

# **2024**

## **Prior Authorization Criteria**

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## Actimmune

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### Drugs

ACTIMMUNE

### Exclusion Criteria

FDA labeled contraindications

### Required Medical Information

Diagnosis, supporting imaging for osteopetrosis. Antibiotic failure if chronic granulomatous disease

### Age Restriction

Ages approved in FDA labeling/compendia

### Prescriber Restriction

Infectious Disease/Hematology-oncology/Orthopedist/rheumatologist

### Coverage Duration

12 months

### Other Criteria

Sulfamethoxazole/Trimethoprim and/or itraconazole failure for infections secondary to chronic granulomatous disease. Osteopetrosis must be severe malignant

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Adalimumab

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### Drugs

HADLIMA, HADLIMA PUSHTOUCH

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

For RA Patient must fail adequate Combination DMARD. For Ankylosing Spondylitis PT must fail Methotrexate or an NSAID. For Plaque Psoriasis patient must fail 3 month trial of MTX or Soriatane. For Psoriatic Arthritis Patient must fail adequate trial (3 months in past 6 months) of MTX or LEF in past 6 months. For inflammatory bowel disease must fail 3 month trial of Renflexis or conventional immunomodulator.

### Indications

All Medically-accepted Indications.

### Off Label Uses

### Part B Prerequisite

No

## Adcirca Tabs

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### Drugs

*tadalafil (pah)*

### Exclusion Criteria

#### Required Medical Information

Right Heart catheterization, vasoreactivity test.

### Age Restriction

#### Prescriber Restriction

Pulmonology, Cardiology

#### Coverage Duration

12 months

### Other Criteria

#### Indications

All FDA-approved Indications.

### Off Label Uses

#### Part B Prerequisite

No

## Adempas

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**Drugs**  
ADEMPAS

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
pulmonologist/cardiologist

**Coverage Duration**  
12 months

**Other Criteria**  
For PAH must have tried and failed ambrisentan and tadalafil, CTPH requires failure of bosentan (based on compendial support)

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Afinitor

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### Drugs

*everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg, everolimus oral tablet soluble*

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Oncology/neurology

### Coverage Duration

12 months or until disease progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**  
AIMOVIG

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Neurology, Pain Management, Headache Specialist

**Coverage Duration**  
12 months

**Other Criteria**  
Recent failure (in the past 6 months) of two medications FDA indicated for chronic or episodic migraine prophylaxis and will not be used in combination with another calcitonin gene peptide inhibitor.

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Akeega

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### **Drugs**

AKEEGA

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Urology/Hematology/Oncology

### **Coverage Duration**

12 months

### **Other Criteria**

Akeega is our preferred PARP + novel hormone therapy combination for BRCA positive metastatic castrate resistant prostate cancer.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

ALECENSA

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Hematology/Oncology

**Coverage Duration**

12 months

**Other Criteria**

Approved for ALK+ Non Small Cell Lung Cancer

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## alitretinoin (Panretin)

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### Drugs

PANRETIN

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**  
ALUNBRIG

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematology/Oncology

**Coverage Duration**  
12 months or until progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Ambrisentan

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### **Drugs**

*ambrisentan*

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Medical notes supporting diagnosis of Group 1 PAH, including right heart catheterization, vasoreactivity test, 6 Minute Walk time

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Pulmonologist or cardiologist

### **Coverage Duration**

12 months

### **Other Criteria**

Pulmonary hypertension must be diagnosed by heart catheterization, an objective test of exercise ability (6 minute walk) must be submitted with referral.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Ampyra

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### **Drugs**

*dalfampridine er*

### **Exclusion Criteria**

History of seizure. Moderate or severe renal impairment (creatinine clearance less than or equal to 50 mL/minute).

### **Required Medical Information**

Diagnosis of multiple sclerosis AND patient is ambulatory (able to walk at least 25 feet) AND patient has walking impairment

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

Initial - 3 months. Renewal - 12 months

### **Other Criteria**

For renewal, walking speed has improved from baseline.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Apokyn

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### **Drugs**

*apomorphine hcl subcutaneous*

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, previous treatment history.

### **Age Restriction**

Ages approved in FDA labeling/compendia

### **Prescriber Restriction**

Neurologist

### **Coverage Duration**

12 months

### **Other Criteria**

Patient must have poorly controlled off time episodes and failed rasagiline and entacapone

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## **Aptiom**

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### **Drugs**

APTIOM

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Neurology

### **Coverage Duration**

12 months

### **Other Criteria**

Failure of carbamazepine and Oxcarbazepine

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**  
ARCALYST

**Exclusion Criteria**  
FDA labeled contraindications

**Required Medical Information**  
Coverage will be based on a Diagnosis of CAPS, failure of 1 other treatment used for this condition such as canakinumab, nsais. Will also be covered for recurrent pericarditis and deficiency of interleukin-1 receptor antagonist.

**Age Restriction**

**Prescriber Restriction**  
Immunologist,dermatologist,rheumatologist,cardiologist

**Coverage Duration**  
12 months

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Armodafinil/Modafinil

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### **Drugs**

*armodafinil, modafinil oral*

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

12 months

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Aubagio

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### **Drugs**

*teriflunomide*

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Neurology

### **Coverage Duration**

12 months

### **Other Criteria**

diagnosis of MS

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Augtyro

---

### Drugs

AUGTYRO

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Oncology/Hematology

### Coverage Duration

12 months

### Other Criteria

Metastatic NSCLC with a ROS-1 rearrangement AND Failure of crizotinib for patients without CNS metastasis OR failure of entrectinib for patients without CNS metastasis.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

AUVELITY

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Psychiatry and Neurology

**Coverage Duration**

12 months

**Other Criteria**

Failure of bupropion and failure of aripiprazole in combination with any antidepressant.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Neurology

**Coverage Duration**

12 months

**Other Criteria**

Failure of glatiramer and leflunomide

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

hematology/oncology/immunology/allergy

**Coverage Duration**

12 months or until progression

**Other Criteria**

Failure of imatinib AND one other tyrosine kinase inhibitor for unresectable or metastatic GIST with a mutation in PDGFRA exon 18 insensitive to imatinib or harboring a PDGFRA D842V mutation.

Diagnosis of advanced systemic mastocytosis.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## aztreonam (Cayston)

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### Drugs

CAYSTON

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 Months

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Balversa

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### Drugs

BALVERSA

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Oncology/Urology

### Coverage Duration

12 months or until disease progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Banzel

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### **Drugs**

*rufinamide*

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Diagnosis

### **Age Restriction**

### **Prescriber Restriction**

Neurology

### **Coverage Duration**

12 months

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

BENLYSTA SUBCUTANEOUS

**Exclusion Criteria**

Member receiving other biologic therapy or intravenous cyclophosphamide.

**Required Medical Information**

FOR SLE Diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE), and member currently receiving one or more of the following standard SLE therapies: Corticosteroids, Antimalarials, Non-steroidal anti-inflammatory drugs (NSAIDs), Immunosuppressants. For lupus nephritis must fail tacrolimus and mycophenolate.

**Age Restriction**

Greater or equal to 18 years of age

**Prescriber Restriction**

Rheumatologist or nephrologist

**Coverage Duration**

Lifetime

**Other Criteria**

None

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Berinert

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### Drugs

BERINERT

### Exclusion Criteria

Must not be taking medications that can exacerbate the frequency and/or severity of hereditary angioedema (HAE) attacks including estrogens and ACE inhibitors.

### Required Medical Information

#### Age Restriction

#### Prescriber Restriction

#### Coverage Duration

12 months

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Besremi

---

### Drugs

BESREMI

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology Oncology

### Coverage Duration

12 months

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Betaseron

---

### Drugs

BETASERON SUBCUTANEOUS KIT

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Neurology

### Coverage Duration

12 months

### Other Criteria

Failure of glatiramer

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Bosulif

---

### Drugs

BOSULIF

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

6 months or until disease progression

### Other Criteria

Requires failure of imatinib for low risk CML based on Sokal or Hasford scores. Can be used first line for Ph+ CML with an intermediate to high risk Sokal or Hasford score

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

BRAFTOVI ORAL CAPSULE 75 MG

**Exclusion Criteria**

**Required Medical Information**

Evidence of BRAF mutation

**Age Restriction**

**Prescriber Restriction**

Hematology/Oncology

**Coverage Duration**

12 months or until disease progresison

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Briviact

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### Drugs

BRIVIACT ORAL

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

failed trial or contraindication or intolerance of Levetiracetam

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Bronchitol

---

### Drugs

BRONCHITOL

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Pulmonology

### Coverage Duration

12 months

### Other Criteria

confirmed diagnosis of cystic fibrosis.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## **Brukinsa**

---

### **Drugs**

BRUKINSA

### **Exclusion Criteria**

Disease progression on a covalent BTK inhibitor

### **Required Medical Information**

#### **Age Restriction**

#### **Prescriber Restriction**

Hematology/oncology

#### **Coverage Duration**

12 months or until progression

#### **Other Criteria**

Intolerance to Imbruvica in overlapping indication.

#### **Indications**

All FDA-approved Indications.

#### **Off Label Uses**

#### **Part B Prerequisite**

No

## Cabometyx

---

### Drugs

CABOMETYX

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/Oncology

### Coverage Duration

12 months

### Other Criteria

Covered until disease progression.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Calquence

---

### Drugs

CALQUENCE

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months or clinical progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Caplyta

---

### Drugs

CAPLYTA

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

written by neurology/psychiatry

### Coverage Duration

12 months

### Other Criteria

Failure of aripiprazole and risperidone for schizophrenia. Failure or lurasidone for bipolar depression

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Caprelsa

---

### Drugs

CAPRELSA

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Oncology

### Coverage Duration

12 months or until disease progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Carbaglu

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### **Drugs**

*carglumic acid oral tablet soluble*

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

12 months

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

*tadalafil oral tablet 2.5 mg, 5 mg*

**Exclusion Criteria**

excluded from part D coverage when prescribed for treatment of erectile dysfunction

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

12 months

**Other Criteria**

Approved for treatment of benign prostatic hyperplasia.

**Indications**

Some FDA-approved Indications Only.

**Off Label Uses**

**Part B Prerequisite**

No

## Cinryze

---

### Drugs

CINRYZE

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Cometriq

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### Drugs

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)

### Exclusion Criteria

combination use with other tyrosine Kinase inhibitors.

### Required Medical Information

Diagnosis

### Age Restriction

### Prescriber Restriction

oncology/hematology

### Coverage Duration

6 months or until disease progression

### Other Criteria

Covered for Metastatic Thyroid Medullary Cancer

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Copiktra

---

### Drugs

COPIKTRA

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/Oncology

### Coverage Duration

12 months or until disease progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

CORLANOR ORAL SOLUTION, CORLANOR ORAL TABLET

**Exclusion Criteria**

**Required Medical Information**

Documentation of the following: 1. Diagnosis of chronic heart failure with left ventricular ejection fraction less than or equal to 35% AND 2. Patient is in sinus rhythm with resting heart rate greater than or equal to 70 beats per minute AND 3. Patient is on maximally tolerated doses of beta-blockers or has a contraindication to beta-blocker use AND 4. Patient is receiving an ACE inhibitor or ARB or has a contraindication to these agents. Approved for the treatment of stable symptomatic heart failure due to dilated cardiomyopathy (with a left ventricular ejection fraction less than or equal to 45%) in pediatric patients ages 6 months and older.

**Age Restriction**

**Prescriber Restriction**

Cardiologist

**Coverage Duration**

12 months

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**  
**COTELLIC**

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematology/Oncology

**Coverage Duration**  
12 months

**Other Criteria**  
Covered for BRAF+ metastatic melanoma for combination use in with Zelboraf. For Histiocytosis coverage is consistent with NCCN guidelines for multiorgan or multifocal or e or unifocal a critical organ in patients who do not harbor a BRAF V600E mutation.

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Cuprimine

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### **Drugs**

*penicillamine oral capsule*

### **Exclusion Criteria**

#### **Required Medical Information**

serum ceruloplasmin if used for wilson's disease

### **Age Restriction**

#### **Prescriber Restriction**

rheumatology/hepatology/neurology/urology/nephrology

#### **Coverage Duration**

12 months

#### **Other Criteria**

Coverage for RA requires failure of a TNF-Agent and JAK inhibitor or abatacept.

#### **Indications**

All FDA-approved Indications.

#### **Off Label Uses**

#### **Part B Prerequisite**

No

## Cyclobenzaprine

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### **Drugs**

*cyclobenzaprine hcl oral tablet 10 mg, 5 mg*

### **Exclusion Criteria**

### **Required Medical Information**

#### **Age Restriction**

Authorization is required for patients over 64 years of age

#### **Prescriber Restriction**

#### **Coverage Duration**

3 weeks for skeletal muscle spasm, 12 months for fibromyalgia

#### **Other Criteria**

For patients over 64 years of age, Physician attests they have counseled patient on risk benefit of muscle relaxers as a high risk medication and patient has been evaluated for fall risk.

#### **Indications**

All Medically-accepted Indications.

#### **Off Label Uses**

#### **Part B Prerequisite**

No

## Daliresp

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### Drugs

*roflumilast oral tablet 250 mcg, 500 mcg*

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

### Indications

All Medically-accepted Indications.

### Off Label Uses

### Part B Prerequisite

No

## Daurismo

---

### Drugs

DAURISMO ORAL TABLET 100 MG, 25 MG

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months or until disease progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## **Diacomit**

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### **Drugs**

DIACOMIT

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Neurology

### **Coverage Duration**

12 months

### **Other Criteria**

Diagnosis of Dravet syndrome used in combination with clobazam.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Dificid

---

### Drugs

DIFICID ORAL TABLET

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

10 days

### Other Criteria

Failure of an adequate treatment of vancomycin and recurrence within 6 months.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Dronabinol

---

### **Drugs**

*dronabinol*

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Previous Treatment History

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Infectious disease/oncologist/gastroenterologist

### **Coverage Duration**

12 months

### **Other Criteria**

For HIV/Cancer related cachexia patient must fail megestrol, For Chemotherapy induced nausea, patient must fail Emend and Ondansetron.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Dupixant

---

### Drugs

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

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Pulmonology

### Coverage Duration

12 months

### Other Criteria

Only covered for severe asthma which requires chronic maintenance oral corticosteroid use to control symptoms despite maximal guideline directed inhaler therapy. Chronic Steroid use would defined as 60 days of prednisone 5mg/day or equivalent in combination with a three month trial of Trelegy 200 or high dose OCS/LABA/LAMA combination.

### Indications

Some FDA-approved Indications Only.

### Off Label Uses

### Part B Prerequisite

No

## Emend

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### **Drugs**

*aprepitant oral capsule*, EMEND ORAL SUSPENSION RECONSTITUTED

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Previous treatment history

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Hematologist/oncologist/Surgeon

### **Coverage Duration**

12 months

### **Other Criteria**

Patient must fail treatment with ondansetron (PA not applicable for PONV)

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Emgality

---

### Drugs

EMGALITY, EMGALITY (300 MG DOSE)

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

Recent Failure (past 6 months) of two formulary medications with different mechanism of action FDA approved for migraine prophylaxis

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**  
EMSAM

**Exclusion Criteria**  
FDA labeled contraindications

**Required Medical Information**  
Medical notes supporting diagnosis, current assessment and plan, prior medication failures

**Age Restriction**  
Ages approved in FDA labeling

**Prescriber Restriction**

**Coverage Duration**  
12 months

**Other Criteria**  
Patient must fail 6 week trial with two formulary anti-depressants

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

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

**Exclusion Criteria**

FDA labeled contraindications combination with other biologic

**Required Medical Information**

Medical notes supporting diagnosis (including imaging, serology when applicable), response to previous treatments, current assessment and plan

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Rheumatology/Dermatology or Specialist trained in management of prescribed condition

**Coverage Duration**

12 months

**Other Criteria**

Failure of Renflexis and adalimumab

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

Yes

## Endari

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**Drugs**  
ENDARI

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematology

**Coverage Duration**  
12 months

**Other Criteria**  
Approved for patients who have had 2 or more sickle cell crises in the past 12 months while stable on hydroxyurea for at least 3 months

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

ROZLYTREK

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**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.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**  
EPIDIOLEX

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Neurology

**Coverage Duration**  
12 months

**Other Criteria**  
Failure of clobazam for Lennox Gastaut syndrome.

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

ERIVEDGE

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Hematologist/Oncologist

**Coverage Duration**

12 months or until progression

**Other Criteria**

Diagnosis of metastatic basal cell carcinoma OR Diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Erleada

---

### Drugs

ERLEADA

### Exclusion Criteria

#### Required Medical Information

#### Age Restriction

#### Prescriber Restriction

Urologist, Oncologist

#### Coverage Duration

12 months or until PSA progression

#### Other Criteria

Failure of LHRH agonist and bicalutamide for non-metastatic disease. Failure of abiraterone for metastatic disease.

#### Indications

All FDA-approved Indications.

#### Off Label Uses

#### Part B Prerequisite

No

**Drugs**

*pirfenidone*

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

12 months

**Other Criteria**

Confirmed Diagnosis of idiopathic pulmonary fibrosis (IPF) through exclusion of other fibrosing conditions/causes and definitive High resolution CT IPF pattern or Biopsy proven IPF. FVC of at least 50% of predicted value DLCO of at least 30%

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Exjade

---

### **Drugs**

*deferasirox oral tablet soluble*

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

iron indices

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Hematologist/oncologist

### **Coverage Duration**

12 months

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Exkivity

---

**Drugs**  
EXKIVITY

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
oncology hematology

**Coverage Duration**  
12 months unless disease progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

FANAPT, FANAPT TITRATION PACK

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Diagnosis

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Neurology/Psychiatry

**Coverage Duration**

12 months

**Other Criteria**

failure of lurasidone and aripiprazole

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Fentanyl Lozenge

---

### **Drugs**

*fentanyl citrate buccal lozenge on a handle*

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Previous treatment history

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Pain management physician/oncologist

### **Coverage Duration**

12 months

### **Other Criteria**

Covered for breakthrough pain in patients receiving long acting opioid treatment and are opioid tolerant. Patient must fail two immediate release C-II opioid such as hydromorphone, morphine, oxycodone.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Fentanyl Patch

---

### Drugs

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

### Exclusion Criteria

FDA labeled contraindications

### Required Medical Information

#### Age Restriction

Ages approved in FDA labeling

#### Prescriber Restriction

Pain management physician/oncologist

#### Coverage Duration

12 months

### Other Criteria

#### Indications

All FDA-approved Indications.

#### Off Label Uses

#### Part B Prerequisite

No

## **Fetzima**

---

### **Drugs**

FETZIMA, FETZIMA TITRATION

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

12 months

### **Other Criteria**

Must fail two generically available anti-depressants in past 12 months

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

FINTEPLA

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Neurology

**Coverage Duration**

12 months

**Other Criteria**

Failure of epidiolex

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Fotivda

---

**Drugs**  
FOTIVDA

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Oncology/Hematology

**Coverage Duration**  
12 months or until progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**  
FRUZAQLA

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematology/Oncology

**Coverage Duration**  
12 months

**Other Criteria**  
Patient has metastatic colorectal cancer and previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and, if RAS wild-type and medically appropriate, an anti-EGFR therapy.

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

FYCOMPA ORAL SUSPENSION, FYCOMPA ORAL TABLET

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Neurology

**Coverage Duration**

12 months

**Other Criteria**

Failure of lacosamide and levetiracetam

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**  
**GATTEX**

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Gastroenterologist

**Coverage Duration**

6 months initially

**Other Criteria**

Diagnosis of Short Bowel Syndrome Dependent on Parenteral Support Baseline Records of parenteral hydration After 6 month trial of Gattex, patient must demonstrate clinical improvement and or reduction in weekly parenteral fluid volume for continuation.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**  
GAVRETO

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematology/Oncology

**Coverage Duration**  
12 months or until disease progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

*fingolimod hcl*

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Neurology

**Coverage Duration**

12 months

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## **Gilotrif**

---

### **Drugs**

GILOTRIF

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Oncology/Hematology

### **Coverage Duration**

12 months

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Gleostine

---

### Drugs

GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

hematology/oncology

### Coverage Duration

12 months

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Glyburide

---

### **Drugs**

*glyburide micronized, glyburide oral*

### **Exclusion Criteria**

#### **Required Medical Information**

failure or contraindication to preferred glipizide and glimeperide

#### **Age Restriction**

Prior authorization required for members 65 years or older. Automatic approval for members less than 65 years of age.

#### **Prescriber Restriction**

#### **Coverage Duration**

Through benefit year

#### **Other Criteria**

#### **Indications**

All FDA-approved Indications.

#### **Off Label Uses**

#### **Part B Prerequisite**

No

**Drugs**

*tasimelteon*

**Exclusion Criteria****Required Medical Information****Age Restriction****Prescriber Restriction****Coverage Duration**

12 months

**Other Criteria**

Confirmed Diagnosis of non-24 hour sleep-Wake disorder Sleep study to rule out Sleep/apnea or other contributory sleep disorders Patient must be totally blind. Covered for microdeletion syndrome Smith-Magenis syndrome.

**Indications**

All FDA-approved Indications.

**Off Label Uses****Part B Prerequisite**

No

## Humira

---

### Drugs

HUMIRA (2 PEN) SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML, 80 MG/0.8ML, HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, HUMIRA-PED $\geq$ 40KG CROHNS START

### Exclusion Criteria

FDA labeled contraindications combination with other biologic

### Required Medical Information

Medical notes supporting diagnosis (including imaging, serology when applicable), response to previous treatments, current assessment and plan

### Age Restriction

Ages approved in FDA labeling

### Prescriber Restriction

Dermatologist/rheumatologist/ Gastroenterologist/Ophthalmologist

### Coverage Duration

12 months

### Other Criteria

Patient must fail infliximab and a preferred biosimilar adalimumab if on formulary. Part B before Part D Step Therapy.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

Yes

## Ibrance

---

### Drugs

IBRANCE

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/Oncology

### Coverage Duration

12 months

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Icatibant

---

### Drugs

*icatibant acetate subcutaneous solution prefilled syringe*

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Allergist or Immunologist

### Coverage Duration

12 months

### Other Criteria

Confirmed Diagnosis of HEA, Failure of Tranexamic acid and Danazol

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Iclusig

---

**Drugs**  
ICLUSIG

**Exclusion Criteria**

**Required Medical Information**  
Diagnosis

**Age Restriction**

**Prescriber Restriction**  
Hematology/Oncology

**Coverage Duration**  
12 months

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Idhifa

---

**Drugs**  
IDHIFA

**Exclusion Criteria**

**Required Medical Information**  
Evidence of IDH-1 mutation

**Age Restriction**

**Prescriber Restriction**  
Hematology/Oncology

**Coverage Duration**  
12 months or until disease progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Imbruvica

---

### Drugs

IMBRUVICA ORAL CAPSULE, IMBRUVICA ORAL TABLET 420 MG

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/Oncology/ transplant specialist

### Coverage Duration

12 months

### Other Criteria

Off Label and combination use must have CMS compliant compendial support that is consistent with section 10.6 in Chapter 6 of the Medicare Part D

### Indications

All Medically-accepted Indications.

### Off Label Uses

### Part B Prerequisite

No

## Imbruvica Sln

---

### **Drugs**

IMBRUVICA ORAL SUSPENSION

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Hematology/Oncology/ transplant specialist

### **Coverage Duration**

12 months

### **Other Criteria**

Unable to swallow or use a tablet or capsule

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

INCRELEX

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Medical notes supporting diagnosis of severe primary IGF-1 deficiency.

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Endocrinologist

**Coverage Duration**

12 months

**Other Criteria**

Diagnostic support and open epiphyseal plates are required for coverage. If the cause growth hormone insensitivity is unknown or there is a partial growth hormone insensitivity a trial of recombinant growth hormone would be required.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**  
INLYTA

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Oncology

**Coverage Duration**  
12 months or until disease progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**  
INQOVI

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematology/oncology

**Coverage Duration**  
12 months unless patient has disease progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Inrebic

---

### **Drugs**

INREBIC

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Hematology/Oncology

### **Coverage Duration**

12 months or until progression

### **Other Criteria**

Failure of Jakafi

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## **Invega Sustenna**

---

### **Drugs**

INVEGA HAFYERA

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Psychiatry or Neurology

### **Coverage Duration**

12 months

### **Other Criteria**

Failure of quetiapine and risperidone

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

*gefitinib*

**Exclusion Criteria**

Severe hypersensitivity to gefitinib or other components.

**Required Medical Information**

Diagnosis

**Age Restriction**

Patient must be at least 18 years old or older.

**Prescriber Restriction**

Hematology/Oncology

**Coverage Duration**

12 months

**Other Criteria**

Approved for Non Small Cell Lung Cancer with Egfr exon 19 deletion or Exon 21 substitution.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Isotretinoin

---

### Drugs

*isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg*

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

5 months

### Other Criteria

For cystic, nodular or scarring acne, must be refractory to oral antibiotics and topical retinoids. Trial of combination oral tetracycline and topical retinoid must have been tried in most recent 6 months.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## IVIG

---

### Drugs

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

### Exclusion Criteria

### Required Medical Information

Diagnosis, immunoglobulin studies

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

For ITP must fail corticosteroids and Anti-D immunoglobulin (if indicated). For other indications must meet current LCD criteria for immunoglobulin therapy. Part B before Part D Step Therapy

### Indications

All Medically-accepted Indications.

### Off Label Uses

### Part B Prerequisite

Yes

## Iwilfin

---

**Drugs**  
IWILFIN

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Oncology

**Coverage Duration**  
12 months

**Other Criteria**  
Documentation supporting high risk neuroblastoma responsive to prior lines of treatment including anti GD2 antibody therapy

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## **Jakafi**

---

### **Drugs**

JAKAFI

### **Exclusion Criteria**

FDA labeled contraindications, Low risk Disease

### **Required Medical Information**

Diagnosis

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Hematology, oncology, transplant specialist

### **Coverage Duration**

12 months

### **Other Criteria**

Not covered when used in combination with antiproliferative drugs (i.e lenalidomide), or other JAK or tyrosine kinase inhibitors.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Jaypirca

---

### **Drugs**

JAYPIRCA ORAL TABLET 100 MG, 50 MG

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Hematology/Oncology

### **Coverage Duration**

12 months

### **Other Criteria**

Indicated for third line treatment of mantle cell lymphoma after failure of a BTK inhibiting treatment.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Juxtapid

---

### Drugs

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

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

3 months initially, 12 months for continuation

### Other Criteria

Clinical confirmation that patient has HoFH and failure of Statin and PCSK-9 therapy. Continuation of Juxtapid after 3 month trial based on LDL reduction while on therapy. If statin intolerant must fail a PCSK-9 inhibitor.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Kalydeco

---

### Drugs

KALYDECO

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

Genotyping supportive of mutation status in the FDA label

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Kerendia

---

### Drugs

KERENDIA

### Exclusion Criteria

Combination use with eplerenone or spironolactone. Potassium greater than 4.8 meq/L, Egfr leff than 25 ml/min

### Required Medical Information

#### Age Restriction

#### Prescriber Restriction

#### Coverage Duration

12 months

### Other Criteria

Patient has CKD with proteinuria with a urinary albumin to creatinine ratio greater than or equal to 30 mg/g on maximal doses of an ACE Inhibitor or maximal dose of an ARB and an SGLT-2 inhibitor.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**  
**KEVZARA****Exclusion Criteria****Required Medical Information**

Medical history and studies are reviewed in Referrals, including available serology, clinical features, inflammatory markers, and radiography to support diagnosis of rheumatoid arthritis. For polymyalgia rheumatic include clinical documentation to support the diagnosis such as steroid responsiveness, elevation of acute phase reactants on two occasions, onset of symptoms after age 50, morning stiffness, primary pain/stiffness manifestations include shoulders, hips, neck, proximal arms or legs.

**Age Restriction****Prescriber Restriction****Coverage Duration**

12 months

**Other Criteria**

Failure of a preferred TNF inhibitor such as Renflexis or adalimumab for rheumatoid arthritis. For polymyalgia rheumatica inability to taper corticosteroids with use of combination methotrexate

**Indications**

All FDA-approved Indications.

**Off Label Uses****Part B Prerequisite**

No

**Drugs**

KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

**Exclusion Criteria**

FDA labeled contraindications combination with other biologic

**Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

**Coverage Duration**

12 months

**Other Criteria**

For RA failure of Enbrel and Humira

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Kisqali

---

### Drugs

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

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/Oncology

### Coverage Duration

12 months or until progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Korlym

---

**Drugs**  
KORLYM

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
endocrinologist

**Coverage Duration**  
12 months

**Other Criteria**  
Diagnosis of Cushings syndrome , Type 2 diabetes mellitus , Failed surgery OR not a candidate for surgery , Failure of ketoconazole

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**  
KOSELUGO

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
neurology/hematology/oncology

**Coverage Duration**  
12 months

**Other Criteria**  
Diagnosis of Type 1 neurofibromatosis with symptomatic or inoperable plexiform neurofibromas

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Krazati

---

### Drugs

KRAZATI

### Exclusion Criteria

Progression on another KRAS inhibitor such as sotorasib

### Required Medical Information

#### Age Restriction

#### Prescriber Restriction

Oncology

#### Coverage Duration

12 months

### Other Criteria

Presence of G12C mutation with metastatic or locally advanced Non-Small Cell Lung Cancer. Patient must not have progressive disease on treatment for continuation of coverage

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

*sapropterin dihydrochloride oral packet, sapropterin dihydrochloride oral tablet*

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Medical notes supporting diagnosis, response to dietary changes, current assessment and plan, serum phenylalanine.

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Medical Geneticist, neurologist, hepatologist, Metabolic specialist

**Coverage Duration**

12 months

**Other Criteria**

Coverage will be based on medical history/status, response to dietary restrictions recommended by medical professionals.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## **Lenvima**

---

### **Drugs**

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)

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Hematology Oncology

### **Coverage Duration**

12 months or until disease progression

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Lidoderm

---

### Drugs

*lidocaine external patch 5 %*

### Exclusion Criteria

FDA labeled contraindications

### Required Medical Information

#### Age Restriction

Ages approved in FDA labeling

#### Prescriber Restriction

#### Coverage Duration

12 months

### Other Criteria

#### Indications

All FDA-approved Indications.

#### Off Label Uses

#### Part B Prerequisite

No

## **liraglutide (Victoza)**

---

### **Drugs**

VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

12 months

### **Other Criteria**

Failure of Bydureon for patients without established Cardiovascular disease or multiple cardiovascular risk factors. Covered for multiple cardiovascular risk factors or established cardiovascular disease. Not covered in combination with a DPP-IV inhibitor.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

LORBRENA

**Exclusion Criteria**

**Required Medical Information**

Evidence of ALK+ mutation

**Age Restriction**

**Prescriber Restriction**

Hematology/Oncology

**Coverage Duration**

12 months or until disease progression

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## **Lokelma**

---

### **Drugs**

LOKELMA

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

12 month

### **Other Criteria**

Two elevated serum potassium levels in absence of potassium sparing medications.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Long Acting Anti-Psychotics Injections

---

### Drugs

ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE, INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE, *risperidone microspheres er*

### Exclusion Criteria

FDA labeled contraindications

### Required Medical Information

#### Age Restriction

Ages approved in FDA labeling

#### Prescriber Restriction

Neurology Psychiatry

#### Coverage Duration

12 months

#### Other Criteria

Failure of two generic oral anti-psychotics in the past 12 months

#### Indications

All FDA-approved Indications.

#### Off Label Uses

#### Part B Prerequisite

No

## **Lonsurf**

---

### **Drugs**

LONSURF

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Hematology/Oncology

### **Coverage Duration**

12 months

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

*alosetron hcl*

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Gastroenterologist

**Coverage Duration**

12 months

**Other Criteria**

Failure of loperimide and a tricyclic antidepressant. Approved initially for 3 months continuation to 12 months if patient has improvement in symptoms.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Lumakras

---

### **Drugs**

LUMAKRAS

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Oncology/Hematology

### **Coverage Duration**

12 months or until progression

### **Other Criteria**

Submission of molecular profile of tumor supporting KRAS G12C mutation

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Lybalvi

---

### Drugs

LYBALVI

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Neurology/Psychiatry

### Coverage Duration

12 months

### Other Criteria

Failure of Olanzapine and asenapine

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

LYNPARZA ORAL TABLET

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Hematology/Oncology

**Coverage Duration**

12 months

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## **Lytgobi**

---

### **Drugs**

LYTGOBI (12 MG DAILY DOSE), LYTGOBI (16 MG DAILY DOSE), LYTGOBI (20 MG DAILY DOSE)

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Oncology/hematology

### **Coverage Duration**

12 months

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Mavyret

---

### Drugs

MAVYRET

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Gastroenterology, infectious disease, Hepatology

### Coverage Duration

8 weeks to 16 weeks

### Other Criteria

Information supporting diagnosis,genotype,and Metavir score.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Mekinist

---

**Drugs**  
MEKINIST

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**  
12 months or until disease progression

**Other Criteria**  
Mutation analysis showing BRAF V600E or V600K positive, not covered for combination use with other anti-neoplastics unless FDA indication or NCCN recommended with a class 2A or greater evidence rating.

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Mektovi

---

### **Drugs**

MEKTOVI

### **Exclusion Criteria**

#### **Required Medical Information**

Evidence of BRAF mutation

### **Age Restriction**

#### **Prescriber Restriction**

Hematology/Oncology

#### **Coverage Duration**

12 months or until disease progression

### **Other Criteria**

#### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

#### **Part B Prerequisite**

No

## Metaxalone

---

### Drugs

*metaxalone oral tablet 800 mg*

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

4 weeks

### Other Criteria

For patients over 64 years of age, Physician attests they have counseled patient on risk benefit of muscle relaxers as a high risk medication and patient has been evaluated for fall risk.

### Indications

All Medically-accepted Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

MOVANTIK

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

12months

**Other Criteria**

Failure of Lactulose and lubiprostone

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**  
NERLYNX

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematologist/Oncologist

**Coverage Duration**  
12 months or until disease progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Neupro

---

### Drugs

NEUPRO

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

Failure of Ropinirole and Pramipexole

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

*sorafenib tosylate*

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Oncology

**Coverage Duration**

12 months or until disease progression

**Other Criteria**

failure of sunitinib for metastatic renal cell carcinoma

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Ninlaro

---

### Drugs

NINLARO

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/Oncology

### Coverage Duration

12 months

### Other Criteria

Failure of bortezomib and lenalidomide required for coverage

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

Yes

**Drugs**

*droxidopa*

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

12 months

**Other Criteria**

Documented orthostatic hypotension or Dopamine-Beta-Hydroxylase deficiency

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Noxafil

---

### Drugs

NOXAFIL ORAL SUSPENSION, *posaconazole oral*

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

3 months

### Other Criteria

Failure, resistance or contraindication to itraconazole, voriconazole

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Nubeqa

---

### Drugs

NUBEQA

### Exclusion Criteria

#### Required Medical Information

Patient has failed Xtandi for premetastatic castrate resistant prostate cancer.

#### Age Restriction

#### Prescriber Restriction

#### Coverage Duration

12 months or until Disease progression

#### Other Criteria

Patient has failed Xtandi for premetastatic castrate resistant prostate cancer. Failed abiraterone for areas of overlapping indication or medically acceptable use.

#### Indications

All FDA-approved Indications.

#### Off Label Uses

#### Part B Prerequisite

No

### Drugs

NUCALA

### Exclusion Criteria

#### Required Medical Information

The following criteria must be met for coverage for oral steroid dependent severe eosinophilic asthma: Prescriber must be a pulmonologist or allergist, and patient must fail trial of LABA+ICS combination and a leukotriene receptor antagonist. For Hypereosinophilic syndrome failure of corticosteroids or imatinib and hydroxyurea. For nasal polyps recent failure (past 3 months) of intranasal corticosteroid and a 10-15 day course of oral corticosteroid at adequate doses based on the literature (ie prednisone 60-40mg for 5 days followed by 10mg-20mg for 5 to 10 days)

### Age Restriction

#### Prescriber Restriction

Pulmonologist, Allergist, Otolaryngologist, hematologist, or Rheumatologist

#### Coverage Duration

12 months

#### Other Criteria

Nucala is an interleukin 5 antagonist covered for indications of eosinophilic asthma and eosophilic granulomatosis with polyangiitis. Medical history and studies are reviewed in Referrals and if approved will notify pharmacy and the physician.

#### Indications

All FDA-approved Indications.

#### Off Label Uses

#### Part B Prerequisite

No

**Drugs**

NUEDEXTA

**Exclusion Criteria**

**Required Medical Information**

Diagnosis

**Age Restriction**

**Prescriber Restriction**

neurology

**Coverage Duration**

12 months

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Nuplazid

---

### Drugs

NUPLAZID ORAL CAPSULE, NUPLAZID ORAL TABLET 10 MG

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Neurology Psychiatry

### Coverage Duration

12 months

### Other Criteria

Notes supporting dementia with hallucinations or delusions secondary to parkinsons dementia.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

NURTEC

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Neurology, Pain management, headache specialist

**Coverage Duration**

12 months

**Other Criteria**

Failure of eletriptan and sumatriptan for abortive treatment, failure of topiramate and Aimovig for migraine prophylaxis.

**Indications**

Some FDA-approved Indications Only.

**Off Label Uses**

**Part B Prerequisite**

No

## Odomzo

---

**Drugs**  
ODOMZO

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematology/Oncology

**Coverage Duration**  
12 months

**Other Criteria**  
Approval will initially be for three months, if patient has a response to therapy will be renewed for 12 months

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**  
**OFEV**

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
pulmonologist

**Coverage Duration**  
12 months

**Other Criteria**

Confirmed Diagnosis of idiopathic pulmonary fibrosis (IPF) through exclusion of other fibrosing conditions/causes and definitive High resolution CT IPF pattern or Biopsy proven IPF. FVC of at least 50% of predicted value DLCO of at least 30%. Confirmed Diagnosis of systemic sclerosis associated interstitial lung disease. Confirmed diagnosis chronic fibrosis interstitial lung diseases and discontinuation of medications which can cause pulmonary fibrosis if risk outweighs benefit.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**  
OGSIVEO

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**  
12 months

**Other Criteria**  
Approve for progressive desmoid tumors requiring systemic treatment.

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**  
OJJAARA

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematology/Oncology

**Coverage Duration**  
12 months

**Other Criteria**  
Failure of Jakafi

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE, OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

studies establishing diagnosis of indication.

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Endocrinologist

**Coverage Duration**

12 months

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**

*clobazam*

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Diagnosis

**Age Restriction**

FDA approved Ages

**Prescriber Restriction**

Restricted to Neurology

**Coverage Duration**

12 Months

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**  
ONUREG

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Oncology/Hematology

**Coverage Duration**  
12 months or until progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**  
OPSUMIT

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
pulmonologist/cardiologist

**Coverage Duration**  
12 months

**Other Criteria**  
Failure of Ambrisentan and tadalafil

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Orenitram

---

### Drugs

ORENITRAM

### Exclusion Criteria

#### Required Medical Information

Right Heart catheterization to confirm the diagnosis

### Age Restriction

#### Prescriber Restriction

Pulmonologist or Cardiologist

#### Coverage Duration

12 months

#### Other Criteria

Failure of combination Ambrisentan and tadalafil

#### Indications

All FDA-approved Indications.

#### Off Label Uses

#### Part B Prerequisite

No

**Drugs**  
ORGOVYX

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Urology/Hematology

**Coverage Duration**  
12 months or until progression

**Other Criteria**  
Failure or intolerance of degaralix and leuprolide

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Orilissa

---

### Drugs

ORILISSA

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

OB/GYN

### Coverage Duration

6 months

### Other Criteria

Covered for endometriosis, failure of NSAID and combinedestrogen-progestin contraceptive or progestin.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Orkambi

---

### Drugs

ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG, ORKAMBI ORAL TABLET

### Exclusion Criteria

#### Required Medical Information

CFTR mutation analysis, spirometry

#### Age Restriction

Ages approved in FDA label

#### Prescriber Restriction

pulmonologist

#### Coverage Duration

12 months

#### Other Criteria

CFTR mutation must be supported by FDA approved label such as homozygous F508-deletion

#### Indications

All FDA-approved Indications.

#### Off Label Uses

#### Part B Prerequisite

No

## Orserdu

---

### Drugs

ORSERDU ORAL TABLET 345 MG, 86 MG

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/Oncology

### Coverage Duration

12 months

### Other Criteria

Approved for ESR-1 mutated ER+ HER2- advanced or metastatic breast cancer which has progressed on a CDK 4/6 inhibitor.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

### **Drugs** OTEZLA

### **Exclusion Criteria**

#### **Required Medical Information**

Documentation of active psoriatic arthritis or mild to moderate plaque psoriasis or Bechet's disease.

### **Age Restriction**

#### **Prescriber Restriction**

Rheumatologist, Dermatologist

#### **Coverage Duration**

12 months

#### **Other Criteria**

For mild plaque Psoriasis (less than 3 % BSA) patient must fail combination calcipotriene and diflorisone or other high potency topical steroid or roflumilast. For moderate plaque psoriasis patient must fail methotrexate and a preferred TNF such as adalimumab or infliximab. For psoriatic arthritis patient must fail a preferred TNF inhibitor (Adalimumab/Infliximab) AND Xeljanz OR methotrexate. Part B before Part D Step Therapy.

#### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

#### **Part B Prerequisite**

Yes

**Drugs**

PEMAZYRE

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Hematology/oncology

**Coverage Duration**

12 months or until progression

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Phenoxybenzamine

---

### Drugs

*phenoxybenzamine hcl oral*

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Piqray

---

### Drugs

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

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months or until progression,

### Other Criteria

HR+ ER- with PIK3CA mutation advanced/metastatic breast cancer and failure of endocrine therapy.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Pomalyst

---

### Drugs

POMALYST

### Exclusion Criteria

FDA contraindications

### Required Medical Information

#### Age Restriction

#### Prescriber Restriction

Hematology/Oncology

#### Coverage Duration

12 months

### Other Criteria

Approve for patients with multiple myeloma who have received at least two prior therapies including lenalidomide and bortezomib and have demonstrated disease progression on or within 60 days of completion of the last therapy. Covered for patients with Kaposi sarcoma.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Prevymis

---

### Drugs

PREVYMIS ORAL

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

100 days post allogeneic stem cell transplantation, 200 days post renal transplantation

### Other Criteria

Patient had an allogeneic stem cell transplant within the last 28 days and CMV seropositive. For renal transplant the donor must be CMV seropositive and the patient must be CMV seronegative AND patient is intolerant, has baseline leukopenia, or had failed valganciclovir.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## **Prolastin-C**

---

### **Drugs**

PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

1 Year

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## **Prolia**

---

### **Drugs**

PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

12 months

### **Other Criteria**

Intolerance or contraindication to injectable bisphosphonate required for coverage of prolia. Part B before Part D Step Therapy

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

Yes

## Promacta

---

### **Drugs**

PROMACTA ORAL PACKET 12.5 MG, PROMACTA ORAL TABLET

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, CBC  
,Platelet count less than 50,000/ml for ITP, Platelet count of less than 75,000/ml for HCV

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Hematologist/oncologist, Hepatologist/gastroenterologist, Infectious Disease

### **Coverage Duration**

12 months

### **Other Criteria**

Chronic ITP Refractory to IVIG, corticosteroids or splenectomy as per FDA approval studies not applicable to HCV related thrombocytopenia

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Pulmozyme

---

### Drugs

PULMOZYME INHALATION SOLUTION 2.5 MG/2.5ML

### Exclusion Criteria

FDA labeled contraindications

### Required Medical Information

Medical notes supporting diagnosis of cystic fibrosis current assessment and plan

### Age Restriction

Ages approved in FDA labeling

### Prescriber Restriction

Pulmonologist

### Coverage Duration

12 months

### Other Criteria

Covered for Patients with Cystic Fibrosis. Not covered for off label indications such as asthma

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## pyrimethamine (Daraprim)

---

### **Drugs**

*pyrimethamine oral*

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

12 Months

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**  
QINLOCK

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
hematology/oncology

**Coverage Duration**  
12 months or until disease progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Ravicti

---

**Drugs**  
RAVICTI

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

hepatologist or metabolic specialist such as a endocrinologist or geneticist

**Coverage Duration**

12 months

**Other Criteria**

Clinical Failure of Buphenyl

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Rebif

---

### Drugs

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

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

Failure of dimethyl fumarate and teriflunomide

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Repatha

---

### Drugs

REPATHA, REPATHA PUSHTRONEX SYSTEM, REPATHA SURECLICK

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

For patients with HoFH, HeFH, or with established atherosclerotic cardiovascular disease and Primary hyperlipidemia who require additional LDL lowering: Failure of rosuvastatin 40mg or Atorvastatin 80 combined with ezetimibe 10mg. Diagnosis of must be HeFH supported by Dutch Lipid Clinic Network criteria. Diagnosis of HOFH must be confirmed by genetic testing. Patients who are intolerant to rosuvastatin/ atorvastatin can use an alternative statin + Ezetimibe 10mg. For statin intolerant patients who required additional LDL lowering and have established cardiovascular disease, HoFH, or HeFH: History of statin intolerance to a hydrophilic statin such as fluvastatin, pravastatin, rosuvastatin in the absence of fibrates or other combinations which can increase risk of myopathy or myalgia when used in combination with a statin.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Retacrit

---

### Drugs

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

### Exclusion Criteria

FDA labeled contraindications

### Required Medical Information

Scr, HGB, T-sat, Ferritin

### Age Restriction

Ages approved in FDA labeling

### Prescriber Restriction

### Coverage Duration

6 months

### Other Criteria

Hemoglobin must be within FDA approved ranges for initiation and maintenance. Patient must have adequate iron stores to initiate and continue treatment. ESRD will be covered under Medicare Part B

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Retevmo

---

### Drugs

RETEVMO

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Oncology

### Coverage Duration

12 months or disease progression

### Other Criteria

Diagnosis of metastatic non-small cell lung cancer or metastatic or advanced medullary thyroid carcinoma with RET alterations

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Revatio

---

### Drugs

*sildenafil citrate oral tablet 20 mg*

### Exclusion Criteria

FDA labeled contraindications

### Required Medical Information

Medical notes supporting diagnosis, current assessment and plan, 6 min walk, diffusion studies, Rt Heart Cath

### Age Restriction

Ages approved in FDA labeling

### Prescriber Restriction

Pulmonologist/Cardiologist

### Coverage Duration

12 months

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Revlimid

---

### **Drugs**

*lenalidomide*

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, CBC, Bone Marrow Biopsy, Karyotype

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Hematologist/oncologist

### **Coverage Duration**

12 months

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Rexulti

---

**Drugs**  
REXULTI

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**  
12months

**Other Criteria**  
Failure of aripiprazole and lurasidone for schizophrenia or failure of combination SSRI and aripiprazole for major depressive disorder. For Alzheimer's agitation failure of quetiapine and olanzapine

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Rezlidhia**

---

**Drugs**  
REZLIDHIA

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematology/Oncology

**Coverage Duration**  
12 months

**Other Criteria**  
Presences of an IDH-1 mutation

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

REZUROCK

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Hematology/Oncology/Transplant

**Coverage Duration**

12 months

**Other Criteria**

Failure of Jakafi and Imbruvica

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Rubraca

---

**Drugs**  
RUBRACA

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Oncology/Hematology

**Coverage Duration**  
12 months or until disease progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Rydapt

---

### Drugs

RYDAPT

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/Oncology

### Coverage Duration

12 months or until progression

### Other Criteria

Labs supporting FLT3 mutation if being used for AML, not required for systemic mastocytosis

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

*vigabatrin*, VIGPODER

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Neurologist

**Coverage Duration**

12 months

**Other Criteria**

For Refractory Partial Complex, failure of 2 adjunctive regimens containing any of the following  
lacosamide, lamotrigine, or levetiracetam

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**

SCSEMBLIX

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Oncology Hematology

**Coverage Duration**

12 months unless disease progression

**Other Criteria**

Failure of ponatinib if T315I mutation present.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**  
SECUADO

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Restricted to Neurology/Psychiatry

**Coverage Duration**  
12 months

**Other Criteria**  
Failure of lurasidone and risperidone

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

*cinacalcet hcl*

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, previous treatment history, associated studies iPTH, calcium, phosphate

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Nephrologist/endocrinologist/oncologist

**Coverage Duration**

12 months

**Other Criteria**

For secondary hyperparathyroidism related to CKD, patient must fail active vit-D therapy/phosphate binders. ESRD use is excluded from medicare Part D and this authorization will include a determination of Part D vs Part B coverage based indication

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Signifor

---

**Drugs**  
SIGNIFOR

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Endocrinologist

**Coverage Duration**  
12 months

**Other Criteria**  
For Cushings Disease failed or poor surgical candidate for pituitary resection

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

*diclofenac sodium external gel 3 %*

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Diagnosis

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Dermatologist, oncologist

**Coverage Duration**

12 months

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**

SOMAVERT

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Endocrinologist

**Coverage Duration**

12 months

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Sprycel

---

**Drugs**  
SPRYCEL

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**  
12 months or until disease progression

**Other Criteria**  
Requires failure of imatinib for low risk CML based on Sokal or Hasford scores.

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

gastroenterologist/rheumatologist/dermatologist

**Coverage Duration**

12 months

**Other Criteria**

For Crohns, patient must fail Entyvio and Renflexis. For plaque psoriasis, patient must fail adalimumab and Renflexis. For psoriatic arthritis, patient must fail a preferred TNF (adalimumab or infliximab) and Xeljanz. Part B before Part D Step Therapy

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

Yes

## Stivarga

---

### Drugs

STIVARGA

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Oncology

### Coverage Duration

12 months or until disease progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

SUNOSI ORAL TABLET 150 MG, 75 MG

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Board Certified Sleep Medicine

**Coverage Duration**

12 months

**Other Criteria**

Covered for narcolepsy requires failure of modafinil/armodafinil and failure of amphetamine/methylphenidate

**Indications**

Some FDA-approved Indications Only.

**Off Label Uses**

**Part B Prerequisite**

No

## Sutent

---

### Drugs

*sunitinib malate*

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Oncology

### Coverage Duration

12 months or until disease progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

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

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, HA1c BG

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Endocrinologist, Internist

**Coverage Duration**

12 months

**Other Criteria**

Patient BG must be non-controlled on optimal doses of insulin

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Sympazan

---

**Drugs**  
SYMPAZAN

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**  
12 months

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

SYNAREL

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Diagnosis, Notes, Previous treatment history

**Age Restriction**

Ages approved in FDA Label

**Prescriber Restriction**

**Coverage Duration**

12 months

**Other Criteria**

Covered after patient fails treatment with Lupron for endometriosis or precocious puberty

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Tabrecta

---

### Drugs

TABRECTA

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Oncology/Hematology

### Coverage Duration

12 months or until progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Tafinlar

---

### Drugs

TAFINLAR

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months or until disease progression

### Other Criteria

Mutation analysis showing BRAF V600E or V600K positive, not covered for combination use with other anti-neoplastics unless FDA indication or NCCN recommended with a class 2A or greater evidence rating.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Tagrisso

---

### Drugs

TAGRISSE

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/Oncology

### Coverage Duration

12 months

### Other Criteria

Coverage requires Diagnosis of Non Small Cell Lung cancer with EGFR mutations as indicated by the FDA.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**  
**TALTZ**

**Exclusion Criteria**

**Required Medical Information**

Notes supporting diagnostic evidence and previous treatment history.

**Age Restriction**

**Prescriber Restriction**

Rheumatology, Dermatology

**Coverage Duration**

12 months

**Other Criteria**

For Plaque Psoriasis must fail a preferred formulary subcutaneous TNF inhibitor(adalumab) and IV TNF inhibitor (Renflexis). For Psoriatic Arthritis must fail a preferred TNF agent(adalimumab/renflexis) and JAK inhibitor(Xeljanz). For Ankylosing Spondylitis must fail adalimumab and Renflexis. For non-radiographic axial spondylarthritis failure of a TNF inhibitor (adalimumab/Renflexis). Part B before Part D Step Therapy

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

Yes

## Talzenna

---

### Drugs

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

### Exclusion Criteria

#### Required Medical Information

Evidence of germline BRCA mutation for breast cancer or HRR mutations for metastatic prostate cancer

### Age Restriction

#### Prescriber Restriction

Hematology/Oncology

#### Coverage Duration

12 months or until disease progression

#### Other Criteria

Evidence of germline BRCA mutation for breast cancer or HRR mutations for metastatic prostate cancer

#### Indications

All FDA-approved Indications.

#### Off Label Uses

#### Part B Prerequisite

No

## Tarceva

---

### **Drugs**

*erlotinib hcl*

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Oncology

### **Coverage Duration**

12 months or until disease progression

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Targretin

---

### **Drugs**

*bexarotene external, bexarotene oral*

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Oncology, dermatology

### **Coverage Duration**

12 months or until disease progression

### **Other Criteria**

Must have failed one prior systemic therapy

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Tasigna

---

### Drugs

TASIGNA

### Exclusion Criteria

FDA labeled contraindications

### Required Medical Information

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan

### Age Restriction

Ages approved in FDA labeling

### Prescriber Restriction

Hematologist/oncologist

### Coverage Duration

12 months

### Other Criteria

Covered for failure or relapse of CML when previously treated with imatinib. Covered for newly diagnosed CML patients who are Philadelphia chromosome +. Will also be covered for intolerance or adverse reaction to imatinib. Combination therapy with other tyrosine kinase inhibitors or MTOR inhibitors for CML is not supported.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Tazorac

---

### **Drugs**

*tazarotene external cream, tazarotene external gel*, TAZORAC EXTERNAL CREAM 0.05 %

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Previous treatment history

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

### **Coverage Duration**

12 months

### **Other Criteria**

For Psoriasis patient must have failed medium to high potency topical corticosteroid, For acne patient must have failed Tretinoin and oral antibiotic

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

TAZVERIK

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Oncology/Hematology

**Coverage Duration**

12 months or until progression

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Tecfidara

---

### **Drugs**

*dimethyl fumarate oral, dimethyl fumarate starter pack oral capsule delayed release therapy pack*

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Neurology

### **Coverage Duration**

12 months

### **Other Criteria**

Diagnosis of MS

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Tepmetko

---

### Drugs

TEPMETKO

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/oncology

### Coverage Duration

12 months or until progression

### Other Criteria

Molecular profile to support MET exon 14 skipping mutation

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Tetrabenazine

---

### **Drugs**

*tetrabenazine*

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Neurology or Psychiatry

### **Coverage Duration**

12 months

### **Other Criteria**

For tardive dyskinesia causative drug must be discontinued or tried at a lower dose

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Thalomid

---

### Drugs

THALOMID

### Exclusion Criteria

FDA labeled contraindications

### Required Medical Information

#### Age Restriction

Ages approved in FDA labeling

#### Prescriber Restriction

Hematologist/oncologist/infectious disease/dermatologist

#### Coverage Duration

12 months

### Other Criteria

#### Indications

All FDA-approved Indications.

#### Off Label Uses

#### Part B Prerequisite

No

**Drugs**

TIBSOVO

**Exclusion Criteria**

**Required Medical Information**

Evidence of IDH-1 Mutation

**Age Restriction**

**Prescriber Restriction**

Hematology/Oncology

**Coverage Duration**

12 months or until disease progression

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**

TOBI PODHALER

**Exclusion Criteria**

**Required Medical Information**

Medical notes describing indication for the management of cystic fibrosis patients with *Pseudomonas aeruginosa* and with forced expiratory volume in 1 second (FEV1) greater than 25% or less than 80%.

**Age Restriction**

6 years and older

**Prescriber Restriction**

**Coverage Duration**

Through benefit year

**Other Criteria**

Safety and efficacy have not been demonstrated in patients with forced expiratory volume in 1 second (FEV1) less than 25% or greater than 80%, or patients colonized with *Burkholderia cepacia*

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**

*bosentan*

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, right heart catheterization, 6 Minute Walk time

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Pulmonologist or cardiologist

**Coverage Duration**

12 months

**Other Criteria**

Pulmonary hypertension must be diagnosed by heart catheterization ,Evaluation, EKG, diffusion studies, catheterization results and an objective test of exercise ability (6 minute walk) must be submitted with referral ,Coverage will be based on medical history/status, vasoreactivity tests, failure of sildenafil. Sildenafil failure does not apply to pediatric patients with congenital or ideopathic PAH

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Tretinoin Topical

---

### Drugs

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

### Exclusion Criteria

FDA labeled contraindications, treatment of photoaging, wrinkles

### Required Medical Information

Diagnosis

### Age Restriction

Ages approved in FDA labeling

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

TRINTELLIX

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

12 months

**Other Criteria**

Failure of vilazodone and another generically available anti-depressant within past 6 months

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Truqap

---

**Drugs**  
TRUQAP

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematology/Oncology

**Coverage Duration**  
12 months

**Other Criteria**  
Patient has had progression on at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy.

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Tukysa

---

**Drugs**  
TUKYSA

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
hematology/oncology

**Coverage Duration**  
12 months or until disease progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Turalio

---

### Drugs

TURALIO ORAL CAPSULE 125 MG

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Oncology/hematology

### Coverage Duration

12 months or until disease progression

### Other Criteria

Patient is not a surgical candidate and has a Tenosynovial giant cell tumor.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

*lapatinib ditosylate*

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan associated studies

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Oncologist/hematologist

**Coverage Duration**

12 months

**Other Criteria**

Patient is using in combination with capecitabine for HER/NEU + Metastatic breast CA, having failed an anthracycline, Herceptin and a taxane, or Patient must be using in combination with an aromatase inhibitor and have HER/NEU+ HR+ metastatic breast CA

**Indications**

All Medically-accepted Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Tymlos

---

### **Drugs** TYMLOS

#### **Exclusion Criteria**

FDA labeled contraindications/ cumulative tx more than 24month

#### **Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, BMD, PTH, VITD

#### **Age Restriction**

Late adolescents and Adults only

#### **Prescriber Restriction**

#### **Coverage Duration**

12 months

#### **Other Criteria**

Patient must fail or have contraindication to bisphosphonates, Vitamin D (25,OH), PTH must be WNL

#### **Indications**

All FDA-approved Indications.

#### **Off Label Uses**

#### **Part B Prerequisite**

No

**Drugs**

UBRELVY

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Neurologist, Headache Specialist, Pain specialist

**Coverage Duration**

12 months

**Other Criteria**

Failure of eletriptan and sumatriptan.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**

*budesonide er oral tablet extended release 24 hour*

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Gastroenterologist

**Coverage Duration**

8 weeks

**Other Criteria**

approved for 8 weeks in patients with active mild-moderate ulcerative colitis who are intolerant or have failed 1-1.5 mg/kg of oral prednisone and mesalamine

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Udenyca

---

### Drugs

FULPHILA, UDENYCA

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

12 months

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

UPTRAVI ORAL, UPTRAVI TITRATION

**Exclusion Criteria**

**Required Medical Information**

Right heart catheterization supporting diagnosis of PAH

**Age Restriction**

**Prescriber Restriction**

Pulmonology or Cardiology

**Coverage Duration**

12 months

**Other Criteria**

diagnosis of WHO group 1 PAH, failure of Ambrisentan and tadalafil

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Valchor

---

### Drugs

VALCHLOR

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Oncology

### Coverage Duration

12 months or until disease progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Valtoco

---

### Drugs

VALTOCO 10 MG DOSE, VALTOCO 15 MG DOSE, VALTOCO 20 MG DOSE, VALTOCO 5 MG DOSE

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Neurology

### Coverage Duration

12 months

### Other Criteria

History of cluster seizures or acute repetitive seizures.

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**  
VANFLYTA

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
hematology/oncology

**Coverage Duration**  
12 months

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

*icosapent ethyl*

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

12 months

**Other Criteria**

Approved for patients on a statin with high cardiovascular risk and elevated triglycerides between 150-499mg/dl. Approved for hypertriglyceridemia after failure of fibrate and omega-3-acid ethyl esters.

Approved for statin intolerant patients with high cardiovascular risk and elevated triglycerides between 150-499mg/dl.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Venclexta

---

### **Drugs**

VENCLEXTA, VENCLEXTA STARTING PACK

### **Exclusion Criteria**

#### **Required Medical Information**

Medical notes supporting diagnosis.

#### **Age Restriction**

#### **Prescriber Restriction**

Hematology/Oncology

#### **Coverage Duration**

12 months

#### **Other Criteria**

approved for all FDA approved indications

#### **Indications**

All FDA-approved Indications.

#### **Off Label Uses**

#### **Part B Prerequisite**

No

## Verzenio

---

### Drugs

VERZENIO

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/Oncology

### Coverage Duration

12 months or clinical progression

### Other Criteria

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

VITRAKVI

**Exclusion Criteria**

**Required Medical Information**

Evidence of a NTRK fusion

**Age Restriction**

**Prescriber Restriction**

**Coverage Duration**

12 months or until disease progression

**Other Criteria**

Intolerance or contraindication of entrectinib

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**

VIZIMPRO

**Exclusion Criteria**

**Required Medical Information**

Evidence of EGFR mutated non-small cell lung cancer

**Age Restriction**

**Prescriber Restriction**

Hematology/Oncology

**Coverage Duration**

12 months or until Disease progression

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**  
VONJO

**Exclusion Criteria**  
FDA labeled contraindications

**Required Medical Information**  
Diagnosis

**Age Restriction**  
Ages approved in FDA labeling

**Prescriber Restriction**  
Hematology, Oncology

**Coverage Duration**  
12 months

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

## Voriconazole

---

### Drugs

*voriconazole intravenous, voriconazole oral*

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

3 months

### Other Criteria

Covered when two of the following medications have been tried, unless resistance or contraindication precludes use, Itraconazole, fluconazole, ketoconazole. Exclusions to prerequisite medications are Invasive pulmonary aspergillosis, *Scedosporium apiospermum*, *Fusarium*

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Votrient**

---

**Drugs**

*pazopanib hcl*

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Oncology

**Coverage Duration**

12 months or until disease progression

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**

VRAYLAR ORAL CAPSULE, VRAYLAR ORAL CAPSULE THERAPY PACK

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Psychiatry or Neurology

**Coverage Duration**

12 months

**Other Criteria**

For Bipolar 1 disorder failure of lurasidone and quetiapine. For treatment of Schizophrenia failure of lurasidone and aripiprazole. For adjunctive treatment of major depressive disorder failure of aripiprazole and quetiapine.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Welireg

---

### Drugs

WELIREG

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

Hematology/Oncology

### Coverage Duration

12 months unless disease progression

### Other Criteria

Clinical information and labs supporting diagnosis

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

**Drugs**

XALKORI

**Exclusion Criteria**

**Required Medical Information**

Diagnosis, documentation support ALK+ NSLC or ROS1 Positive for NSCLC indication.

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Hematology-oncology

**Coverage Duration**

6 months

**Other Criteria**

Continuation will be based on lack of disease progression

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## **Xcopri**

---

### **Drugs**

XCOPRI, XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG,  
XCOPRI (350 MG DAILY DOSE)

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Neurology

### **Coverage Duration**

12 months

### **Other Criteria**

Recent failure (past 6 months) of lacosamide and lamotrigine

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

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

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Rheumatology/Gastroenterologist

**Coverage Duration**

12 months

**Other Criteria**

For Rheumatoid arthritis- 3 month trial of Combination DMARD therapy in past 6 months, For Psoriatic Arthritis Patient must fail 3 month trial of MTX or LEF in past 6 months. For ulcerative colitis patient must fail azathioprine/6MP in combination with a 5-ASA compound.

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## Xermelo

---

### **Drugs**

XERMELO

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Hematologist, oncologist, gastroenterologist

### **Coverage Duration**

12 months

### **Other Criteria**

Failure of Sandostatin LAR

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**  
XGEVA

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
oncology/endocrinology

**Coverage Duration**  
12 months

**Other Criteria**  
Failure or contraindication to bisphosphonate for osteolytic cancer indications other than giant cell tumor of the bone.

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

XIFAXAN ORAL TABLET 550 MG

**Exclusion Criteria**

**Required Medical Information**

Notes to substantiate diagnosis of Hepatic Encephalopathy or Irritable Bowel Syndrome with Diarrhea

**Age Restriction**

**Prescriber Restriction**

Gastroenterology/Hepatology

**Coverage Duration**

12 months for Hepatic Encephalopathy or Three 14 day courses for IBS-D

**Other Criteria**

Approve for IBS-D if patient has failed a tricyclic antidepressant and loperamide, approval will be limited to three 14 day treatments. Approval for hepatic encephalopathy is based on failure or intolerance of therapeutic doses of lactulose (30-45ml two to four times daily).

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## **Xolair**

---

### **Drugs**

XOLAIR

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan. For asthma please submit RAST, aeroallergens results, IgE values

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Pulmonologist, allergist, dermatologist, otolaryngologist

### **Coverage Duration**

12 months

### **Other Criteria**

For Asthma patient Must Fail Combination LABA/ICS. For chronic ideopathic urticaria failure of hydroxyzine and H-2 antagonist.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## **Xospata**

---

### **Drugs**

XOSPATA

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

### **Coverage Duration**

12 months or until disease progression

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

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

**Exclusion Criteria****Required Medical Information****Age Restriction****Prescriber Restriction**

Oncology/Hematology

**Coverage Duration**

12 months or until disease progression

**Other Criteria****Indications**

All FDA-approved Indications.

**Off Label Uses****Part B Prerequisite**

No

## Xtandi

---

### Drugs

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

### Exclusion Criteria

### Required Medical Information

### Age Restriction

### Prescriber Restriction

### Coverage Duration

6 months or until disease progression

### Other Criteria

Failure of Abiraterone for metastatic prostate cancer

### Indications

All FDA-approved Indications.

### Off Label Uses

### Part B Prerequisite

No

## Xyrem

---

### **Drugs**

*sodium oxybate*

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Physician Board certified in Sleep Medicine or neurologist

### **Coverage Duration**

12 months

### **Other Criteria**

Failure of Modafanil/Armodafinil and sulriamfetol or failure of fluoxetine and sulriamfetol for narcolepsy with cataplexy in adult patients. Failure of Modafanil and in pediatric patients

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

*miglustat*

**Exclusion Criteria**

FDA labeled contraindications

**Required Medical Information**

Medical notes supporting diagnosis, current assessment and plan

**Age Restriction**

Ages approved in FDA labeling

**Prescriber Restriction**

Oncologist/Hematologist, Neurologist, Medical Geneticist, Metabolic Specialist.

**Coverage Duration**

12 months

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

## **Zejula**

---

### **Drugs**

ZEJULA ORAL CAPSULE, ZEJULA ORAL TABLET

### **Exclusion Criteria**

#### **Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan

### **Age Restriction**

#### **Prescriber Restriction**

Hematology/Oncology

#### **Coverage Duration**

12 months or until progression

### **Other Criteria**

#### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

#### **Part B Prerequisite**

No

## Zelboraf

---

### Drugs

ZELBORAF

### Exclusion Criteria

### Required Medical Information

#### Age Restriction

Ages approved in FDA labeling

#### Prescriber Restriction

Oncology

#### Coverage Duration

3 months

#### Other Criteria

Authorization for continuation past 90 days will be based on absence of disease progression.

#### Indications

All FDA-approved Indications.

#### Off Label Uses

#### Part B Prerequisite

No

**Drugs**

ZEPATIER

**Exclusion Criteria****Required Medical Information**

Gentotype, Viral Load, Fibroscan/Fibrosure or liver biopsy, RAV NS5A panel

**Age Restriction****Prescriber Restriction**

Infectious disease, Gastroenterology/Hepatology

**Coverage Duration**

12 or 16 weeks depending on RAV profile as supported by current AASLD guidelines

**Other Criteria**

Contraindication to GLECAPREVIR/PIBRENTASVIR

**Indications**

All FDA-approved Indications.

**Off Label Uses****Part B Prerequisite**

No

## **zileuton (Zyflo)**

---

### **Drugs**

*zileuton er*

### **Exclusion Criteria**

### **Required Medical Information**

### **Age Restriction**

### **Prescriber Restriction**

Pulmonology

### **Coverage Duration**

12 months

### **Other Criteria**

Uncontrolled Asthma while on maximal doses of long acting bronchodilators and inhaled corticosteroids  
AND montelukast.

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Zolinza

---

### **Drugs**

ZOLINZA

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Medical notes supporting diagnosis, response to previous treatments, current assessment and plan

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Oncologist/hematologist/dermatologist

### **Coverage Duration**

12 months

### **Other Criteria**

Failed minimum of two systemic treatments, one of which must be Targretin, unless contraindicated

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

**Drugs**

ZTALMY

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**

Neurology

**Coverage Duration**

12 months

**Other Criteria**

Diagnosis of CDK15 deficiency disorder

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**

ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

Woman of childbearing age

**Prescriber Restriction**

obstetrics/gynecology/psychiatry

**Coverage Duration**

14 days

**Other Criteria**

**Indications**

All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**

No

**Drugs**  
ZYDELIG

**Exclusion Criteria**

**Required Medical Information**

**Age Restriction**

**Prescriber Restriction**  
Hematology/Oncology

**Coverage Duration**  
12 months or until disease progression

**Other Criteria**

**Indications**  
All FDA-approved Indications.

**Off Label Uses**

**Part B Prerequisite**  
No

**Drugs**

ZYKADIA ORAL TABLET

**Exclusion Criteria****Required Medical Information****Age Restriction****Prescriber Restriction**

Hematology/Oncology

**Coverage Duration**

12 months or until disease progression

**Other Criteria**

Restricted to use in ALK+ Non Small Cell Lung Cancer

**Indications**

All FDA-approved Indications.

**Off Label Uses****Part B Prerequisite**

No

## Zyprexa Injection

---

### **Drugs**

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

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Diagnosis

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

### **Coverage Duration**

12 months

### **Other Criteria**

Failure of two generic anti-psychotics in the past 12 months

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

## Zytiga

---

### **Drugs**

*abiraterone acetate oral tablet 250 mg*

### **Exclusion Criteria**

FDA labeled contraindications

### **Required Medical Information**

Diagnosis

### **Age Restriction**

Ages approved in FDA labeling

### **Prescriber Restriction**

Oncology/urology

### **Coverage Duration**

12 months

### **Other Criteria**

### **Indications**

All FDA-approved Indications.

### **Off Label Uses**

### **Part B Prerequisite**

No

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