people powered health plans

2023 PRIOR AUTHORIZATION CRITERIA

UCare Your Choice (PPO)
UCare Your Choice Plus (PPO)

UCare requires your provider to get prior authorization for certain drugs. This means that you'll need to get approval from us before you fill your prescriptions. If you don't get approval, UCare may not cover the drug.

Last updated: 12/1/2023

H8070_11983_072022_C

U11983 (07/2022)

Notice of Nondiscrimination

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

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **612-676-3200 (voice)** or toll free at **1-800-203-7225 (voice)**, **612-676-6810 (TTY)**, or **1-800-688-2534 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**.

If you believe that UCare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current UCare member, please call the number on the back of your membership card. Otherwise please call **612-676-3200** or toll free at **1-800-203-7225 (voice)**; **612-676-6810** or toll free at **1-800-688-2534 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance
Mailing Address
UCare
Attn: Appeals and Grievances
PO Box 52
Minneapolis, MN 55440-0052
Email: cag@ucare.org
Fax: 612-884-2021

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

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

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 612-676-3200/1-800-203-7225（TTY：612-676-6810/1-800-688-2534）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 612-676-3200/1-800-203-7225 (телетайп: 612-676-6810/1-800-688-2534).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 612-676-3200/1-800-203-7225 (መስማት ለተሳናቸው: 612-676-6810/1-800-688-2534).

ဟသျှဉ်ဟသး–နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့် ကျိာ်အတၢ်မၤစၢၤလ၊ တလာ်ဘျဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ៉ែខ្មរ, រសារជំនួយរ័ផ្តកភាសា ដោយមិនគិតឈ្លួល គឺអាចមានសំរាប់បំរីអ្នក។ ចូរ ទូរស័ព្ទ 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534)។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 612-676-3200/1-800-203-7225 (رقم هاتف الصم والبكم: 612-676-6810/1-800-688-2534).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 612-676-3200/1-800-203-7225 (ATS : 612-676-6810/1-800-688-2534).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 612-676-3200/1-800-203-7225 (TTY: 612-676-6810/1-800-688-2534).

adempas

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PAH and CTEPH- must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	1 year
Other Criteria	For PAH - must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Non-small cell lung cancer-approve if the patient has metastatic disease and anaplastic lymphoma kinase (ALK)-positive non-small cell lung disease. Anaplastic large cell lymphoma-approve if the patient has ALK-positive disease. Erdheim-Chester disease-approve if the patient has ALK rearrangement/fusion-positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Anaplastic large cell lymphoma, Erdheim Chester disease
Part B Prerequisite	No

Alosetron

Products Affected

- *alosetron*

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

Alpha 1 Proteinase Inhibitors

Products Affected

- PROLASTIN-C INTRAVENOUS RECON SOLN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Alpha1-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease)-approve if the patient has a baseline (pretreatment) AAT serum concentration of less than 80 mg/dL or 11 micromol/L
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ALUNBRIG

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ALK status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Erdheim-Chester disease-approve if the patient has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease. Inflammatory myofibroblastic tumor (IMT)-approve if the patient has IMT with ALK translocation. Metastatic NSCLC, must be ALK-positive, as detected by an approved test.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Erdheim-Chester disease, Inflammatory myofibroblastic tumor (IMT)
Part B Prerequisite	No

AMJEVITA

Products Affected

- AMJEVITA(CF) AUTOINJECTOR
- AMJEVITA(CF) SUBCUTANEOUS SYRINGE 10 MG/0.2 ML, 20 MG/0.4 ML, 40 MG/0.8 ML

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with another biologic DMARD or targeted synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried
Age Restrictions	Crohn's disease (CD), 6 or older (initial therapy only). Ulcerative colitis (UC), 5 or older (initial therapy only). PP-18 years and older (initial therapy only).
Prescriber Restrictions	RA/JIA/JRA/Ankylosing spondylitis, prescribed/consult w/rheumatologist (initial therapy only). Psoriatic arthritis (PsA), prescribed/consult w/a rheumatologist or dermatologist (initial therapy only). Plaque psoriasis (PP), prescribed/consult w/a dermatologist (initial therapy only). UC/ CD, prescribed/consult w/gastroenterologist (initial therapy only). HS, prescr/consult w/dermatologist (initial therapy only). UV, presc/consult w/ophthalmologist (initial therapy only).
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA initial. Tried one other systemic therapy for this condition (e.g MTX, sulfasalazine, leflunomide, NSAID) or biologic (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. Plaque psoriasis (PP) initial. approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial. Tried corticosteroids (CSs) or if CSs are contraindicated or if pt currently on CSs or patient has tried one other conventional systemic therapy for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR pt had ilecolonic resection OR enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC initial. Pt has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab, golimumab SC, or a corticosteroid such as prednisone or methylprednisolone) or the pt has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. HS - tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). FDA approve indications cont tx - must respond to tx as determined by prescriber.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Antifungals

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	onychomycosis, foot baths
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

APOKYN

Products Affected

- APOKYN
- *apomorphine*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a serotonin 5-HT3 Antagonist
Required Medical Information	Diagnosis, other therapies
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Parkinson's disease (PD), new to therapy-approve if the patient meets the following criteria: 1. Patient has advanced PD, 2. patient is experiencing off episodes such as muscle stiffness, slow movements, or difficulty starting movements, 3. Patient is currently receiving carbidopa/levodopa. Parkinson's disease (PD), patients currently receiving apokyn or apomorphine-approve if the patient meets the following criteria: 1. patient has advanced PD, 2. patient is experiencing off episodes such as muscle stiffness, slow movements, or difficulty starting movements, 3. patient is currently receiving carbidopa/levodopa and 4.patient has previously tried one other treatment for off episodes and had significant intolerance or inadequate efficacy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

arcalyst

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent biologic therapy
Required Medical Information	
Age Restrictions	Initial tx CAPS/Pericarditis-Greater than or equal to 12 years of age.
Prescriber Restrictions	Initial tx CAPS-prescribed by, or in consultation with, a rheumatologist, geneticist, allergist/immunologist, or dermatologist. DIRA initial-rheum, geneticist, derm, or a physician specializing in the treatment of autoinflammatory disorders. Pericarditis-cardiologist or rheum
Coverage Duration	CAPS-3 mos initial, 1 yr cont. DIRA-6 mos initial, 1 yr cont. Pericard-3 mos initial, 1 yr cont
Other Criteria	CAPS renewal - approve if the patient has had a response as determined by the prescriber. DIRA initial-approve if the patient weighs at least 10 kg, genetic test confirms a mutation in the IL1RN gene and the patient has demonstrated a clinical benefit with anakinra subcutaneous injection. DIRA cont-approve if the patient has responded to therapy. Pericarditis initial-approve if the patient has recurrent pericarditis AND for the current episode, the patient is receiving standard treatment or standard treatment is contraindicated. Continuation-approve if the patient has had a clinical response.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Austedo

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Chorea-prescribed by or in consult with a neuro. TD-Prescribed by or in consultation with a neurologist or a psychiatrist
Coverage Duration	1 year
Other Criteria	Chorea associated with Huntington's Disease-approve if the diagnosis of Huntington's Disease is confirmed by genetic testing.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

avonex

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of other disease-modifying agent used for multiple sclerosis
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year
Other Criteria	Cont tx-approve if the patient has been established on Avonex.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ayvakit

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	GIST-approve if the tumor is positive for platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation or if the patient has tried two of the following: Gleevec (imatinib), Sutent (sunitinib), Sprycel (dasatinib), Stivarga (regorafenib) or Qinlock (ripretinib). Myeloid/Lymphoid Neoplasms with eosinophilia-approve if the tumor is positive for PDGFRA D842V mutation. Systemic mastocytosis-Approve if the patient has a platelet count greater than or equal to 50,000/mcL and patient has either indolent systemic mastocytosis or one of the following subtypes of advanced systemic mastocytosis-aggressive systemic mastocytosis, systemic mastocytosis with an associated hematological neoplasm or mast cell leukemia.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Myeloid/Lymphoid neoplasms with Eosinophilia
Part B Prerequisite	No

BALVERSA

Products Affected

- BALVERSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, previous therapies, test results
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Urothelial Carcinoma, locally advanced or metastatic-approve if the patient has susceptible fibroblast growth factor receptor 3 or fibroblast growth factor receptor 2 genetic alterations AND the patient has progressed during or following prior platinum-containing chemotherapy or checkpoint inhibitor therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with Other Biologics or Lupkynis
Required Medical Information	Diagnosis, medications that will be used in combination, autoantibody status
Age Restrictions	18 years and older (initial).
Prescriber Restrictions	SLE-Prescribed by or in consultation with a rheumatologist, clinical immunologist, nephrologist, neurologist or dermatologist (initial and continuation). Lupus Nephritis-nephrologist or rheum. (Initial/cont)
Coverage Duration	SLE-Initial-4 months, cont-1 year. Lupus Nephritis-6 mo initial, 1 year cont

PA Criteria	Criteria Details
Other Criteria	Lupus Nephritis Initial-approve. Cont-approve if the patient has responded to the requested medication. SLE-Initial-The patient has autoantibody-positive SLE, defined as positive for antinuclear antibodies [ANA] and/or anti-double-stranded DNA antibody [anti-dsDNA] AND Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician. Continuation-Benlysta is being used concurrently with at least one other standard therapy (i.e., antimalarials [e.g., hydroxychloroquine], a systemic corticosteroid [e.g., prednisone], and/or other immunosuppressants [e.g., azathioprine, mycophenolate mofetil, methotrexate]) unless the patient is determined to be intolerant due to a significant toxicity, as determined by the prescribing physician AND The patient has responded to Benlysta as determined by the prescriber.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Besremi

Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other interferon products
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Bexarotene (Oral)

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
Coverage Duration	3 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Bosentan/Ambrisentan

Products Affected

- *ambrisentan*
- *bosentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (PAH) WHO Group 1, results of right heart cath
Age Restrictions	
Prescriber Restrictions	For treatment of pulmonary arterial hypertension, ambrisentan or bosentan must be prescribed by or in consultation with a cardiologist or a pulmonologist. CTEPH - prescribed by or in consultation with a cardiologist or pulmonologist
Coverage Duration	Authorization will be for 1 year.
Other Criteria	CTEPH - pt must have tried Adempas, has a contraindication to Adempas, or is currently receiving bosentan for CTEPH. Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Chronic thromboembolic pulmonary hypertension (CTEPH) (bosentan)
Part B Prerequisite	No

bosulif

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis. For CML/ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For ALL, prior therapies tried.
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, patient must have Ph-positive CML. For ALL, patient must have Ph-positive ALL and has tried ONE other tyrosine kinase inhibitors that are used for Philadelphia chromosome positive ALL (e.g., Gleevec, Sprycel, etc).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Patients with Philadelphia chromosome positive Acute Lymphoblastic Leukemia
Part B Prerequisite	No

BRAFTOVI

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, BRAF V600 status
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation. Colon or Rectal cancer-approve if the patient meets the following (A, B, and C): A) The patient has BRAF V600E mutation-positive disease AND B) The patient has previously received a chemotherapy regimen for colon or rectal cancer AND C) The agent is prescribed as part of a combination regimen for colon or rectal cancer. NSCLC- approve if pt has BRAF V600E mutation-positive metastatic disease AND this medication will be taken in combination with Mektovi (binimetinib tablets).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Brukinsa

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	'Mantle Cell Lymphoma - approve if the patient has tried at least one systemic regimen or patient is not a candidate for a systemic regimen (i.e., an elderly patient who is frail). Chronic lymphocytic leukemia/small lymphocytic lymphoma-approve. Marginal zone lymphoma-approve if the patient has tried at least one systemic regimen. Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma-approve.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

C1 ESTERASE INHIBITORS

Products Affected

- CINRYZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	prescribed by or in consultation with an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders
Coverage Duration	1 year
Other Criteria	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II], Prophylaxis, Initial Therapy: approve if the patient has HAE type I or type II confirmed by low levels of functional C1-INH protein (less than 50% of normal) at baseline and lower than normal serum C4 levels at baseline. Patient is currently taking Cinryze for prophylaxis - approve if the patient meets the following criteria (i and ii): i) patient has a diagnosis of HAE type I or II, and ii) according to the prescriber, the patient has had a favorable clinical response since initiating Cinryze as prophylactic therapy compared with baseline. HAE Due to C1-INH Deficiency [Type I or Type II], Treatment of Acute Attacks, Initial Therapy: approve if the patient has HAE type I or type II confirmed by low levels of functional C1-INH protein (less than 50% of normal) at baseline and lower than normal serum C4 levels at baseline. Patient who has treated previous acute HAE attacks with Cinryze: approve if the patient has a diagnosis of HAE Type I or Type II and according to the prescriber, the patient has had a favorable clinical response.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

cablivi

Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, concurrent medications
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	Approve for 12 months
Other Criteria	aTTP-approve if the requested medication was initiated in the inpatient setting in combination with plasma exchange therapy AND patient is currently receiving at least one immunosuppressive therapy AND if the patient has previously received Cablivi, he/she has not had more than two recurrences of aTTP while on Cablivi.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CABOMETYX

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, histology, RET gene rearrangement status
Age Restrictions	Thyroid carcinoma-12 years and older, other dx (except bone cancer)-18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Renal Cell Carcinoma-Approve if the patient has relapsed or stage IV disease. Hepatocellular Carcinoma-approve if the patient has been previously treated with at least one other systemic therapy (e.g., Nexavar, Lenvima). Bone cancer-approve if the patient has Ewing sarcoma or osteosarcoma and has tried at least one previous systemic regimen. Thyroid carcinoma-approve if the patient has differentiated thyroid carcinoma, patient is refractory to radioactive iodine therapy and the patient has tried a vascular endothelial growth factor receptor (VEGFR)-targeted therapy. Endometrial carcinoma-approve if the patient has tried one systemic regimen. GIST-approve if the patient has tried two of the following-imatinib, Ayvakit, sunitinib, dasatinib, Stivarga or Qinlock. NSCLC-approve if the patient has RET rearrangement positive tumor.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Patients with Non-Small Cell Lung Cancer, Gastrointestinal stromal tumors (GIST), Bone cancer, Endometrial Carcinoma

PA Criteria	Criteria Details
Part B Prerequisite	No

CALQUENCE

Products Affected

- CALQUENCE
- CALQUENCE (ACALABRUTINIB MAL)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma, Marginal zone lymphoma.
Part B Prerequisite	No

CAMZYOS

Products Affected

- CAMZYOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older (initial and continuation)
Prescriber Restrictions	Prescribed by a cardiologist (initial and continuation)
Coverage Duration	Initial-8 months, continuation- 1 year

PA Criteria	Criteria Details
Other Criteria	Obstructive hypertrophic cardiomyopathy, initial-Approve if the pt meets the following criteria (i, ii, iii and iv): i.Pt meets both of the following (a and b): a)Pt has at least 1 symptom associated w/obstructive hypertrophic cardiomyopathy (Note: examples include shortness of breath, chest pain, lightheadedness, fainting, fatigue, and reduced ability to perform physical exercise), AND b)Pt has New York Heart Association Class II or III symptoms of heart failure (Note:Class II signifies mild symptoms with moderate physical activity and some exercise limitations whereas Class III denotes noticeable symptoms with minimal physical activity and patients are only comfortable at rest), AND ii.Pt has left ventricular hypertrophy and meets 1 of the following (a or b): a)Pt has maximal left ventricular wall thickness greater than or equal to 15 mm, OR b)Pt has familial hypertrophic cardiomyopathy with a maximal left ventricular wall thickness greater than or equal to 13 mm, AND iii.Pt has a peak left ventricular outflow tract gradient greater than or equal to 50 mmHg (at rest or after provocation [Valsalva maneuver or post exercise]), AND iv. Pt has a left ventricular ejection fraction of greater than or equal to 55 percent. Cont-Approve if pt meets ALL of the following criteria (i, ii, iii and iv): i.Pt has been established on therapy for at least 8 months (Note: pt who has received less than 8 months of therapy or who is restarting therapy is reviewed under initial therapy), AND ii.Pt meets both of the following (a and b): a)Currently or prior to starting therapy, pt has or has experienced at least 1 symptom associated with obstructive hypertrophic cardiomyopathy, AND b)Currently or prior to starting therapy, pt is in or was in New York Heart Association Class II or III heart failure, AND iii.Pt has a current left ventricular ejection fraction of greater than or equal to 50 percent, AND iv.Pt meets at least 1 of the following (a or b): a)Pt experienced a beneficial clinical response when assessed by at least 1 objective measure (Note:Examples include improved peak oxygen consumption/mixed venous oxygen tension, decreases in left ventricular outflow tract gradient, reductions in

PA Criteria	Criteria Details
	N-terminal pro-B-type natriuretic peptide levels, decreased high-sensitivity cardiac troponin I levels, reduced ventricular mass index, and/or a reduction in maximum left atrial volume index), OR b)Pt experienced stabilization or improvement in at least 1 symptom related to obstructive hypertrophic cardiomyopathy (Note:Examples of symptoms include shortness of breath, chest pain, lightheadedness, fainting, fatigue, ability to perform physical exercise, and/or favorable changes in the Kansas City Cardiomyopathy Questionnaire-23 (KCCQ-23) Clinical Summary Score (CSS) or Hypertrophic Cardiomyopathy Symptom Questionnaire (HCMSQ) Shortness of Breath domain scores.)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CAPRELSA

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	MTC - approve. DTC - approve if refractory to radioactive iodine therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma. Non-Small Cell Lung Cancer with RET Gene Rearrangements
Part B Prerequisite	No

CARBAGLU

Products Affected

- *carglumic acid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist or a specialist who focuses in the treatment of metabolic diseases
Coverage Duration	NAGS-Pt meets criteria no genetic test - 3 mo. Pt had genetic test - 12 mo, other-approve for 7 days
Other Criteria	N-Acetylglutamate synthase deficiency with hyperammonemia-Approve if genetic testing confirmed a mutation leading to N-acetylglutamate synthase deficiency or if the patient has hyperammonemia. Propionic Acidemia or Methylmalonic Acidemia with Hyperammonemia, Acute Treatment-approve if the patient's plasma ammonia level is greater then or equal to 50 micromol/L and the requested medication will be used in conjunction with other ammonia-lowering therapies.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Acute hyperammonemia due to propionic acidemia (PA) or methylmalonic acidemia (MMA) (generic carglumic acid)
Part B Prerequisite	No

CAYSTON

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in the treatment of cystic fibrosis.
Coverage Duration	1 year
Other Criteria	Approve if the patient has Pseudomonas aeruginosa in culture of the airway (e.g., sputum culture, oropharyngeal culture, bronchoalveolar lavage culture).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

chenodal

Products Affected

- CHENODAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 1 year
Other Criteria	For the treatment of gallstones, approve if the patient has tried or is currently using an ursodiol product.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CLOBAZAM

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, other medications tried
Age Restrictions	2 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with a neurologist (initial therapy)
Coverage Duration	1 year
Other Criteria	Lennox-Gastaut Syndrome, initial therapy-patient has tried one of the following: lamotrigine, topiramate, rufinamide, felbamate, or Epidiolex. Treatment refractory seizures/epilepsy, initial therapy-patient has tried and/or is concomitantly receiving at least two other antiepileptic drugs (e.g., valproic acid, lamotrigine, topiramate, clonazepam, levetiracetam, zonisamide, felbamate). Continuation-prescriber confirms patient is responding to therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Dravet Syndrome and treatment-refractory seizures/epilepsy
Part B Prerequisite	No

cometriq

Products Affected

- COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1), 140 MG/DAY(80 MG X1-20 MG X3), 60 MG/DAY (20 MG X 3/DAY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis.
Age Restrictions	NSCLC/MTC-18 years and older, DTC-12 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MTC - approve. Non-Small Cell Lung Cancer with RET Gene Rearrangements - approve. Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma-approve if the patient's carcinoma is refractory to radioactive iodine therapy and patient has tried a Vascular Endothelial Growth Factor Receptor (VEGFR)-targeted therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Non-Small Cell Lung Cancer with RET Gene Rearrangements, Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma
Part B Prerequisite	No

Continuous Glucose Monitors

Products Affected

- DEXCOM G6 RECEIVER
- DEXCOM G6 SENSOR
- DEXCOM G6 TRANSMITTER
- DEXCOM G7 RECEIVER
- DEXCOM G7 SENSOR
- FREESTYLE LIBRE 14 DAY READER
- FREESTYLE LIBRE 14 DAY SENSOR
- FREESTYLE LIBRE 2 READER
- FREESTYLE LIBRE 2 SENSOR
- FREESTYLE LIBRE 3 SENSOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Diabetes Mellitus - Approve if pt is treated with insulin at least once per day OR has a history of problematic hypoglycemia with documentation of at least one of the following: Recurrent level 2 hypoglycemic events (glucose less than 54mg/dL (3.0mmol/L) that persist despite multiple (2 or more) attempts to adjust medication(s) and/or modify the diabetes treatment plan, or, a history of one level 3 hypoglycemic event (glucose less than 54mg/dL (3.0mmol/L) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia, AND the patient (or the patient's caregiver) must have been properly trained on using the requested continuous glucose monitor (CGM) as evidenced by the treating practitioner providing a prescription, AND the CGM is prescribed according to its Food and Drug Administration (FDA) indicated use, AND the prescriber has had an in-person visit or approved telehealth visit with the patient within the past six months, prior to ordering the CGM, to evaluate their diabetes control AND the patient will be reassessed at least every 6 months to discuss diabetes treatment plan and use of CGM.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

COPIKTRA

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, previous therapies
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	T-cell lymphoma-For peripheral T-cell lymphoma, approve. For breast implant-associated anaplastic large cell lymphoma, or hepatosplenic T-cell lymphoma, approve if the patient has relapsed or refractory disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	T-cell Lymphoma
Part B Prerequisite	No

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Melanoma initial - must have BRAF V600 mutation.
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Melanoma (unresectable, advanced or metastatic) - being prescribed in combination with Zelboraf. CNS Cancer-approve if the patient has BRAF V600 mutation-positive disease AND medication is being used for one of the following situations (i, ii, or iii): i) Adjuvant treatment of pilocytic astrocytoma or pleomorphic xanthoastrocytoma or ganglioglioma, OR ii) recurrent disease for low-grade glioma or anaplastic glioma or glioblastoma, OR iii) melanoma with brain metastases AND medication will be taken in combination with Zelboraf (vemurafenib tablets). Histiocytic Neoplasm-approve if the patient meets one of the following (i, ii, or iii): i) patient has Langerhans cell histiocytosis and one of the following: multisystem disease or pulmonary disease or central nervous system lesions, OR ii) patient has Erdheim Chester disease, OR iii) patient has Rosai-Dorfman disease AND patient has BRAF V600 mutation-positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Central Nervous System Cancer, Histocytic Neoplasm

PA Criteria	Criteria Details
Part B Prerequisite	No

Cysteamine (Ophthalmic)

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or a metabolic disease specialist or specialist who focuses in the treatment of metabolic diseases
Coverage Duration	1 year
Other Criteria	Approve if the patient has corneal cysteine crystal deposits confirmed by slit-lamp examination
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CYSTEAMINE (ORAL)

Products Affected

- CYSTAGON

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Cystagon and Procysbi
Required Medical Information	Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist or a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	1 year
Other Criteria	Cystinosis, nephropathic-approve if the prescriber confirms the diagnosis was confirmed by genetic testing confirming a mutation of the CTNS gene OR white blood cell cystine concentration above the upper limit of the normal reference range for the reporting laboratory.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Dalfampridine

Products Affected

- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years and older (initial and continuation therapy)
Prescriber Restrictions	MS - prescribed by or in consultation with a neurologist or MS specialist (initial and continuation).
Coverage Duration	Initial - 4months, Continuation - 1 year.
Other Criteria	Initial-approve if the patient is ambulatory, the requested medication is being used to improve or maintain mobility in a patient with MS and the patient has impaired ambulation as evaluated by an objective measure (e.g., timed 25 foot walk and multiple sclerosis walking scale-12). Continuation-approve if the patient is ambulatory, the requested medication is being used to improve or maintain mobility in a patient with MS and the patient has responded to or is benefiting from therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

daliresp

Products Affected

- *roflumilast*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD), medications tried.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 1 year.
Other Criteria	COPD, approve in patients who meet all of the following conditions: Patients has severe COPD or very severe COPD, AND Patient has a history of exacerbations, AND Patient has tried a medication from two of the three following drug categories: long-acting beta2-agonist (LABA) [eg, salmeterol, indacaterol], long-acting muscarinic antagonist (LAMA) [eg, tiotropium], inhaled corticosteroid (eg, fluticasone).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DAURISMO

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, medications that will be used in combination, comorbidities
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	AML - approve if Daurismo will be used in combination with cytarabine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Deferasirox

Products Affected

- *deferasirox oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Serum ferritin level
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hematologist
Coverage Duration	1 year
Other Criteria	Transfusion-related chronic iron overload, initial therapy - approve if the patient is receiving blood transfusions at regular intervals for various conditions (eg, thalassemia syndromes, myelodysplastic syndrome, chronic anemia, sickle cell disease) AND prior to starting therapy, the serum ferritin level is greater than 1,000 mcg/L. Non-transfusion-dependent thalassemia syndromes chronic iron overload, initial therapy - approve if prior to starting therapy the serum ferritin level is greater than 300 mcg/L. Continuation therapy - approve is the patient is benefiting from therapy as confirmed by the prescribing physician.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Diacomit

Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of diagnosis.
Age Restrictions	6 months and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with an neurologist (initial therapy)
Coverage Duration	1 year
Other Criteria	Dravet Syndrome-Initial therapy-approve if the patient is concomitantly receiving clobazam or is unable to take clobazam due to adverse events. Dravet Syndrome-Continuation-approve if the patient is responding to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Dimethyl Fumarate

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DUPIXENT

Products Affected

- DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML, 300 MG/2 ML
- DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML, 200 MG/1.14 ML, 300 MG/2 ML

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Xolair or another Anti-interleukin (IL) Monoclonal Antibody.
Required Medical Information	Diagnosis, prescriber specialty, other medications tried and length of trials
Age Restrictions	AD-6 months and older, asthma-6 years of age and older, Esophagitis-12 and older, Chronic Rhinosinusitis/Prurigo nodularis-18 and older
Prescriber Restrictions	Atopic Dermatitis/prurigo nodularis-Prescribed by or in consultation with an allergist, immunologist or dermatologist, asthma-prescribed by or in consultation with an allergist, immunologist or pulmonologist. Rhinosinusitis-prescribed by or in consultation with an allergist, immunologist or otolaryngologist. Esophagitis-presc/consult-allergist or gastro
Coverage Duration	AD-Init-4mo, Cont-1 yr, asthma/Rhinosinusitis/esophagitis/prurigo nod-init-6 mo, cont 1 yr

PA Criteria	Criteria Details
Other Criteria	AD,Init-pt 2yrs and older-pt meets a and b:a.used at least 1 med,med-high,high, and/or super-high-potency rx top CS OR AD affecting ONLY face,eyes/lids,skin folds,and/or genitalia and tried tacrolimus oint AND b.Inadeq efficacy was demonstrated w/prev tx.AD,Init-pt between 6 mo and less than 2 yr-pt meets a and b:a.used at least 1 med,med-high,high, and/or super-high-potency rx top CS and b.inadeq efficacy was demonstrated w/prev tx OR AD affecting ONLY face,eyes/lids,skin folds,and/or genitalia.Cont-pt responded to Dupixent.Asthma,init-pt meets (i, ii, and iii):i.Pt meets (a or b):a)blood eosinophil greater than or equal to 150 cells per microliter w/in prev 6 wks or within 6 wks prior to tx with any IL tx or Xolair OR b)has oral CS-dependent asthma, AND ii.received combo tx w/following (a and b): a)ICS AND b)1 add asthma control/maint med(NOTE:exception to the requirement for a trial of 1 add asthma controller/maint med can be made if pt already received anti-IL-5 tx or Xolair used concomitantly w/an ICS AND iii.asthma uncontrolled or was uncontrolled prior to starting anti-IL tx or Xolair defined by 1 (a, b, c, d or e): a)exper 2 or more asthma exacer req tx with systemic CS in prev yr OR b)exper 1 or more asthma exacer requiring hosp or ED visit in prev yr OR c)FEV1 less than 80percent predicted OR d)FEV1/FVC less than 0.80 OR e)asthma worsens w/tapering of oral CS tx.Cont-pt meets (i and ii): i.cont to receive tx with 1 ICS or 1 ICS-containing combo inhaler AND ii.has responded to Dupixent.Chronic rhinosinusitis w/nasal polyposis,init-pt receiving tx with an intranasal CS and experi rhinosinusitis symptoms like nasal obstruction, rhinorrhea, or reduction/loss of smell AND meets 1 (a or b): a)received tx w/syst CS w/in prev 2 yrs or has contraindication to systemic CS tx OR b)prior surgery for nasal polyps. Cont-pt cont to receive tx with an intranasal CS and responded to Dupixent. Eosino esoph, init-weighs greater than or equal to 40 kg, has dx of eosino esophagitis confirmed by endoscopic biopsy demonstrating greater than or equal to 15 intraepithelial eosinophils per high-power field, and does not have a secondary cause of eosino

PA Criteria	Criteria Details
	esophagitis, and has received at least 8 wks of tx with a Rx strength PPI. Cont-pt received at least 6mo of tx with Dupixent and has experi reduced intraepithelial eosinophil count or decreased dysphagia/pain upon swallowing or reduced frequency/severity of food impaction.Prurigo Nod, init-pt has greater than or equal to 20 nodular lesions and pt has experienced pruritus at least 6 wks, AND pt tried at least 1 high- or super-high-potency Rx topical CS. Cont-pt received at least 6 mo of tx with Dupixent and has experi reduced nodular lesion count, decreased pruritis or reduced nodular lesion size.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EMGALITY

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Combination therapy with Aimovig, Vyepti or Ajovy
Required Medical Information	Diagnosis, number of migraine or cluster headaches per month, prior therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Cluster headache tx-6 months, migraine prevention-1 year
Other Criteria	Migraine headache prevention-Approve if the patient meets the following criteria (A and B): A) Patient has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine-preventative medication), AND B) Patient has tried at least one standard prophylactic pharmacologic therapy (e.g., anticonvulsant, beta-blocker) and has had inadequate response or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician. A patient who has already tried an oral or injectable calcitonin gene-related peptide (CGRP) inhibitor indicated for the prevention of migraine or Botox (onabotulinumtoxinA injection) for the prevention of migraine is not required to try a standard prophylactic pharmacologic therapy. Episodic cluster headache treatment-approve if the patient has between one headache every other day and eight headaches per day.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

enbrel

Products Affected

- ENBREL MINI
- ENBREL SUBCUTANEOUS SOLUTION
- ENBREL SUBCUTANEOUS SYRINGE
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with biologic therapy or targeted synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	PP-4 years and older (initial therapy)
Prescriber Restrictions	Initial-RA/AS/JIA/JRA,prescribed by or in consult w/ rheumatologist. PsA, prescribed by or in consultation w/ rheumatologist or dermatologist. PP, prescribed by or in consult w/ dermatologist.GVHD,prescribed by or in consult w/ oncologist,hematologist,or physician affiliated w/ transplant center.Behcet's disease,prescribed by or in consult w/ rheumatologist,dermatologist,ophthalmologist,gastroenterologist,or neurologist.
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA, approve if the pt has aggressive disease, as determined by the prescriber, or the pt has tried one other systemic therapy for this condition (eg, MTX, sulfasalazine, leflunomide, NSAID), biologic or the pt will be started on Enbrel concurrently with MTX, sulfasalazine, or leflunomide or the pt has an absolute contraindication to MTX (eg, pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias), sulfasalazine, or leflunomide.Plaque psoriasis (PP) initial approve if the patient meets one of the following conditions: 1) patient has tried at least one traditional systemic agent for at least 3 months for plaque psoriasis, unless intolerant (eg, MTX, cyclosporine, Soriatane, oral methoxsalen plus PUVA, (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) the patient has a contraindication to one oral agent for psoriasis such as MTX. GVHD-approve. Behcet's. Has tried at least 1 conventional tx (eg, systemic corticosteroid, immunosuppressant, interferon alfa, MM, etc) or adalimumab or infliximab. RA/AS/JIA/PP/PsA Cont - must have a response to tx according to the prescriber. Behcet's, GVHD Cont-if the patient has had a response to tx according to the prescriber. Clinical criteria incorporated into the Enbrel 25 mg quantity limit edit, approve additional quantity (to allow for 50 mg twice weekly dosing) if one of the following is met: 1) Patient has plaque psoriasis, OR 2) Patient has RA/JIA/PsA/AS and is started and stabilized on 50 mg twice weekly dosing, OR 3) Patient has RA and the dose is being increased to 50 mg twice weekly and patient has taken MTX in combination with Enbrel 50 mg once weekly for at least 2 months, unless MTX is contraindicated or intolerant, OR 4) Patient has JIA/PsA/AS and the dose is being increased to 50 mg twice weekly after taking 50 mg once weekly for at least 2 months.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Graft versus host disease (GVHD), Behcet's disease
Part B Prerequisite	No

EPIDIOLEX

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, previous therapies
Age Restrictions	Patients 1 year and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with a neurologist (initial therapy)
Coverage Duration	1 year
Other Criteria	Dravet Syndrome-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs or if the patient has tried or is concomitantly receiving one of Diacomit or clobazam or Fintepla. Lennox Gastaut Syndrome-approve if the patient has tried or is concomitantly receiving at least two other antiepileptics drugs. Tuberous Sclerosis Complex-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs. Continuation of therapy-approve if the patient is responding to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EPOETIN ALFA

Products Affected

- RETACRIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CRF anemia in patients not on dialysis.Hemoglobin (Hb) of less than 10.0 g/dL for adults or less than or equal to 11 g/dL for children to start.Hb less than or equal to 11.5 g/dL for adults or 12 g/dL or less for children if previously on epoetin alfa, Mircera or Aranesp. Anemia w/myelosuppressive chemotx.pt must be currently receiving myelosuppressive chemo and Hb 10.0 g/dL or less to start.Hb less than or equal to 12.0 g/dL if previously on epoetin alfa or Aranesp.MDS, approve if Hb is 10 g/dL or less or serum erythropoietin level is 500 mU/mL or less to start.Previously receiving Aranesp or EA, approve if Hb is 12.0 g/dL or less. Anemia in HIV with zidovudine, Hb is 10.0 g/dL or less or endogenous erythropoietin levels are 500 mU/mL or less at tx start.Previously on EA approve if Hb is 12.0 g/dL or less. Surgical pts to reduce RBC transfusions - Hgb is less than or equal to 13, surgery is elective, nonvascular and non-cardiac and pt is unwilling or unable to donate autologous blood prior to surgery
Age Restrictions	MDS anemia = 18 years of age and older
Prescriber Restrictions	MDS anemia/myelofibrosis, prescribed by or in consultation with, a hematologist or oncologist.
Coverage Duration	Chemo-6m,Transfus-1m,Myelofibrosis-init-3 mo, cont-1 yr, all others-1 yr
Other Criteria	Myelofibrosis-Initial-patient has a Hb less than 10 or serum erythropoietin less than or equal to 500 Mu/mL. Cont-approve if according to the prescriber the patient has had a response to therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Anemia due to myelodysplastic syndrome (MDS), Myelofibrosis
Part B Prerequisite	No

erivedge

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	BCC (La or Met) - must not have had disease progression while on Odomzo.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years
Other Criteria	Locally advanced basal cell carcinoma (LABCC), approve if 1. the patient's BCC has recurred following surgery or radiation, OR 2. the patient is not a candidate for surgery and radiation therapy. Central nervous system cancer (this includes brain and spinal cord tumors)-approve if the patient has tried at least one chemotherapy agent and according to the prescriber, the patient has a mutation of the sonic hedgehog pathway. Basal cell carcinoma, metastatic-approve.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Central nervous System Cancer
Part B Prerequisite	No

ERLEADA

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Prostate cancer-non-metastatic, castration resistant and prostate cancer-metastatic, castration sensitive-approve if the requested medication will be used in combination with a gonadotropin-releasing hormone (GnRH) agonist or the medication is concurrently used with Firmagon or if the patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Erlotinib

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Advanced or Metastatic NSCLC, approve if the patient has sensitizing EGFR mutation positive non-small cell lung cancer as detected by an approved test. Note-Examples of sensitizing EGFR mutation-positive non-small cell lung cancer include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I. RCC, approve if the patient has recurrent or advanced non-clear cell histology RCC or if the patient had hereditary leiomyomatosis and renal cell carcinoma and erlotinib will be used in combination with bevacizumab. Bone cancer-chordoma-approve if the patient has chordoma and has tried at least one previous therapy. Pancreatic cancer-approve if the medication is used in combination with gemcitabine and if the patient has locally advanced, metastatic or recurrent disease. Vulvar cancer-approve if the patient has advanced, recurrent or metastatic disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Renal Cell Carcinoma, vulvar cancer and Bone Cancer-Chordoma.
Part B Prerequisite	No

esbriet

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist
Coverage Duration	1 year
Other Criteria	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Everolimus

Products Affected

- *everolimus (antineoplastic) oral tablet*
- *everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Breast Cancer-HER2 status, hormone receptor (HR) status.
Age Restrictions	All dx except TSC associated SEGA or partial onset seizures-18 years and older.
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

PA Criteria	Criteria Details
Other Criteria	Breast Cancer-approve if pt meets ALL the following (A, B, C, D, E, and F):A)pt has recurrent or metastatic,HR+ disease AND B)pt has HER2-negative breast cancer AND C)pt has tried at least 1 prior endocrine therapy AND D)pt meets 1 of the following conditions (i or ii):i.pt is a postmenopausal woman or man OR ii.pt is pre/perimenopausal woman AND is receiving ovarian suppression/ablation with a GnRH agonist, or has had surgical bilateral oophorectomy or ovarian irradiation AND E)pt meets 1 of the following conditions (i or ii): i.Afinitor will be used in combo with exemestane and pt meets 1 of the following:pt is male and is receiving a GnRH analog or pt is a woman or ii. Afinitor will be used in combo with fulvestrant or tamoxifen AND F)pt has not had disease progression while on Afinitor. RCC, relapsed or Stage IV disease-approve if using for non-clear cell disease or if using for clear cell disease, pt has tried 1 prior systemic therapy (e.g., Inlyta, Votrient, Sutent, Cabometyx, Nexavar).TSC Associated SEGA-approve if pt requires therapeutic intervention but cannot be curatively resected. Thymomas and Thymic Carcinomas-approve if pt has tried chemotherapy or cannot tolerate chemotherapy. TSC associated renal angiomyolipoma -approve. WM/LPL - approve if pt has progressive or relapsed disease or if pt has not responded to primary therapy. Thyroid Carcinoma, differentiated-approve if pt is refractory to radioactive iodine therapy. Endometrial Carcinoma-approve if Afinitor will be used in combo with letrozole. GIST-approve if pt has tried 2 of the following drugs: Sutent, Sprycel, Stivarga, Ayvakit, Qinlock or imatinib AND there is confirmation that Afinitor will be used in combo with 1 of these drugs (Sutent, Stivarga, or imatinib) in the treatment of GIST. TSC-associated partial-onset seizures-approve. NET tumors of the pancreas, GI Tract, Lung and Thymus (carcinoid tumors)-approve. Meningioma-approve if pt has recurrent or progressive disease. Soft tissue sarcoma-approve if pt has perivascular epithloid cell tumors (PE Coma) or recurrent angiomyolipoma/lymphangioleiomyomatosis. Classic hodgkin lymphoma-approve if pt has relapsed or
	refractory disease. Histiocytic neoplasm-approve if pt has Erdheim-Chester disease or, Rosai-Dorfman disease or Langerhans cell histiocytosis with bone disease, central nervous system lesions, multisystem disease or pulmonary disease. Patient must also have PIK3CA mutation.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	neuroendocrine tumors of the thymus (Carcinoid tumors). Soft tissue sarcoma, classical Hodgkin lymphoma, Waldenstrom's Macroglobulinemia/Lymphoplasmacytic Lymphoma (WM/LPL), Thymomas and Thymic carcinomas, Differentiated (i.e. papillary, follicular, and Hurthle cell) Thyroid Carcinoma, Endometrial Carcinoma, Gastrointestinal Stromal Tumors (GIST), Meningioma, men with breast cancer, Histiocytic Neoplasm
Part B Prerequisite	No

Exkivity

Products Affected

- EXKIVITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-approve if the patient meets (A, B and C): A) Patient has locally advanced or metastatic NSCLC AND B) Patient has epidermal growth factor receptor (EGFR) exon 20 insertion mutation, as determined by an approved test AND C) Patient has previously tried at least one platinum-based chemotherapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Filgrastim

Products Affected

- ZARXIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Cancer/AML, MDS, ALL, oncologist or a hematologist. Cancer patients receiving BMT and PBPC, prescribed by or in consultation with an oncologist, hematologist, or a physician who specializes in transplantation. Radiation-expertise in acute radiation. SCN, AA - hematologist. HIV/AIDS neutropenia, infectious disease (ID) physician (MD), hematologist, or MD specializing in HIV/AIDS.
Coverage Duration	chemo/SCN/AML-6mo.HIV/AIDS-4mo.MDS-3mo.PBPC,Drug induce A/N,AA,ALL,BMT-3mo.Rad-1mo.All others=12mo.

PA Criteria	Criteria Details
Other Criteria	Cancer patients receiving chemotherapy, approve if the patient meets one of the following conditions: patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status, or HIV infection), patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor (eg, Leukine, filgrastim products, pegfilgrastim products) and a reduced dose or frequency of chemotherapy may compromise treatment, patient has received chemotherapy has febrile neutropenia and has at least one risk factor (eg, sepsis syndrome, aged greater than 65 years, severe neutropenia [absolute neutrophil account less than 100 cells/mm3], neutropenia expected to be greater than 10 days in duration, invasive fungal infection).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Neutropenia associated with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). Treatment of myelodysplastic syndromes (MDS). Drug induced agranulocytosis or neutropenia. Aplastic anemia (AA). Acute lymphocytic leukemia (ALL). Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome).
Part B Prerequisite	No

FINTEPLA

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	2 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with an neurologist (initial therapy)
Coverage Duration	1 year
Other Criteria	Dravet Syndrome-Initial therapy-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs or patient has tried or is concomitantly receiving Epidiolex, Clobazam or Diacomit. Dravet Syndrome-Continuation-approve if the patient is responding to therapy. Lennox-Gastaut Syndrome, initial-approve if the patient has tried or is concomitantly receiving at least two other antiepileptic drugs. Lennox-Gastaut Syndrome, continuation-approve if the patient is responding to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Fotivda

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, other therapies
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years
Other Criteria	Renal Cell Carcinoma (RCC)-approve if the patient has relapsed or Stage IV disease and has tried at least two other systemic regimens. Note: Examples of systemic regimens for renal cell carcinoma include axitinib tablets, axitinib + pembrolizumab injection, cabozantinib tablets, cabozantinib + nivolumab injection, sunitinib malate capsules, pazopanib tablets, sorafenib tablets, and lenvatinib capsules + everolimus.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GATTEX

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	1 year and older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist (initial and continuation)
Coverage Duration	1 year
Other Criteria	Initial-approve if the patient is currently receiving parenteral nutrition on 3 or more days per week or according to the prescriber, the patient is unable to receive adequate total parenteral nutrition required for caloric needs. Continuation-approve if the patient has experienced improvement.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Gavreto

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	NSCLC-18 years and older, MTC/thyroid cancer-12 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	NSCLC-approve if the patient has metastatic disease and rearranged during transfection (RET) fusion-positive disease detected by an Food and Drug Administration (FDA) approved test. Medullary thyroid cancer (MTC)-approve if the patient has advanced or metastatic rearranged during transfection (RET)-mutant disease and the disease requires treatment with systemic therapy. Thyroid cancer (other than MTC)-approve if the patient has advanced or metastatic rearranged during transfection (RET) fusion-positive disease, the disease is radioactive iodine-refractory AND the disease requires treatment with systemic therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

gilotrif

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC - EGFR exon deletions or mutations or if NSCLC is squamous cell type
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	NSCLC EGFR pos - For the treatment of advanced or metastatic non small cell lung cancer (NSCLC)-approve if the patient has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: examples of sensitizing EGFR mutation-positive NSCLC include the following mutations : exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I. NSCLC metastatic squamous cell must have disease progression after treatment with platinum based chemotherapy. Head and neck cancer-approve if the patient has non-nasopharyngeal head and neck cancer and the patient has disease progression on or after platinum based chemotherapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Head and neck cancer
Part B Prerequisite	No

Glatiramer

Products Affected

- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agent used for multiple sclerosis
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by or after consultation with a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

glucagon-like peptide-1 agonists

Products Affected

- BYDUREON BCISE
- BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML, 5 MCG/DOSE (250 MCG/ML) 1.2 ML
- MOUNJARO
- TRULICITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GONADOTROPIN-RELEASING HORMONE AGONISTS - INJECTABLE LONG ACTING

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prostate cancer-prescr/consult with oncologist or urologist. For the treatment of other cancer diagnosis must be prescribed by or in consultation with an oncologist.
Coverage Duration	uterine leiomyomata 3 mo.All other=12 mo
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Ovarian cancer, breast cancer, prophylaxis or treatment of uterine bleeding or menstrual suppression in patients with hematologic malignancy or undergoing cancer treatment or prior to bone marrow/stem cell transplantation, head and neck cancer-salivary gland tumors
Part B Prerequisite	No

growth hormones

Products Affected

- OMNITROPE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	GHD in Children/Adolescents. Pt meets one of the following-1-had 2 GH stim tests with the following-levodopa, insulin-induced hypoglycemia, arginine, clonidine, or glucagon and both are inadequate as defined by a peak GH response which is below the normal reference range of the testing laboratory OR had at least 1 GH test and results show inadequate response and has at least one risk factor for GHD (e.g., ht for age curve deviated down across 2 major height percentiles [e.g., from above the 25 percentile to below the 10 percentile], growth rate is less than the expected normal growth rate based on age and gender, low IGF-1 and/or IGFBP-3 levels). 2.brain radiation or tumor resection and pt has 1 GH stim test and results is inadequate response or has def in at least 1 other pituitary hormone (that is, ACTH, TSH, gonadotropin deficiency [LH and/or FSH} are counted as 1 def], or prolactin).3. congenital hypopituitarism and has one GH stim test with inadequate response OR def in at least one other pituitary hormone and/or the patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk 4.pt has panhypopituitarism and has pituitary stalk agenesis, empty sella, sellar or supra-sellar mass lesion, or ectopic posterior pituitary 'bright spot' on MRI or CT or pt has 3 or more pituitary hormone deficiencies or pt has had one GH test and results were inadequate 5.pt had a hypophysectomy. Cont-pt responding to therapy
Age Restrictions	ISS 5 y/o or older, SGA 2 y/o or older, SBS 18 y/o or older
Prescriber Restrictions	GHD (Initial tx children or adolescents w/o hypophysectomy), GHD adults or transitional adolescents, Noonan (initial), Prader Willi (initial for child/adult and cont tx in adults), SHOX (initial), SGA (initial) - prescribed by or in consultation with an endocrinologist. CKD (initial) endocrinologist or nephrologist.

PA Criteria	Criteria Details
Coverage Duration	ISS - 6 mos initial, 12 months cont tx, SBS-1 month, others 12 mos
Other Criteria	GHD initial in adults and adolescents 1. endocrine must certify not being prescribed for anti-aging or to enhance athletic performance, 2. has either childhood onset or adult onset resulting from GHD alone, multiple hormone deficiency from pituitary dx, hypothalamic dz, pituitary surgery, cranial radiation tx, tumor treatment, TBI or subarachnoid hemorrhage, AND 3. meets one of the following - A. has known mutations, embryonic lesions, congenital or genetic defects or structural hypothalamic pituitary defects, B. 3 or more pituitary hormone def (ACTH, TSH, LH/FSH, or prolactin, IGF1 less than 84 mcg/L (Esoterix RIA), AND other causes of low serum IGF-1 have been excluded, C. Neg response to ONE preferred GH stim test (insulin peak response less than or equal to 5 mcg/L, Glucagon peak less than or equal to 3 mcg/L (BMI is less than or equal to 25), less than or equal to 3 and BMI is greater than or equal to 25 and less than or equal to 30 with a high pretest probability of GH deficiency, less than or equal to 1 and BMI is greater than or equal to 25 and less than or equal to 30 with a low pretest probability of GH deficiency or less than or equal to 1 mcg/L (BMI is greater than 30), if insulin and glucagon contraindicated then Arginine alone test with peak of less than or equal to 0.4 mcg/L, or Macrilen peak less than 2.8 ng/ml AND BMI is less than or equal to 40 AND if a transitional adolescent must be off tx for at least one month before retesting. Cont tx - endocrine must certify not being prescribed for anti-aging or to enhance athletic performance. ISS initial - baseline ht less than the 1.2 percentile or a standard deviation score (SDS) less than -2.25 for age and gender, open epiphyses, does not have CDGP and height velocity is either growth rate (GR) is a. less than 4 cm/yr for pts greater than or equal to 5 or b. growth velocity is less than 10th percentile for age/gender. Cont tx - prescriber confirms response to therapy. CKD initial - CKD defined by abnormal CrCl. Noonan initial - baseline height less than 5th percentile. PW cont tx in adults or adolescents who don't meet child requir - physician certifies not being used for anti-aging or to enhance athletic performance. SHOX initial - SHOX def by

PA Criteria	Criteria Details
	chromo analysis, open epiphyses, height less than 3rd percentile for age/gender. SGA initial -baseline ht less than 5th percentile for age/gender and born SGA (birth weight/length that is more than 2 SD below mean for gestational age/gender and didn't have sufficient catch up growth by 2-4 y/o). Cont tx - prescriber confirms response to therapy. Cont Tx for CKD, Noonan, PW in child/adolescents, SHOX, and TS - prescriber confirms response to therapy. SBS initial pt receiving specialized nutritional support. Cont tx - 2nd course if pt responded to tx with a decrease in the requirement for specialized nutritional support.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	SHOX, Noonan Syndrome, CKD, SBS
Part B Prerequisite	No

HETLIOZ

Products Affected

- *tasimelteon*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Non-24-patient is totally blind with no perception of light
Age Restrictions	Non-24-18 years or older (initial and continuation), SMS-16 years and older
Prescriber Restrictions	prescribed by, or in consultation with, a neurologist or a physician who specializes in the treatment of sleep disorders (initial and continuation)
Coverage Duration	6 mos initial, 12 mos cont
Other Criteria	Initial - patient is totally blind with no perception of light, dx of Non-24 is confirmed by either assessment of one physiologic circadian phase marker (e.g., measurement of urinary melatonin levels, dim light melatonin onset, assessment of core body temperature), or if assessment of physiologic circadian phase marker cannot be done, the diagnosis must be confirmed by actigraphy plus evaluation of sleep logs. Cont - Approve if patient is totally blind with no perception of light and pt has achieved adequate results with Hetlioz therapy according to the prescribing physician (e.g., entrainment, clinically meaningful or significant increases in nighttime sleep, clinically meaningful or significant decreases in daytime sleep). Nighttime sleep disturbances in Smith-Magenis Syndrome (SMS)-approve.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

high risk medications - benzodiazepines

Products Affected

- *alprazolam oral tablet*
- *clonazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- *clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg, 2 mg*
- *clorazepate dipotassium oral tablet 15 mg, 3.75 mg, 7.5 mg*
- DIAZEPAM INTENSOL
- *diazepam oral solution 5 mg/5 ml (1 mg/ml)*
- *diazepam oral tablet*
- LORAZEPAM INTENSOL
- *lorazepam oral tablet 0.5 mg, 1 mg, 2 mg*
- *oxazepam*
- *temazepam oral capsule 15 mg, 30 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Patients aged less than 65 years, approve. Patients aged 65 years and older, other criteria apply.
Prescriber Restrictions	
Coverage Duration	Procedure-related sedation - 1 month. All other conditions - 12 months.
Other Criteria	Insomnia - Approve lorazepam, temazepam, or oxazepam if the patient has had a trial with two of the following: ramelteon, trazodone, doxepin 3mg or 6 mg. Prior to approval, the physician must have assessed risk versus benefit for the patient and must confirm that they would still like to initiate/continue therapy. All medically accepted indications other than insomnia - Approve.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

humira

Products Affected

- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML, 80 MG/0.8 ML-40 MG/0.4 ML
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PEDIATRIC UC
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML
- HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with another biologic DMARD or targeted synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried
Age Restrictions	Crohn's disease (CD), 6 or older (initial therapy only). Ulcerative colitis (UC), 5 years and older (initial therapy), PP-18 or older (initial therapy only).
Prescriber Restrictions	Initial therapy only for all dx-RA/JIA/JRA/Ankylosing spondylitis, prescribed by or in consultation with rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. UC/ CD, prescribed by or in consultation with a gastroenterologist. HS - dermatologist.UV-ophthalmologist
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to "step back" and try a conventional synthetic DMARD). JIA/JRA initial. Tried one other systemic therapy for this condition (e.g MTX, sulfasalazine, leflunomide, NSAID) or biologic (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to "step back" and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial. Tried corticosteroids (CSs) or if CSs are contraindicated or if pt currently on CSs or patient has tried one other conventional systemic therapy for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR pt had ilecolonic resection OR enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC initial. Pt has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab, golimumab SC, or a corticosteroid such as prednisone or methylprednisolone), or the pt has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. FDA approve indications cont tx - must respond to tx as determined by prescriber. HS - tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). Clinical criteria incorporated into the Humira 40 mg quantity limit edit allow for approval of additional quantities to accommodate induction dosing. The allowable quantity is dependent upon the induction dosing regimen for the applicable FDA-labeled indications as outlined in product labeling.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Breast cancer - approve recurrent or metastatic, hormone receptor positive (HR+) [i.e., estrogen receptor positive- (ER+) and/or progesterone receptor positive (PR+)] disease, and HER2-negative breast cancer when the pt meets ONE of the following 1. Pt is postmenopausal and Ibrance will be used in combination with anastrozole, exemestane, or letrozole 2, pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonists, or has had surgical bilateral oophorectomy, or ovarian irradiation AND meets one of the following conditions: Ibrance will be used in combination with anastrozole, exemestane, or letrozole or Ibrance will be used in combination with fulvestrant 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving GnRH analog AND Ibrance with be used in combination with anastrozole, exemestane, or letrozole or Ibrance will be used in combination with fulvestrant 4. Pt is postmenopausal and Ibrance will be used in combination with fulvestrant. Liposarcoma-approve if the patient has well-differentiated/dedifferentiated liposarcoma (WD-DDLS).

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Liposarcoma, pre/peri-menopausal women with breast cancer in combination with an aromatase inhibitor
Part B Prerequisite	No

Icatibant

Products Affected

- *icatibant*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an allergist/immunologist or a physician that specializes in the treatment of HAE or related disorders.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency [Type I or Type II] - Treatment of Acute Attacks, Initial Therapy-the patient has HAE type I or type II as confirmed by the following diagnostic criteria (i and ii): i. the patient has low levels of functional C1-INH protein (less than 50% of normal) at baseline, as defined by the laboratory reference values AND ii. the patient has lower than normal serum C4 levels at baseline, as defined by the laboratory reference values. Patients who have treated previous acute HAE attacks with icatibant-the patient has treated previous acute HAE type I or type II attacks with icatibant AND according to the prescribing physician, the patient has had a favorable clinical response (e.g., decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, decrease in HAE acute attack frequency or severity) with icatibant treatment.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

iclusig

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, the Philadelphia chromosome (Ph) status of the leukemia must be reported. T315I status
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Approve if the patient meets one of the following: 1. Patient has CML or ALL that is Ph+, T315I positive or, 2. patient has CML, chronic phase with resistance or intolerance to at least two prior TKIs or, 3. patient has accelerated phase or blast phase CML or Philadelphia chromosome positive ALL for whom no other TKIs are indicated. GIST - approve if the patient tried all of the FDA-approved therapies first to align with NCCN recommendations which include: Imatinib or Ayvakit (avapritinib tablets), AND Sunitinib or Sprycel (dasatinib tablets), AND Stivarga (regorafenib tablets), AND Qinlock (ripretinib tablets). Myeloid/Lymphoid Neoplasms with Eosinophilia - approve if the tumor has ABL1 rearrangement or FGFR1 rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Gastrointestinal Stromal Tumor, Myeloid/Lymphoid Neoplasms with Eosinophilia
Part B Prerequisite	No

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	IDH2-mutation status
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	AML - approve if the patient is IDH2-mutation status positive as detected by an approved test
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IMATINIB

Products Affected

- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported.
Age Restrictions	ASM, DFSP, HES, MDS/MPD/Myeloid/Lymphoid Neoplasms-18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	For ALL/CML, must have Ph-positive for approval of imatinib. Kaposi's Sarcoma-approve if the patient has tried at least one regimen AND has relapsed or refractory disease. Pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT)-patient has tried Turalio or according to the prescriber, the patient cannot take Turalio. Myelodysplastic/myeloproliferative disease-approve if the condition is associated with platelet-derived growth factor receptor (PDGFR) gene rearrangements.Graft versus host disease, chronic-approve if the patient has tried at least one conventional systemic treatment (e.g., imbruvica). Metastatic melanoma-approve if the patient has c-Kit-positive advanced/recurrent or metastatic melanoma. Myeloid/lymphoid neoplasms with eosinophilia-approve if the tumor has an ABL1 rearrangement or an FIP1L1-PDGFRA or PDGFRB rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Chordoma, advanced, aggressive or unresectable fibromatosis (desmoid tumors), cKit positive advanced/recurrent or metastatic melanoma, Kaposi's Sarcoma and pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor, myeloid/lymphoid neoplasms with eosinophilia.
Part B Prerequisite	No

imbruvica

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 420 MG 70 MG
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET 280 MG,

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	GVHD-1 year, all others-3 years
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Central Nervous System Lymphoma (Primary), Hairy Cell Leukemia, B-Cell Lymphoma (e.g., gastric MALT lymphoma, nongastric MALT lymphoma, AIDS related, post-transplant lymphoproliferative disorder).
Part B Prerequisite	No

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

inlyta

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Advanced Renal cell carcinoma-approve. Differentiated thyroid cancer, approve if patient is refractory to radioactive iodine therapy. Soft tissue sarcoma-approve if the patient has alveolar soft part sarcoma and the medication will be used in combination with Keytruda (pembrolizumab).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Differentiated (i.e., papillary, follicular, and Hurthle) Thyroid Carcinoma, Soft tissue sarcoma
Part B Prerequisite	No

INQOVI

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Myelodysplastic Syndrome/Myeloproliferative Neoplasm Overlap Neoplasms
Part B Prerequisite	No

INREBIC

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Myelofibrosis (MF), including Primary MF, Post-Polycythemia Vera MF, and Post-Essential Thrombocythemia MF-approve if the patient has intermediate-2 or high-risk disease. Myeloid/Lymphoid Neoplasms with Eosinophilia-approve if the tumor has a JAK2 rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Myeloid/Lymphoid Neoplasms with Eosinophilia
Part B Prerequisite	No

IRESSA

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	NSCLC-approve if the patient has advanced or metastatic disease and the patient has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: Examples of sensitizing EGFR mutation-positive NSCLC include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S768I.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Ivermectin

Products Affected

- *ivermectin oral*

PA Criteria	Criteria Details
Exclusion Criteria	Coronavirus disease 2019 (COVID-19)
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Ascariasis. Cutaneous larva migrans. Enterobiasis. Loa loa infection. Mansonelliasis. Phthirus pubis infestation. Scabies. Wucheria bancrofti infection.
Part B Prerequisite	No

ivig

Products Affected

- GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)
- PRIVIGEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Part B versus D determination per CMS guidance to establish if drug used for PID in pt's home.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

jakafi

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	ALL-less than 21 years of age, GVHD-12 and older, MF/PV/CMML-2/essential thrombo/myeloid/lymphoid neoplasm-18 and older
Prescriber Restrictions	
Coverage Duration	GVHD-1 year, all others-Authorization will be for 3 years.
Other Criteria	For polycythemia vera patients must have tried hydroxyurea. ALL-approve if the mutation/pathway is Janus associated kinase (JAK)-related. GVHD, chronic-approve if the patient has tried one conventional systemic treatment for graft versus host disease. GVHD, acute-approve if the patient has tried one systemic corticosteroid. GVHD, acute-approve if the patient has tried one systemic corticosteroid. Polycythemia vera-approve if the patient has tried hydroxyurea. Atypical chronic myeloid leukemia-approve if the patient has a CSF3R mutation or a janus associated kinase mutation 2 (JAK2). Chronic monomyelocytic leukemia-2 (CMML-2)-approve if the patient is also receiving a hypomethylating agent. Essential thrombocythemia-approve if the patient has tried hydroxyurea, peginterferon alfa-2a or anagrelide. Myeloid/lymphoid neoplasms-approve if the patient has eosinophilia and the tumor has a janus associated kinase 2 (JAK2) rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Acute lymphoblastic leukemia, atypical chronic myeloid leukemia, chronic monomyelocytic leukemia-2 (CMML-2), essential thrombocythemia, myeloid/lymphoid neoplasms
Part B Prerequisite	No

JAYPIRCA

Products Affected

- JAYPIRCA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	Mantle cell lymphoma-approve if the patient has tried at least one systemic regimen or patient is not a candidate for a systemic regimen (i.e., an elderly patient who is frail), AND the patient has tried one Bruton tyrosine kinase inhibitor (BTK) for mantle cell lymphoma.Note: Examples of a systemic regimen contain one or more of the following products: rituximab, dexamethasone, cytarabine, carboplatin, cisplastin, oxaliplatin, cyclophosphamide, doxorubicin, vincristine, prednisone, methotrexate, bendamustine, Velcade (bortezomib intravenous or subcutaneous injection), lenalidomide, gemcitabine, and Venclexta (venetoclax tablets). Note: Examples of BTK inhibitors indicated for mantle cell lymphoma include Brukinsa (zanubrutinib capsules), Calquence (acalabrutinib capsules), and Imbruvica (ibrutinib capsules, tablets, and oral suspension). CLL/SLL-patient meets (A or B): A) patient has resistance or intolerance to Imbruvica (ibrutinib tablets, capsules, or oral solution), Calquence (acalabrutinib tablets), or Brukinsa (zanubrutinib capsules) or B) patient has relapsed or refractory disease and has tried a Bruton tyrosine kinase (BTK) inhibitor and Venclexta (venetoclax tablet)-based regimen. Examples of BTK inhibitor include: Imbruvica (ibrutinib tablets, capsules, or oral solution), Calquence (acalabrutinib tablets), or Brukinsa (zanubrutinib capsules).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Chronic Lymphocytic Leukemia and Small Lymphocytic Leukemia
Part B Prerequisite	No

KALYDECO

Products Affected

- KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 25 MG, 50 MG, 75 MG
- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Orkambi, Trikafta or Symdeko
Required Medical Information	
Age Restrictions	1 month of age and older
Prescriber Restrictions	prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	1 year
Other Criteria	CF - must have one mutation in the CFTR gene that is responsive to the requested medication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

KERENDIA

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with spironolactone or eplerenone
Required Medical Information	Diagnosis
Age Restrictions	18 years and older (initial and continuation therapy)
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Diabetic kidney disease, initial-approve if the patient meets the following criteria (i, ii and iii): i. Patient has a diagnosis of type 2 diabetes, AND ii. Patient meets one of the following (a or b): a)Patient is currently receiving a maximally tolerated labeled dosage of an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) OR b)According to the prescriber, patient has a contraindication to ACE inhibitor or ARB therapy, AND iii.At baseline (prior to the initiation of Kerendia), patient meets all of the following (a, b, and c): a)Estimated glomerular filtration rate greater than or equal to 25 mL/min/1.73 m2 AND b)Urine albumin-to-creatinine ratio greater than or equal to 30 mg/g AND c)Serum potassium level less than or equal to 5.0 mEq/L. Diabetic kidney disease, continuation-approve if the patient meets the following criteria (i and ii): i.Patient has a diagnosis of type 2 diabetes, AND ii. Patient meets one of the following (a or b): a.Patient is currently receiving a maximally tolerated labeled dosage of an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) OR b.According to the prescriber, patient has a contraindication to ACE inhibitor or ARB therapy.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Kesimpta

Products Affected

- KESIMPTA PEN

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other disease-modifying agents used for multiple sclerosis (MS)
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include, clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease.
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist or a physician who specializes in the treatment of multiple sclerosis
Coverage Duration	Authorization will be for 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

KISQALI

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years

PA Criteria	Criteria Details
Other Criteria	Breast cancer - approve recurrent or metastatic hormone receptor positive (HR+) [i.e., estrogen receptor positive (ER+) and/or progesterone receptor positive (PR+)]disease, and HER2-negative breast cancer when the pt meets ONE of the following 1. Pt is postmenopausal and Kisqali will be used in combination with anastrozole, exemestane, or letrozole 2. pt is premenopausal or perimenopausal and is receiving ovarian suppression/ablation with GnRH agonist, or has had surgical bilateral oophorectomy, or ovarian irradiation AND Kisqali will be used in combination with anastrozole, exemestane, or letrozole 3. pt is a man (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) who is receiving GnRH analog AND Kisqali with be used in combination with anastrozole, exemestane or letrozole. 4. Patient is postmenopausal, pre/perimenopausal (patient receiving ovarian suppression/ablation with a GnRH agonist or has had surgical bilateral oophorectomy or ovarian irradiation) or a man, and Kisqali (not Co-Pack) will be used in combination with fulvestrant. If the request is for Kisqali Femara, patients do not need to use in combination with anastrozole, exemestane or letrozole.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, prior surgeries
Age Restrictions	18 years and older
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the treatment of Cushing's syndrome.
Coverage Duration	Endogenous Cushing's Syndrome-1 year. Pts awaiting surgery or response after radiotherapy-4 months
Other Criteria	Endogenous Cushing's Syndrome-Approve if, according to the prescribing physician, the patient is not a candidate for surgery or surgery has not been curative AND if Korlym is being used to control hyperglycemia secondary to hypercortisolism in patients who have type 2 diabetes mellitus or glucose intolerance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Patients with Endogenous Cushing's Syndrome, awaiting surgery.Patients with Endogenous Cushing's syndrome, awaiting a response after radiotherapy
Part B Prerequisite	No

Koselugo

Products Affected

- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	Neurofibromatosis Type 1-2 years and older, Pilocytic astrocytoma-pt is 3 to 21 years of age
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Neurofibromatosis Type 1-approve if prior to starting Koselugo, the patient has symptomatic, inoperable plexiform neurofibromas. Pilocytic astrocytoma-approve if the patient has recurrent, refractory or progressive disease AND the tumor is BRAF fusion positive OR BRAF V600E activating mutation positive AND this medication will be used as a single agent.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Pilocytic Astrocytoma
Part B Prerequisite	No

KRAZATI

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-approve if the patient has KRAS G12C-mutated locally advanced or metastatic NSCLC, as determined by an approved test AND has been previously treated with at least one systemic regimen. Note: Examples of systemic regimens include those containing one or more of the following products: Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), Tecentriq (atezolizumab intravenous infusion), Alimta (pemetrexed intravenous infusion), Yervoy (ipilimumab intravenous infusion), Abraxane (albumin-bound paclitaxel intravenous infusion), bevacizumab, cisplatin, carboplatin, docetaxel, gemcitabine, paclitaxel, vinorelbine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Lapatinib

Products Affected

- *lapatinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis for which lapatinib is being used. Metastatic breast cancer, HER2 status or hormone receptor (HR) status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	HER2-positive recurrent or metastatic breast cancer, approve if lapatinib will be used in combination with capecitabine OR trastuzumab and the patient has tried at least two prior anti-HER2 based regimens OR the medication will be used in combination with an aromatase inhibitor and and the patient has HR+ dusease and the patient is a postmenopausal woman or the patient is premenopausal or perimenopausal woman and is receiving ovarian suppression/ablation with a GnRH agonist, surgical bilateral oophorectomy or ovarian irradiation OR the patient is a man and is receiving a GnRH analog. Colon or rectal cancer-approve if the patient has unresectable advanced or metastatic disease that is human epidermal receptor 2 (HER2) amplified and with wild-type RAS and BRAF disease and the patient has tried at least one chemotherapy regimen or is not a candidate for intensive therapy and the medication is used in combination with trastuzumab and the patient has not been previously treated with a HER2-inhibitor. Bone Cancer-approve if the patient has recurrent chordoma and if the patient has epidermal growth-factor receptor (EGFR)-positive disease.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Bone cancer-chordoma, colon or rectal cancer
Part B Prerequisite	No

Ledipasvir-Sofosbuvir

Products Affected

- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin
Required Medical Information	
Age Restrictions	3 years or older
Prescriber Restrictions	Prescribed by or in consultation w/ GI, hepatologist, ID, or a liver transplant MD
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Indications consistent with current AASLD/IDSA guidance.
Part B Prerequisite	No

LENVIMA

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years

PA Criteria	Criteria Details
Other Criteria	DTC - must be refractory to radioactive iodine treatment for approval. RCC - approve if the pt meets ALL of the following criteria: 1) pt has advanced disease AND if the patient meets i or ii-i. Lenvima is is being used in combination with Keytruda OR ii. Lenvima is used in combination with Afinitor/Afinitor Disperz and the patient meets a or b-a. Patient has clear cell histology and patient has tried one antiangiogenic therapy or b. patient has non-clear cell histology. MTC-approve if the patient has tried at least one systemic therapy. Endometrial Carcinoma-Approve if the patient meets the following criteria (A, B, C, and D): A) The patient has advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) AND B) The medication is used in combination with Keytruda (pembrolizumab for intravenous injection) AND C)the disease has progressed on at least one prior systemic therapy AND D) The patient is not a candidate for curative surgery or radiation. Thymic carcinoma-approve if the patient has tried at least one chemotherapy regimen. Melanoma - approve if the patient has unresectable or metastatic melanoma AND the medication will be used in combination with Keytruda (pembrolizumab intravenous injection) AND the patient has disease progression on anti-programmed death receptor-1 (PD-1)/programmed death-ligand 1 (PD-L1)-based therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Patients with Medullary Thyroid Carcinoma (MTC), thymic carcinoma, Renal cell carcinoma with non-clear cell histology and Melanoma
Part B Prerequisite	No

LIDOCAINE PATCH

Products Affected

- *lidocaine topical adhesive patch,medicated 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Diabetic neuropathic pain, chronic back pain
Part B Prerequisite	No

Livtencity

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with ganciclovir or valganciclovir
Required Medical Information	Diagnosis
Age Restrictions	12 years and older
Prescriber Restrictions	Prescribed by or in consultation with a hematologist, infectious diseases specialist, oncologist, or a physician affiliated with a transplant center.
Coverage Duration	2 months
Other Criteria	Cytomegalovirus Infection, Treatment-approve if the patient meets the following criteria (A, B, and C): A) Patient weighs greater than or equal to 35 kg, AND B) Patient is post-transplant, AND Note: This includes patients who are post hematopoietic stem cell transplant or solid organ transplant. C) Patient has cytomegalovirus infection/disease that is refractory to treatment with at least one of the following: cidofovir, foscarnet, ganciclovir, or valganciclovir or patient has a significant intolerance to ganciclovir or valganciclovir.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LONG ACTING OPIOIDS

Products Affected

- BELBUCA
- *buprenorphine*
- *hydromorphone oral tablet extended release 24 hr*
- *methadone oral solution 10 mg/5 ml, 5 mg/5 ml*
- *methadone oral tablet 10 mg, 5 mg*
- *morphine oral tablet extended release*

PA Criteria	Criteria Details
Exclusion Criteria	Acute (ie, non-chronic) pain
Required Medical Information	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	'For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been tried and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, in hospice, sickle cell disease or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Gastric or Gastroesophageal Junction Adenocarcinoma-approve if the patient has been previously treated with at least two chemotherapy regimens for gastric or gastroesophageal junction adenocarcinoma. Colon and rectal cancer-approve per labeling if the patient has been previously treated with a fluropyrimidine, oxaliplatin and irinotecan. If the patient's tumor or metastases are wild-type RAS (KRAS wild type and NRAS wild type) they must also try Erbitux or Vectibix.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LORBRENA

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, ALK status, ROS1 status, previous therapies
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Erdheim Chester disease-approve if the patient has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease. Inflammatory myofibroblastic tumor (IMT)-approve if the patient has IMT with ALK translocation. NSCLC - Approve if the patient has ALK-positive metastatic NSCLC, as detected by an approved test. NSCLC-ROS1 Rearrangement-Positive, metastatic NSCLC-approve if the patient has tried at least one of crizotinib, entrectinib or ceritinib.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	'Non-small cell lung cancer (NSCLC)-ROS1 Rearrangement-Positive, Erdheim Chester Disease, Inflammatory Myofibroblastic Tumor (IMT)
Part B Prerequisite	No

Lumakras

Products Affected

- LUMAKRAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-approve if the patient has KRAS G12C-mutated locally advanced or metastatic NSCLC, as determined by an FDA-approved test AND has been previously treated with at least one systemic regimen. Pancreatic Adenocarcinoma- approve if patient has KRAS G12C-mutated disease, as determined by an approved test AND either (i or ii): (i) patient has locally advanced or metastatic disease and has been previously treated with at least one systemic regimen OR (ii) patient has recurrent disease after resection.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	'Pancreatic Adenocarcinoma
Part B Prerequisite	No

lynparza

Products Affected

- LYNPARZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years

PA Criteria	Criteria Details
Other Criteria	Ovarian Cancer - Treatment-initial-Approve if the patient meets the following criteria (i and ii): i. The patient has a germline BRCA-mutation as confirmed by an approved test AND has progressed on two or more prior lines of chemotherapy. Ovarian, Fallopian Tube, or Primary Peritoneal Cancer - Maintenance monotherapy-Approve if the patient meets one of the following criteria (A or B): A) The patient meets both of the following criteria for first-line maintenance therapy (i and ii): i. The patient has a germline or somatic BRCA mutation-positive disease as confirmed by an approved test AND ii. The patient is in complete or partial response to first-line platinum-based chemotherapy regimen (e.g., carboplatin with paclitaxel, carboplatin with doxorubicin, docetaxel with carboplatin) OR B) The patient is in complete or partial response after at least two platinum-based chemotherapy regimens (e.g., carboplatin with gemcitabine, carboplatin with paclitaxel, cisplatin with gemcitabine). Ovarian, fallopian tube, or primary peritoneal cancer-maintenance, combination therapy-approve if the medication is used in combination with bevacizumab, the patient has homologous recombination deficiency (HRD)-positive disease, as confirmed by an approved test and the patient is in complete or partial response to first-line platinum-based chemotherapy regimen. Breast cancer, adjuvant-approve if the patient has germline BRCA mutation-positive, HER2-negative breast cancer and the patient has tried neoadjuvant or adjuvant therapy. Breast cancer, recurrent or metastatic disease-approve if the patient has recurrent or metastatic disease, and has germline BRCA mutation-positive breast cancer. Pancreatic Cancer-maintenance therapy-approve if the patient has a germline BRCA mutation-positive metastatic disease and the disease has not progressed on at least 16 weeks of treatment with a first-line platinum-based chemotherapy regimen. Prostate cancer-castration resistant-approve if the patient has metastatic disease, the medication is used concurrently with a gonadotropin-releasing hormone (GnRH) analog or the pateint has had a bilateral orchiectomy,

PA Criteria	Criteria Details
	and the patient meets either (i or ii): i) the patient has germline or somatic homologous recombination repair (HRR) gene-mutated disease, as confirmed by an approved test and the patient has been previously treated with at least one androgen receptor directed therapy or ii) the patient has a BRCA mutation and the medication is used in combination with abiraterone plus one of prednisone or prednisolone. Uterine Leiomyosarcoma-approve if the patient has BRCA2-altered disease and has tried one systemic regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Uterine Leiomyosarcoma
Part B Prerequisite	No

LYTGOBI

Products Affected

- LYTGOBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Cholangiocarcinoma-approve if the patient has unresectable locally advanced or metastatic disease, tumor has fibroblast growth factor receptor 2 (FGFR2) gene fusions or other rearrangements as detected by an approved test and if the patient has been previously treated with at least one systemic regimen. Note: Examples of systemic regimens include gemcitabine + cisplatin, 5-fluorouracil + oxaliplatin or cisplatin, capecitabine + cisplatin or oxaliplatin, gemcitabine + Abraxane (albumin-bound paclitaxel) or capecitabine or oxaliplatin, and gemcitabine + cisplatin + Abraxane.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MAVYRET

Products Affected

- MAVYRET ORAL PELLETS IN PACKET
- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	3 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Current AASLD/IDSA guidance and, if not available, FDA labeling
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance and, if not available, FDA labeling.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Megace

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for weight gain for cosmetic reasons.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

mekinist

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis for which Mekinist is being used. For melanoma, thyroid cancer and NSCLC must have documentation of BRAF V600 mutations
Age Restrictions	6 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

PA Criteria	Criteria Details
Other Criteria	Melanoma must be used in patients with BRAF V600 mutation, and patient has unresectable, advanced (including Stage III or Stage IV disease), or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery.For NSCLC requires BRAF V600E Mutation and use in combination with Tafinlar. Thyroid cancer, anaplastic-patient has locally advanced or metastatic anaplastic disease AND Mekinist will be taken in combination with Tafinlar, unless intolerant AND the patient has BRAF V600-positive disease. Ovarian/fallopian tube/primary peritoneal cancer-approve if the patient has recurrent disease and the medication is used for low-grade serous carcinoma. Biliary Tract Cancer-approve if the patient has tried at least one systemic chemotherapy regimen, patient has BRAF V600 mutation positive disease and the medication will be taken in combination with Tafinlar. Central Nervous System Cancer-approve if the medication is being used for one of the following situations (i, ii, or iii): i) adjuvant treatment of one of the following conditions: pilocytic astrocytoma or pleomorphic xanthoastrocytoma or ganglioglioma, OR ii) recurrent disease for one of the following conditions: low-grade glioma OR anaplastic glioma OR glioblastoma, OR iii) melanoma with brain metastases AND patient has BRAF V600 mutation-positive disease AND medication will be taken in combination with Tafinlar (dabrafenib). Histiocytic neoplasm-approve if patient has Langerhans cell histiocytosis and one of the following: multisystem disease or pulmonary disease or central nervous system lesions or patient has Erdheim Chester disease or Rosai-Dorfman disease AND patient has BRAF V600-mutation positive disease. Metastatic or Solid Tumors-Approve if the patient meets the following (A, B, and C): A) Patient has BRAF V600 mutation-positive disease, AND B) The medication will be taken in combination with Tafinlar (dabrafenib capsules), AND C) Patient has no satisfactory alternative treatment options.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Ovarian/Fallopian Tube/Primary Peritoneal Cancer, Biliary Tract Cancer, Central Nervous System Cancer, Histiocytic Neoplasm
Part B Prerequisite	No

MEKTOVI

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, BRAF V600 status, concomitant medications
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Melanoma - approve if the patient has unresectable, advanced or metastatic melanoma AND has a BRAF V600 mutation AND Mektovi will be used in combination with Braftovi. Histiocytic neoplasm-approve if the patient has Langerhans cell histiocytosis and one of the following (i, ii, or iii): i. multisystem disease OR, ii. pulmonary disease or, iii. central nervous system lesions. NSCLC-approve if pt has BRAF V600E mutation-positive metastatic disease AND this medication will be taken in combination with Braftovi (encorafenib capsules).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Histiocytic Neoplasms
Part B Prerequisite	No

memantine

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Indication for which memantine is being prescribed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Patients with mild to moderate vascular dementia.
Part B Prerequisite	No

Modafinil/Armodafinil

Products Affected

- *armodafinil*
- *modafinil oral tablet 100 mg, 200 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Fatigue due to MS and Idiopathic hypersomnia - 18 years of age and older. All others - 17 years of age and older.
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Excessive daytime sleepiness associated with Shift Work Sleep Disorder (SWSD) - Approve if the patient is working at least 5 overnight shifts per month. Adjunctive/augmentation treatment for depression in adults - Approve if the patient is concurrently receiving other medication therapy for depression. Excessive daytime sleepiness associated with obstructive sleep apnea/hypoapnea syndrome - Approve. Excessive daytime sleepiness associated with Narcolepsy - Approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT). Fatigue due to multiple sclerosis - Approve. Idiopathic hypersomnia - Approve.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Excessive daytime sleepiness (EDS) associated with myotonic dystrophy - modafinil only. Adjunctive/augmentation for treatment of depression in adults - modafinil only. Fatigue due to multiple sclerosis - modafinil only. Idiopathic hypersomnia - modafinil only.

PA Criteria	Criteria Details
Part B Prerequisite	No

myalept

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, an endocrinologist or a geneticist physician specialist
Coverage Duration	Authorization will be for 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist.
Coverage Duration	1 year
Other Criteria	Chronic hypoparathyroidism, initial therapy - approve if before starting Natpara, serum calcium concentration is greater than 7.5 mg/dL and 25-hydroxyvitamin D stores are sufficient per the prescribing physician. Chronic hypoparathyroidism, continuing therapy - approve if during Natpara therapy, the patient's 25-hydroxyvitamin D stores are sufficient per the prescribing physician, AND the patient is responding to Natpara therapy, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NAYZILAM

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, other medications used at the same time
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nerlynx

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Stage of cancer, HER2 status, previous or current medications tried
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Adjuvant tx-Approve for 1 year (total), advanced or metastatic disease-3yrs
Other Criteria	Breast cancer adjuvant therapy - approve if the patient meets all of the following criteria: patient will not be using this medication in combination with HER2 antagonists, Patient has HER2-positive breast cancer AND patient has completed one year of adjuvant therapy with trastuzumab OR could not tolerate one year of therapy. Breast cancer, recurrent or metastatic disease-approve if the patient has HER-2 positive breast cancer, Nerlynx will be used in combination with capecitabine and the patient has tried at least two prior anti-HER2 based regimens.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

nexavar

Products Affected

- *sorafenib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Osteosarcoma, approve if the patient has tried standard chemotherapy and have relapsed/refractory or metastatic disease. GIST, approve if the patient has tried TWO of the following: Gleevec (imatinib mesylate), Ayvakit (avapritinib), Sutent (sunitinib), Sprycel (dasatinib), Qinlock (ripretinib) or Stivarga (regorafenib). Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma (DTC), approve if the patient is refractory to radioactive iodine treatment. Medullary thyroid carcinoma, approve if the patient has tried Caprelsa (vandetanib) or Cometriq (cabozantinib). AML - Approve if disease is FLT3-ITD mutation positive as detected by an approved test. Renal cell carcinoma (RCC)-approve if the patient has relapsed or Stage IV clear cell histology and the patient has tried at least one prior systemic therapy (e.g., Inlyta, Votrient, Sutent Cabometyx). Ovarian, fallopian tube, primary peritoneal cancer-approve if the patient has platinum resistant disease and Nexavar (sorafenib) is used in combination with topotecan.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Osteosarcoma, angiosarcoma, desmoids tumors (aggressive fibromatosis), gastrointestinal stromal tumors (GIST), medullary thyroid carcinoma, Acute Myeloid Leukemia, Chordoma with recurrent disease, solitary fibrous tumor and hemangiopericytoma, ovarian, fallopian tube, primary peritoneal cancer
Part B Prerequisite	No

NILUTAMIDE

Products Affected

- *nilutamide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Prostate cancer-approve if nilutamide is used concurrently with a luteinizing hormone-releasing hormone (LHRH) agonist.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	MM - be used in combination with Revlimid and dexamethasone OR pt had received at least ONE previous therapy for multiple myeloma OR the agent will be used following autologous stem cell transplantation (ASCT). Systemic light chain amyloidosis-approve if the patient has tried at least one other regimen for this condition. Waldenstrom Macroglobulinemia/lymphoplasmacytic lymphoma-approve if used in combination with a rituximab product and dexamethasone.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Patients with systemic light chain amyloidosis, Waldenstrom Macroglobulinemia/lymphoplasmacytic lymphoma
Part B Prerequisite	No

Nitisinone

Products Affected

- *nitisinone*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of therapy with nitisinone products
Required Medical Information	Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	1 year
Other Criteria	HereditaryTyrosinemia, Type 1-approve if the prescriber confirms the diagnosis was confirmed by genetic testing confirming a mutation of the FAH gene OR elevated levels of succinylacetone.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Northera

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medication history
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or a neurologist
Coverage Duration	12 months
Other Criteria	NOH, approve if the patient meets ALL of the following criteria: a) Patient has been diagnosed with symptomatic NOH due to primary autonomic failure (Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, or non-diabetic autonomic neuropathy, AND b) Patient has tried midodrine
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NUBEQA

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Prostate cancer - non-metastatic, castration resistant-approve if the requested medication will be used concurrently with a gonadotropin-releasing hormone (GnRH) analog or if the patient has had a bilateral orchiectomy or if the medication is used concurrently with Firmagon. Prostate cancer-metastatic, castration sensitive-approve if (A and B): A) the medication is used in combination with docetaxel or patient has completed docetaxel therapy, and B) the medication will be used in combination with a GnRH agonist or in combination with Firmagon or if the patient had a bilateral orchiectomy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NUPLAZID

Products Affected

- NUPLAZID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Nurtec ODT

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Aimovig, Ajovy, Emgality, or Vyepti if Nurtec ODT is being used for preventive treatment of episodic migraines
Required Medical Information	Diagnosis, other therapies used
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Migraine, acute treatment - Pt has tried at least one triptan therapy or has a contraindication to triptans according to the prescriber. Preventive treatment of episodic migraine - Approve if pt has greater than or equal to 4 migraine headache days per month (prior to initiating a migraine preventive medication) and has tried at least two standard prophylactic pharmacologic therapies, at least one drug each from a different pharmacologic class (e.g., anticonvulsant, beta-blocker), and either had inadequate responses to those therapies or experienced adverse event(s) severe enough to warrant discontinuation or the patient has a contraindication to other prophylactic pharmacologic therapies according to the prescribing physician. A patient who has already tried an oral or injectable calcitonin gene-related peptide (CGRP) inhibitor indicated for the prevention of migraine or Botox (onabotulinumtoxinA injection) for the prevention of migraine is not required to try two standard prophylactic pharmacologic therapies.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

ocaliva

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prescriber specialty, lab values, prior medications used for diagnosis and length of trials
Age Restrictions	18 years and older (initial)
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician (initial)
Coverage Duration	6 months initial, 1 year cont.
Other Criteria	Initial treatment of PBC-Patient must meet both 1 and 2-1. Patient has a diagnosis of PBC as defined by TWO of the following:a)Alkaline phosphatase (ALP) elevated above the upper limit of normal as defined by normal laboratory reference values b)Positive anti-mitochondrial antibodies (AMAs) or other PBC-specific auto-antibodies, including sp100 or gp210, if AMA is negative c)Histologic evidence of primary biliary cholangitis (PBC) from a liver biopsy 2. Patient meets ONE of the following: a) Patient has been receiving ursodiol therapy for greater than or equal to 1 year and has had an inadequate response. b) Patient is unable to tolerate ursodiol therapy. Cont tx - approve if the patient has responded to Ocaliva therapy as determined by the prescribing physician (e.g., improved biochemical markers of PBC (e.g., alkaline phosphatase [ALP], bilirubin, gamma-glutamyl transpeptidase [GGT], aspartate aminotransferase [AST], alanine aminotransferase [ALT] levels)).
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Octreotide

Products Affected

- *octreotide acetate injection solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Acromegaly-prescr/consult w/endocrinologist. NETs-prescr/consult w/oncologist, endocrinologist, or gastroenterologist. Pheochromocytoma/paraganglioma-prescr/consult w/endo/onc/neuro.Meningioma-prescr/consult w/oncologist, radiologist, neurosurg/thymoma/thymic carcinoma-presc/consult with oncologist
Coverage Duration	1 year
Other Criteria	Acromegaly-approve if patient meets ONE of the following (i, ii, or iii): i. Patient has had an inadequate response to surgery and/or radiotherapy OR ii. Patient is NOT an appropriate candidate for surgery and/or radiotherapy OR iii. Patient is experiencing negative effects due to tumor size (e.g., optic nerve compression) AND Patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal based on age and gender for the reporting laboratory.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Meningioma, thymoma and thymic carcinoma, pheochromocytoma and paraganglioma
Part B Prerequisite	No

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BCC - Must not have had disease progression while on Erivedge (vismodegib).
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Locally advanced BCC approve if the BCC has recurred following surgery/radiation therapy or if the patient is not a candidate for surgery AND the patient is not a candidate for radiation therapy, according to the prescribing physician. Metastatic BCC - approve.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Metastatic BCC
Part B Prerequisite	No

ofev

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age and older
Prescriber Restrictions	IPF-Prescribed by or in consultation with a pulmonologist. Interstitial lung disease associated with systemic sclerosis-prescribed by or in consultation with a pulmonologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	IPF - must have FVC greater than or equal to 40 percent of the predicted value AND IPF must be diagnosed with either findings on high-resolution computed tomography (HRCT) indicating usual interstitial pneumonia (UIP) or surgical lung biopsy demonstrating UIP. Interstitial lung disease associated with systemic sclerosis-approve if the FVC is greater than or equal to 40 percent of the predicted value and the diagnosis is confirmed by high-resolution computed tomography. Chronic fibrosing interstitial lung disease-approve if the forced vital capacity is greater than or equal to 45% of the predicted value AND according to the prescriber the patient has fibrosing lung disease impacting more than 10% of lung volume on high-resolution computed tomography AND according to the prescriber the patient has clinical signs of progression.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

OJJAARA

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years of age and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Myelofibrosis-approve if the patient has intermediate-risk or high-risk disease and the patient has anemia, defined as hemoglobin less than 10g/dL.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Omnipod

Products Affected

- OMNIPOD 5 G6 INTRO KIT (GEN 5)
- OMNIPOD 5 G6 PODS (GEN 5)
- OMNIPOD DASH INTRO KIT (GEN 4)
- OMNIPOD DASH PDM KIT (GEN 4)
- OMNIPOD DASH PODS (GEN 4)

PA Criteria	Criteria Details
Exclusion Criteria	Omnipod 5 - Type 2 DM
Required Medical Information	Diagnosis, insulin usage
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Diabetes mellitus, type 1 - Omnipod 3, 4, and 5 - approve. Diabetes mellitus, type 2, insulin dependent - approve if pt is using at least three injections of insulin per day (Omnipod 3 and 4 only). Omnipod 5 - deny. Continuation - approve.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Onureg

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	AML - Approve if the patient meets the following criteria (both A and B): A)Following intensive induction chemotherapy, the patient achieves one of the following according to the prescriber (i or ii): i. First complete remission OR ii. First complete remission with incomplete blood count recovery AND B) Patient is not able to complete intensive curative therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

opsumit

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PAH WHO group, right heart catheterization
Age Restrictions	
Prescriber Restrictions	PAH - must be prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 3 years
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1 patients are required to have had a right-heart catheterization to confirm the diagnosis of PAH to ensure appropriate medical assessment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Orgovyx

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Prostate Cancer-approve
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ORKAMBI

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with Kalydeco, Trikafta or Symdeko.
Required Medical Information	
Age Restrictions	1 year of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - homozygous for the Phe508del (F508del) mutation in the CFTR gene (meaning the patient has two copies of the Phe508del mutation)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ORSERDU

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Breast cancer in postmenopausal women or Men-approve if the patient meets the following criteria (A, B, C, D, and E): A) Patient has recurrent or metastatic disease, AND B) Patient has estrogen receptor positive (ER+) disease, AND C) Patient has human epidermal growth factor receptor 2 (HER2)-negative disease, AND D) Patient has estrogen receptor 1 gene (ESR1)-mutated disease, AND E) Patient has tried at least one endocrine therapy. Note: Examples of endocrine therapy include fulvestrant, anastrozole, exemestane, letrozole, and tamoxifen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

otezla

Products Affected

- OTEZLA
- OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, previous drugs tried
Age Restrictions	18 years and older (initial)
Prescriber Restrictions	All dx-initial only-PsA - Prescribed by or in consultation with a dermatologist or rheumatologist. PP - prescribed by or in consultation with a dermatologist. Behcet's-prescribed by or in consultation with a dermatologist or rheumatologist
Coverage Duration	1 year
Other Criteria	PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. PsA initial-approve. Behcet's-patient has oral ulcers or other mucocutaneous involvement AND patient has tried at least ONE other systemic therapy. PsA/PP/Behcet's cont - pt has received 4 months of therapy and had a response, as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Oxervate

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	Treatment duration of greater than 8 weeks for the same eye.
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by an ophthalmologist or an optometrist
Coverage Duration	8 weeks
Other Criteria	Neurotrophic Keratitis - Approve. Continuation therapy or retreatment is not allowed for the same affected eye.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Panretin

Products Affected

- PANRETIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist, oncologist, or infectious disease specialist
Coverage Duration	1 year
Other Criteria	Kaposi Sarcoma-approve if the patient is not receiving systemic therapy for Kaposi Sarcoma.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PDE5 Inhibitors

Products Affected

- ALYQ
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PAH - diagnosis, right heart cath results. Raynaud phenomenon - diagnosis, previous medications
Age Restrictions	
Prescriber Restrictions	PAH - prescribed by or in consultation with a cardiologist or a pulmonologist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment. Clinical criteria incorporated into the quantity limit edits for sildenafil 20 mg tablets and suspension require confirmation that the indication is PAH (ie, FDA labeled use) prior to reviewing for quantity exception. Raynaud phenomenon - must have previous trial and failure of one CCB, such as amlodipine or nifedipine.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Raynaud phenomenon
Part B Prerequisite	No

PEGASYS

Products Affected

- PEGASYS SUBCUTANEOUS SOLUTION
- PEGASYS SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Pegfilgrastim

Products Affected

- UDENYCA
- UDENYCA AUTOINJECTOR
- ZIEXTENZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Cancer patients receiving chemotherapy, if prescribed by or in consultation with an oncologist or hematologist. PBPC-prescribed by or in consultation with an oncologist, hematologist, or physician that specializes in transplantation
Coverage Duration	Cancer pts receiving chemo-6 mo. PBPC-1 mo. Rad-1mo.
Other Criteria	Cancer Patients Receiving Chemotherapy - approve if the patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen), OR the patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia but the risk is less than 20% based on the chemotherapy regimen and the patient has one or more risk factors for febrile neutropenia according to the prescribing physician (eg, aged greater than or equal to 65 years, prior chemotherapy or radiation therapy, persistent neutropenia, bone marrow involvement by tumor, recent surgery and/or open wounds, liver and/or renal dysfunction, poor performance status or HIV infection, OR the patient has had a neutropenic complication from prior chemotherapy and did not receive prophylaxis with a colony stimulating factor and a reduced dose or frequency of chemotherapy may compromise treatment.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Patients undergoing PBPC collection and therapy
Part B Prerequisite	No

PEMAZYRE

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years
Other Criteria	Cholangiocarcinoma-approve if the patient has unresectable locally advanced or metastatic disease and the tumor has a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement, as detected by an approved test AND the patient has been previously treated with at least one systemic therapy regimen. Myeloid/lymphoid neoplasms-approve if the patient has eosinophilia and the cancer has fibroblast growth factor receptor 1 (FGFR1) rearrangement, as detected by an approved test and the cancer is in chronic phase or blast phase.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PENICILLAMINE

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Wilson's Disease-Prescribed by or in consultation with a gastroenterologist, hepatologist or liver transplant physician
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PHENYLBUTYRATE

Products Affected

- *sodium phenylbutyrate*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use of Ravicti and Buphenyl
Required Medical Information	Diagnosis, genetic tests and lab results (as specified in the Other Criteria field)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a metabolic disease specialist (or specialist who focuses in the treatment of metabolic diseases)
Coverage Duration	Pt meets criteria with no genetic test - 3 mo approval. Pt had genetic test - 12 mo approval
Other Criteria	Urea cycle disorders-approve if genetic testing confirmed a mutation resulting in a urea cycle disorder or if the patient has hyperammonemia.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PHEOCHROMOCYTOMA

Products Affected

- *metyrosine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, prior medication trials
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician who specializes in the management of pheochromocytoma (initial and continuation therapy for metyrosine)
Coverage Duration	Authorization will be for 1 year
Other Criteria	If the requested drug is metyrosine for initial therapy, approve if the patient has tried a selective alpha blocker (e.g., doxazosin, terazosin or prazosin) AND the patient has tried phenoxybenzamine (brand or generic). If the requested drug is metyrosine for continuation therapy, approve if the patient is currently receiving metyrosine or has received metyrosine in the past.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PIQRAY

Products Affected

- PIQRAY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Breast Cancer. Approve if the patient meets the following criteria (A, B, C, D, E and F): A) The patient is a postmenopausal female or a male or premenopausal and is receiving ovarian suppression with a gonadotropin-releasing hormone (GnRH) analog or has had surgical bilateral oophorectomy or ovarian irradiation AND B) The patient has advanced or metastatic hormone receptor (HR)-positive disease AND C) The patient has human epidermal growth factor receptor 2 (HER2)-negative disease AND D) The patient has PIK3CA-mutated breast cancer as detected by an approved test AND E) The patient has progressed on or after at least one prior endocrine-based regimen (e.g., anastrozole, letrozole, exemestane, tamoxifen, toremifene) AND F) Piqray will be used in combination with fulvestrant injection.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Treatment of breast cancer in premenopausal women
Part B Prerequisite	No

PLEGRIDY

Products Affected

- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of with other disease-modifying agents used for multiple sclerosis (MS).
Required Medical Information	Relapsing form of Multiple Sclerosis (MS), to include clinically-isolated syndrome, relapsing-remitting disease, and active secondary progressive disease
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a neurologist or an MS specialist.
Coverage Duration	Authorization will be for 1 year
Other Criteria	Cont tx-approve if the patient has been established on Plegridy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	Kaposi Sarcoma/MM-18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years
Other Criteria	Kaposi Sarcoma-Approve if the patient meets one of the following (i or ii): i. patient is Human Immunodeficiency Virus (HIV)-negative OR ii. patient meets both of the following (a and b): a) The patient is Human Immunodeficiency Virus (HIV)-positive AND b) The patient continues to receive highly active antiretroviral therapy (HAART). CNS Lymphoma-approve if the patient has relapsed or refractory disease. MM-approve if the patient has received at least one other Revlimid (lenalidomide tablets)-containing regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Systemic Light Chain Amyloidosis, Central Nervous System (CNS) Lymphoma
Part B Prerequisite	No

promacta

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cause of thrombocytopenia. Thrombocytopenia due to HCV-related cirrhosis, platelet counts. Severe aplastic anemia, platelet counts and prior therapy. MDS-platelet counts.
Age Restrictions	
Prescriber Restrictions	Immune Thrombocytopenia or Aplastic Anemia, approve if prescribed by, or after consultation with, a hematologist (initial therapy). Thrombocytopenia in pt with chronic Hep C, approve if prescribed by, or after consultation with, a gastroenterologist, hematologist, hepatologist, or a physician who specializes in infectious disease (initial therapy). MDS-presc or after consult with heme/onc (initial therapy).
Coverage Duration	Immune thrombo/MDS initial-3 mo, cont 1yr, AA-initial-4 mo, cont-1 yr, Thrombo/Hep C-1 yr

PA Criteria	Criteria Details
Other Criteria	Thrombocytopenia in patients with immune thrombocytopenia, initial-approve if the patient has a platelet count less than 30, 000 microliters or less than 50, 000 microliters and the patient is at an increased risk for bleeding AND the patient has tried ONE other therapy or has undergone a splenectomy. Cont-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications. Treatment of thrombocytopenia in patients with Chronic Hepatitis C initial-approve if the patient will be receiving interferon-based therapy for chronic hepatitis C AND to allow for initiation of antiviral therapy if the patient has low platelet counts at baseline (eg, less than 75,000 microliters). Aplastic anemia initial - approve if the patient has low platelet counts at baseline/pretreatment (e.g., less than 30,000 microliters) AND tried one immunosuppressant therapy (e.g., cyclosporine, mycophenolate moefetil, sirolimus) OR patient will be using Promacta in combination with standard immunosuppressive therapy. Cont-approve if the patient demonstrates a beneficial clinical response. MDS initial-approve if patient has low- to intermediate-risk MDS AND the patient has a platelet count less than 30, 000 microliters or less than 50, 000 microliters and is at an increased risk for bleeding. Cont-approve if the patient demonstrates a beneficial clinical response and remains at risk for bleeding complications.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Thrombocytopenia in Myelodysplastic Syndrome (MDS)
Part B Prerequisite	No

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient's immune status (Toxoplasma gondii Encephalitis, chronic maintenance and prophylaxis, primary)
Age Restrictions	
Prescriber Restrictions	Toxoplasma gondii Encephalitis, Chronic Maintenance and Prophylaxis (Primary)-prescribed by or in consultation with an infectious diseases specialist. Toxoplasmosis Treatment-prescribed by or in consultation with an infectious diseases specialist, a maternal-fetal medicine specialist, or an ophthalmologist.
Coverage Duration	12 months
Other Criteria	Toxoplasma gondii Encephalitis, Chronic Maintenance, approve if the patient is immunosuppressed. Toxoplasma gondii Encephalitis Prophylaxis (Primary), approve if the patient is immunosuppressed.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Chronic maintenance and prophylaxis of Toxoplasma Gondii encephalitis
Part B Prerequisite	No

QINLOCK

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, other therapies tried
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years
Other Criteria	Gastrointestinal stromal tumor (GIST), advanced-approve if, the patient has two of the following imatinib, sunitinib, Sprycel or Stivarga OR if the patient has tried Ayvakit and Sprycel. Melanoma, cutaneous-approve if the patient has metastatic or unresectable disease, AND the patient has an activating KIT mutation, AND the patient has tried at least one systemic regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Melanoma, cutaneous
Part B Prerequisite	No

Quinine

Products Affected

- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	Leg cramps, muscle cramps
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RELISTOR

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

REPATHA

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Leqvio or Praluent.
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history (as specified in the Other Criteria field)
Age Restrictions	ASCVD/Primary Hyperlipidemia - 18 yo and older, HoFH/HeFH - 10 yo and older.
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	3 years
Other Criteria	Primary Hyperlipidemia/Hyperlipidemia with ASCVD/HoFH/HeFH - Approve if provider attests that the patient has tried at least ONE statin and/or ezetimibe and was unable to meet LDL goals after 8 weeks with maximally tolerated therapy or is intolerant of both.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RETEVMO

Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	Medullary Thyroid Cancer/Thyroid Cancer-12 years and older, all others 18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-Approve if the patient has metastatic disease AND the tumor is RET fusion-positive. Medullary Thyroid Cancer-approve if the patient has advanced or metastatic RET-mutant disease and the disease requires treatment with systemic therapy.Thyroid Cancer-approve if the patient has advanced or metastatic RET fusion positive disease, the disease is radioactive iodine-refractory (if radioactive iodine is appropriate) and the disease requires treatment with systemic therapy. Anaplastic thyroid cancer-approve if the patient has RET fusion-positive anaplastic thyroid carcinoma. Solid tumors-approve if the patient has recurrent, advanced or metastatic disease and the tumor is rearranged during transfection (RET) fusion-positive.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Anaplastic thyroid carcinoma
Part B Prerequisite	No

revlimid

Products Affected

- *lenalidomide*
- REVLIMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis and previous therapies or drug regimens tried.
Age Restrictions	18 years and older (except Kaposi's Sarcoma, Castleman's Disease, CNS Lymphoma)
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

PA Criteria	Criteria Details
Other Criteria	Follicular lymphoma-approve if the patient is using lenalidomide (brand or generic) in combination with rituximab or has tried at least on prior therapy. MCL-approve -if the patient is using lenalidomide (brand or generic) in combination with rituximab or has tried at least two other therapies or therapeutic regimens. MZL-approve if the patient is using lenalidomide (brand or generic) in combination with rituximab or has tried at least one other therapy or therapeutic regimen. Multiple myeloma-approve. MDS-approve if the patient meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Epogen, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). B-cell-lymphoma (other)-approve if the pt has tried at least one prior therapy. Myelofibrosis-approve if according to the prescriber the patient has anemia and the pt has serum erythropoietin levels greater than or equal to 500 mU/mL or according to the prescriber the patient has anemia, has serum erythropoietin levels less than 500 mU/mL and patient has experienced no response or loss of response to erythropoietic stimulating agents. Peripheral T-Cell Lymphoma or T-Cell Leukemia/Lymphoma-approve if the pt has tried at least one other therapy or regimen. CNS lymphoma-approve if according to the prescriber the patient has relapsed or refractory disease. Hodgkin lymphoma, classical-approve if the patient has tried at least one other therapy or therapeutic regimen. Castleman's disease-approve if the patient has relapsed/refractory or progressive disease. Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and the patient has relapsed or refractory disease. Systemic light chain amyloidosis-approve if lenalidomide (brand or generic) is used in combination with dexamethasone.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Off label uses for Revlimid and lenalidomide include-Systemic Amyloidosis Light Chain, Diffuse Large B Cell Lymphoma (Non-Hodgkin's Lymphoma), Myelofibrosis. Castleman's Disease, Hodgkin lymphoma (Classical), Peripheral T-Cell Lymphoma, T-Cell Leukemia/Lymphoma, Central nervous system Lymphoma,Kaposi's sarcoma. Off label uses for lenalidomide include-follicular lymphoma, marginal zone lymphoma and multiple myeloma following autologous hematopoietic stem cell transplantation.

PA Criteria	Criteria Details
Part B Prerequisite	No

REZLIDHIA

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Acute myeloid leukemia-approve if the patient has relapsed or refractory disease and the patient has isocitrate dehydrogenase-1 (IDH1) mutation positive disease as detected by an approved test.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rezurock

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	12 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Graft-versus-host disease-approve if the patient has chronic graft-versus-host disease and has tried at least two conventional systemic treatments (e.g., ibrutinib, cyclosporine) for chronic graft-versus-host disease.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Riluzole

Products Affected

- *riluzole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist, a neuromuscular disease specialist, or a physician specializing in the treatment of ALS.
Coverage Duration	1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RINVOQ

Products Affected

- RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a biologic or with a targeted synthetic DMARD. Concurrent use with other potent immunosuppressants. Concurrent use with an anti-interleukin monoclonal antibody, Concurrent use with other janus kinase inhibitors, or concurrent use with Xolair.
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	PsA/RA/UC/AS/CD-18 years and older (initial therapy), AD-12 years and older (initial therapy)
Prescriber Restrictions	RA/AS/Non-Radiographic Spondy, prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or a dermatologist. AD-prescr/consult with allergist, immunologist or derm. UC/CD-prescribed by or in consultation with a gastroenterologist.
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	RA/PsA/UC/AS/CD initial-approve if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. AD-approve if the patient has had a 3 month trial of at least one traditional systmic therapy or has tried at least one traditional systemic therapy but was unable to tolerate a 3 month trial. Note: Examples of traditional systemic therapies include methotrexate, azathioprine, cyclosporine, and mycophenolate mofetil. A patient who has already tried Dupixent (dupilumab subcutaneous injection) or Adbry (tralokinumab-ldrm subcutaneous injection) is not required to step back and try a traditional systemic agent for atopic dermatitis. Non-Radiographic Axial Spondyloarthritis-approve if the patient has objective signs of inflammation defined as at least one of the following: C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory OR sacroiliitis reported on MRI and patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3- month trial. Continuation Therapy - Patient must have responded, as determined by the prescriber
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Rozlytrek

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	Solid Tumors-12 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	'Solid Tumors-Approve if the patient's tumor is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion AND the tumor is metastatic OR surgical resection of tumor will likely result in severe morbidity. Non-Small Cell Lung Cancer-Approve if the patient has ROS1-positive metastatic disease.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

rubraca

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis for which Rubraca is being used. BRCA-mutation (germline or somatic) status. Other medications tried for the diagnosis provided
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years

PA Criteria	Criteria Details
Other Criteria	Ovarian, Fallopian Tube or Primary Peritoneal Cancer-treatment - Approve if the patient meets the following criteria (i and ii): i.The patient has a BRCA-mutation (germline or somatic) as confirmed by an approved test, AND ii.The patient has progressed on two or more prior lines of chemotherapy. Maintenance Therapy of Ovarian, Fallopian tube or Primary peritoneal cancer-Approve if the patient is in complete or partial response after at least two platinum-based chemotherapy regimens. Castration-Resistant Prostate Cancer - Approve if the patient meets the following criteria (A, B, C, and D): A) The patient has metastatic disease that is BRCA-mutation positive (germline and/or somatic) AND B) The patient meets one of the following criteria (i or ii): i. The medication is used concurrently with a gonadotropin-releasing hormone (GnRH) analog OR ii. The patient has had a bilateral orchiectomy AND C) The patient has been previously treated with at least one androgen receptor-directed therapy AND D) The patient meets one of the following criteria (i or ii): i. The patient has been previously treated with at least one taxane-based chemotherapy OR ii. The patient is not a candidate or is intolerant to taxane-based chemotherapy. Uterine leiomyosarcoma-approve if the patient has BRCA2-altered disease and has tried one systemic regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Uterine Leiomyosarcoma, treatment of patients with deleterious BRCA mutation associated advanced ovarian cancer who have been treated with two or more chemotherapies
Part B Prerequisite	No

Rufinamide

Products Affected

- *rufinamide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	Patients 1 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Initial therapy-approve if rufinamide is being used for adjunctive treatment. Continuation-approve if the patient is responding to therapy
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Treatment-Refractory Seizures/Epilepsy
Part B Prerequisite	No

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, FLT3 status
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	AML-approve if the patient is FLT3-mutation positive as detected by an approved test. Myeloid or lymphoid Neoplasms with eosinophilia-approve if the patient has an FGFR1 rearrangement or has an FLT3 rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Myeloid or lymphoid neoplasms with eosinophilia
Part B Prerequisite	No

Sapropterin

Products Affected

- *sapropterin*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with Palynziq
Required Medical Information	Diagnosis, Phe concentration
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a specialist who focuses in the treatment of metabolic diseases (initial therapy)
Coverage Duration	Initial-12 weeks, Continuation-1 year
Other Criteria	Initial - approve. Continuation (Note-if the patient has received less than 12 weeks of therapy or is restarting therapy with sapropterin should be reviewed under initial therapy) - approve if the patient has had a clinical response (e.g., cognitive and/or behavioral improvements) as determined by the prescribing physician OR patient had a 20 percent or greater reduction in blood Phe concentration from baseline OR treatment with sapropterin has resulted in an increase in dietary phenylalanine tolerance.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Scemblix

Products Affected

- SCEMBLIX ORAL TABLET 20 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Chronic Myeloid Leukemia (CML)-approve if the patient meets the following (A and B): A) Patient has Philadelphia chromosome-positive chronic myeloid leukemia, AND B) Patient meets one of the following (i or ii): i. The chronic myeloid leukemia is T315I-positive, OR ii. Patient has tried at least two other tyrosine kinase inhibitors indicated for use in Philadelphia chromosome-positive chronic myeloid leukemia. Note: Examples of tyrosine kinase inhibitors include imatinib tablets, Bosulif (bosutinib tablets), Iclusig (ponatinib tablets), Sprycel (dasatinib tablets), and Tasigna (nilotinib capsules). Myeloid/Lymphoid Neoplasms with Eosinophilia - approve if the tumor has an ABL1 rearrangement.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Myeloid/Lymphoid Neoplasms with Eosinophilia
Part B Prerequisite	No

Sensipar

Products Affected

- *cinacalcet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	Hypercalcemia d/t parathyroid CA-prescr/consult w/onco or endo.Hypercalcemia w/primary hyperparathyroidism-prescr/consult w/nephro or endo. Hyperparathyroidism in post-renal transplant-prescr/consult w/transplant physician/nephro/endo.
Coverage Duration	12 months
Other Criteria	Hypercalcemia due to parathyroid carcinoma-approve. Hypercalcemia in patients with primary hyperparathyroidism-approve if the patient has failed or is unable to undergo a parathyroidectomy due to a contraindication. Secondary Hyperparathyroidism in patients with chronic kidney disease on dialysis - deny under Medicare Part D (claim should be submitted under the ESRD bundles payment benefit). Hyperparathyroidism in Post-Renal Transplant Patients-approve if the baseline (prior to starting cinacalcet therapy) calcium and intact parathyroid hormone (iPTH) levels are above the normal range, as defined by the laboratory reference values.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	hyperparathyroidism in post-renal transplant patients
Part B Prerequisite	No

Signifor

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist or a physician or specializes in the treatment of Cushing's syndrome (initial therapy)
Coverage Duration	Cushing's disease/syndrome-Initial therapy - 4 months, Continuation therapy - 1 year.
Other Criteria	Cushing's disease, initial therapy - approve if, according to the prescribing physician, the patient is not a candidate for surgery, or surgery has not been curative. Cushing's disease, continuation therapy - approve if the patient has already been started on Signifor/Signifor LAR and, according to the prescribing physician, the patient has had a response and continuation of therapy is needed to maintain response.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	Patients weighing less than 15 kg
Required Medical Information	Diagnosis, concomitant therapy
Age Restrictions	Patients 5 years of age or older
Prescriber Restrictions	Prescribed by, or in consultation with an infectious diseases specialist
Coverage Duration	9 months
Other Criteria	Tuberculosis (Pulmonary) - Approve if the patient has multidrug-resistant tuberculosis and the requested medication is prescribed as part of a combination regimen with other anti-tuberculosis agents
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Skyrizi

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent Use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, Previous medication use
Age Restrictions	18 years of age and older (initial therapy)
Prescriber Restrictions	PP-Prescribed by or in consultation with a dermatologist (initial therapy), PsA-prescribed by or in consultation with a rheumatologist or dermatologist (initial therapy). CD-presc/consult-gastro
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	PP-Initial Therapy-The patient meets ONE of the following conditions (a or b): a) The patient has tried at least one traditional systemic agent for psoriasis (e.g., methotrexate [MTX], cyclosporine, acitretin tablets, or psoralen plus ultraviolet A light [PUVA]) for at least 3 months, unless intolerant. NOTE: An exception to the requirement for a trial of one traditional systemic agent for psoriasis can be made if the patient has already had a 3-month trial or previous intolerance to at least one biologic (e.g., an adalimumab product [Humira], a certolizumab pegol product [Cimzia], an etanercept product [Enbrel, Erelzi], an infliximab product [e.g., Remicade, Inflectra, Renflexis], Cosentyx [secukinumab SC injection], Ilumya [tildrakizumab SC injection], Siliq [brodalumab SC injection], Stelara [ustekinumab SC injection], Taltz [ixekizumab SC injection], or Tremfya [guselkumab SC injection]). These patients who have already tried a biologic for psoriasis are not required to 'step back' and try a traditional systemic agent for psoriasis)b) The patient has a contraindication to methotrexate (MTX), as determined by the prescribing physician.Continuation Therapy - Patient must have responded, as determined by the prescriber. Psoriatic arthritis (initial)-approve. Continuation-patient must have responded as determined by the prescriber. CD, initial-approve if the patient has tried or is currently taking crticosteroids, or corticosteroids are contraindicated or if the patient has tried one other conventional systemic therapy for CD (Please note: Examples of conventional systemic therapy for Crohn's disease include azathioprine, 6-mercaptopurine, or methotrexate. An exception to the requirement for a trial of or contraindication to steroids or a trial of one other conventional systemic agent can be made if the patient has already tried at least one biologic other than the requested medication. A biosimilar of the requested biologic does not count. A trial of mesalamine does not count as a systemic agent for Crohn's disease.) or if the patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas or if the patient had ileocolonic resection (to reduce the chance of CD recurrence).
	Patients must be receiving an induction dosing with Skyrizi IV within 3 month of initiating therapy with Skyrizi subcutaneous. Continuation-patient must have responded as determined by the prescriber.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

Sofosbuvir-Velpatasvir

Products Affected

- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	Combination use with other direct acting antivirals, excluding ribavirin.
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	3 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Indications consistent with current AASLD/IDSA guidance.
Part B Prerequisite	No

solaraze

Products Affected

- *diclofenac sodium topical gel 3 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 6 months.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SOMAVERT

Products Affected

- SOMAVERT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, previous therapy, concomitant therapy
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	1 year
Other Criteria	Acromegaly-approve if patient meets ONE of the following (i, ii, or iii): i. patient has had an inadequate response to surgery and/or radiotherapy OR ii. The patient is NOT an appropriate candidate for surgery and/or radiotherapy OR iii. The patient is experiencing negative effects due to tumor size (e.g., optic nerve compression) AND patient has (or had) a pre-treatment (baseline) insulin-like growth factor-1 (IGF-1) level above the upper limit of normal (ULN) based on age and gender for the reporting laboratory.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

sprycel

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis for which Sprycel is being used. For indications of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For melanoma, cutaneous- KIT mutation and previous therapies.
Age Restrictions	GIST/chondrocarcoma or chordoma/melanoma, cutaneous-18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For CML, patient must have Ph-positive CML. For ALL, patient must have Ph-positive ALL. GIST - approve if the patient has tried imatinib or avapritinib. For melanoma, cutaneous - approve if patient has metastatic or unresectable disease AND has an activating KIT mutation AND has tried at least one systemic regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	'GIST, chondrosarcoma, chordoma, melanoma cutaneous
Part B Prerequisite	No

stelara

Products Affected

- STELARA SUBCUTANEOUS SOLUTION
- STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML, 90 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	Ustekinumab should not be given in combination with a Biologic DMARD or Targeted Synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	18 years and older-UC/CD (initial therapy). PP-6 years and older (initial therapy).
Prescriber Restrictions	Plaque psoriasis.Prescribed by or in consultation with a dermatologist (initial therapy). PsA-prescribed by or in consultation with a rheumatologist or dermatologist (initial therapy). CD/UC-prescribed by or in consultation with a gastroenterologist (initial therapy).
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	PP initial - Approve Stelara SC. CD, induction therapy - approve single dose of IV formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other conventional systemic therapy for CD (eg, azathioprine, 6-MP, MTX, certolizumab, vedolizumab, adalimumab, infliximab) OR 3) patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR 4) patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). UC, initial therapy-approve SC if the patient received a single IV loading dose within 2 months of initiating therapy with Stelara SC. CD, initial therapy (only after receiving single IV loading dose within 2 months of initiating therapy with Stelara SC) - approve 3 months of the SC formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other agent for CD. PP/PsA/CD/UC cont - approve Stelara SC if according to the prescribing physician, the patient has responded to therapy.PP initial - approve Stelara SC. CD, initial therapy - approve 3 months of the SC formulation if the patient meets ONE of the following criteria: 1) patient has tried or is currently taking corticosteroids, or corticosteroids are contraindicated, OR 2) patient has tried one other conventional systemic therapy for CD OR 3) patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas OR 4) patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). UC, initial therapy-approve SC if the patient received a single IV loading dose within 2 months of initiating therapy with Stelara SC. PP/PsA/CD/UC cont - approve Stelara SC if according to the prescribing physician, the patient has responded to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

stivarga

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis for which Stivarga is being used. Prior therapies tried. For metastatic CRC, KRAS/NRAS mutation status.
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	For GIST, patient must have previously been treated with imatinib or Ayvakit and sunitinib or Sprycel. For HCC, patient must have previously been treated with at least one systemic regimen. Soft tissue sarcoma, advanced or metastatic disease-approve if the patient has non-adipocytic sarcoma, angiosarcoma, or pleomorphic rhabdomyosarcoma.Osteosarcoma-approve if the patient has relapsed/refractory or metastatic disease and the patient has tried one systemic chemotherapy regimen. Colon and Rectal cancer-approve if the patient has advanced or metastatic disease, has been previously treated with a fluoropyrimidine, oxaliplatin, irinotecan and if the patient's tumor or metastases are wild-type RAS, the patient has tried Erbitux or Vectibix. Glioblastoma-approve if the patient has recurrent disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Soft tissue Sarcoma, Osteosarcoma, Glioblastoma
Part B Prerequisite	No

SUCRAID

Products Affected

- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, genetic and lab test results (as specified in the Other Criteria field)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a geneticist, gastroenterologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of congenital diarrheal disorders
Coverage Duration	1 year
Other Criteria	Approve if the patient has a laboratory test demonstrating deficient sucrase or isomaltase activity in duodenal or jejunal biopsy specimens OR patient has a sucrose hydrogen breath test OR has a molecular genetic test demonstrating sucrose-isomaltase mutation in saliva or blood.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

sutent

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Gastrointestinal stromal tumors (GIST), approve if the patient has previously tried imatinib (Gleevec). Chordoma, approve if the patient has recurrent disease. Differentiated thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Medullary thyroid carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq). Meningioma, approve if the patient has recurrent or progressive disease. Thymic carcinoma - has tried chemotherapy or radiation therapy. Renal Cell Carcinoma (RCC), clear cell or non-clear cell histology-approve if the patient is at high risk of recurrent clear cell RCC following nephrectomy and Sutent is used for adjuvant therapy or if the patient has relapsed or Stage IV disease. Neuroendocrine tumors of the pancreas-approve for advanced or metastatic disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Chordoma, angiosarcoma, solitary fibrous tumor/hemangiopericytoma, alveolar soft part sarcoma (ASPS), differentiated (ie, papillary, follicular, and Hurthle) thyroid carcinoma, medullary thyroid carcinoma, meningioma, thymic carcinoma.
Part B Prerequisite	No

TABRECTA

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Non-Small Cell Lung Cancer (NSCLC)-Approve if the patient has metastatic disease AND the tumor is positive for a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping or high-level MET amplification, as detected by an approved test.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Non-small cell lung cancer with high-level MET amplification.
Part B Prerequisite	No

tafinlar

Products Affected

- TAFINLAR ORAL CAPSULE
- TAFINLAR ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis for which Tafinlar is being used. BRAF V600 mutations
Age Restrictions	6 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

PA Criteria	Criteria Details
Other Criteria	Melanoma with BRAF V600 mutation AND patient has unresectable, advanced (including Stage III or Stage IV disease) or metastatic melanoma. Note-This includes adjuvant treatment in patients with Stage III disease with no evidence of disease post-surgery. For NSCLC, must have BRAF V600E mutation. Thyroid Cancer, anaplastic-must have BRAF V600-positive disease AND Tafinlar will be taken in combination with Mekinist, unless intolerant AND the patient has locally advanced or metastatic anaplastic disease. Thyroid Cancer, differentiated (i.e., papillary, follicular, or Hurthle cell) AND the patient has disease that is refractory to radioactive iodine therapy AND the patient has BRAF-positive disease. Biliary Tract Cancer-approve if the patient has tried at least one systemic chemotherapy regimen, patient has BRAF V600 mutation positive disease and the medication will be taken in combination with Mekinist. Central Nervous System Cancer-approve if the medication is being used for one of the following situations (i, ii, or iii): i) adjuvant treatment of pilocytic astrocytoma OR pleomorphic xanthoastrocytoma OR ganglioglioma, OR ii) recurrent disease for one of the following: low-grade glioma OR anaplastic glioma OR glioblastoma, OR iii) melanoma with brain metastases AND patient has BRAF V600 mutation-positive disease AND medication will be taken in combination with Mekinist (trametinib tablets). Histiocytic neoplasm-approve if patient has Langerhans cell histiocytosis and one of the following: multisystem disease OR pulmonary disease OR central nervous system lesions OR patient has Erdheim Chester disease AND patient has BRAF V600-mutation positive disease. Metastatic or solid tumors-approve if BRAF V600 mutation-positive disease AND medication will be taken in combination with Mekinist (trametinib tablets) AND patient has no satisfactory alternative treatment options.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Patients with Differentiated Thyroid Cancer, Biliary tract cancer, central nervous system cancer, histiocytic neoplasm
Part B Prerequisite	No

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	NSCLC - EGFR mutation positive-must meet one of the following-metastatic epidermal growth factor receptor (EGFR) T790M mutation-positive NSCLC as detected by an approved test AND has progressed on one of the EGFR tyrosine kinase inhibitors (e.g.,Tarceva, Iressa, Vizimpro or Gilotrif) therapy OR metastatic Non-Small Cell Lung Cancer (NSCLC) who have EGFR exon 19 deletion or exon 21 (L858R) mutation as detected by an approved test or if the medication is used as adjuvant therapy after tumor resection and the tumor is positive for EGFR exon 19 deletions or exon 21 L858R mutations as detected by an approved test.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Taltz

Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with other Biologics or Targeted Synthetic Disease-Modifying Antirheumatic Drugs (DMARDs)
Required Medical Information	Diagnosis, Previous medication use
Age Restrictions	PP-6 years and older (initial therapy), all other dx-18 years of age and older (initial therapy)
Prescriber Restrictions	All dx initial therapy only-PP-Prescribed by or in consultation with a dermatologist. PsA prescribed by or in consultation with a rheumatologist or a dermatologist. AS/spondylo-prescribed by or in consultation with a rheum.
Coverage Duration	1 year
Other Criteria	Initial Therapy - Plaque Psoriasis-approve if the patient has tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant OR the patient has a contraindication to methotrexate (MTX), as determined by the prescribing physician. An exception to the requirement for a trial of one traditional systemic agent for psoriasis can be made if the patient has already had a 3-month trial or previous intolerance to at least one biologic. PsA-Approve. AS initial-approve. Non-Radiographic Axial Spondyloarthritis-approve if the patient has objective signs of inflammation, defined as at least one of the following: C-reactive protein elevated beyond the upper limit of normal for the reporting laboratory or sacroiliitis reported on magnetic resonance imaging. Continuation Therapy - approve if the patient has responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

TALZENNA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Recurrent or metastatic breast cancer-approve if the patient has germline BRCA mutation-positive disease. Prostate cancer - approve if the patient has metastatic castration resistant prostate cancer, AND is using this medication concurrently with a gonadotropin-releasing hormone (GnRH) analog or has had a bilateral orchiectomy AND the patient has homologous recombination repair (HRR) gene-mutated disease [Note: HRR gene mutations include ATM, ATR, BRCA1, BRCA2, CDK12, CHEK2, FANCA, MLH1, MRE11A, NBN, PALB2, or RAD51C] AND the medication is used in combination with Xtandi (enzalutamide capsules and tablets).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TARGRETIN TOPICAL

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, previous therapies tried
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist (initial and continuation)
Coverage Duration	3 years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

tasigna

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis for which Tasigna is being used. For indication of CML and ALL, the Philadelphia chromosome (Ph) status of the leukemia must be reported. For indication of gastrointestinal stromal tumor (GIST) and melanoma, cutaneous, prior therapies tried. For melanoma, cutaneous, KIT mutation status.
Age Restrictions	ALL/GIST/Myeloid/lymphoid neoplasms/melanoma, cutaneous-18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For CML, patient must have Ph-positive CML. For GIST, approve if the patient has tried two of the following: imatinib, avapritinib, sunitinib, dasatinib, regorafinib or ripretinib. For ALL, Approve if the patient has philadelphia chromosome-positive acute lymphoblastic leukemia. Myeloid/lymphoid neoplasms with eosinophilia-approve if the tumor has an ABL1 rearrangement. Pigmented villonodular synovitis/tenosynovial giant cell tumor-approve if the patient has tried Turalio or cannot take Turalio, according to the prescriber. For melanoma, cutaneous - approve if the patient has metastatic or unresectable disease AND has an activating KIT mutation AND has tried at least one systemic regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	'Philadelphia positive Acute Lymphoblastic Leukemia (ALL) and Gastrointestinal Stromal Tumor (GIST), Pigmented villonodular synovitis/tenosynovial giant cell tumor, Myeloid/Lymphoid neoplasms with Eosinophilia, melanoma cutaneous.
Part B Prerequisite	No

TAZAROTENE

Products Affected

- *tazarotene topical cream*
- *tazarotene topical gel*

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic uses
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Acne vulgaris after a trial with at least 1 other topical retinoid product (eg, tretinoin cream/gel/solution/microgel, adapalene).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Tazverik

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	Epithelioid Sarcoma-16 years and older, Follicular Lymphoma-18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Epitheliod Sarcoma-approve if the patient has metastatic or locally advanced disease and the patient is not eligible for complete resection. Follicular Lymphoma-approve if the patient has relapsed or refractory disease and according to the prescriber, there are no appropriate alternative therapies or the patient's tumor is positive for an EZH2 mutation and the patient has tried at least two prior systemic therapies.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Tepmetko

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	NSCLC-approve if the patient has metastatic disease and the tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutations or patient has high-level MET amplification, as detected by an approved test.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Non-small cell lung cancer with high-level MET amplification.
Part B Prerequisite	No

TERIPARATIDE

Products Affected

- *teriparatide*

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other medications for osteoporosis
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	High risk for fracture-2 yrs, Not high risk-approve a max of 2 yrs of therapy (total)/lifetime.

PA Criteria	Criteria Details
Other Criteria	Treatment of PMO, approve if pt has tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the pt cannot swallow or has difficulty swallowing or the pt cannot remain in an upright position post oral bisphosphonate administration or pt has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR pt has severe renal impairment (creatinine clearance less than 35 mL/min) or CKD or pt has had an osteoporotic fracture or fragility fracture. Increase bone mass in men (a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression) with primary or hypogondal osteoporosis/Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture. Patients who have already taken teriparatide for 2 years - approve if the patient is at high risk for fracture.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Testosterone - Injectable Products

Products Affected

- *testosterone enanthate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, lab results
Age Restrictions	Delayed puberty or induction of puberty in males-14 years and older
Prescriber Restrictions	
Coverage Duration	Delayed puberty or induction of puberty in males-6 months, all others-12 months

PA Criteria	Criteria Details
Other Criteria	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. Delayed puberty or induction of puberty in males - Approve testosterone enanthate. Breast cancer in females-approve testosterone enanthate. Male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression. Female is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Female-to-male transsexual - Gender dysphoria
Part B Prerequisite	No

Testosterone - Non-Injectable Products

Products Affected

- *testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)*
- *testosterone transdermal solution in metered pump w/app*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, lab results
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. [Note: male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Female-to-male transsexual - Gender dysphoria
Part B Prerequisite	No

Tetrabenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years and older
Prescriber Restrictions	For treatment of chorea associated with Huntington's disease, Tourette syndrome or related tic disorders, hyperkinetic dystonia, or hemiballism, must be prescribed by or after consultation with a neurologist. For TD, must be prescribed by or after consultation with a neurologist or psychiatrist.
Coverage Duration	Authorization will be for 1 year.
Other Criteria	Chorea associated with Huntington's Disease-approve if the diagnosis of Huntington's Disease is confirmed by genetic testing.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Tardive dyskinesia (TD). Tourette syndrome and related tic disorders. Hyperkinetic dystonia. Hemiballism.
Part B Prerequisite	No

thalomid

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	MM, myelofibrosis-18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Erythem Nodosum Leprosum-approve. Multiple Myeloma-approve. Discoid lupus erythematosus or cutaneous lupus erythematosus, approve if the patient has tried at least two other therapies (eg, corticosteroids [oral, topical, intralesional], hydroxychloroquine, tacrolimus [Protopic], methotrexate, dapsone, acitretin [Soriatane]). Myelofibrosis, approve if according to the prescriber the patient has anemia and has serum erythropoietin levels greater than or equal to 500 mU/mL or if the patient has serum erythropoietin level less than 500 mU/mL and experienced no response or loss of response to erythropoietic stimulating agents. Prurigo nodularis, approve. Recurrent aphthous ulcers or aphthous stomatitis, approve if the patient has tried at least two other therapies (eg, topical or intralesional corticosteroids, systemic corticosteroids, topical anesthetics/analgesics [eg, benzocaine lozenges], antimicrobial mouthwashes [eg, tetracycline], acyclovir, colchicine). Kaposi's Sarcoma-approve if the patient has tried at least one regimen or therapy and has relapsed or refractory disease. Castleman's disease-approve if the patient has multicentric Castleman's disease and is negative for the human immunodeficiency virus (HIV) and human herpesvirus-8 (HHV-8).

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Discoid lupus erythematosus or cutaneous lupus erythematosus, Myelofibrosis, Prurigo nodularis, Recurrent aphthous ulcers or aphthous stomatitis, Kaposi's Sarcoma, Castleman's Disease.
Part B Prerequisite	No

TIBSOVO

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, IDH1 Status
Age Restrictions	All diagnoses (except chondrosarcoma)-18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	AML- approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive, as detected by an approved test. Cholangiocarcinoma-approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive and has been previously treated with at least one chemotherapy regimen (Part B before Part D Step Therapy - applies only to beneficiaries enrolled in an MA-PD plan). Chondrosarcoma-approve if the disease is isocitrate dehydrogenase-1 (IDH1) mutation positive. Central nervous system cancer-approve if the patient has recurrent or progressive disease, AND patient has World Health Organization (WHO) grade 2 or 3 oligodendroglioma, OR Patient has WHO grade 2 astrocytoma.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Chondrosarcoma, Central nervous system cancer
Part B Prerequisite	No

Tobramcyin

Products Affected

- *tobramycin in 0.225 % nacl*
- *tobramycin inhalation*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	Bronchiectasis, Non-cystic fibrosis-18 years and older
Prescriber Restrictions	CF-prescr/consult w/pulm/phys specializes in tx of CF.Bronchiectasis, non CF-prescr/consult w/pulm
Coverage Duration	1 year
Other Criteria	Part B versus Part D determination will be made at time of prior authorization review per CMS guidance. Cystic fibrosis/Bronchiectasis, non-cystic fibrosis-approve if the patient has pseudomonas aeruginosa in the culture of the airway.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Bronchiectasis, non-cystic fibrosis
Part B Prerequisite	No

TOLCAPONE

Products Affected

- *tolcapone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, current medications and medication history
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Parkinson's disease-approve if the patient is currently receiving carbidopa/levodopa therapy and the patient has tried entacapone and according to the prescriber, experienced significant intolerance or inadequate efficacy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TOPICAL AGENTS FOR ATOPIC DERMATITIS

Products Affected

- *pimecrolimus*
- *tacrolimus topical*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	Authorize use in patients who have tried a prescription strength topical corticosteroid (brand or generic) for the current condition. Dermatologic condition on or around the eyes, eyelids, axilla, or genitalia, authorize use without a trial of a prescription strength topical corticosteroid.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

topical retinoid products

Products Affected

- *tretinoin*

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for cosmetic use.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

topiramate/zonisamide

Products Affected

- EPRONTIA
- *topiramate oral capsule, sprinkle*
- *topiramate oral tablet*
- ZONISADE
- *zonisamide*

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for weight loss or smoking cessation.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 1 year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRANSDERMAL FENTANYL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Acute (i.e., non-chronic) pain.
Required Medical Information	Pain type (chronic vs acute), prior pain medications/therapies tried, concurrent pain medications/therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	'For pain severe enough to require daily, around-the-clock, long-term opioid treatment, approve if all of the following criteria are met: 1) patient is not opioid naive, AND 2) non-opioid therapies have been tried and are being used in conjunction with opioid therapy according to the prescribing physician, AND 3) the prescribing physician has checked the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP), AND 4) the prescribing physician has discussed risks (eg, addiction, overdose) and realistic benefits of opioid therapy with the patient, AND 5) according to the prescriber physician there is a treatment plan (including goals for pain and function) in place and reassessments are scheduled at regular intervals. Patients with cancer, sickle cell disease, in hospice or who reside in a long term care facility are not required to meet above criteria. Clinical criteria incorporated into the quantity limit edits for all oral long-acting opioids (including transdermal fentanyl products) require confirmation that the indication is intractable pain (ie, FDA labeled use) prior to reviewing for quantity exception.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

transmucosal fentanyl drugs

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 12 months.
Other Criteria	For breakthrough pain in patients with cancer if patient is unable to swallow, has dysphagia, esophagitis, mucositis, or uncontrollable nausea/vomiting OR patient is unable to take 2 other short-acting narcotics (eg, oxycodone, morphine sulfate, hydromorphone, etc) secondary to allergy or severe adverse events AND patient is on or will be on a long-acting narcotic (eg, Duragesic), or the patient is on intravenous, subcutaneous, or spinal (intrathecal, epidural) narcotics (eg, morphine sulfate, hydromorphone, fentanyl citrate). Clinical criteria incorporated into the quantity limit edits for all transmucosal fentanyl drugs require confirmation that the indication is breakthrough cancer pain (ie, FDA labeled use) prior to reviewing for quantity exception.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TRIENTINE

Products Affected

- *trientine oral capsule 250 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, medication history, pregnancy status, disease manifestations
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, or liver transplant physician.
Coverage Duration	Authorization will be for 1 year
Other Criteria	For Wilson's Disease, approve if the patient meets A and B: A) Diagnosis of Wilson's disease is confirmed by ONE of the following (i or ii): i. Genetic testing results confirming biallelic pathogenic ATP7B mutations (in either symptomatic or asymptomatic individuals), OR ii. Confirmation of at least two of the following (a, b, c, or d): a. Presence of Kayser-Fleischer rings, OR b. Serum ceruloplasmin levels less than 20mg/dL, OR c. Liver biopsy findings consistent with Wilson's disease, OR d. 24-hour urinary copper greater than 40 micrograms/24 hours, AND B) Patient meets ONE of the following: 1) Patient has tried a penicillamine product and per the prescribing physician the patient is intolerant to penicillamine therapy, OR 2) Per the prescribing physician, the patient has clinical features indicating the potential for intolerance to penicillamine therapy (ie, history of any renal disease, congestive splenomegaly causing severe thrombocytopenia, autoimmune tendency), OR 3) Per the prescribing physician, the patient has a contraindication to penicillamine therapy, OR 4) The patient has neurologic manifestations of Wilson's disease, OR 5) The patient is pregnant, OR 6) the patient has been started on therapy with trientine.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Trikafta

Products Affected

- TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL
- TRIKAFTA ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Exclusion Criteria	Patients with unknown CFTR gene mutations. Combination therapy with Orkambi, Kalydeco or Symdeko.
Required Medical Information	Diagnosis, specific CFTR gene mutations, concurrent medications
Age Restrictions	2 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or a physician who specializes in CF
Coverage Duration	3 years
Other Criteria	CF - must have at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive to the requested medication.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TUKYSA

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Breast Cancer-approve if the patient has advanced unresectable or metastatic human epidermal growth factor receptor 2 (HER2)-positive disease, has received at least one prior anti-HER2-based regimen in the metastatic setting and Tukysa is used in combination with trastuzumab and capecitabine. Colon/Rectal Cancer-approve if the requested medication is used in combination with trastuzumab, patient has unresectable or metastatic disease, human epidermal growth factor receptor 2 (HER2)-positive disease, AND Patient's tumor or metastases are wild-type RAS (KRAS wild-type and NRAS wild-type).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TURALIO

Products Affected

- TURALIO ORAL CAPSULE 125 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Tenosynovial Giant Cell Tumor (Pigmented Villonodular Synovitis)- approve if, according to the prescriber, the tumor is not amenable to improvement with surgery. Histiocytic Neoplasms-approve if the patient has a colony stimulating factor 1 receptor (CSF1R) mutation AND has one of the following conditions (i, ii, or iii): i. Langerhans cell histiocytosis OR ii. Erdheim-Chester disease OR iii. Rosai-Dorfman disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Histiocytic Neoplasms
Part B Prerequisite	No

UPTRAVI

Products Affected

- UPTRAVI ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmation of right heart catheterization, medication history.
Age Restrictions	
Prescriber Restrictions	PAH must be prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	1 year
Other Criteria	Must have PAH (WHO Group 1) and had a right heart catheterization to confirm the diagnosis of PAH (WHO Group 1). Patient new to therapy must meet a) OR b): a) tried one or is currently taking one oral therapy for PAH for 30 days, unless patient has experienced treatment failure, intolerance, or oral therapy is contraindicated: PDE5 inhibitor (eg, sildenafil, Revatio), endothelin receptor antagonist (ERA) [eg, Tracleer, Letairis or Opsumit], or Adempas, OR b) receiving or has received in the past one prostacyclin therapy for PAH (eg, Orenitram, Ventavis, or epoprostenol injection).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	Cutaneous lymphoma-18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Cutaneous Lymphomas (Note-includes mycosis fungoides/Sezary syndrome, primary cutaneous B-cell lymphoma, primary cutaneous CD30+ T-cell lymphoproliferative disorders)-approve. Adult T-Cell Leukemia/Lymphoma-approve if the patient has chronic/smoldering subtype of adult T-cell leukemia/lymphoma. Langerhans cell histiocytosis-approve if the patient has unifocal Langerhans cell histiocytosis with isolated skin disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Adults with T-cell leukemia/lymphoma, Langerhans Cell Histiocytosis
Part B Prerequisite	No

Valtoco

Products Affected

- VALTOCO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, other medications used at the same time
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Intermittent Episodes of Frequent Seizure Activity (i.e., seizure clusters, acute repetitive seizures)-approve if the patient is currently receiving maintenance antiepileptic medication(s).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VANFLYTA

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	1 year
Other Criteria	Acute Myeloid Leukemia: approve if the patient has FLT3-ITD mutation-positive disease as detected by an approved test and this medication is being used for induction, consolidation, or maintenance treatment.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VENCLEXTA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Systemic light chain amyloidosis-approve if the patient has t (11, 14) translocation and has tried at least one systemic regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Mantle Cell Lymphoma, waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, multiple myeloma, systemic light chain amyloidosis
Part B Prerequisite	No

VERKAZIA

Products Affected

- VERKAZIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	4 years and older
Prescriber Restrictions	Prescribed by or in consultation with an optometrist or ophthalmologist
Coverage Duration	1 year
Other Criteria	Vernal keratoconjunctivitis-approve if the patient has moderate to severe vernal keratoconjunctivitis and has tried one other ophthalmic medication for the maintenance treatment of vernal keratoconjunctivitis. Note: Examples of other ophthalmic medications for the maintenance treatment of vernal keratoconjunctivitis include ophthalmic antihistamines and ophthalmic mast-cell stabilizers (e.g.,lodoxamide tromethamine 0.1% ophthalmic solution). A previous trial of one ophthalmic cyclosporine product (e.g., Cequa [cyclosporine 0.09% ophthalmic solution], Restasis [cyclosporine 0.05% ophthalmic emulsion]) other than the requested drug also counts as a trial of one agent for vernal keratoconjunctivitis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HR status, HER2 status, previous medications/therapies tried, concomitant therapy, menopausal status
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Breast cancer, early-approve for 2 years, all other-3 years

PA Criteria	Criteria Details
Other Criteria	Breast Cancer, Early-Approve if pt meets (A,B,C and D): A)Pt has HR+disease, AND B)Pt has HER2-negative breast cancer, AND C)Pt meets the following:Pt has node-positive disease at high risk of recurrence (Note-High risk includes patients with greater than or equal to 4 positive lymph nodes, or 1-3 positive lymph nodes with one or more of the following: Grade 3 disease, tumor size greater than or equal to 5 cm, or a Ki-67 score of greater than or equal to 20percent) AND D)Pt meets ONE of the following (i or ii): i.Verzenio will be used in combo w/anastrozole, exemestane, or letrozole AND pt meets one of the following (a,b, or c): a)Pt is a postmenopausal woman, OR b)Pt is a pre/perimenopausal woman and meets one of the following 1 or 2:1-Pt is receiving ovarian suppression/ablation with a gonadotropin-releasing hormone (GnRH) agonist, OR 2-Pt has had surgical bilateral oophorectomy or ovarian irradiation, OR c)Pt is a man and pt is receiving a GnRH analog, OR ii.Verzenio will be used in combo with tamoxifen AND pt meets one of the following (a or b): a)Pt is a postmenopausal woman or man OR b)Pt is a pre/perimenopausal woman and meets one of the following 1 or 2:1-Pt is receiving ovarian suppression/ablation with a GnRH agonist, OR 2-Patient has had surgical bilateral oophorectomy or ovarian irradiation. Breast Cancer-Recurrent or Metastatic in Women-Approve if pt meets (A, B, C and D): A) Pt has HR+ disease, AND B)Pt has HER2-negative breast cancer, AND C)Pt meets ONE of the following criteria (i or ii): i.Pt is a postmenopausal woman, OR ii.Pt is a pre/perimenopausal woman and meets one of the following (a or b): a)Pt is receiving ovarian suppression/ablation with a GnRH agonist, OR b)Pt has had surgical bilateral oophorectomy or ovarian irradiation, AND D)Pt meets ONE of the following criteria (i, ii, or iii): i.Verzenio will be used in combo with anastrozole, exemestane, or letrozole, OR ii.Verzenio will be used in combo with fulvestrant, OR iii.pt meets the following conditions (a, b, and c): a)Verzenio will be used as monotherapy, AND b)Pt's breast cancer has progressed on at least one prior endocrine therapy, AND c)Pt has tried

PA Criteria	Criteria Details
	chemotherapy for metastatic breast cancer.Breast Cancer-Recurrent or Metastatic in Men-Approve if pt meets the following criteria (A,B and C): A)Pt has HR+ disease, AND B)Pt has HER2-negative breast cancer, AND C)Pt meets ONE of the following criteria (i, ii, or iii): i.Pt meets BOTH of the following conditions (a and b): a)Pt is receiving a GnRH analog, AND b)Verzenio will be used in combo with anastrozole, exemestane, or letrozole, OR ii.Verzenio will be used in combo with fulvestrant, OR iii.Pt meets the following conditions (a, b, and c): a)Verzenio will be used as monotherapy, AND b)Pt's breast cancer has progressed on at least one prior endocrine therapy, AND c)Pt has tried chemotherapy for metastatic breast cancer.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	treatment of advanced or metastatic breast cancer in combination with an aromatase inhibitor in pre-menopausal women
Part B Prerequisite	No

VIGABATRIN

Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 1 year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VIJOICE

Products Affected

- VIJOICE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	2 years and older (initial therapy)
Prescriber Restrictions	Prescribed by or in consultation with a physician that specializes in treatment of genetic disorder (initial therapy)
Coverage Duration	Initial-6 months, continuation- 1 year
Other Criteria	PIK3CA-Related Overgrowth Spectrum (PROS), initial therapy-Approve if the patient has at least one severe clinical manifestation of PROS and the patient has a PIK3CA mutation as confirmed by genetic testing Note: Examples of severe clinical manifestations include excessive tissue growth, blood vessel malformations, scoliosis, vascular tumors, cardiac or renal manifestations, and those that require systemic treatment. PIK3CA-Related Overgrowth Spectrum (PROS), continuation-Approve if the patient has been established on Vijoice for at least 6 months and has experienced a reduction in volume from baseline (prior to initiating Vijoice) in at least one lesion as confirmed by measurement and has experienced an improvement in at least one sign or symptom of PROS from baseline (prior to initiating Vijoice) Note: Examples of signs or symptoms of PROS include pain, fatigue, vascular malformation, limb asymmetry, or disseminated intravascular coagulation.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

VITRAKVI

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, NTRK gene fusion status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Solid tumors - approve if the tumor is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion AND the tumor is metastatic or surgical resection of tumor will likely result in severe morbidity.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VIZIMPRO

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, EGFR status, exon deletions or substitutions
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	NSCLC-approve if the patient has advanced or metastatic disease, has sensitizing EGFR mutation-positive NSCLC as detected by an approved test. Note: Examples of sensitizing EGFR mutation-positive NSCLC include the following mutations: exon 19 deletions, exon 21 (L858R) substitution mutations, L861Q, G719X and S7681.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VONJO

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Myelofibrosis (MF), including primary MF, post-polycythemia Vera MF, and Post-Essential Thrombocythemia MF-approve if the patient has intermediate risk or high risk disease and the patient has a platelet count of less than 50 X 10 9/L (less than 50,000/mcL)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Voriconazole

Products Affected

- *voriconazole*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Aspergillus-Prophy, systemic w/risk neutropenia-Prophy, systemic w/HIV-Prophy/Tx-6 mo, others-3 mo
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Aspergillus Infections - prophylaxis, oropharyngeal candidiasis (fluconazole-refractory) - treatment, candidia endophthalmitis - treatment, blastomycosis - treatment, fungal infections (systemic) in patients at risk of neutropenia - prophylaxis, fungal infections (systemic) in patients with human immunodeficiency virus (HIV) - prophylaxis or treatment.
Part B Prerequisite	No

VOSEVI

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Genotype, prescriber specialty, other medications tried or used in combination with requested medication
Age Restrictions	18 years or older
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist, hepatologist, infectious diseases physician, or a liver transplant physician
Coverage Duration	Will be c/w AASLD guidance and inclusive of treatment already received for the requested drug
Other Criteria	Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Off-label uses consistent with current AASLD/IDSA guidance
Part B Prerequisite	No

votrient

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Soft tissue sarcoma other than GIST [angiosarcoma, Pleomorphic rhabdomyosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma that is unresectable or progressive, soft tissue sarcoma of the extremity/superficial trunk or head/neck, including synovial sarcoma, or solitary fibrous tumor/hemangiopericytoma or alveolar soft part sarcoma], approve. Differentiated (ie, papillary, follicular, Hurthle) thyroid carcinoma, approve if the patient is refractory to radioactive iodine therapy. Uterine sarcoma, approve if the patient has recurrent, advanced or metastatic disease. Renal Cell Carcinoma, Clear Cell or non-Clear Cell histology-approved if the patient has relapsed or stage IV disease. Ovarian Cancer (ie, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer) - approve if the patient has persistent or recurrent disease. GIST - approve if the patient has tried TWO of the following: Gleevec, Sutent, or Stivarga. Medullary Thyroid Carcinoma, approve if the patient has tried vandetanib (Caprelsa) or cabozantinib (Cometriq).
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Differentiated (ie, papillary, follicular, Hurthle cell) thyroid carcinoma. Uterine sarcoma, Epithelial Ovarian, Fallopian Tube, or Primary Peritoneal Cancer, Gastrointestinal Stromal Tumor (GIST), Medullary thyroid carcinoma.
Part B Prerequisite	No

Welireg

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Van Hippel-Lindau Disease-approve if the patient meets the following (A, B, and C): A) Patient has a von Hippel-Lindau (VHL) germline alteration as detected by genetic testing, B) Does not require immediate surgery and C) Patient requires therapy for ONE of the following conditions (i, ii, iii, or iv): i. Central nervous system hemangioblastomas, OR ii. Pancreatic neuroendocrine tumors, OR iii. Renal cell carcinoma, OR iv. Retinal hemangioblastoma.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

xalkori

Products Affected

- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	Anaplastic large cell lymphoma-patients greater than or equal to 1 year of age. All other diagnoses (except soft tissue sarcoma)-18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Metastatic non-small cell lung cancer-approve if the patient has anaplastic lymphoma kinase (ALK)-positive disease, as detected by an approved test or ROS1 rearrangement positive disease, as detected by an approved test. Metastatic non-small cell lung cancer-approve if the patient has anaplastic lymphoma kinase (ALK)-positive disease, as detected by an approved test or ROS1 rearrangement positive disease, as detected by an approved test. Anaplastic Large Cell Lymphoma-approve if the patient has anaplastic lymphoma kinase (ALK)-positive disease AND has received at least one prior systemic treatment. Histiocytic neoplasm-approve if the patient has ALK rearrangement/fusion-positive disease and meets one of the following criteria (i, ii, or iii): (i. Patient has Langerhans cell histiocytosis, OR ii. Patient has Erdheim-Chester disease OR iii. Patient has Rosai-Dorfman disease. NSCLC with MET mutation-approve if the patient has high level MET amplification or MET exon 14 skipping mutation. Soft Tissue Sarcoma - Inflammatory Myofibroblastic Tumor with Anaplastic Lymphoma Kinase (ALK) Translocation-approve. Melanoma, cutaneous-approve if the patient has ALK fusion disease or ROS1 fusion disease.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	NSCLC with high level MET amplification or MET Exon 14 skipping mutation, Histiocytic neoplasms, melanoma, cutaneous.
Part B Prerequisite	No

xeljanz

Products Affected

- XELJANZ ORAL SOLUTION
- XELJANZ ORAL TABLET
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with a biologic or with a Targeted Synthetic DMARD for an inflammatory condition (eg, tocilizumab, anakinra, abatacept, rituximab, certolizumab pegol, etanercept, adalimumab, infliximab, golimumab). Concurrent use with potent immunosuppressants that are not methotrexate (MTX) [eg, azathioprine, tacrolimus, cyclosporine, mycophenolate mofetil].
Required Medical Information	Diagnosis, concurrent medications, previous drugs tried.
Age Restrictions	AS/PsA/RA/UC-18 years and older (initial therapy)
Prescriber Restrictions	RA, JIA/JRA/AS-prescribed by or in consultation with a rheumatologist. PsA-prescribed by or in consultation with a rheumatologist or a dermatologist. UC-prescribed by or in consultation with a gastroenterologist.
Coverage Duration	1 year

PA Criteria	Criteria Details
Other Criteria	RA initial-approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. PsA initial, approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial and the requested medication will be used in combination with methotrexate or another conventional synthetic disease modifying antirheumatic drug (DMARD), unless contraindicated. UC-Approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least ONE tumor necrosis factor inhibitor for ulcerative colitis or was unable to tolerate a 3-month trial. Juvenile Idiopathic Arthritis (JIA) [or Juvenile Rheumatoid Arthritis] (regardless of type of onset) [Note: This includes patients with juvenile spondyloarthropathy/active sacroiliac arthritis]-initial-approve Xeljanz immediate release tablets or solution if the patient meets the following: patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. AS-approve Xeljanz/XR tablets if the patient has had a 3 month trial of at least one tumor necrosis factor inhibitor or was unable to tolerate a 3 month trial. Continuation Therapy - Patient must have responded, as determined by the prescriber.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XIFAXAN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	Traveler's diarrhea - 12 years of age or older. Hepatic encephalopathy, irritable bowel syndrome - 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Hepatic Encephalopathy-6 months, IBS with diarrhea-14 days, Traveler's Diarrhea-3 days
Other Criteria	Hepatic Encephalopathy-approve if the patient has previously had overt hepatic encephalopathy and the requested medication will be used concomitantly with lactulose. Traveler's Diarrhea-approve if the patient is afebrile and does not have blood in the stool.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

xolair

Products Affected

- XOLAIR SUBCUTANEOUS RECON SOLN
- XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 75 MG/0.5 ML

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with an Interleukin (IL) Antagonist Monoclonal Antibody
Required Medical Information	Moderate to severe persistent asthma, baseline IgE level of at least 30 IU/mL. For asthma, patient has a baseline positive skin test or in vitro testing (ie, a blood test for allergen-specific IgE antibodies such as an enzyme-linked immunoabsorbant assay (eg, immunoCAP, ELISA) or the RAST) for 1 or more perennial aeroallergens (eg, house dust mite, animal dander [dog, cat], cockroach, feathers, mold spores) and/or for 1 or more seasonal aeroallergens (grass, pollen, weeds). CIU - must have urticaria for more than 6 weeks (prior to treatment with Xolair), with symptoms present more than 3 days/wk despite daily non-sedating H1-antihistamine therapy (e.g., cetirizine, desloratadine, fexofenadine, levocetirizine, loratadine).
Age Restrictions	Moderate to severe persistent asthma-6 years and older. CIU-12 years and older. Polyps-18 years and older
Prescriber Restrictions	Moderate to severe persistent asthma if prescribed by, or in consultation with an allergist, immunologist, or pulmonologist. CIU if prescribed by or in consultation with an allergist, immunologist, or dermatologist. Polyps-prescribed by or in consult with an allergist, immunologist, or otolaryngologist
Coverage Duration	asthma/CIU-Initial tx 4 months, Polyps-initial-6 months, continued tx 12 months

PA Criteria	Criteria Details
Other Criteria	Moderate to severe persistent asthma approve if pt meets criteria 1 and 2: 1) pt has received at least 3 months of combination therapy with an inhaled corticosteroid and at least one the following: long-acting beta-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist, or theophylline, and 2)patient's asthma is uncontrolled or was uncontrolled prior to receiving any Xolair or anti-IL-4/13 therapy (Dupixent) therapy as defined by ONE of the following (a, b, c, d, or e): a) The patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b) The patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year OR c) Patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d) Patient has an FEV1/forced vital capacity (FVC) less than 0.80 OR e) The patient's asthma worsens upon tapering of oral corticosteroid therapy NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-4/13 therapy (Dupixent) used concomitantly with an ICS. For continued Tx for asthma - patient has responded to therapy as determined by the prescribing physician and continues to receive therapy with one inhaled corticosteroid or inhaled corticosteroid containing combination product. For CIU cont tx - must have responded to therapy as determined by the prescribing physician. Nasal Polyps Initial-Approve if the patient has a baseline IgE level greater than or equal to 30 IU/ml, patient is experiencing significant rhinosinusitis symptoms such as nasal obstruction, rhinorrhea, or reduction/loss of smell and patient is currently receiving therapy with an intranasal corticosteroid. Nasal polyps continuation-approve if the patient continues to receive therapy with an intranasal corticosteroid and has responded to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XOSPATA

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, FLT3-mutation status
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	AML - approve if the patient has relapsed or refractory disease AND the disease is FLT3-mutation positive as detected by an approved test. Lymphoid, Myeloid Neoplasms-approve if the patient has eosinophilia and the disease is FLT3-mutation positive as detected by an approved test.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Lymphoid, Myeloid Neoplasms
Part B Prerequisite	No

XPOVIO

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years

PA Criteria	Criteria Details
Other Criteria	Multiple Myeloma-Approve if the patient meets the following (A and B): A) The medication will be taken in combination with dexamethasone AND B) Patient meets one of the following (i, ii, or iii): i. Patient has tried at least four prior regimens for multiple myeloma OR ii. Patient meets both of the following (a and b): a) Patient has tried at least one prior regimen for multiple myeloma AND b) The medication will be taken in combination with bortezomib OR iii. Patient meets both of the following (a and b): a) Patient has tried at least one prior regimen for multiple myeloma AND b) The medication will be taken in combination with Darzalex (daratumumb infusion), Darzlaex Faspro (daratumumab and hyaluronidase-fihj injection), or Pomalyst (pomalidomide capsules). Note: Examples of regimens for multiple myeloma include bortezomib/Revlimid (lenalidomide capsules)/dexamethasone, Kyprolis (carfilzomib infusion)/Revlimid/dexamethasone, Darzalex (daratumumab injection)/bortezomib or Kyprolis/dexamethasone, or other regimens containing a proteasome inhibitor, immunomodulatory drug, and/or anti-CD38 monoclonal antibody. Diffuse large B-cell lymphoma-approve if the patient has been treated with at least two prior systemic therapies.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Treatment of multiple myeloma in combination with daratumumb or pomalidomide
Part B Prerequisite	No

xtandi

Products Affected

- XTANDI ORAL CAPSULE
- XTANDI ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis for which Xtandi is being used.
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Prostate cancer-castration-resistant [Metastatic or Non-metastatic] and Prostate cancer-metastatic, castration sensitive-approve if Xtandi will be used concurrently with a gonadotropin-releasing hormone (GnRH) agonist or the medication is concurrently used with Firmagon or if the patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

xyrem

Products Affected

- *sodium oxybate*
- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with Xywav, Wakix or Sunosi
Required Medical Information	Medication history
Age Restrictions	7 years and older
Prescriber Restrictions	Prescribed by a sleep specialist physician or a Neurologist
Coverage Duration	12 months.
Other Criteria	For Excessive daytime sleepiness (EDS) in patients with narcolepsy, 18 years and older - approve if the patient has tried one CNS stimulant (e.g., methylphenidate, dextroamphetamine), modafinil, or armodafinil and narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT). For EDS in patients with narcolepsy, less than 18 years old-approve if the patient has tried one CNS stimulant (e.g., methylphenidate, dextramphetamine) or modafinil and narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT). Cataplexy treatment in patients with narcolepsy-approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZEJULA

Products Affected

- ZEJULA ORAL CAPSULE
- ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years and older
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Ovarian, fallopian tube, or primary peritoneal cancer, maintenance therapy - approve if the patient is in complete or partial response after platinum-based chemotherapy regimen. Uterine leiomyosarcoma-approve if the patient has BRCA2 mutation and has tried one systemic regimen.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Uterine Leiomyosarcoma
Part B Prerequisite	No

zelboraf

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BRAFV600 mutation status required.
Age Restrictions	All diagnoses (except CNS cancer)-18 years and older
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

PA Criteria	Criteria Details
Other Criteria	Melanoma, patient new to therapy must have BRAFV600 mutation for approval AND have unresctable, advanced or metastatic melanoma. HCL - must have tried at least one other systemic therapy for hairy cell leukemia OR is unable to tolerate purine analogs and Zelboraf will be used in combination with Gazyva (obinutuzumab intravenous infusion) as initial therapy. Thyroid Cancer-patient has disease that is refractory to radioactive iodine therapy. Erdheim-Chester disease, in patients with BRAF V600 mutation-approve. Central Nervous System Cancer-approve if the patient has BRAF V600 mutation-positive disease AND medication is being used for one of the following situations (i, ii, or iii): i. Adjuvant treatment of one of the following conditions (a, b, or c): a) Pilocytic astrocytoma OR b) Pleomorphic xanthoastrocytoma OR c) Ganglioglioma OR ii. Recurrent disease for one of the following conditions (a, b, or c): a) glioma OR b) Anaplastic glioma OR c) Glioblastoma OR iii. Melanoma with brain metastases AND the medication with be taken in combination with Cotellic (cobimetinib tablets). Histiocytic Neoplasm-approve if the patient has Langerhans cell histiocytosis and one of the following (i, ii, or iii): i. Multisystem disease OR ii. Pulmonary disease OR iii. Central nervous system lesions AND the patient has BRAF V600-mutation positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Patients with Hairy Cell Leukemia, Non-Small Cell Lung Cancer (NSCLC) with BRAF V600E Mutation, Differentiated thyroid carcinoma (i.e., papillary, follicular, or Hurthle cell) with BRAF-positive disease, Central Nervous System Cancer, Histiocytic Neoplasm
Part B Prerequisite	No

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 years
Other Criteria	Cutaneous T-Cell Lymphoma including Mycosis Fungoides/Sezary Syndrome-approve.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZTALMY

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis
Age Restrictions	2 years and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1 year
Other Criteria	Seizures associated with cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder-approve if the patient has a molecularly confirmed pathogenic or likely pathogenic mutation in the CDKL5 gene.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

zydelig

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	small lymphocytic lymphoma
Part B Prerequisite	No

zykadia

Products Affected

- ZYKADIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have metastatic NSCLC that is anaplastic lymphoma kinase (ALK)-positive as detected by an approved test or ROS1 Rearrangement. IMT - ALK Translocation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.
Other Criteria	Erdheim-Chester Disease-approve if the patient has anaplastic lymphoma kinase (ALK) rearrangement/fusion-positive disease.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Soft Tissue Sarcoma Inflammatory Myofibroblastic Tumor (IMT) with ALK Translocation. Patients with NSCLC with ROS1 Rearrangement. Erdheim-Chester disease.
Part B Prerequisite	No

Zytiga

Products Affected

- *abiraterone oral tablet 250 mg, 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorization will be for 3 years.

PA Criteria	Criteria Details
Other Criteria	Prostate Cancer-Metastatic, Castration-Resistant (mCRPC)-Approve if abiraterone is being used in combination with prednisone or dexamethasone and the medication is concurrently used with a gonadotropin-releasing hormone (GnRH) agonist, or the medication is concurrently used with Firmagon or the patient has had a bilateral orchiectomy. Prostate cancer-metastatic, castration-sensitive (mCSPC)-approve if the medication is used in combination with prednisone and the medication is concurrently used with a GnRH agonist or concurrently used with Firmagon or the patient has had a bilateral orchiectomy. Prostate Cancer - Regional Risk Group - Approve if the patient meets all of the following criteria (A, B, and C): A)abiraterone is used in combination with prednisone AND B) Patient has regional lymph node metastases and no distant metastases AND C) Patient meets one of the following criteria (i, ii or iii): i.abiraterone with prednisone is used in combination with GnRH agonist OR ii. Patient has had a bilateral orchiectomy OR iii. the medication is used in combination with Firmagon. Prostate cancer-very-high-risk-group-approve if according to the prescriber the patient is in the very-high-risk group, the medication will be used in combination with external beam radiation therapy and the patient meets one of the following criteria (i, ii or iii): i. abiraterone is used in combination with GnRH agonist OR ii. Patient has had a bilateral orchiectomy OR iii. the medication is used in combination with Firmagon. Prostate cancer-radical prostatectomy-approve if the medication is used in combination with prednisone, the patient has prostate specific antigen (PSA) persistence or recurrence following radical prostatectomy, patient has pelvic recurrence, the medication will be used concurrently with GnRH agonist, Firmagon or the patient has had a bilateral orchiectomy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Prostate Cancer-Regional Risk Group, Prostate cancer-very-high-risk group, Prostate cancer-radical prostatectomy
Part B Prerequisite	No

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