

**2022**

**Prior Authorization Criteria**

**For**

**Grandfathered Commercial Plans**

# abaloteriparatide (Tymlos)

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## Products Affected

- Tymlos

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Patient is diagnosed with osteoporosis with a BMD less than -2.5. Patient fails treatment with IV bisphosphonate and denosumab. For Patients with Calculated GFR or CRcl < 60ml/min Referral must include recent iPTH. Vitamin D (25 OH, 1,25 OH) labs. Must be within normal limits. |
| <b>Exclusion Criteria</b>           | Children, adolescents, Pagets patients with Pagets disease or hypercalcemia, or patients with a history of primary or metastatic bone cancer.   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Tymlos is indicated to treat osteoporosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. Limitations of treatment - 2 years of treatment.   |

## abiraterone (Zytiga)

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### Products Affected

- Abiraterone Acetate Oral Tablet 250 MG

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | FDA approved indications  |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             | Ages approved in FDA labeling/compendia   |
| Prescriber Restrictions      |   |
| Coverage Duration            | Up to 12 months or until disease progression or toxicity  |
| Other Criteria               | Abiraterone is indicated to treat metastatic prostate cancer. It is taken orally along with prednisone daily. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

# adalimumab (Humira)

## Products Affected

- Humira Pediatric Crohns Start Subcutaneous Prefilled Syringe Kit 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
- Humira Pen Subcutaneous Pen-Injector Kit 40 MG/0.4ML, 40 MG/0.8ML
- Humira Pen-CD/UC/HS Starter
- Humira Pen-Ps/UV/Adol HS Start Subcutaneous Pen-Injector Kit 40 MG/0.8ML
- Humira Pen-Psor/Uveit Starter
- Humira Subcutaneous Prefilled Syringe Kit

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | Must be written by Rheumatology, Dermatology or Specialist trained in management of prescribed condition. Dosing for indication is the FDA approved dose, off label dosing for an indication is not covered. In Commercial and ACA plans- Patient must fail Enbrel, Simponi, Kevzara, and Renflexis in areas of overlapping indication (RA, PSA,PP, UC,AS), for IBD Disease must fail Renflexis, Entyvio, Simponi/Simponi ARIA, Azathioprine, and 6 Mercaptopurine. For hidradenitis suppurativa must have moderate to severe disease and have failed recent trial 8 to 12 week trial in past month of oral clindamycin and rifampin or doxycycline/Minocycline , Infliximab, AND oral retinoid (acitretin or isotretinoin) unless contraindicated in the past 6 months. For Uveitis patient must fail 8-12 week trial of methotrexate |
| <b>Exclusion Criteria</b>           | Off label dosing for an indication is not covered.   |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Must be written by Rheumatology, Dermatology or Specialist trained in management of prescribed condition.  |
| <b>Coverage Duration</b>            | Up to 12 months  |
| <b>Other Criteria</b>               | Humira is indicated for the treatment of confirmed rheumatoid arthritis (RA), plaque psoriasis (PP), Psoriatic Arthritis (PSA) Crohns disease (CD), ulcerative colitis (UC) Humira, Hydradenitis suppurativa, uveitis. This is non-preferred for ACA and Exchange. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.   |

## afatinib (Gilotrif)

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### Products Affected

- Gilotrif

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Patient must have NSCLC mutations consistent with FDA label. Test for T790M mutation if previously on a TKI inhibitor   |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> | Medical notes, previous treatment history and associated studies, including test for T790M mutation if previously on a TKI inhibitor  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Prescribing restricted to oncology.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Gilotrif is an oral tyrosine kinase inhibitor indicated to treat NCSLC with the genetic tumor markers of exon 19 deletion and exon 21 substitution. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## alectinib (Alecensa)

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### Products Affected

- Alecensa

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater   |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Prescriber must be an oncologist  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Alecensa is indicated to treat patients with ALK+ metastatic Non-Small cell lung cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician |

## alitretinoin (Panretin)

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### Products Affected

- Panretin

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications. Failure of vinblastine.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      |  |
| Coverage Duration            | 12 months  |
| Other Criteria               | Panretin is a retinoid indicated for Kaposi sarcoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## ambrisentan (Letairis)

### Products Affected

- Ambrisentan

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Pulmonary hypertension must be diagnosed by heart catheterization. Patient must have failed or have contraindication to sildenafil. Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral. Approved referrals will initially provide coverage for 12 weeks. Continuation of coverage will be determined by an improvement of an objective test of exercise (6 minute walk) from baseline. Follow-up documentation must be submitted for continuation of coverage. Patients who have had an initial positive response based the 12 week follow-up will be approved for an additional 6 months, and re-evaluation with documentation will be required every 6 months for continuation of coverage. |
| <b>Exclusion Criteria</b>           | This medication is contraindicated in pregnancy, those of childbearing ability who are not using contraception.  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | Initial approval for 12 weeks. See "Covered Use" for continuation of coverage details.   |
| <b>Other Criteria</b>               | Letairis is an endothelin receptor antagonist used to treat WHO group 1 pulmonary arterial hypertension. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.   |

## anakinra (Kineret)

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### Products Affected

- Kineret Subcutaneous Solution Prefilled Syringe

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications. Patient must fail two anti-TNF biologics and Xeljanz.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      |  |
| Coverage Duration            | Up to 12 months  |
| Other Criteria               | Kineret is a biologic agent indicated for treatment of rheumatoid arthritis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## aprepitant (Emend)

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### Products Affected

- Aprepitant Oral Capsule
- **Emend Oral Suspension Reconstituted**

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Patient must have failed Zofran. A pre-packaged three-day course of this medication will be approved per each co-pay incidental to a chemotherapy treatment cycle.   |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Medication will be approved through referrals when written by Oncology   |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Emend is used as part of a three day regimen for chemotherapy induced nausea and vomiting (CINV) of moderate to highly emetogenic Chemotherapy treatments, and Post-Operative Nausea and Vomiting. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## aripiprazole (Abilify)

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### Products Affected

- **Abilify Maintena Intramuscular Prefilled Syringe**

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Failure of oral aripiprazole.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Approved when written/ordered by a Psychiatrist or Neurologist through referrals for new starts.                                       |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Aripiprazole is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. |

## axitinib (Inlyta)

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### Products Affected

- Inlyta

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Inlyta is an oral tyrosine kinase inhibitor indicated for advanced renal cell carcinoma.                      |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Prescribing restricted to oncology.   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

# Benefix

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## Products Affected

- **Benefix Intravenous Kit**

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Approval will be based on Diagnosis of Hemophilia B and history of Bleeding or joint effusions OR perioperative prophylaxis |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               |   |

# bosentan (Tracleer)

## Products Affected

- Bosentan

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Pulmonary hypertension must be diagnosed by heart catheterization. Patient must have failed or have contraindication to sildenafil, ambrisentan, and tadalafil. Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral. Approved referrals will initially provide coverage for 12 weeks. Continuation of coverage will be determined by an improvement of an objective test of exercise (6 minute walk) from baseline. Follow-up documentation must be submitted for continuation of coverage. Patients who have had an initial positive response based the 12 week follow-up will be approved for an additional 6 months, and re-evaluation with documentation will be required every 6 months for continuation of coverage. |
| <b>Exclusion Criteria</b>           | This medication is contraindicated in pregnancy, those of childbearing ability who are not using contraception, those on glyburide or cyclosporine and in those with active liver disease.   |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | Initial approval for 12 weeks. See "Covered Use" for continuation of coverage details.   |
| <b>Other Criteria</b>               | Tracleer is indicated for the treatment of Primary pulmonary arterial hypertension or pulmonary hypertension related to connective tissue disease. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.   |

## bosutinib (Bosulif)

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### Products Affected

- Bosulif

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. AND Failure of imatinib.                          |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Restricted to hematology/oncology  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Bosulif is indicated for treatment of Ph+ CML after failure of a first line tyrosine kinase inhibitor. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. |

## budesonide oral product (Entocort)

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### Products Affected

- Budesonide Oral

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Entocort is an oral steroid capsule that has low bioavailability. Entocort is indicated for mild to moderately active Crohns disease involving the ileum and/or the ascending colon and the maintenance of clinical remission in mild-to moderate Crohns disease involving the ileum and/or the ascending colon for up to 3 months. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Written by a gastroenterologist.  |
| <b>Coverage Duration</b>            | Approved referrals will be for a maximum of 6 months.   |
| <b>Other Criteria</b>               | Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.   |

## C1 esterase inhibitor (Berinert)

### Products Affected

- Berinert

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D.   |
| <b>Exclusion Criteria</b>           | Must not be taking medications that can exacerbate the frequency and/or severity of hereditary angioedema(HAE) attacks including estrogens and ACE inhibitors.   |
| <b>Required Medical Information</b> | Must have C1INH deficiency demonstrated by labs (C1INH and C4 labs)  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      | Must be prescribed by an immunologist, allergist or hematologist   |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | BERINERT is a plasma-derived C1 Esterase Inhibitor (Human) indicated for the treatment of acute abdominal, facial, or laryngeal hereditary angioedema (HAE) attacks in adult and pediatric patients. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## cabozantinib (Cometriq)

### Products Affected

- **Cometriq (100 MG Daily Dose) Oral Kit 80 & 20 MG**
- **Cometriq (140 MG Daily Dose) Oral Kit 3 x 20 MG & 80 MG**
- **Cometriq (60 MG Daily Dose)**

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications.  |
| <b>Exclusion Criteria</b>           | Combination use with other tyrosine kinase inhibitors is excluded.   |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Prescriber must be a Hematologist/Oncologist.  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Cometriq is indicated for treatment of metastatic medullary thyroid cancer Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## ceritinib (Zykadia)

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### Products Affected

- Zykadia Oral Tablet

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Must have progressed on Xalkori.  |
| <b>Exclusion Criteria</b>           | Not covered in combination with other tyrosine kinase inhibitors or EGRf inhibitors.  |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Must be written by oncologist.  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Zykadia is a TKI inhibitor indicated for metastatic NSCLC which is ALK (anaplastic lymphoma kinase) positive, it is indicated for patients who have failed/progressed on crizotinib (Xalkori) Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## cinacalcet hydrochloride (Sensipar)

### Products Affected

- Cinacalcet HCl

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Patient is identified as having hypercalcemia associated with parathyroid carcinoma OR Patient is identified as having hyperparathyroidism secondary ESRD in patient with elevated PTH. Patient must have failed phosphate binders and active Vitamin-D therapy, iPTH must be >300 in dialysis patients. This information is sent to the Referrals Department. |
| <b>Exclusion Criteria</b>           | Not for use in children, pregnancy, seizure disorder.  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | This medication must be prescribed by Nephrology or Endocrinology or Oncology  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Sensipar is indicated to treat hyperparathyroidism that is secondary to renal insufficiency or hypercalcemia secondary to parathyroid carcinoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.   |

## clobazam (Onfi)

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### Products Affected

- Clobazam

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Failure of levetiracetam, topiramate ,and clonazepam.   |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Approved when written/ordered by a Neurologist through referrals for new starts.  |
| <b>Coverage Duration</b>            | 12 Months   |
| <b>Other Criteria</b>               | Onfi is a benzodiazepine indicated to treat seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## cobimetinib (Cotellic)

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### Products Affected

- Cotellic

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Must be prescribed by Oncologist. Must be used in combination with Zelboraf. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Must be prescribed by Oncologist.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Cotellic is indicated for treatment of BRAF+ metastatic or unresectable melanoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.                               |

## crizotinib (Xalkori)

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### Products Affected

- Xalkori

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications.  |
| <b>Exclusion Criteria</b>           | Not covered in combination with other tyrosine kinase inhibitors or EGRF inhibitors.   |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Must be written by oncologist.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Xalkori is a TKI inhibitor for metastatic NSCLC which is ALK (anaplastic lymphoma kinase) positive, or ROS positive. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## dabrafenib (Tafinlar)

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### Products Affected

- Tafinlar

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Patient must have BRAF V600E/K mutation  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Must be written by an oncologist.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Tafinlar is a BRAF inhibitor indicated to treat BRAF+ V600e/k mutation Stage IIIc-IV metastatic Melanoma and NSCLC. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## dalfampridine (Ampyra)

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### Products Affected

- Dalfampridine ER

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | Diagnosis of multiple sclerosis AND patient is ambulatory (able to walk at least 25 feet) AND patient has walking impairment. For renewal, walking speed has improved from baseline (based on 25 foot timed walk).AND currently using a disease modifying agent. |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | Initial - 3 months. Renewal - 12 months.   |
| <b>Other Criteria</b>               | Ampyra is indicated to treat patients with multiple sclerosis who have walking disability. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.   |

## dasatinib (Sprycel)

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### Products Affected

- Sprycel

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications AND failure of imatinib.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      |  |
| Coverage Duration            | Up to 12 months or until disease progression or toxicity   |
| Other Criteria               | Sprycel is an oral antineoplastic agent used to treat Philadelphia Chromosome + CML and PH+ ALL. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## deferasirox (Exjade)

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### Products Affected

- Deferasirox Oral Tablet Soluble

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications Patient has failed or is intolerant to Deferoxamine.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Exjade is an oral medication used to treat iron overload typically in patients receiving chronic RBC transfusions. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## degarelix (Firmagon)

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### Products Affected

- Firmagon

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications. Limited to two per month.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      | Written by oncology or urology   |
| Coverage Duration            | 12 months  |
| Other Criteria               | Firmagon is indicated to treat advanced prostate cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## denosumab (Prolia)

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### Products Affected

- **Prolia Subcutaneous Solution Prefilled Syringe**

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications Intolerance or contraindication to injectable bisphosphonate required for coverage of Prolia.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Prolia is a RANK-L ligand antagonist indicated for treatment of osteoporosis and prevention of osteoporosis for patients taking aromatase inhibitors. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## dextromethorphan / quinidine (Nuedexta)

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### Products Affected

- Nuedexta

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | FDA approved indications.   |
| Exclusion Criteria           | Not covered for off-label use   |
| Required Medical Information |   |
| Age Restrictions             | Ages approved in FDA labeling/compendia   |
| Prescriber Restrictions      | Prescriber must be a neurologist.   |
| Coverage Duration            | Up to 12 months   |
| Other Criteria               | Nuedexta is indicated to treat pseudobulbar affect. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## diclofenac Sodium (Solaraze)

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### Products Affected

- Diclofenac Sodium Transdermal Gel 3 %

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | Diagnosis of actinic keratosis.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      | Prescribed by a dermatologist.   |
| Coverage Duration            | 12 months  |
| Other Criteria               | This medication is a topical NSAID indicated for treatment of Actinic Keratosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## dimethyl fumarate (Tecfidera)

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### Products Affected

- Dimethyl Fumarate Oral
- Dimethyl Fumarate Starter Pack

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D. All FDA-approved indications   |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      | Neurology   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Dimethyl fumarate is an oral CMT (disease modifying treatment) indicated to treat relapsing remitting multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## dornase alfa (Pulmozyme)

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### Products Affected

- Pulmozyme Inhalation Solution 1 MG/ML

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Patient must have an FVC $\geq$ 40% of predicted value and recurrent pulmonary infections.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Must be written by a pulmonologist.   |
| <b>Coverage Duration</b>            | Up to 12 months   |
| <b>Other Criteria</b>               | Pulmozyme is indicated to reduce pulmonary exacerbation in patients with cystic fibrosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## dronedarone (Multaq)

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### Products Affected

- Multaq

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Must have previously failed or have contraindication to both sotalol and amiodarone.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Multaq is indicated for treatment of atrial fibrillation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## elagolix (Orilissa)

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### Products Affected

- Orilissa

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D. Orilissa is indicated for moderate to severe pain due to endometriosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. Criteria for coverage as follows: FDA approved indications. Failure of an NSAID and oral contraceptive/progestin for endometriosis. |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      | OB/GYN   |
| <b>Coverage Duration</b>            | 6 months   |
| <b>Other Criteria</b>               |  |

## elagolix/estra/noreth (Oraihnn)

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### Products Affected

- Oraihnn

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D. Oraihnn is indicated for treatment of heavy menstrual bleeding due to uterine fibroids. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. Criteria for coverage as follows: FDA approved indications. Failure of an NSAID and oral contraceptive/progestin for endometriosis. |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      | OB/GYN   |
| <b>Coverage Duration</b>            | 24 months  |
| <b>Other Criteria</b>               |  |

## eltrombopag (Promacta)

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### Products Affected

- Promacta Oral Packet 12.5 MG
- Promacta Oral Tablet

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Patient must have chronic ITP and bleed risk, with platelet count less than 30,000, and refractory to IVIG, corticosteroids or splenectomy.                             |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | Up to 12 months   |
| <b>Other Criteria</b>               | Promacta is indicated to treat ITP and thrombocytopenia secondary to HCV treatment. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## enasidenib (Idhifa)

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### Products Affected

- Idhifa

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Prescriber must be a Hematologist/Oncologist  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Idhifa is indicated for treatment of relapsed or refractory AML in patients with an IDH2 mutation as detected by an approved test Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## entrectinib (Rozlytrek)

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### Products Affected

- Rozlytrek

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | All FDA-approved indications not otherwise excluded from Part D.  |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             |   |
| Prescriber Restrictions      |   |
| Coverage Duration            | 12 months   |
| Other Criteria               | Rozlytrek is a kinase inhibitor indicated for solid tumors with NTRK-Fusions and ROS-1 mutated Non-Small Cell lung cancer. Medical history, studies, and appropriate confirmatory tests are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## enzalutamide (Xtandi)

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### Products Affected

- Xtandi Oral Capsule

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Coverage will be based on failure of Abiraterone for overlapping indications.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Must be prescribed by oncologist or urologist.   |
| <b>Coverage Duration</b>            | Covered for 6 months and continuation based on lack of disease progression.  |
| <b>Other Criteria</b>               | Xtandi is an androgen receptor blocker used for Castrate Resistant Prostate Cancer pre- and post-chemotherapy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## epoetin alpha-epbx (Retacrit)

### Products Affected

- Retacrit Injection Solution 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D. Pharmacy coverage criteria as follows: FDA approved indications. Patient must have adequate iron stores (ferritin greater than or equal to 100 ng/ml, transferrin saturation greater than 20%). Hemoglobin for initiation and maintenance must be compliant with current FDA labeling. |
| <b>Exclusion Criteria</b>           | ESAs are not indicated for patients receiving myelosuppressive therapy when the anticipated outcome is cure.  |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 6 months  |
| <b>Other Criteria</b>               | ESAs are used to treat anemia related to Chronic Kidney Disease, Chemotherapy, Myelodysplastic Syndrome, Antiviral therapy. Prior authorization is required for pharmacy coverage of medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy.  |

## erenumab (Aimovig)

### Products Affected

- Aimovig

| PA Criteria         | Criteria Details   |
|---------------------|--|
| <b>Covered Uses</b> | <p>Aimovig is a anti-CGRP antibody indicated for prophylaxis of Episodic and Chronic Migraines</p> <p><b>Episodic Migraines</b></p> <p>Aimovig will be approved based upon all of the following criteria:</p> <ol style="list-style-type: none"> <li>(1) Diagnosis of episodic migraines with both of the following: <ol style="list-style-type: none"> <li>(a) Less than 15 headache days per month</li> <li>(b) Patient has 4 to 14 migraine days per month-AND-</li> </ol> </li> <li>(2) Recent trial and failure (trial of at least three months) of two generic medications FDA indicated for migraine prophylaxis (topiramate/divalproex). If either or both are contraindicated or not tolerated the medications below could be used: <ol style="list-style-type: none"> <li>(a) Amitriptyline</li> <li>(b) atenolol, metoprolol, nadolol, propranolol, or timolol</li> <li>(e) Venlafaxine (Effexor/Effexor XR)</li> </ol> </li> <li>(3) Medication will not be used in combination with an oral CGRP antagonist or inhibitor</li> </ol> <p>Authorization will be issued for 6 months.</p> <p><b>2. Reauthorization</b></p> <p>Aimovig will be approved based on all of the following criteria:</p> <ol style="list-style-type: none"> <li>(1) Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity-AND-</li> <li>(2) Medication will not be used in combination with an oral CGRP Antagonist.</li> </ol> <p>Authorization will be issued for 12 months.</p> <p><b>B. Chronic Migraines</b></p> <p><b>1. Initial Therapy</b></p> <p>Aimovig will be approved based upon all of the following criteria:</p> <ol style="list-style-type: none"> <li>(1) Diagnosis of chronic migraines with both of the following: <ol style="list-style-type: none"> <li>(a) Greater than or equal to 15 headache days per month continued.</li> <li>(b) Greater than or equal to 8 migraine days per month-AND-</li> </ol> </li> <li>(2) Recent trial and failure (trial of at least three months) of two generic medications FDA indicated for migraine prophylaxis (topiramate/divalproex). If either or both are contraindicated or not tolerated the medications below could be used: <ol style="list-style-type: none"> <li>(a) Amitriptyline</li> <li>(b) atenolol, metoprolol, nadolol, propranolol, or timolol</li> <li>(e) Venlafaxine (Effexor/Effexor XR)</li> </ol> </li> <li>(3) Medication will not be used in combination with an oral CGRP antagonist</li> </ol> <p>Authorization will be issued for 6 months.</p> <p><b>2. Reauthorization</b></p> <p>Aimovig will be approved based on all of the following criteria:</p> <ol style="list-style-type: none"> <li>(1) Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity-AND-</li> <li>(2) Medication will not be used in combination with an oral CGRP Antagonist.</li> </ol> <p>Authorization will be issued for 12 months.</p> |

| PA Criteria                  | Criteria Details |
|------------------------------|------------------|
| Exclusion Criteria           |                  |
| Required Medical Information |                  |
| Age Restrictions             |                  |
| Prescriber Restrictions      |                  |
| Coverage Duration            | 6 to 12 months   |
| Other Criteria               |                  |

## erlotinib (Tarceva)

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### Products Affected

- Erlotinib HCl

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Tarceva is indicated to treat patients with metastatic non-small cell lung cancer who possess an EGFR mutation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## eslicarbazepine (Aptiom)

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### Products Affected

- Aptiom

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Failure of Oxcarbazepine and carbamazepine.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Must be written by neurology for adjunctive treatment of seizures.   |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Aptiom is an anti-convulsant indicated for adjunctive treatment of partial seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. |

## estrogens, esterified (USP) (Menest)

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### Products Affected

- **Menest Oral Tablet 0.3 MG, 0.625 MG, 1.25 MG**

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Used for palliative treatment of breast cancer.   |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Must be written by an oncologist.   |
| <b>Coverage Duration</b>            | Up to 12 months   |
| <b>Other Criteria</b>               | Menest is only covered for palliative treatment of breast cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

# etanercept (Enbrel)

## Products Affected

- Enbrel Mini
- Enbrel Subcutaneous Solution 25 MG/0.5ML
- Enbrel Subcutaneous Solution Prefilled Syringe
- Enbrel Subcutaneous Solution Reconstituted
- Enbrel SureClick Subcutaneous Solution Auto-Injector

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | Indicated for RA, JRA, PSA, and Plaque Psoriasis. See "Guidelines for Enbrel" form.  |
| <b>Exclusion Criteria</b>           | FDA labeled contraindications  |
| <b>Required Medical Information</b> | Medical notes, previous treatment history and associated studies   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Rheumatology, Dermatology or Specialist trained in management of prescribed condition  |
| <b>Coverage Duration</b>            | Up to 12 months  |
| <b>Other Criteria</b>               | For RA, patient must fail adequate trial of MTX in combination with a DMARD. If MTX is contraindicated, must try combination of 2-nonbiologic DMARDS (3month trial in past 6 months). For Ankylosing Spondylitis, patient must fail MTX (3 month trial in past 6 months) or sulfasalazine and 2 NSAIDS within past 6 months. For Plaque Psoriasis, patient must fail MTX or Soriatane (3 month trial in past 6 months) and topical therapy. For Psoriatic Arthritis, patient must fail adequate trial of MTX or LEF (3month trial in past 6 months). |

## everolimus (Afinitor)

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### Products Affected

- Everolimus Oral Tablet 2.5 MG, 5 MG, 7.5 MG

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Afinitor is an oral tyrosine kinase inhibitor indicated to treat several malignancies.                        |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Prescribing restricted to oncology.   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## everolimus (Zortress)

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### Products Affected

- Everolimus Oral Tablet 0.25 MG, 0.5 MG, 0.75 MG, 1 MG

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Patient must have failure or intolerance to a calcineurin inhibitor.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Prescriber must be a transplant specialist.   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Zortress is an immunosuppressive anti-rejection agent for solid organ transplant. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## fentanyl citrate lozenge (Actiq)

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### Products Affected

- FentaNYL Citrate Buccal Lozenge On A Handle

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | All FDA-approved indications not otherwise excluded from Part D. Fentanyl citrate lozenges approved after failure of hydromorphone IR and morphine IR and oxycodone IR                                  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Approved when written/ordered by an Oncologist or Pain Management through referrals.  |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Fentanyl Citrate Lozenge is a short acting opioid indicated for cancer breakthrough pain. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## fentanyl transdermal product (Duragesic)

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### 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  |
|------------------------------|---|
| Covered Uses                 | FDA approved indications.   |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             | Ages approved in FDA labeling/compendia   |
| Prescriber Restrictions      | Approved when written/ordered by an Oncologist or Pain Management through referrals.  |
| Coverage Duration            | 12 months   |
| Other Criteria               | Fentanyl patch is a long acting opioid analgesic indicated for moderate to severe chronic pain. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## fingolimod (Gilenya)

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### Products Affected

- Fingolimod HCl

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Covered for patients who have failed a trial of glatiramer and Dimethyl Fumerate  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Must be written by a neurologist  |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Gilenya is an oral medication indicated for treatment of relapsing remitting multiple sclerosis Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## galcanezumab (Emgality)

### Products Affected

- Emgality
- Emgality (300 MG Dose)

| PA Criteria         | Criteria Details  |
|---------------------|---|
| <b>Covered Uses</b> | <p>All FDA-approved indications not otherwise excluded from Part D.</p> <p>Emgality is an anti-CGRP antibody indicated for prophylaxis of Episodic and Chronic Migraines, and Cluster Headaches.</p> <p><b>Episodic Migraines</b></p> <p>Emgality 120 mg will be approved based upon all of the following criteria:</p> <p>(1) Diagnosis of episodic migraines with both of the following:</p> <p>(a) Less than 15 headache days per month</p> <p>(b) Patient has 4 to 14 migraine days per month-AND-</p> <p>(2) Recent trial and failure (trial of at least three months) of two generic medications FDA indicated for migraine prophylaxis (topiramate/divalproex). If either or both are contraindicated or not tolerated the medications below could be used:</p> <p>(a) Amitriptyline (b) atenolol, metoprolol, nadolol, propranolol, or timolol (e) Venlafaxine (Effexor/Effexor XR)-AND-</p> <p>(3) Medication will not be used in combination with an oral CGRP antagonist or inhibitor.</p> <p>Authorization will be issued for 6 months.</p> <p><b>B. Chronic Migraines</b></p> <p>1. Initial Therapy</p> <p>Emgality 120 mg will be approved based upon all of the following criteria:</p> <p>(1) Diagnosis of chronic migraines with both of the following:</p> <p>(a) Greater than or equal to 15 headache days per month</p> <p>Continued. (b) Greater than or equal to 8 migraine days per month-AND-</p> <p>Recent trial and failure (trial of at least three months) of two generic medications FDA indicated for migraine prophylaxis (topiramate/divalproex). If either or both are contraindicated or not tolerated the medications below could be used:</p> <p>(a) Amitriptyline (b) atenolol, metoprolol, nadolol, propranolol, or timolol (e) Venlafaxine (Effexor/Effexor XR)-AND-</p> <p>(3) Medication will not be used in combination with an oral CGRP antagonist.</p> <p>Authorization will be issued for 6 months.</p> <p><b>C. Episodic Cluster Headache</b></p> <p>1. Initial Therapy</p> <p>Emgality 100 mg will be approved based upon all of the following criteria:</p> <p>(1) Diagnosis of episodic cluster headache-AND-</p> <p>(2) Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months.-AND-</p> <p>(3) Medication will not be used in combination with an oral CGRP antagonist.</p> <p>Authorization will be issued for 6 months.</p> |

| PA Criteria                  | Criteria Details            |
|------------------------------|-----------------------------|
| Exclusion Criteria           |                             |
| Required Medical Information |                             |
| Age Restrictions             |                             |
| Prescriber Restrictions      | consultation with NEUROLOGY |
| Coverage Duration            | See covered uses            |
| Other Criteria               |                             |

## gefitinib (Iressa)

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### Products Affected

- Iressa

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. T790 mutation testing when indicated i.e. previously treated with a TKI inhibitor           |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Must be prescribed by Oncologist   |
| <b>Coverage Duration</b>            | 12 Months  |
| <b>Other Criteria</b>               | Iressa is indicated to treat non-small cell lung cancer with EGFR mutation exon 19 deletion or Exon 21 substitution mutations. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## glucagon (Baqsimi) nasal powder

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### Products Affected

- Baqsimi One Pack

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | All FDA-approved indications not otherwise excluded from Part D.  |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             |   |
| Prescriber Restrictions      | Ordered by an endocrinologist.  |
| Coverage Duration            | 12 months   |
| Other Criteria               | Baqsimi is indicated for severe hypoglycemia where patient is unable to eat, drink or follow commands. Baqsimi is intranasal but does not need to be inhaled, patient does not need to be conscious for Baqsimi to be administered. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. Limit of 1 device per dispensing, two per year. |

## golimumab (Simponi)

### Products Affected

- **Simponi Subcutaneous Solution Auto-Injector**
- **Simponi Subcutaneous Solution Prefilled Syringe**

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | For use in RA must be written by rheumatology, fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2-nonbiologic DMARDS (3month trial in past 6 months).For use in Ankylosing Spondylitis PT must fail MTX or sulfasalazine and 2 NSAIDS within past 6 months.For Psoriatic Arthritis must fail adequate trial of MTX or LEF in past 6 months.For with ulcerative colitis must be written by a gastroenterologist and had recent failure of an immunosuppressant (Azathioprine, 6-mp or Methotrexate) and an anti-inflammatory (5-asa, sulfasalazine, balsalazide, mesalamine) |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | For use in RA Simponi must be written by rheumatology. For Simponi coverage in ulcerative colitis must be written by a gastroenterologist.  |
| <b>Coverage Duration</b>            | Up to 12 months   |
| <b>Other Criteria</b>               | Simponi is a TNF antagonist indicated for Moderate to severe rheumatoid arthritis, ankylosing spondylitis, active psoriatic arthritis, moderate to severe ulcerative colitis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.   |

# Hepatitis C Direct Acting Antivirals (DAA)

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## Products Affected

- Mavyret Oral Tablet
- Zepatier

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Mavyret is the preferred DAA for all genotypes, other DAAs will be covered on a case by case basis if Mavyret use is not supported by current FDA indication or HCV guidelines based on patient specific characteristics.                       |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Gastroenterologist or Infectious Disease  |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Mavyret is the exclusive and preferred DAA for treatment of HCV in chronically infected non-cirrhotic and compensated cirrhotic patients for genotypes 1-6. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

# Humulin U-500

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## Products Affected

- **Humulin R U-500 (Concentrated)**
- **Humulin R U-500 KwikPen Subcutaneous Solution Pen-Injector**

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Initiation restricted to endocrinology. Insulin requirements of >200 units/day.   |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Initiation restricted to endocrinology.   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Humulin U 500 is used to treat insulin resistant diabetes mellitus. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## ibrutinib (Imbruvica)

### Products Affected

- Imbruvica Oral Capsule
- Imbruvica Oral Tablet 420 MG, 560 MG

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. NCCN supported use with evidence rating 2a or greater.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Must be prescribed by Hematologist/oncologist.  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Imbruvica is a BTK inhibitor used to treat B cell lymphomas. It is indicated for relapsed waldenstroms macroglobinemia, refractory chronic lymphocytic leukemia and Mantle Cell Lymphoma, and first line CLL. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## ibrutiniv (Imbruvica Sln)

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### Products Affected

- Imbruvica Oral Suspension

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | All FDA-approved indications not otherwise excluded from Part D. |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             |  |
| Prescriber Restrictions      | Hematology/ Oncology/ Transplant Specialist                      |
| Coverage Duration            | 12 months  |
| Other Criteria               | Unable to swallow or use a tablet or capsule                     |

## idelalisib (Zydelig)

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### Products Affected

- Zydelig

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      | Must be written by oncologist.   |
| Coverage Duration            | Up to 12 months or until disease progression or toxicity   |
| Other Criteria               | Zydelig is a PI3K kinase inhibitor for treatment of relapsed Chronic lymphocytic leukemia, relapsed follicular lymphoma, and small lymphocytic lymphoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## iloperidone (Fanapt)

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### Products Affected

- Fanapt
- Fanapt Titration Pack

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications. Failure of aripiprazole, risperidone.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      | Approved when written/ordered by a Psychiatrist or Neurologist through referrals for new start.  |
| Coverage Duration            | 12 months  |
| Other Criteria               | Fanapt is indicated to treat schizophrenia. Prior authorization only applies to existing members who are new starts on the drug. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## incobotulinumtoxinA (Xeomin)

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### Products Affected

- Xeomin

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FHCP covers this medication only for medically necessary purposes, like cervical dystonia, not responsive to physical therapy, blepharospasm that interferes significantly with vision, and headache not responsive to preventive and acute therapy by Neurology for at least 16 weeks. |
| <b>Exclusion Criteria</b>           | FDA labeled contraindications OR cosmetic conditions  |
| <b>Required Medical Information</b> | Medical notes, previous treatment history and associated studies  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               |   |

## interferon beta-1a (Avonex)

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### Products Affected

- **Avonex Pen Intramuscular Auto-Injector Kit**
- **Avonex Prefilled Intramuscular Prefilled Syringe Kit**

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | Failure of glatiramer and Dimethyl Fumerate for new starts.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Avonex is an interferon indicated to treat multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## interferon beta-1a (Rebif)

### Products Affected

- **Rebif Rebidose Subcutaneous Solution Auto-Injector**
- **Rebif Rebidose Titration Pack Subcutaneous Solution Auto-Injector**
- **Rebif Subcutaneous Solution Prefilled Syringe**
- **Rebif Titration Pack Subcutaneous Solution Prefilled Syringe**

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Failure of glatiramer and Dimethyl Fumerate for new starts.   |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Rebif is an interferon indicated to treat multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## interferon beta-1b (Betaseron)

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### Products Affected

- Betaseron Subcutaneous Kit

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | Failure of glatiramer for new starts.   |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             | Ages approved in FDA labeling/compendia   |
| Prescriber Restrictions      |   |
| Coverage Duration            | 12 months   |
| Other Criteria               | Betaseron is an interferon indicated to treat multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## Interferon gamma-1b (Actimmune)

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### Products Affected

- Actimmune

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Coverage will be based on medical history/status, antibiotic failure for chronic granulomatous disease.   |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Limited to specialist trained in management of prescribed condition.  |
| <b>Coverage Duration</b>            | Up to 12 months   |
| <b>Other Criteria</b>               | Actimmune is indicated to prevent infection in Chronic Granulomatous disease, and also delay the time to progression with severe malignant osteopetrosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## ivacaftor (Kalydeco)

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### Products Affected

- Kalydeco

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications. Patient must have an FDA approved mutation.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      | Must be prescribed by a Pulmonologist.   |
| Coverage Duration            | 12 months  |
| Other Criteria               | Kalydeco is an oral medication indicated to treat Cystic fibrosis patients with specific genetic mutations in the CFTR gene. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## ixazomib (Ninlaro)

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### Products Affected

- Ninlaro

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Must have failed Pomalyst.                                       |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Must be prescribed by Oncology.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Ninlaro is an oral proteasome inhibitor indicated to treat relapsed or refractory multiple myeloma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## lacosamide (Vimpat)

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### Products Affected

- Lacosamide Oral Solution

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Failure of Levetiracetam, topiramate, and lamotrigine.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Approved when written/ordered by a Neurologist.   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Vimpat is indicated as an adjunct agent used to treat partial onset seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## Ianreotide (Somatuline)

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### Products Affected

- Somatuline Depot

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications. Failure of octreotide.   |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      | Prescriber must be an endocrinologist.   |
| Coverage Duration            | 12 months  |
| Other Criteria               | This medication is used to treat Acromegaly. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

# lanthanum carbonate (Fosrenol)

## Products Affected

- Lanthanum Carbonate

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | Patient has ESRD. Patient has elevated calcium on phosphate binders, or not a candidate for calcium based phosphate binders based on KDOQI guidelines. Failure of Sevelamer.   |
| <b>Exclusion Criteria</b>           | Not covered in combination with other non-calcium based phosphate binders.   |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Prescribed by a nephrologist.  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Fosrenol is a non-calcium based, chewable, phosphate binder indicated to manage hyperphosphatemia in ESRD. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## lapatinib (Tykerb)

### Products Affected

- Lapatinib Ditosylate

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Patient has HER2/neu + breast cancer that has failed treatment/progressed with a regimen including an anthracycline, a taxane and Herceptin. Used to treat Metastatic HR+ HER2/neu+ breast cancer in combination with an aromatase inhibitor. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Prescriber is an oncologist.  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Tykerb is indicated to treat Advanced HER2+ breast cancer in combination with Xeloda. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.   |

# lenalidomide (Revlimid)

## Products Affected

- Lenalidomide

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Patient must have failed Aranesp & Procrit for MDS anemia. Mantle cell Lymphoma requires failure of two prior treatment regimens one of which being bortezomib.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Prescriber is a hematologist/oncologist.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Revlimid is indicated for treatment of Multiple Myeloma , Myelodysplastic syndrome, anemia that is transfusion dependent and has 5q deletion karyotype, mantle cell lymphoma Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

# lenvatinib (Lenvima)

## Products Affected

- Lenvima (10 MG Daily Dose)
- Lenvima (12 MG Daily Dose)
- Lenvima (14 MG Daily Dose)
- Lenvima (18 MG Daily Dose)
- Lenvima (20 MG Daily Dose)
- Lenvima (24 MG Daily Dose)
- Lenvima (4 MG Daily Dose)
- Lenvima (8 MG Daily Dose)

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | FDA approved indications.   |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             | Ages approved in FDA labeling/compendia   |
| Prescriber Restrictions      | Must be written by an oncologist/hematologist.  |
| Coverage Duration            | Up to 12 months or until disease progression or toxicity  |
| Other Criteria               | Lenvima is a tyrosine kinase inhibitor indicated for several cancers. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## linaclotide (Linzess)

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### Products Affected

- Linzess

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | FDA approved indications. Failure of lactulose and Miralax.   |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             | Ages approved in FDA labeling/compendia   |
| Prescriber Restrictions      |   |
| Coverage Duration            | 12 months   |
| Other Criteria               | Linzess is indicated for chronic constipation and irritable bowel syndrome. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## liraglutide (Victoza)

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### Products Affected

- **Victoza Subcutaneous Solution Pen-Injector**

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | Covered after failure of metformin and Bydureon. Covered for use in established cardiovascular disease for patients on a Statin who have failed metformin. |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Victoza is a medication indicated for treatment of type 2 diabetes mellitus.   |

## lubiprostone (Amitiza)

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### Products Affected

- Lubiprostone

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Must have failed lactulose and Miralax.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Prescriber must be a gastroenterologist.   |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Amitiza is indicated for chronic constipation and irritable bowel syndrome Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. |

## lurasidone (Latuda)

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### Products Affected

- Latuda Oral Tablet 120 MG, 20 MG, 40 MG, 60 MG, 80 MG

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications. Failure of aripiprazole, risperidone and quetiapine Approved through referrals.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      |  |
| Coverage Duration            | 12 months  |
| Other Criteria               | Latuda is indicated for bipolar depression, prior authorization only applies to existing members who are new starts on the drug. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## mecasermin (Increlex)

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### Products Affected

- Increlex

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Coverage will be based on medical history/status, response to previous treatments, and the consideration of other therapeutic options.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Must be prescribed by a Pediatric Endocrinologist.  |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Increlex is indicated to treat short stature in patient with primary Insulin like Growth Factor deficiency, and patients with neutralizing antibodies to HGH. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## mepolizumab (Nucala)

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### Products Affected

- Nucala

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | The following criteria must be met for coverage for severe eosinophilic asthma: Prescriber must be a pulmonologist or allergist. Two or more severe exacerbations in the past 12 months. Patient must fail 3 months of therapy on maximal indicated doses of Trelegy and Montelukast.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Nucala is an interleukin 5 antagonist indicated for eosinophilic asthma and eosinophilic granulomatosis with polyangiitis and nasal polyps. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. Nasal Polyp indication is covered only by exception and will be based on all available treatment options including nebulized sinus treatments and devices. |

## midostaurin (Rydapt)

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### Products Affected

- Rydapt

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.   |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Must be prescribed by an oncologist/hematologist.  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Rydapt is a kinase inhibitor indicated to treat AML, MCL, and systemic mastocytosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## mipomersen (Kynamro)

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### Products Affected

- **Kynamro Subcutaneous Solution Prefilled Syringe**

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Genetic confirmation that patient is HoFH. Failure of Statin, Ezetimibe, and PCSK-9 therapy. Continuation of Kynamro after 3 month trial based on LDL reduction of at least 25% while on therapy. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 3 months initially, up to 12 months after response  |
| <b>Other Criteria</b>               | Kynamro is indicated to treat Homozygous Familial hypercholesterolemia<br>Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.                                     |

## mirabegron (Myrbetriq)

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### Products Affected

- **Myrbetriq Oral Tablet Extended Release 24 Hour**

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Failure of solifenacin, trospium, and Toviaz.   |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | This medication is used to treat over active bladder. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## nafarelin acetate (Synarel)

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### Products Affected

- Synarel

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | FDA approved indications.   |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             | Ages approved in FDA labeling/compendia   |
| Prescriber Restrictions      | Approved when written by an endocrinologist or gynecologist.  |
| Coverage Duration            | Up to 12 months   |
| Other Criteria               | Synarel is a GNRH analog (intranasal formulation) indicated to treat precocious puberty in children or endometriosis in adults. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## naloxegol (Movantik)

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### Products Affected

- **Movantik**

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Requires failure of lactulose and Miralax.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Movantik is a Peripherally Acting Mu Opioid Antagonist (PAMORA) indicated for opioid induced constipation Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## neratinib (Nerlynx)

### Products Affected

- Nerlynx

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Prescriber must be a Hematologist/Oncologist  |
| <b>Coverage Duration</b>            | 12 Months   |
| <b>Other Criteria</b>               | Nerlynx is indicated for extended adjuvant treatment of early stage HER2 breast cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## nicotine (Nicotrol)

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### Products Affected

- Nicotrol

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Must have previously failed or have contraindication to Bupropion. Coverage is approved for 24 weeks of treatment. Copayment will be applied per package. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 24 weeks  |
| <b>Other Criteria</b>               | Indicated for smoking cessation therapy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.    |

## nilotinib (Tasigna)

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### Products Affected

- Tasigna

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Covered for treatment failure with imatinib.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compedia  |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Tasigna is an oral antineoplastic agent used to treat Philadelphia Chromosome + CML Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## niraparib (Zejula)

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### Products Affected

- Zejula

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when used in alignment with NCCN recommendations of class 2A or greater.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Must be prescribed by an oncologist/hematologist.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Zejula is a poly (ADP-ribose) polymerase (PARP) inhibitor indicated for the maintenance treatment of adult patients with recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer who are in a complete or partial response to platinum-based chemotherapy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## ocrelizumab (Ocrevus)

### Products Affected

- Ocrevus

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. For Relapsing Remitting Multiple Sclerosis - must have failed rituximab AND Dimethyl Fumerate or Glatiramer  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Must be prescribed by a neurologist.   |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Ocrevus is a CD20-directed cytolytic antibody indicated for the treatment of relapsing remitting or primary progressive forms of multiple sclerosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## olanzapine (Zyprexa)

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### Products Affected

- Zyprexa Relprevv

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Failure of oral aripiprazole and olanzapine.   |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Approved when written/ordered by a Psychiatrist or Neurologist through referrals for new starts.   |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Zyprexa Relprevv is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. |

## olaparib (Lynparza)

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### Products Affected

- Lynparza Oral Tablet

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Lynparza is used to treat BRCA+ ovarian or breast cancers.  |
| <b>Exclusion Criteria</b>           | Progression on a PARP inhibitor   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Restricted to Hematology/Oncology.  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

# omalizumab (Xolair)

## Products Affected

- Xolair

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | The following criteria must be met for coverage for severe asthma: Prescriber must be a pulmonologist or allergist. Patient must have baseline IGE levels within indicated range for Xolair labeling. Patient must test positive to an aeroallergen (either skin test or blood test). Patient must fail 3 months of therapy on maximal indicated doses of Trelegy. Patient must have failed leukotriene receptor antagonist Failed Nucala if eosophillic asthma. The following criteria must be met for coverage for chronic idiopathic urticaria: Prescribed by an allergist, immunologist, or dermatologist Patient must have a diagnosis of chronic idiopathic urticaria (at least a 6 week history) Patient must have tried, for a minimum of 2 weeks and failed 2 of the following antihistamines at maximal doses used to treat CIU: cetirizine(40mg/day), levocetirizine (20mg/day), desloratadine(20mg/day), fexofenadine (540mg/day), loratadine (40mg/day)and montelukast |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | For coverage for severe asthma, prescriber must be a pulmonologist or allergist. For coverage for chronic idiopathic urticaria, prescribed by an allergist, immunologist, or dermatologist.   |
| <b>Coverage Duration</b>            | 12 months   |

| PA Criteria           | Criteria Details  |
|-----------------------|---|
| <b>Other Criteria</b> | <p>Xolair is an anti-IgE monoclonal antibody indicated for patients 12 years and older with moderate to severe persistent asthma who have a positive skin test or in-vitro reactivity to an aeroallergen and chronic idiopathic urticaria. Xolair was not studied in patients who smoke. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. Nasal Polyp indication is covered only by exception and will be based on all available treatment options including nebulized sinus treatments and devices.</p> |

# Omnipod/ Omnipod Dash

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## Products Affected

- Omnipod 5 G6 Pod (Gen 5)
- Omnipod Classic Pods (Gen 3)
- Omnipod DASH Pods (Gen 4)

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | Omnipod and Omnipod Dash are covered for Type 1 diabetics who meet MCG (Milliman Coverage Guideline) criteria |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             |   |
| Prescriber Restrictions      |   |
| Coverage Duration            | 12 months   |
| Other Criteria               | Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician  |

## onabotulinumtoxinA (Botox)

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### Products Affected

- Botox

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | Non-Cosmetic FDA approved indications  |
| Exclusion Criteria           | FDA labeled contraindications, and excluded for cosmetic conditions  |
| Required Medical Information | Medical notes, previous treatment history and associated studies   |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      |  |
| Coverage Duration            | 12 months  |
| Other Criteria               | FHCP covers this medication only for medically necessary purposes, like cervical dystonia, not responsive to physical therapy, blepharospasm that interferes significantly with vision, and headache not responsive to preventive and acute therapy by Neurology for at least 16 weeks |

## osimertinib mesylate (Tagrisso)

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### Products Affected

- Tagrisso

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Must possess the t790m mutation if being used after progression on an EGFR tyrosine kinase inhibitor. |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Tagrisso is indicated to treat patients with metastatic non-small cell lung cancer who possess an EGFR mutation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.                         |

## oxandrolone (Oxandrin)

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### Products Affected

- Oxandrolone Oral

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      | Approved when written by Oncology, through referrals.  |
| Coverage Duration            | up to 12 months  |
| Other Criteria               | Oxandrin is an anabolic steroid indicated for weight gain in cachexia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## oxymetholone (Anadrol-50)

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### Products Affected

- Anadrol-50

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Medical history and information reviewed by referrals. Coverage will be response to previous treatments, and the consideration of other therapeutic options (ESAs, B12/folate, iron). |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | Up to 12 months   |
| <b>Other Criteria</b>               | Anadrol is an anabolic steroid indicated to treat various types of anemia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.                        |

## palbociclib (Ibrance)

### Products Affected

- Ibrance

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Diagnosis Metastatic ER+ HER- Breast cancer.   |
| <b>Exclusion Criteria</b>           | Progression on a CDK 4/6 inhibitor   |
| <b>Required Medical Information</b> | Medical notes, previous treatment history and associated studies, including diagnosis of metastatic ER+ HER- breast cancer.  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Must be prescribed by Hematologist/oncologist.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Ibrance is a CDK 4/6 inhibitor indicated for first-line/second line treatment of metastatic ER+/HER- breast cancer used in combination with an aromatase inhibitor Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## paliperidone (Invega Sustenna) injection

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### Products Affected

- Invega Sustenna Intramuscular Suspension  
Prefilled Syringe

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | FDA approved indications. Failure of oral aripiprazole, paliperidone and risperidone.   |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             | Ages approved in FDA labeling/compendia   |
| Prescriber Restrictions      | Approved when written/ordered by a Psychiatrist or Neurologist through referrals.   |
| Coverage Duration            | 12 months   |
| Other Criteria               | Invega Sustenna is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. |

## panobinostat (Farydak)

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### Products Affected

- Farydak

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      | Must be written by an oncologist.  |
| Coverage Duration            | Up to 12 months or until disease progression or toxicity   |
| Other Criteria               | Farydak is indicated to treat multiple myeloma in patients who have received at least two therapies including Velcade and an immunomodulatory agent. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## pazopanib (Votrient)

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### Products Affected

- Votrient

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Votrient is an oral tyrosine kinase inhibitor indicated to treat Renal cell carcinoma, and soft tissue sarcoma. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Prescribing restricted to oncology.   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.   |

# PegFilgrastim

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## Products Affected

- Fulphila
- Udenyca

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | All FDA-approved indications not otherwise excluded from Part D.  |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             |   |
| Prescriber Restrictions      |   |
| Coverage Duration            | 6 months  |
| Other Criteria               | All FDA approved uses, Off-Label uses must be NCCN supported with a grade 2a recommendation or greater. |

## peginterferon alfa-2b (Sylatron)

### Products Affected

- Sylatron Subcutaneous Kit 200 MCG, 300 MCG, 600 MCG

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Must be used as adjuvant treatment within 84 days of surgical resection in patients with metastatic melanoma with nodal involvement.           |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Prescriber must be an oncologist.  |
| <b>Coverage Duration</b>            | Up to 12 months  |
| <b>Other Criteria</b>               | Sylatron is an adjuvant treatment for metastatic melanoma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## penicillamine (Cuprimine)

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### Products Affected

- Penicillamine Oral Capsule

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Coverage for Rheumatoid Arthritis requires failure of a TNF Agent, and a JAK inhibitor or Abatacept.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Written by a Rheumatologist, or Neurologist, or Urologist or Hepatologist.  |
| <b>Coverage Duration</b>            | 12 Months   |
| <b>Other Criteria</b>               | Cuprimine is indicated for treatment of Rheumatoid arthritis, Wilsons Disease and cystinuria. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## pentamidine isothionate (Nebupent) nebulized

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### Products Affected

- Pentamidine Isethionate Inhalation

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Failure of topical ketoconazole, econazole, clotrimazole betamethasone, nystatin triamcinolone.   |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Nebupent is a inhaled solution used to treat PCP pneumonia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## perampanel (Fycompa)

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### Products Affected

- Fycompa Oral Tablet

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Written by a neurologist for treatment of seizures. Failure of Levetiracetam, topiramate, and lamotrigine.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      | Written by a neurologist.   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Fycompa is an anti-convulsant indicated for adjunctive treatment of partial seizures. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## pirfenidone (Esbriet)

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### Products Affected

- Pirfenidone Oral Tablet 267 MG, 801 MG

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Pirfenidone is indicated for idiopathic pulmonary fibrosis. Medical history and studies are reviewed in Referrals and if approved will notify the physician. Criteria for coverage as follows: Confirmed diagnosis of IPF by high resolution CT or surgical biopsy. Prescribed by a pulmonologist |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      | pulmonologist   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               |   |

## pomalidomide (Pomalyst)

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### Products Affected

- Pomalyst

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications, Off label use must be supported by NCCN with evidence rating of 2a or greater. Coverage requires failure of Revlimid and Velcade.                            |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Restricted to Hematology/Oncology.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Pomalyst is thalidomide analog used to treat refractory Multiple Myeloma Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## ponatinib (Iclusig)

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### Products Affected

- Iclusig

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      | Must be prescribed by Hematologist/oncologist.   |
| Coverage Duration            | Up to 12 months or until disease progression or toxicity   |
| Other Criteria               | Iclusig is a tyrosine Kinase inhibitor indicated to treat Chronic Myelogenous Leukemia. Coverage will be based on failure of first or second line TKI for CML or presence of T350I mutation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## posaconazole (Noxafil)

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### Products Affected

- Noxafil Oral Suspension
- Posaconazole

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications. Organism must be resistant to itraconazole, voriconazole, and fluconazole.   |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      |  |
| Coverage Duration            | 3 months   |
| Other Criteria               | Noxafil is an anti-fungal indicated for aspergillus and Candida in immunocompromised patients. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## pramlintide acetate (Symlin)

### Products Affected

- SymlinPen 120 Subcutaneous Solution Pen-Injector
- SymlinPen 60 Subcutaneous Solution Pen-Injector

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Patient is uncontrolled despite optimal insulin utilization with Ha1c between 7%-9%. Not for use in patients with gastroparesis.   |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> | Medical notes, previous treatment history, and labs, including HA1c  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Prescriber is an endocrinologist.  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Symlin is indicated to treat Type 1 and 2 Diabetes. Symlin is indicated for adjunctive treatment of DM with insulin. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## pyrimethamine (Daraprim)

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### Products Affected

- Pyrimethamine Oral

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Toxoplasmosis. Patient must have failed recent trial of combination of inhaled corticosteroids AND long acting beta Agonist AND inhaled anti-cholinergic. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 Months   |
| <b>Other Criteria</b>               | Daraprim is used to treat toxoplasmosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.    |

## quinine (Qualaquin)

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### Products Affected

- Quinine Sulfate Oral

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      |  |
| Coverage Duration            | 12 months  |
| Other Criteria               | This medication is indicated for treatment of malaria. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## rasagiline (Azilect)

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### Products Affected

- Rasagiline Mesylate Oral

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Must have failed recent trial of combination selegiline and Levodopa/Carbidopa.   |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Azilect is a monoamine oxidase inhibitor type B indicated for treatment of Parkinsons disease Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. |

## regorafenib (Stivarga)

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### Products Affected

- Stivarga

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | Stivarga is an oral tyrosine kinase inhibitor indicated to treat Colorectal cancer and , Hepatocellular carcinoma. |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Prescribing restricted to oncology.  |
| <b>Coverage Duration</b>            | 12 Months  |
| <b>Other Criteria</b>               | Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.      |

## rilonacept (Arcalyst)

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### Products Affected

- Arcalyst

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | Diagnosis of CAPS and Documentation of disability due to the condition, failure of anakinra, and nsaid.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Prescribing limited to immunologist.   |
| <b>Coverage Duration</b>            | Up to 12 months  |
| <b>Other Criteria</b>               | Arcalyst is indicated to treat Cryopyrin Associated Periodic Syndromes (CAPS). Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. |

## riluzole (Rilutek)

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### Products Affected

- Riluzole

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Diagnosis is definite or probable ALS by Neurology. Symptoms have been present for less than 5 years. Vital Capacity is 60% or more of predicted. Patient does not have a tracheostomy. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Rilutek is indicated for the treatment of ALS. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.  |

## risperidone (Risperdal Consta) injection

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### Products Affected

- **RisperDAL Consta Intramuscular  
Suspension Reconstituted ER**

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Failure of oral aripiprazole and risperidone.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Approved when written/ordered by a Psychiatrist or Neurologist through referrals.  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Risperdal Consta is a psychotropic medication. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. |

## roflumilast (Daliresp)

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### Products Affected

- Daliresp

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Patient must have failed recent trial of combination of inhaled corticosteroids AND long acting beta Agonist AND inhaled anti-cholinergic.                                    |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Daliresp is indicated to treat COPD, it is a selective phosphodiesterase type 4 inhibitor Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## rotigotine (Neupro)

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### Products Affected

- Neupro

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | FDA approved indications. Failure of Ropinorole and Pramipexole.  |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             | Ages approved in FDA labeling/compendia   |
| Prescriber Restrictions      |   |
| Coverage Duration            | 12 months   |
| Other Criteria               | Neupro is a transdermal dopamine agonist indicated for treatment of Parkinsons disease. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## rufinamide (Banzel)

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### Products Affected

- Rufinamide

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications   |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             | Ages approved in FDA labeling/compendia  |
| Prescriber Restrictions      | Approved when written/ordered by a Neurologist for seizures through referrals.   |
| Coverage Duration            | 12 months  |
| Other Criteria               | Banzel is indicated for treatment of Lennox Gastaut syndrome. Prior authorization only applies to existing members who are new starts on the drug. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy. |

## ruxolitinib (Jakafi)

### Products Affected

- Jakafi

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Not used in combination with lenalidomide/thalidomide, other JAK or TKI inhibitors. Continuation in therapy will require 50% reduction in baseline spleen size, or 35% reduction in spleen volume, or a 50% reduction in baseline Myelofibrosis symptom score.   |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Ages approved in FDA labeling/compendia  |
| <b>Prescriber Restrictions</b>      | Prescriber is a hematologist/oncologist.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Jakafi is an oral JAK inhibitor indicated for treatment of intermediate to high risk myelofibrosis including primary myelofibrosis, polycythemia vera, myelofibrosis, and essential thrombocythemia myelofibrosis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## sarilumab (Kevzara)

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### Products Affected

- Kevzara

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

## sildenafil (Revatio)

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### Products Affected

- Sildenafil Citrate Oral Tablet 20 MG

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Pulmonary hypertension must be diagnosed by heart catheterization. Evaluation, EKG, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral.                       |
| <b>Exclusion Criteria</b>           | This medication is contraindicated in patients using organic nitrates either regularly or intermittently   |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Revatio is indicated for the treatment of Primary pulmonary hypertension or pulmonary hypertension related to connective tissue disease. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## sitagliptin (Januvia)

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### Products Affected

- Januvia

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Patient must be on maximal doses of Metformin and Sulfonylurea or other combination therapy if metformin contraindicated for at least 6 months, or have intolerance/contraindication. Failure of Onglyza. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Januvia is an oral anti-diabetic agent used to treat Type 2 Diabetes (DPP-IV inhibitor). Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.                              |

## sodium oxybate (Xyrem)

---

### Products Affected

- Xyrem

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | Only covered for narcolepsy with cataplexy. Coverage will be based on recent failure of Modafinil AND Armodafinil AND Amphetamine/Dextroamphetamine, and soriamfetol.. Tricyclic Antidepressant shown to be effective in cataplexy(Clomipramine/Protriptyline) Three month discontinuation trials for moderate to highly sedating medications such as benzodiazepines, opioids, anticholinergics, muscle relaxers, atypical antipsychotics, dopamine agonists. |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      | Must be prescribed by physician board certified in sleep medicine.   |
| <b>Coverage Duration</b>            | Up to 12 months  |
| <b>Other Criteria</b>               | This medication is used for treatment of narcolepsy with cataplexy or excessive daytime sleepiness due to narcolepsy. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.  |

## sodium zirconium cyclosilicate (Lokelma)

---

### Products Affected

- Lokelma

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Hyperkalemia after discontinuation trial of potassium sparing medications, trial of a loop diuretic if clinically indicated.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Lokelma is indicated for the treatment of hyperkalemia. Medical history and studies are reviewed in referrals and if approved will notify pharmacy and the physician. |

## somatropin (Omnitrope)

---

### Products Affected

- Omnitrope Subcutaneous Solution
- Omnitrope Subcutaneous Solution Reconstituted

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications. This information with the lab attached is sent to the Referrals Department.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             |  |
| Prescriber Restrictions      |  |
| Coverage Duration            | 12 months  |
| Other Criteria               | Growth Hormone is a pituitary hormone used for endogenous HGH deficiencies Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## sonidegib (Odomzo)

---

### Products Affected

- Odomzo

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             |  |
| Prescriber Restrictions      | Must be prescribed by Oncology.  |
| Coverage Duration            | Up to 12 months or until disease progression or toxicity   |
| Other Criteria               | Odomzo is an oral oncology agent indicated to treat locally advanced basal cell carcinoma which has recurred following radiation or surgery. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## sorafenib (Nexavar)

---

### Products Affected

- Nexavar

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | Nexavar is an oral tyrosine kinase inhibitor indicated to treat Renal cell carcinoma, Hepatocellular carcinoma, and thyroid carcinoma. |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      | Prescribing restricted to oncology.  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.                          |

## sunitinib (Sutent)

---

### Products Affected

- SUNItinib Malate

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | Sutent is an oral tyrosine kinase inhibitor indicated to treat Renal cell carcinoma, Gastrointestinal Stromal Tumors, and pancreatic neuroendocrine tumors. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      | Prescribing restricted to oncology.   |
| <b>Coverage Duration</b>            | 12 Months   |
| <b>Other Criteria</b>               | Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.   |

## tadalafil (Adcirca)

---

### Products Affected

- Tadalafil (PAH)

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Pulmonary hypertension must be diagnosed by right heart catheterization. Evaluation, EKG, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral. |
| <b>Exclusion Criteria</b>           | This medication is contraindicated in patients using organic nitrates either regularly or intermittently.  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Adcirca is indicated for treatment of pulmonary arterial hypertension (WHO group 1). Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.                                     |

## tazarotene (Tazorac)

---

### Products Affected

- Tazarotene External Cream
- Tazarotene External Gel
- **Tazorac External Cream 0.05 %**

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. For Psoriasis patient must have failed medium to high potency topical corticosteroid. For acne patient must have failed adapalene or tretinoin or oral tetracycline class antibiotic. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      | Must be written by dermatology.   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Tazorac is a topical retinoid indicated to treat Acne or Psoriasis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.                               |

## tetrabenazine (Xenazine)

---

### Products Affected

- Tetrabenazine

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Patient must have moderate to severe chorea that is refractory to amantadine, neuroleptics or anticonvulsants.   |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      | Prescriber must be a neurologist.  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Xenazine is indicated to treat chorea associated with Huntingtons disease. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## tetrahydrocannabinol (Marinol)

---

### Products Affected

- Dronabinol

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | For cachexia, patient must fail megestrol acetate. For nausea and vomiting patient must fail Ondansetron and Emend.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               | Dronabinol is indicated to treat HIV/Cancer related Cachexia and chemotherapy induced nausea and vomiting. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## thalidomide (Thalomid)

---

### Products Affected

- Thalomid

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | FDA approved indications.   |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             |   |
| Prescriber Restrictions      | Approved when written by Oncology, Infectious Disease or in HIV through referrals.                            |
| Coverage Duration            | 12 months   |
| Other Criteria               | Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## tipiracil / trifluridine (Lonsurf)

---

### Products Affected

- Lonsurf

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.   |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      | Must be prescribed by an Oncologist  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Lonsurf is indicated to treat patients with metastatic colorectal cancer who have progressed on two to three lines of treatment. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## tofacitinib (Xeljanz)

### Products Affected

- Xeljanz Oral Solution
- Xeljanz Oral Tablet
- Xeljanz XR

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. For rheumatoid arthritis must be written by Rheumatology, Patient must fail adequate trial of MTX in combination with a DMARD If MTX contraindicated, must try combination of 2- nonbiologic DMARDS (3 month trial in past 6 months) and a preferred TNF. For Psoriatic Arthritis Patient must fail adequate trial of MTX or LEF in past 6 months. For with ulcerative colitis must be written by a gastroenterologist and had recent failure of an immunosuppressant (Azathioprine, 6-mp or Methotrexate) and an anti-inflammatory (5-asa, sulfasalazine, balsalazide, mesalamine) |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      | For rheumatoid arthritis must be written by Rheumatology. For with ulcerative colitis must be written by a gastroenterologist.  |
| <b>Coverage Duration</b>            | Up to 12 months   |
| <b>Other Criteria</b>               | Xeljanz is indicated for treatment of Moderate to severe Rheumatoid arthritis in adults, Psoriatic Arthritis, Ulcerative colitis, JIA. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.  |

## trametinib (Mekinist)

---

### Products Affected

- Mekinist

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Patient must have BRAF V600E/K mutation.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      | Must be written by an oncologist.  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Mekinist is a MEK inhibitor indicated to treat BRAF+ V600e/k mutation Stage IIIc-IV metastatic Melanoma and NSCLC. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## tretinoin ( )

### Products Affected

- Tretinoin Oral

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications.  |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             |  |
| Prescriber Restrictions      | Approved when written by Oncology through referrals.   |
| Coverage Duration            | 12 months  |
| Other Criteria               | Vesanoid is indicated to treat promyelocytic leukemia. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## tretinoin (Retin-A)

---

### Products Affected

- Tretinoin External Cream
- Tretinoin External Gel 0.01 %, 0.025 %

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | Tretinoin is indicated to treat moderate to severe acne and diseases of keratinization such as ichthyosis and keratosis follicularis. Prior authorization only required for patients greater than 30 years of age. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. Criteria for coverage as follows: FDA approved indications. This medication is not covered for wrinkles or photo aging. |
| <b>Exclusion Criteria</b>           | This medication is not covered for wrinkles or photo aging.  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             | Prior authorization only required for patients greater than 30 years of age.   |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | 12 months  |
| <b>Other Criteria</b>               |  |

## vandetanib (Caprelsa)

---

### Products Affected

- Caprelsa

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater.  |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      | Prescriber must be a Hematologist/Oncologist.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity  |
| <b>Other Criteria</b>               | Caprelsa medication indicated for treatment of metastatic medullary thyroid cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## vemurafenib (Zelboraf)

---

### Products Affected

- Zelboraf

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications, off label use will be covered when there is an NCCN supported indication with a recommendation of class 2A or greater. Patient must have BRAF V600E/K mutation.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      | Must be written by an oncologist.  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Zelboraf is a BRAF inhibitor indicated to treat BRAF+ V600e/k mutation Stage IIIc-IV metastatic Melanoma, NSCLC, and Metastatic colorectal cancer. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## venetoclax (Venclexta)

---

### Products Affected

- Venclexta
- Venclexta Starting Pack

| PA Criteria                  | Criteria Details  |
|------------------------------|---|
| Covered Uses                 | FDA approved indications.   |
| Exclusion Criteria           |   |
| Required Medical Information |   |
| Age Restrictions             |   |
| Prescriber Restrictions      | Restricted to Hematology/Oncology.  |
| Coverage Duration            | Up to 12 months or until disease progression or toxicity  |
| Other Criteria               | Venclexta is a BCL-2 inhibitor indicated for treatment of B-cell Lymphomas. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## vismodegib (Erivedge)

---

### Products Affected

- Erivedge

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Patient has Metastatic basal cell cancer, or recurrent basal cell cancer, or who are not candidates for surgery and not candidates for radiation.  |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      | Prescriber is a hematologist/oncologist.   |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Erivedge is indicated for treatment of metastatic or locally advanced basal cell carcinoma that has recurred following surgery or who are not candidates for surgery and are not candidates for radiation. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## voriconazole (Vfend)

---

### Products Affected

- Voriconazole Oral

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Two of the following medications have been tried, unless resistance or contraindication precludes use, Itraconazole, fluconazole, ketoconazole. Exclusions to pre-requisite medications are Invasive pulmonary aspergillosis, Scedosporium apiospermum, and fusarium. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      |   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Voriconazole is an antifungal medication used to treat aspergillosis and other invasive fungal infections. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.  |

## vorinostat (Zolinza)

---

### Products Affected

- Zolinza

| PA Criteria                         | Criteria Details   |
|-------------------------------------|--|
| <b>Covered Uses</b>                 | FDA approved indications. Failed minimum of two systemic treatments, one of which must be Targretin, unless contraindicated.   |
| <b>Exclusion Criteria</b>           |  |
| <b>Required Medical Information</b> |  |
| <b>Age Restrictions</b>             |  |
| <b>Prescriber Restrictions</b>      |  |
| <b>Coverage Duration</b>            | Up to 12 months or until disease progression or toxicity   |
| <b>Other Criteria</b>               | Zolinza is indicated for cutaneous manifestations of cutaneous T-cell Lymphoma Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## vortioxetine (Trintellix)

---

### Products Affected

- Trintellix

| PA Criteria                  | Criteria Details   |
|------------------------------|--|
| Covered Uses                 | FDA approved indications. Failure or intolerance to two generically available anti-depressants in past 6 months.   |
| Exclusion Criteria           |  |
| Required Medical Information |  |
| Age Restrictions             |  |
| Prescriber Restrictions      |  |
| Coverage Duration            | 12 months  |
| Other Criteria               | Trintellix is an antidepressant used to treat major depressive disorder. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician. |

## zileuton (Zyflo)

---

### Products Affected

- Zileuton ER

| PA Criteria                         | Criteria Details  |
|-------------------------------------|---|
| <b>Covered Uses</b>                 | FDA approved indications. Uncontrolled Asthma while on maximal doses of long acting bronchodilators and inhaled corticosteroids AND montelukast. 6 months of medication compliance with maintenance treatments. |
| <b>Exclusion Criteria</b>           |   |
| <b>Required Medical Information</b> |   |
| <b>Age Restrictions</b>             |   |
| <b>Prescriber Restrictions</b>      | Must be written by a pulmonologist.   |
| <b>Coverage Duration</b>            | 12 months   |
| <b>Other Criteria</b>               | Zyflo is indicated for treatment of asthma. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.   |

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