafenib.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

METHAMPHETAMINE

Products Affected

- *methamphetamine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	Use for exogenous obesity, patients with glaucoma, advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, or a history of drug abuse, use during or within 14 days following the administration of monoamine oxidase inhibitors
Required Medical Information	Diagnosis of covered use. For patients 65 years of age and older, attestation provider is aware medication is considered a high-risk medication for elderly patients according to the Centers for Medicare and Medicaid Services (CMS) and that the benefits of methamphetamine therapy outweigh the potential risks to the patient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. PA will not be authorized if using for exogenous obesity (excluded category per CMS).
Indications	All Medically-accepted Indications.
Off Label Uses	

METHOTREXATE INJECTABLE (SUBCUTANEOUS)

Products Affected

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

- REDITREX

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, documentation of intolerance or inadequate response to oral or non-subcutaneous injectable forms of methotrexate.
Age Restrictions	
Prescriber Restrictions	Restricted to rheumatology and dermatology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

METHYLTESTOSTERONE

Products Affected

- METHITEST
- *methyltestosterone oral*

PA Criteria	Criteria Details
Exclusion Criteria	Male patients with breast or prostate cancer, women who are or may become pregnant
Required Medical Information	Diagnosis of covered use. For patients 65 years of age and older, attestation provider is aware medication is considered a high-risk medication for elderly patients according to the Centers for Medicare and Medicaid Services (CMS) and that the benefits of methyltestosterone therapy outweigh the potential risks to the patient.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

MIGLUSTAT

Products Affected

- *miglustat*

PA Criteria	Criteria Details
Exclusion Criteria	Severe renal impairment (CrCl less than 30 mL/min)
Required Medical Information	Diagnosis of covered use, documentation that enzyme replacement is not a therapeutic option.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

MODANIFIL AND DERIVATIVES

Products Affected

- *armodafinil*
- *modafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	17 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

MYALEPT (metreleptin)

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Exclusion Criteria	General obesity not associated with congenital leptin deficiency
Required Medical Information	Diagnosis of covered use, submission of leptin level laboratory test result confirming leptin deficiency, baseline HbA1c, fasting glucose, fasting triglyceride levels, and weight.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. Continuation of approval requires submission of patient weight, updated HbA1c, fasting glucose, and fasting triglyceride levels.
Indications	All Medically-accepted Indications.
Off Label Uses	

MYCAPSSA (otcreotide)

Products Affected

- MYCAPSSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of prior use of either injectable octreotide or lanreotide and attestation to its successful treatment of acromegaly using clinical biomarkers or chart notes.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to endocrinology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

MYFEMBREE (relugolix/estradiol/norethindrone)

Products Affected

- MYFEMBREE

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, known liver impairment or disease, known osteoporosis, undiagnosed abnormal uterine bleeding, women at increased risk of or current/a history of thrombotic or thromboembolic disorders (including women over 35 years of age who smoke and women with uncontrolled hypertension), current/history of breast cancer or other hormone-sensitive cancer
Required Medical Information	Diagnosis of covered use, attestation patient is premenopausal, pregnancy status for female patients of childbearing potential.
Age Restrictions	
Prescriber Restrictions	Restricted to endocrinology and gynecology
Coverage Duration	1 year
Other Criteria	PA applies to all. Use of this drug for more than 2 years increases risk of bone loss and requests for therapy for more than 2 years will not be approved.
Indications	All Medically-accepted Indications.
Off Label Uses	

MYTESI (crofelemer)

Products Affected

- MYTESI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

NAMZARIC (memantine and donepezil)

Products Affected

- NAMZARIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of documentation that the patient has been stabilized on donepezil 10 mg daily.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

NATPARA (parathyroid hormone)

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation that (albumin-corrected) serum calcium is greater than 7.5 mg/dL and confirmation that 25-hydroxyvitamin D stores are sufficient.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to endocrinology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

NERLYNX (neratinib)

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with proton pump inhibitors
Required Medical Information	Diagnosis of covered use, submission of genetic tumor testing showing that the primary tumor type is HR-positive, HER2-positive, confirmation member has completed adjuvant trastuzumab-based therapy or will be using in combination with capecitabine, submission of baseline liver function tests, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

NEXAVAR (sorafenib)

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

NINLARO (ixazomib)

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation that medication will be administered concomitantly with lenalidomide and dexamethasone, documentation of prior therapy regimen for multiple myeloma, submission of baseline platelet count and absolute neutrophil count.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	Initially 3 months, then 1 year
Other Criteria	PA applies to new starts only. For continuation, documentation of platelet count greater than 30,000/mm3, ANC greater than 500/mm3, and Grade 1 or lower non-hematological toxicities (including rash, peripheral neuropathies) required.
Indications	All Medically-accepted Indications.
Off Label Uses	

NITISINONE

Products Affected

- *nitisinone*
- NITYR
- ORFADIN ORAL CAPSULE 20 MG
- ORFADIN ORAL SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initially 6 months, then 1 year
Other Criteria	PA applies to all. Submission of liver function tests, urine succinylacetone levels, alpha-fetoprotein level, serum tyrosine level, serum phenylalanine level required for reauthorization.
Indications	All Medically-accepted Indications.
Off Label Uses	

NORTHERA (droxidopa)

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

NUEDEXTA (dextromethorphan and quinidine)

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	Prolonged QT interval, congenital long QT syndrome, heart failure, history suggestive of torsades de pointes, AV block without implanted pacemaker
Required Medical Information	Diagnosis of covered use, submission of ECG (specifically QT interval).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology and psychiatry
Coverage Duration	1 year
Other Criteria	PA applies to all. The medication will not be approved for agitation or Alzheimer's disease without pseudobulbar affect as this is considered an off-label use.
Indications	All Medically-accepted Indications.
Off Label Uses	

NUPLAZID (pimavanserin)

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis unrelated to Parkinson's disease psychosis
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

OCALIVA (obeticholic acid)

Products Affected

- OCALIVA ORAL TABLET 10 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Complete biliary obstruction, decompensated cirrhosis (Child-Pugh B or C) or prior decompensation event, compensated cirrhosis with evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia)
Required Medical Information	Diagnosis of covered use, documentation either (1) drug will be used in combination with ursodeoxycholic acid (UDCA) and UDCA has been used for 1 year or (2) patient had intolerance to UDCA, submission of baseline LFTs including ALP and total bilirubin, attestation patient does not have evidence of portal hypertension and has not had a prior decompensation event.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initially 3 months, then 1 year
Other Criteria	PA applies to all. Submission of ALP obtained within the previous 3 months required for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

ODOMZO (sonidegib)

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ONUREG (azacitidine)

Products Affected

- ONUREG ORAL TABLET 200 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of absolute neutrophil count, submission of pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	Initially 6 months, then 1 year
Other Criteria	PA applies to new starts only. Attestation of clinical benefit or stabilization and absence of unacceptable toxicity will be required for reauthorization. This dosage form is not intended to be a substitute for or substituted for injectable azacitidine.
Indications	All Medically-accepted Indications.
Off Label Uses	

ORENITRAM (treprostinil)

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe (Child-Pugh class B or C) hepatic impairment
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to cardiology and pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ORGOVYX (relugolix)

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology and urology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ORIAHNN (elagolix/estradiol/norethindrone)

Products Affected

- ORIAHNN

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, known liver impairment or disease, known osteoporosis, undiagnosed abnormal uterine bleeding, women at increased risk of or current/a history of thrombotic or thromboembolic disorders (including women over 35 years of age who smoke and women with uncontrolled hypertension), current/history of breast cancer or other hormone-sensitive cancer
Required Medical Information	Diagnosis of covered use, attestation patient is premenopausal, pregnancy status for female patients of childbearing potential.
Age Restrictions	
Prescriber Restrictions	Restricted to endocrinology and gynecology
Coverage Duration	1 year
Other Criteria	PA applies to all. Use of this drug for more than 2 years increases risk of bone loss and requests for therapy for more than 2 years will not be approved.
Indications	All Medically-accepted Indications.
Off Label Uses	

ORILISSA (elagolix)

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, severe hepatic impairment (Child-Pugh class C), known osteoporosis
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to endocrinology and gynecology
Coverage Duration	Up to 24 months based on liver function and coexisting dyspareunia. See "Other Criteria" section.
Other Criteria	PA applies to all. For endometriosis with dyspareunia or in women with moderate hepatic impairment, 6 months. For endometriosis without dyspareunia, 150 mg daily for 24 months.
Indications	All Medically-accepted Indications.
Off Label Uses	

ORKAMBI (lumacaftor/ivacaftor)

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation that the patient is homozygous for the F508del mutation in the CFTR gene provided from an FDA-cleared CF mutation test, attestation baseline and follow-up ophthalmologic exams will be performed in pediatric patients starting on therapy.
Age Restrictions	2 years of age or older
Prescriber Restrictions	Restricted to pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ORLADEYO (berotralstat)

Products Affected

- ORLADEYO

PA Criteria	Criteria Details
Exclusion Criteria	End-stage renal disease
Required Medical Information	Diagnosis of covered use.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. For approval, the patient must have tried and failed to have an adequate response to or had an intolerance to Takhzyro.
Indications	All Medically-accepted Indications.
Off Label Uses	

OXBRYTA (voxelotor)

Products Affected

- OXBRYTA

PA Criteria	Criteria Details
Exclusion Criteria	Hemoglobin greater than 10.5 g/dL
Required Medical Information	Diagnosis of covered use, submission of hemoglobin level.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Restricted to hematology
Coverage Duration	6 months
Other Criteria	PA applies to all. Continuation of therapy requests require objective documentation from the prescriber that the patient's hemoglobin level has increased.
Indications	All Medically-accepted Indications.
Off Label Uses	

OXERVATE (cenegermin-bkbj)

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	Restricted to optometry and ophthalmology
Coverage Duration	8 weeks
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

PALYNZIQ (pegvaliase-pqpz)

Products Affected

- PALYNZIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of blood phenylalanine concentration.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. Continuation of therapy after 1 year requires documentation of blood phenylalanine concentration below 600 micromol/L or at least a 20% reduction in blood phenylalanine concentration from pre-treatment baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	

PCSK9 INHIBITORS

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For all indications, submission of LDL level obtained within the previous 6 months. For primary hyperlipidemia (including HeFH) and ASCVD indications, documentation that medication is being used as an adjunct to maximally-tolerated statin therapy or documentation of inability to tolerate statin therapy (with at least one hydrophilic statin having been tried and failed). For HeFH, documentation of genetic test result documenting HeFH or diagnosis by clinical criteria using Simon Broom or WHO/Dutch Lipid Network criteria. For ASCVD, documented history of MI, ACS, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, or PAD.
Age Restrictions	For Repatha, 13 years of age or older. For Praluent, 18 years of age or older.
Prescriber Restrictions	Restricted to prescribing by/under the documented recommendation of a cardiologist, lipidologist, or endocrinologist with experience in and a focus on lipid management
Coverage Duration	Initially 6 months, then 1 year
Other Criteria	PA applies to all. Submission of LDL level documenting clinically significant response to therapy will be required for reauthorization.
Indications	All Medically-accepted Indications.
Off Label Uses	

PDE5 INHIBITORS (PAH)

Products Affected

- *alyq*
- *sildenafil citrate oral suspension reconstituted*
- *sildenafil citrate oral tablet 20 mg*
- *tadalafil (pah)*

PA Criteria	Criteria Details
Exclusion Criteria	For tadalafil, diagnosis of severe (Child-Pugh class C) hepatic impairment, creatinine clearance below 30 mL/min or on hemodialysis
Required Medical Information	Diagnosis of covered use. For tadalafil, submission of patient weight and serum creatinine (to calculate estimated creatinine clearance).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to cardiology and pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

PEMAZYRE (pemigatinib)

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of test result confirming presence of FGFR2 fusion or rearrangement, submission of previous systemic treatment(s) tried.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

PENICILLAMINE

Products Affected

- *penicillamine oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy unless being treated for Wilson's disease or certain patients with cystinuria, rheumatoid arthritis patients with a history or other evidence of renal insufficiency
Required Medical Information	Diagnosis of covered use, laboratory analysis applicable to indication for use, documentation that patient has tried and failed or had an intolerance to penicillamine tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

PIQRAY (alpelisib)

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with strong CYP3A inducers or BCRP inhibitors
Required Medical Information	Diagnosis of covered use, submission of genetic tumor testing showing that the primary tumor type is HR-positive, HER2-negative, PIK3CA-mutated, attestation that patient has advanced or metastatic disease and will be taking concurrently with fulvestrant, submission of prior therapies tried, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

POMALYST (pomalidomide)

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, submission of baseline serum bilirubin, AST, ALT, CBC including ANC and platelet count, prior therapies, when prior therapy was completed, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

PRETOMANID

Products Affected

- PRETOMANID

PA Criteria	Criteria Details
Exclusion Criteria	Inability to use bedaquiline or linezolid
Required Medical Information	Diagnosis of covered use, attestation pretomanid will be used in combination with bedaquiline and linezolid.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to infectious diseases and pulmonology.
Coverage Duration	26 weeks
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

PREVYMIS (letermovir)

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of day number post-HSCT, documentation of any previous doses of letermovir.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology, oncology, transplant specialist, and infectious diseases
Coverage Duration	100 days
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

PRIOR AUTHORIZATION TO OVERRIDE SPECIALTY RESTRICTIONS

Products Affected

- APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE
- CRINONE
- FABIOR
- PEG-INTRON REDIPEN SUBCUTANEOUS KIT 50 MCG/0.5ML
- PEG-INTRON SUBCUTANEOUS KIT 50 MCG/0.5ML
- PEGASYS PROCLICK
- PEGASYS SUBCUTANEOUS SOLUTION
- PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- PEGINTRON SUBCUTANEOUS KIT 50 MCG/0.5ML
- *tazarotene external*
- TAZORAC EXTERNAL CREAM 0.05 %
- TAZORAC EXTERNAL GEL
- VABOMERE
- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	The following physician specialties are exempt from prior authorization (by drug): (a) for Fabior, tazarotene, and Tazorac: dermatology exempt, (b) for Pegasys: gastroenterology, hepatology, or infectious diseases exempt, (c) for Crinone: gynecology, obstetrics, reproductive endocrinology, or women's health exempt, (d) for Vabomere: infectious diseases or nephrology exempt, (e) for Apokyn: neurology exempt, (f) for Xyrem: neurology or pulmonology exempt
Coverage Duration	1 year
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

PRIOR AUTHORIZATION TO OVERRIDE SPECIALTY RESTRICTIONS (PROTECTED CLASS DRUGS)

Products Affected

- *temsirolimus*
- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. Physicians who specialize in the treatment of medical conditions most commonly treated with this medication are exempt from prior authorization. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

PROCYSBI (cysteamine)

Products Affected

- PROCYSBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation that patient has tried and failed or had an intolerance to immediate-release cysteamine.
Age Restrictions	1 year of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. For approval, the patient must have tried and failed to have an adequate response to, had an intolerance to, or have a contraindication to therapy with immediate-release cysteamine.
Indications	All Medically-accepted Indications.
Off Label Uses	

PROLIA (denosumab)

Products Affected

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Hypocalcemia, pregnancy
Required Medical Information	Diagnosis of covered use. "High risk for fracture" is defined as (1) a history of osteoporotic fracture or (2) multiple risk factors for fracture or (3) patients who have failed or are intolerant of other available osteoporosis therapies, confirmation of osteoporosis diagnosis either through densitometry (T-score less than or equal to -2.5 at the total hip, femoral neck, or lumbar spine) or clinically (documented presence of fragility fracture).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

PROMACTA (eltrombopag)

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use (including cause of thrombocytopenia if being used for that indication), documentation of previous therapies tried (corticosteroids, immunoglobulins), submission of platelet count.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	PA applies to all. Not indicated for treatment of patients with myelodysplastic syndrome and will not be approved for this use.
Indications	All Medically-accepted Indications.
Off Label Uses	

PROMETHAZINE IN OLDER PATIENTS

Products Affected

- PHENADOZ RECTAL SUPPOSITORY 12.5 MG
- *promethazine hcl oral solution*
- PROMETHAZINE HCL ORAL SYRUP
- PROMETHAZINE HCL ORAL TABLET
- PROMETHAZINE HCL RECTAL SUPPOSITORY 12.5 MG, 25 MG
- PROMETHEGAN RECTAL SUPPOSITORY 25 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For all diagnoses of covered use, justification why the benefits of the drug will outweigh the risks for the specific patient must be submitted. For allergic conditions, documentation must be submitted showing patient has tried and failed or had an inadequate response to a second-generation antihistamine.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Promethazine is a potent anticholinergic considered high-risk in older patients due to risks of confusion, dry mouth, constipation, and decreased clearance with advanced age.
Indications	All Medically-accepted Indications.
Off Label Uses	

PROMETHAZINE VC

Products Affected

- *promethazine vc plain*
- *promethazine-phenylephrine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use including treatment of medical condition causing a cough, not due to symptomatic relief of cough and/or cold.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

PROSTATE CANCER ORAL MEDICATIONS

Products Affected

- *abiraterone acetate oral tablet 250 mg*
- ERLEADA
- NUBEQA
- XTANDI

PA Criteria	Criteria Details
Exclusion Criteria	For abiraterone, severe hepatic impairment (Child-Pugh class C)
Required Medical Information	Diagnosis of covered use and documentation of other treatments tried. For Nubeqa, documentation of other treatments tried. For abiraterone, confirmation patient will receive concurrent prednisone, submission of baseline ALT, AST, bilirubin, and serum potassium level.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology, oncology, and urology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. Nubeqa will be authorized only if the patient previously tried and had an inadequate clinical response or an intolerance to both Erleada and Xtandi.
Indications	All Medically-accepted Indications.
Off Label Uses	

QINLOCK (ripretinib)

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of previous kinase inhibitor therapies, including a trial of imatinib, attestation patient does not have uncontrolled hypertension, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

RAVICTI (glycerol phenylbutyrate)

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of baseline fasting plasma ammonia level.
Age Restrictions	2 months of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

RETACRIT (epoetin alfa-epbx)

Products Affected

- RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of hemoglobin or hematocrit level, serum iron, total iron-binding capacity (TIBC), and transferrin within 30 days of request date, documentation that the patient does not have uncontrolled hypertension.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For non-ESRD-related conditions: 90 days. For ESRD-related conditions: 1 year.
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

RETEVMO (selpercatinib)

Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of RET gene fusion or mutation, attestation patient does not have uncontrolled hypertension, pregnancy status for female patients of childbearing potential. For patients with RET fusion-positive thyroid cancer, submission of date or year of previous previous radioactive iodine treatment or reason why radioactive iodine therapy is not appropriate.
Age Restrictions	12 years of age or older based on indication
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

REVLIMID (lenalidomide)

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy, chronic lymphocytic leukemia (outside of a controlled clinical trial)
Required Medical Information	Diagnosis of covered use, submission of CBC including ANC and platelet count, pregnancy status for female patients of childbearing potential. For mantle cell lymphoma, documentation of at least two prior therapies tried, one of which included bortezomib (or a documented contraindication to bortezomib).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

REZUROCK (belumosudil)

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of at least 2 previous therapies tried and failed for chronic graft-versus-host disease, pregnancy status for female patients of childbearing potential.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Restricted to hematology, oncology, and transplant specialty
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	

ROZLYTREK (entrectinib)

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with moderate or strong CYP3A inducers
Required Medical Information	Diagnosis of covered use. For non-small cell lung cancer, submission of results showing tumor is ROS1-positive as detected by an FDA-approved test. For solid tumors, submission of evidence of a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

RUBRACA (rucaparib)

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of baseline CBC. For BRCA mutation-associated ovarian, fallopian tube, primary peritoneal or metastatic castration-resistant prostate cancer, confirmation of deleterious BRCA mutation as detected by FDA-approved companion diagnostic test, documentation that the patient has been treated with two or more chemotherapies.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology, oncology, and urology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. For initial approval, patient must have recovered from hematological toxicity caused by previous chemotherapy (Grade 1 or less).
Indications	All Medically-accepted Indications.
Off Label Uses	

RUZURGI (amifampridine)

Products Affected

- RUZURGI

PA Criteria	Criteria Details
Exclusion Criteria	History of seizure
Required Medical Information	Diagnosis of covered use.
Age Restrictions	6 years of age through 16 years of age
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

RYDAPT (midostaurin)

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. For acute myeloid leukemia, submission of FDA-approved test confirming presence of FLT3 mutation.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

SAMSCA (tolvaptan)

Products Affected

- SAMSCA ORAL TABLET 15 MG
- *tolvaptan*

PA Criteria	Criteria Details
Exclusion Criteria	Anuria
Required Medical Information	Diagnosis of covered use, submission of serum sodium.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	PA applies to all. Treatment is limited to 30 days to prevent liver injury.
Indications	All Medically-accepted Indications.
Off Label Uses	

SEDATING ANTIHISTAMINES IN OLDER PATIENTS

Products Affected

- *carbinoxamine maleate oral solution*
- *carbinoxamine maleate oral tablet 4 mg*
- *clemastine fumarate oral tablet 2.68 mg*
- *cyproheptadine hcl oral*
- *diphenhydramine hcl oral elixir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All 4 of the following criteria must be met: (1) diagnosis of covered use, (2) unless using carbinoxamine or cyproheptadine for dermatographism, documentation patient tried and failed or had an inadequate response to a second-generation antihistamine, (3) documentation provider is aware the medication is considered a high-risk medication for elderly patients according to the Centers for Medicare and Medicaid Services, and (4) justification is submitted which explains the benefits of the drug and how that benefit outweighs the potential risks to the patient.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

SEROSTIM (somatropin)

Products Affected

- SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

SIGNIFOR (pasireotide)

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment (Child-Pugh class C)
Required Medical Information	Diagnosis of covered use, submission of ALT, aspartate aminotransferase, alkaline phosphatase, and total bilirubin.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to endocrinology
Coverage Duration	1 year
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

SIMVASTATIN 80 mg per day

Products Affected

- *ezetimibe-simvastatin oral tablet 10-80 mg*
- *simvastatin oral tablet 80 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Any new start to therapy. Not recommended as initial therapy nor for patients already taking lower doses of simvastatin whose response is inadequate.
Required Medical Information	Diagnosis of covered use, documentation that patient has been taking simvastatin 80 mg daily for 12 months or longer without ill effect, submission of lipid panel, liver function tests, and serum creatinine level all obtained within the past 12 months.
Age Restrictions	10 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

SIRTURO (bedaquiline)

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of baseline ECG, serum potassium, calcium, magnesium, ALT, AST, alkaline phosphatase, and bilirubin, confirmation that Sirturo will be co-administered with pretomanid and linezolid or at least 3 other drugs proven to be or at least 4 other drugs suspected to be effective against the patient's M. tuberculosis isolate and submission of susceptibility testing, if available.
Age Restrictions	5 years of age or older
Prescriber Restrictions	Restricted to infectious diseases and pulmonology
Coverage Duration	26 weeks
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

SIVEXTRO (tedizolid)

Products Affected

- SIVEXTRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation of a culture and sensitivity showing that the suspected causative agent is susceptible to this medication.
Age Restrictions	12 years of age or older
Prescriber Restrictions	Restricted to infectious diseases
Coverage Duration	6 days
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

SKELETAL MUSCLE RELAXANTS IN OLDER PATIENTS

Products Affected

- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine hcl oral*
- *metaxalone*
- *methocarbamol oral*
- *orphenadrine citrate er*
- ROBAXIN-750

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of fibromyalgia, coverage will be provided for cyclobenzaprine for patients who have tried and failed to tolerate or had an inadequate response to at least 2 of the following: duloxetine, gabapentin, milnacipran, or pregabalin. For treatment of acute, painful musculoskeletal conditions, coverage will be provided when the prescriber attests to understanding the risks of skeletal muscle relaxants in the elderly, which include increased risk of fall and fracture due to sedation and anticholinergic effects.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

SOMAVERT (pegvisomant)

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of baseline IGF-1, ALT, AST, alkaline phosphatase, and serum total bilirubin.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to endocrinology
Coverage Duration	1 year
Other Criteria	PA applies to all. Continuation of therapy requests require submission of updated IGF-1, ALT, AST, alkaline phosphatase, and serum total bilirubin levels.
Indications	All Medically-accepted Indications.
Off Label Uses	

SOVALDI (sofosbuvir)

Products Affected

- SOVALDI ORAL PACKET
- SOVALDI ORAL TABLET 200 MG, 400 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, laboratory confirmation of hepatitis C virus (HCV) genotype 1a, 1b, 2, 3, or 4 infection, documentation of whether cirrhosis is present or not and whether or not it is compensated or decompensated, confirmation a test for HBV infection (HBsAg and anti-HBc) was completed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria for coverage duration will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

SPRYCEL (dasatinib)

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Uncorrected hypokalemia, uncorrected hypomagnesemia
Required Medical Information	Diagnosis of covered use, submission of serum potassium and magnesium. For adults with resistance or intolerance to prior therapy, documentation of prior therapy.
Age Restrictions	
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

STIVARGA (regorafenib)

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	Severe or uncontrolled hypertension
Required Medical Information	Diagnosis of covered use, submission of previous therapies, submission of baseline ALT, AST, serum bilirubin, and blood pressure reading.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

SUCRAID (sacrosidase)

Products Affected

- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of laboratory-confirmed congenital sucrase-isomaltase deficiency via differential urinary disaccharide test or measurement of intestinal disaccharides following small bowel biopsy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

SUNOSI (solriamfetol)

Products Affected

- SUNOSI ORAL TABLET 150 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	End stage renal disease, concurrent treatment with monoamine oxidase inhibitor (MAOI) or use of an MAOI within the past 14 days
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. Solriamfetol is not indicated to treat the underlying airway obstruction in obstructive sleep apnea and will not be approved for this use.
Indications	All Medically-accepted Indications.
Off Label Uses	

SUTENT (sunitinib)

Products Affected

- *sunitinib malate*
- SUTENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

SYMDEKO (tezacaftor/ivacaftor)

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. Documentation that the patient is homozygous for the F508del mutation or has at least one mutation in the CTFR gene responsive to the drug (see section 12.1, table 4 of package insert for full list) provided from an FDA-cleared CF mutation test. Submission of documentation that baseline and follow-up ophthalmologic exams will be performed in pediatric patients starting on therapy.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Restricted to pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

SYMLIN (pramlintide)

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Gastroparesis
Required Medical Information	Diagnosis of covered use, confirmation of current use of a mealtime insulin.
Age Restrictions	
Prescriber Restrictions	PA not required for endocrinology
Coverage Duration	1 year
Other Criteria	PA applies to all except when prescribed by endocrinology.
Indications	All Medically-accepted Indications.
Off Label Uses	

SYMPROIC (naldemedine)

Products Affected

- SYMPROIC

PA Criteria	Criteria Details
Exclusion Criteria	Known or suspected gastrointestinal obstruction or increased risk of recurrent obstruction, severe hepatic impairment (Child-Pugh class C)
Required Medical Information	Diagnosis of covered use, documentation patient has been using opioids at a morphine equivalent dose of at least 30 mg daily for at least 4 weeks prior to initiation, provider must attest that if opioid medication is stopped for any reason, naldemedine will be discontinued.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

SYNAREL (nafarelin)

Products Affected

- SYNAREL

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy/breast-feeding, undiagnosed abnormal vaginal bleeding
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For endometriosis, 6 months. For all other diagnoses, 1 year.
Other Criteria	PA applies to all. Re-treatment for endometriosis is not recommended because safety data are not available.
Indications	All Medically-accepted Indications.
Off Label Uses	

SYNRIBO (omacetaxine)

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

TABRECTA (capmatinib)

Products Affected

- TABRECTA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of prior therapies used, submission of FDA-approved test confirming presence of MET exon 14 skipping mutation, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TAFAMIDIS

Products Affected

- VYNDAMAX
- VYNDAQEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to cardiology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

TAFINLAR (dabrafenib)

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with strong CYP2C8 or CYP3A4 inhibitors
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of BRAF V600E or V600K mutation. For non-small cell lung cancer or unresectable/metastatic melanoma with a BRAF V600K mutation, attestation that therapy will be used in combination with trametinib.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TAGRISSO (osimertinib)

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, confirmation of the presence of required genetic mutations/deletions as detected by an FDA-approved test. For EGFR T790M mutation-positive NSCLC, documentation that the patient has progressed on or after EGFR TKI therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	Initially 3 months, then 1 year
Other Criteria	PA applies to new starts only. Continuation of approval requires affirmation of absence of unacceptable toxicities.
Indications	All Medically-accepted Indications.
Off Label Uses	

TAKHZYRO (lanadelumab-flyo)

Products Affected

- *takhzyro*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TALZENNA (talazoparib)

Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA-approved companion test results showing patient is a candidate for therapy and pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TARGRETIN (bexarotene) GEL

Products Affected

- TARGRETIN EXTERNAL

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, submission of previous therapies.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to dermatology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	

TASIGNA (nilotinib)

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Exclusion Criteria	Uncorrected hypokalemia, uncorrected hypomagnesemia, long QT syndrome
Required Medical Information	Diagnosis of covered use, submission of baseline EKG, Philadelphia chromosome (Ph) status, potassium and magnesium levels.
Age Restrictions	
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TAVALISSE (fostamatinib)

Products Affected

- TAVALISSE ORAL TABLET 100 MG, 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of platelet count, documentation patient had an insufficient response to prior treatment (including at least one of the following: corticosteroids, immunoglobulins, splenectomy, and/or a thrombopoietin receptor agonist).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology
Coverage Duration	Initially 12 weeks, then 1 year
Other Criteria	PA applies to all. Continuation of therapy requires submission of platelet count.
Indications	All Medically-accepted Indications.
Off Label Uses	

TAZVERIK (tazemetostat)

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with strong CYP3A inhibitors or moderate or strong CYP3A inducers
Required Medical Information	Diagnosis of covered use, pregnancy status for female patients of childbearing potential.
Age Restrictions	16 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	Initially 16 weeks, then 1 year
Other Criteria	PA applies to new starts only. Continuation of therapy requires (a) documentation of a positive clinical response and (b) attestation no known secondary malignancies have developed.
Indications	All Medically-accepted Indications.
Off Label Uses	

TEGSEDI (inotersen)

Products Affected

- TEGSEDI

PA Criteria	Criteria Details
Exclusion Criteria	Platelet count less than 100 x 10^9 L
Required Medical Information	Diagnosis of covered use, submission of platelet count.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

TEPMETKO (tepotinib)

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of prior therapies used, submission of FDA-approved test confirming presence of MET exon 14 skipping mutation, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TERIPARATIDE

Products Affected

- FORTEO SUBCUTANEOUS SOLUTION 600 MCG/2.4ML
- FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR
- TERIPARATIDE (RECOMBINANT)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, postmenopausal status, submission of serum calcium level, documentation that other treatment options have failed (or are contraindicated), submission of a value, condition, or past medical history that assesses fracture risk (e.g., DEXA scan results or prior fracture), submission of number of total months of all prior use of parathyroid hormone analogs and parathyroid hormone related peptides.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 years maximum dependent on patient's prior use of all PTH analogs and PTH-related peptides
Other Criteria	PA applies to all. Use of parathyroid hormone analogs and/or parathyroid hormone related peptides for more than 2 years during a patient's lifetime is not recommended and requests for therapy with any of these agents for a combined total of greater than 2 years will not be approved.
Indications	All Medically-accepted Indications.
Off Label Uses	

TESTOSTERONE REPLACEMENT PRODUCTS

Products Affected

- ANDRODERM TRANSDERMAL PATCH 24 HOUR
- NATESTO
- TESTOSTERONE TRANSDERMAL GEL 10 MG/ACT (2%)
- *testosterone transdermal gel 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)*
- *testosterone transdermal solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of serum testosterone level, documentation that patient has been evaluated for the presence of breast and prostate cancer prior to initiation of therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

THROMBOPOIETIN RECEPTOR AGONISTS

Products Affected

- DOPTELET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology, gastroenterology, and surgery
Coverage Duration	Doptelet: 5 days for undergoing a procedure or 1 year for immune thrombocytopenia
Other Criteria	PA applies to all. These medications should not be administered to patients with chronic liver disease in an attempt to normalize platelet counts and will not be approved for this indication.
Indications	All Medically-accepted Indications.
Off Label Uses	

TIBSOVO (ivosidenib)

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with strong CYP3A inducers
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of IDH1 mutation.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TOBI PODHALER (tobramycin)

Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	6 years of age or older
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TOPICAL ONYCHOMYCOSIS TREATMENTS

Products Affected

- JUBLIA
- *tavaborole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of culture-proven Trichophyton rubrum or Trichophyton mentagrophytes infection, documentation patient has tried and failed to respond to or tolerate oral terbinafine therapy or a documented contraindication to its use exists.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	48 weeks
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

TRICYCLIC ANTIDEPRESSANTS IN OLDER PATIENTS

Products Affected

- *amitriptyline hcl oral*
- *chlordiazepoxide-amitriptyline*
- *clomipramine hcl oral*
- *doxepin hcl oral capsule*
- *doxepin hcl oral concentrate*
- *imipramine hcl oral*
- *perphenazine-amitriptyline*
- *trimipramine maleate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use. Patient must have tried and failed to tolerate or had an inadequate response to two preferred alternative therapies for labeled indications or off-labeled uses including the following: (1) for depression (applies to amitriptyline, imipramine, doxepin, and trimipramine): paroxetine, sertraline, venlafaxine, duloxetine, citalopram, escitalopram, fluoxetine, or trazodone, (2) for headache treatment and prophylaxis (applies to amitriptyline): propranolol, timolol, topiramate, valproic acid, or divalproex, (3) for anxiety (applies to doxepin): paroxetine, venlafaxine, duloxetine, or buspirone, (4) for postherpetic neuralgia (applies to amitriptyline) or other neuropathic pain: gabapentin or pregabalin, (5) for obsessive-compulsive disorder (applies to clomipramine): paroxetine, sertraline, fluoxetine, or fluvoxamine, (6) for irritable bowel syndrome (applies to amitriptyline): laxatives or loperamide. For covered diagnoses not listed above, must try two FDA-approved alternatives (or one, if there is only one). Documentation must be submitted confirming that the prescriber is aware the medication is considered a high-risk medication for elderly patients according to the Centers for Medicare and Medicaid Services and justification is submitted by the prescriber which explains how the benefits outweigh the potential risks for the specific patient.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TRIENTINE

Products Affected

- *clovique*
- *trientine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation of intolerance to penicillamine.
Age Restrictions	6 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

TRIKAFTA (elexacaftor/tezacaftor/ivacaftor)

Products Affected

- TRIKAFTA ORAL TABLET THERAPY PACK 100-50-75 & 150 MG, 50-25-37.5 & 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment
Required Medical Information	Diagnosis of covered use, documentation that the patient has at least one mutation in the CFTR gene responsive to the drug (see section 12.1, table 4 of package insert for full list) or a mutation that is responsive based on in vitro data provided from an FDA-cleared CF mutation test, submission of documentation that baseline and follow-up ophthalmologic exams will be performed in pediatric patients starting on therapy.
Age Restrictions	
Prescriber Restrictions	Restricted to pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TRUSELTIQ (infigratinib)

Products Affected

- TRUSELTIQ (100MG DAILY DOSE)
- TRUSELTIQ (125MG DAILY DOSE)
- TRUSELTIQ (50MG DAILY DOSE)
- TRUSELTIQ (75MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with moderate or strong CYP3A inducers or inhibitors, coadministration with proton pump inhibitors
Required Medical Information	Diagnosis of covered use, submission of test result confirming presence of FGFR2 fusion or rearrangement, submission of previous systemic treatment(s) tried.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TUKYSA (tucatinib)

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	Diagnosis of covered use, submission of genetic tumor testing showing that the primary tumor type is HER2-positive, submission of previous systemic treatment including prior HER2-directed therapy, pregnancy status for female patients of childbearing potential, confirmation that the treatment regimen will include concomitant use of capecitabine and trastuzumab.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TURALIO (pexidartinib)

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	Active liver or biliary tract disease, pre-existing increased serum transaminases, total or direct bilirubin greater than the upper limit of normal, unavoidable concomitant use of other hepatotoxic medications, strong CYP3A inducers, or proton pump inhibitors
Required Medical Information	Diagnosis of covered use (and surgical intervention is not possible or practical), submission of serum transaminases, total and direct bilirubin, and ALP.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TYKERB (lapatinib)

Products Affected

- *lapatinib ditosylate*

PA Criteria	Criteria Details
Exclusion Criteria	Uncorrected hypokalemia, uncorrected hypomagnesemia
Required Medical Information	Diagnosis of covered use, submission of baseline LVEF and potassium and magnesium levels.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

TYMLOS (abaloparatide)

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	Males
Required Medical Information	Diagnosis of covered use where "high risk for fracture" is defined as (1) a history of osteoporotic fracture or (2) multiple risk factors for fracture or (3) patients who have failed or are intolerant of other available osteoporosis therapies, submission of baseline serum calcium, postmenopausal status, documentation that at least one bisphosphonate was tried and failed (or a bisphosphonate is contraindicated), submission of a value, condition, or past medical history that assesses fracture risk (e.g., DEXA scan results or prior fracture), submission of number of total months of all prior use of parathyroid hormone analogs and parathyroid hormone related peptides.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 years maximum dependent on patient's prior use of all PTH analogs and PTH-related peptides
Other Criteria	PA applies to all. Use of parathyroid hormone analogs and/or parathyroid hormone related peptides for more than 2 years during a patient's lifetime is not recommended and requests for therapy with any of these agents for a combined total of greater than 2 years will not be approved.
Indications	All Medically-accepted Indications.
Off Label Uses	

UKONIQ (umbralisib)

Products Affected

- UKONIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of pregnancy status for female patients of childbearing potential, attestation patient will receive prophylaxis for Pneumocystis jirovecii pneumonia (PJP) and, if necessary, cytomegalovirus. For follicular lymphoma, submission of at least three prior systemic therapies used. For marginal zone lymphoma, submission of at least one prior anti-CD20-based regimen used.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

UPNEEQ (oxymetazoline)

Products Affected

- UPNEEQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to ophthalmologic surgery
Coverage Duration	Initially 90 days, then 1 year
Other Criteria	PA applies to all. Submission of clinically significant response to therapy will be required for reauthorization. Not FDA-approved for cosmetic use and therefore uses outside of acquired blepharoptosis will not be approved.
Indications	All FDA-approved Indications.
Off Label Uses	

UPTRAVI (selexipag)

Products Affected

- UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG
- UPTRAVI ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	Severe (Child-Pugh class C) hepatic impairment
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to cardiology and pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

VECAMYL (mecamylamine)

Products Affected

- VECAMYL

PA Criteria	Criteria Details
Exclusion Criteria	Mild, moderate, labile hypertension, coronary insufficiency or history of recent myocardial infarction, uremia, glaucoma, organic pyloric stenosis
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to cardiology and neurology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

VEMLIDY (tenofovir alafenamide)

Products Affected

- VEMLIDY

PA Criteria	Criteria Details
Exclusion Criteria	End stage renal disease patients not receiving chronic hemodialysis, decompensated (Child-Pugh class B or C) hepatic impairment
Required Medical Information	Diagnosis of covered use, confirmation of HIV test and that drug will not be used by itself in the case of HIV co-infection.
Age Restrictions	18 years of age or older
Prescriber Restrictions	PA not required for gastroenterology or infectious diseases
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

VENCLEXTA (venetoclax)

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

VENTAVIS (iloprost)

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to cardiology and pulmonology
Coverage Duration	1 year
Other Criteria	This medication is covered as a Part B benefit except for enrollees residing in a long-term care facility. PA applies to new starts only when covered as a Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	

VERQUVO (vericiguat)

Products Affected

- VERQUVO ORAL TABLET 10 MG, 2.5 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of another soluble guanylate cyclase (sGC) stimulator or a phosphodiesterase-5 (PDE-5) inhibitor
Required Medical Information	Diagnosis, including either hospitalization for heart failure with reduced ejection fraction (HFrEF) within the previous 6 months or outpatient IV diuretic use within the previous 3 months, submission of left ventricular ejection fraction and pregnancy status for female patients of childbearing potential. Prescribers are also required to submit current regimen for the treatment of HFrEF, which must include (1) a renin-angiotensin system (RAS) inhibitor (ACE inhibitor, ARB, or sacubitril/valsartan), (2) a beta-blocker (BB), and (3) a mineralocorticoid receptor antagonist (MRA), each at maximally-tolerated doses. If any of these three therapies are not currently being used, prescriber is required to submit documentation as to why (e.g., contraindications, intolerances, etc.). Using the recommended dose of each therapeutic component to treat HFrEF is required. If the doses of any of these three components have not been optimized to the recommended dose to treat HFrEF, the prescriber is required to submit documentation as to why (e.g., intolerances, physiologic parameters, etc.). If the patient is using a BB not indicated for HFrEF, the patient will be required to switch to one of the three FDA-approved BBs for HFrEF (bisoprolol, carvedilol, or metoprolol succinate).
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All FDA-approved Indications.
Off Label Uses	

VERZENIO (abemaciclib)

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of genetic tumor testing showing that the primary tumor type is HR-positive, HER2-negative, submission of baseline liver function tests and CBC, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

VIBERZI (eluxadoline)

Products Affected

- VIBERZI

PA Criteria	Criteria Details
Exclusion Criteria	Prior cholecystectomy, known or suspected biliary duct obstruction, known or suspected sphincter of Oddi disease or dysfunction, alcoholism, alcohol abuse, alcohol addiction, or patients who drink more than 3 alcoholic beverages/day, history of pancreatitis, structural diseases of pancreas including known or suspected pancreatic duct obstruction, severe hepatic impairment (Child-Pugh class C), severe constipation or sequelae from constipation, known or suspected mechanical gastrointestinal obstruction
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to gastroenterology
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

VITRAKVI (larotrectinib)

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of evidence the solid tumor has a neurotrophic receptor tyrosine kinase (NTRK) gene fusion without a known acquired resistance mutation, pregnancy status for female patients of childbearing potential.
Age Restrictions	
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

VIZIMPRO (dacomitinib)

Products Affected

- VIZIMPRO ORAL TABLET 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	Coadministration with a proton pump inhibitor
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of EGFR exon 19 deletion or exon 21 L858R substitution mutation, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

VMAT2 INHIBITORS

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- INGREZZA ORAL CAPSULE 40 MG, 60 MG, 80 MG
- INGREZZA ORAL CAPSULE THERAPY PACK
- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	For tetrabenazine and Austedo, actively suicidal or untreated/undertreated depression, hepatic impairment
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology and psychiatry
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

VOSEVI (sofosbuvir, velpatasvir, voxilaprevir)

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	Patients on rifampin
Required Medical Information	Diagnosis of covered use, laboratory confirmation of hepatitis C virus (HCV) and genotype, documentation of whether cirrhosis is present or not and whether or not it is compensated or decompensated, confirmation a test for HBV infection (HBsAg and anti-HBc) was completed.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

VOTRIENT (pazopanib)

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment
Required Medical Information	Diagnosis of covered use, submission of baseline ALT, AST, and bilirubin.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

VRAYLAR (cariprazine)

Products Affected

- VRAYLAR

PA Criteria	Criteria Details
Exclusion Criteria	Dementia-related psychosis
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology and psychiatry
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

VUMERITY (diroximel fumarate)

Products Affected

- VUMERITY
- VUMERITY (STARTER)

PA Criteria	Criteria Details
Exclusion Criteria	Moderate or severe renal impairment, hypersensitivity to dimethyl fumarate, co-administration with dimethyl fumarate
Required Medical Information	Diagnosis of covered use, submission of patient weight and serum creatinine (to calculate estimated creatinine clearance).
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to all. For approval of Vumerity, the patient must have tried and failed to have an adequate response to or had an intolerance to dimethyl fumarate.
Indications	All Medically-accepted Indications.
Off Label Uses	

WAKIX (pitolisant)

Products Affected

- WAKIX ORAL TABLET 17.8 MG, 4.45 MG

PA Criteria	Criteria Details
Exclusion Criteria	Severe hepatic impairment, end stage renal disease
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology and sleep medicine
Coverage Duration	1 year
Other Criteria	PA applies to all. Wakix will be authorized only if the patient previously tried and had an inadequate clinical response or an intolerance to armodafinil or modafinil.
Indications	All Medically-accepted Indications.
Off Label Uses	

WEIGHT LOSS MEDICATIONS

Products Affected

- ADIPEX-P
- CONTRAVE
- *phentermine hcl oral*
- QSYMIA
- SAXENDA

PA Criteria	Criteria Details
Exclusion Criteria	Body mass index (BMI) less than 30 kg/m2 or less than 27 kg/m2 if the patient also has diabetes, high blood pressure, or dyslipidemia.
Required Medical Information	Submission of BMI and patient's exercise/diet plan.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. Medication will not be approved if patient does not have a diet/exercise plan.
Indications	All Medically-accepted Indications.
Off Label Uses	

WELIREG (belzutifan)

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use including confirmation patient does not require immediate surgery, submission of pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

WHITE BLOOD CELL STIMULATORS

Products Affected

- NEULASTA ONPRO
- NEULASTA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- NIVESTYM
- UDENYCA
- ZARXIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of FDA-approved indication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All FDA-approved Indications.
Off Label Uses	

XALKORI (crizotinib)

Products Affected

- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	Congenital long QT syndrome
Required Medical Information	Diagnosis of covered use, submission of results showing tumor is ALK or ROS1-positive as detected by an FDA-approved test, pregnancy status for female patients of childbearing potential.
Age Restrictions	For ALK-positive systemic anaplastic large cell lymphoma only, 1 year of age to 21 years of age
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

XATMEP (methotrexate oral solution)

Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy (for polyarticular juvenile idiopathic arthritis [pJIA] indication only)
Required Medical Information	Diagnosis of covered use. For pJIA, confirmation that member is intolerant to or had an inadequate response to first-line therapy. For acute lymphoblastic leukemia, confirmation that medication is being used as a component of a combination chemotherapy maintenance regimen.
Age Restrictions	2 years of age through 18 years of age
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

XCOPRI (cenobamate)

Products Affected

- XCOPRI (250 MG DAILY DOSE)
- XCOPRI (350 MG DAILY DOSE)
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG
- XCOPRI ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	Familial short QT syndrome, patients with end-stage renal disease (creatinine clearance less than 15 mL/min) undergoing dialysis, severe hepatic impairment
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to neurology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

XERMELO (telotristat)

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation patient has been on at least 12 weeks of prior somatostatin analog therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	PA applies to all. Continuation of therapy requires that symptoms have stabilized or improved and that the patient has not experienced episodes of severe constipation.
Indications	All Medically-accepted Indications.
Off Label Uses	

XGEVA (denosumab)

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	Hypocalcemia
Required Medical Information	Diagnosis of covered use.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

XOLAIR (omalizumab)

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	Patients whose pre-treatment serum IgE level and body weight place them in the "insufficient data to recommend a dose" category based on dosing charts in the prescribing information
Required Medical Information	Diagnosis of covered use. For asthma, documentation that patient's symptoms are poorly controlled with inhaled corticosteroids, submission of patient's current body weight, pre-treatment serum IgE level, pulmonary function test results including FEV1, positive skin test result or demonstrated in vitro reactivity (RAST test) to a perennial aeroallergen, frequency of inhaled short-acting beta2-agonist therapy, frequency of daily and nighttime symptoms and exacerbations, and effect of exacerbations on activity. For chronic idiopathic urticaria, documentation that the patient continues to experience severe itching and hives despite the use of an H1 antihistamine at an approved dose. For nasal polyps, documentation that patient's symptoms are poorly controlled with intranasal corticosteroids and current intranasal corticosteroid therapy.
Age Restrictions	6 years of age or older
Prescriber Restrictions	Restricted to allergy, dermatology, immunology, otolaryngology/otorhinolaryngology, and pulmonology
Coverage Duration	1 year
Other Criteria	PA applies to all. Continuation of therapy requests require objective documentation from the prescriber that the patient's symptoms have improved. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

XOSPATA (gilteritinib)

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of FLT3 mutation, pregnancy status for female patients of childbearing potential.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

XPOVIO (selinexor)

Products Affected

- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 40 MG
- XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 40 MG
- XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 40 MG
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, documentation of treatment failure with or intolerance to all prior therapies to match the indication.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All FDA-approved Indications.
Off Label Uses	

XURIDEN (uridine triacetate)

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of baseline CBC including neutrophil count and mean corpuscular volume, baseline urine orotic acid level.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all. Continuation of approval requires submission of CBC including neutrophil count and mean corpuscular volume and urine orotic acid level.
Indications	All Medically-accepted Indications.
Off Label Uses	

XYWAV (oxybate salts)

Products Affected

- XYWAV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	7 years of age or older
Prescriber Restrictions	Restricted to neurology, psychiatry, and sleep medicine
Coverage Duration	1 year
Other Criteria	PA applies to all. Xywav will be authorized only if the patient has used sodium oxybate (Xyrem) and prescriber submits a clinical reason detailing the need to switch to Xywav.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZEJULA (niraparib)

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZELBORAF (vemurafenib)

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	Long QT syndrome, QTc greater than 500 msec, uncorrected electrolyte abnormalities
Required Medical Information	Diagnosis of covered use, submission of results showing BRAF V600 mutation as detected by an FDA-approved test, submission of ECG, serum potassium, magnesium, and calcium levels.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only. Not indicated in wild-type BRAF melanoma and will not be approved for this use.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZERBAXA (ceftolozane/tazobactam)

Products Affected

- ZERBAXA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, confirmation patient will receive concurrent metronidazole therapy when used for the treatment of complicated intra-abdominal infections.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	For UTI including pyelonephritis, 7 days. For all other FDA-approved indications, 14 days.
Other Criteria	PA applies to all. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZILEUTON ER

Products Affected

- ZILEUTON ER

PA Criteria	Criteria Details
Exclusion Criteria	Active liver disease or persistent hepatic function elevation enzyme greater than or equal to 3 times the upper limit of normal
Required Medical Information	Diagnosis of covered use, submission of hepatic function enzymes and serum bilirubin.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZILRETTA (triamcinolone intra-articular injection)

Products Affected

- ZILRETTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 treatment only
Other Criteria	PA applies to all. Use for hip and shoulder osteoarthritis were not evaluated in trials and PA will not be approved for this use. Re-authorization will not be approved. A description of how the drug will be used and/or obtained may be required to determine whether it will be covered under Medicare Part B or Part D. If the medication will be self-administered after proper training or the provider agrees to have the medication filled at a pharmacy and delivered to the office by the patient for provider administration, it may be covered under Part D. If these conditions are not satisfied this medication may be covered under Part B.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZOKINVY (lonafarnib)

Products Affected

- ZOKINVY ORAL CAPSULE 50 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	Body surface area less than 0.39 m^2
Required Medical Information	Diagnosis of covered use including results of genetic testing supporting diagnosis, pregnancy status for female patients of childbearing potential.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to all.
Indications	All FDA-approved Indications.
Off Label Uses	

ZOLPIDEM IN OLDER PATIENTS

Products Affected

- AMBIEN
- AMBIEN CR
- *zolpidem tartrate er*
- *zolpidem tartrate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All 4 of the following criteria must be met: (1) diagnosis of covered use, (2) documentation provider is aware of risks of therapy including cognitive impairment, delirium, unsteady gait, syncope, falls, fractures and motor vehicle accidents and that the medication is considered a high-risk medication for elderly patients according to the Centers for Medicare and Medicaid Services, (3) documentation that the benefits of the drug outweigh the potential risks to the patient, (4) documentation that at least two of the following medications were tried and deemed ineffective or intolerable: Belsomra, doxepin tablets, ramelteon, and trazodone.
Age Restrictions	PA applies to patients 65 years of age or older. PA does not apply to patients 64 years of age or younger.
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZONTIVITY (vorapaxar)

Products Affected

- ZONTIVITY

PA Criteria	Criteria Details
Exclusion Criteria	History of stroke, transient ischemic attack, or intracranial hemorrhage, active pathological bleeding, severe hepatic impairment
Required Medical Information	Diagnosis of covered use, confirmation that patient has not had prior stroke, transient ischemic attack, or intracranial hemorrhage, documentation of concurrent use with aspirin and/or clopidogrel.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZORBTIVE (somatropin)

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	4 weeks
Other Criteria	PA applies to all.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZYDELIG (idelalisib)

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	History of serious hypersensitivity reactions, including anaphylaxis and toxic epidermal necrolysis
Required Medical Information	Diagnosis of covered use. For relapsed small lymphocytic lymphoma and follicular B-cell non-Hodgkin lymphoma, documentation of at least two prior systemic therapies.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZYKADIA (ceritinib)

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of covered use, submission of FDA-approved test confirming presence of ALK-positive tumor.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Restricted to hematology and oncology
Coverage Duration	1 year
Other Criteria	PA applies to new starts only.
Indications	All Medically-accepted Indications.
Off Label Uses	

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