2024

Prior Authorization Criteria

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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

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

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

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

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

Drugs
AKEEGA

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Urology/Hematology

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

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

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

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

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 entacopone

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Aptiom

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 cancakinumab, nsaids. Will also be covered for recurrent pericarditis and deficiency of interluekin-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

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

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

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 ORfailure 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

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

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

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

Drugs
BERINERT

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

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

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

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

Drugs
BOSULIF ORAL TABLET

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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 ORAL CAPSULE

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria
Rozyltrek 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

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

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

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

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

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 past12 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

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

Fycompa

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

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

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

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

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>/=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

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

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

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

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

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

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 deficieny.

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

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

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

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 teracycline and topical retinoid most have been tried in most recent 6 months.

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

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

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

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

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

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

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

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

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

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

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

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

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

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

Drugs
ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE, INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE, RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION RECONSTITUTED 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 anti-psychotics in the past 12 months

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

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

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

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

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

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

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

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

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
NATPARA

Exclusion Criteria

Required Medical Information
iPTH, Calcium

Age Restriction

Prescriber Restriction
endocrinologist

Coverage Duration
12 months

Other Criteria
Hypocalcemia despite using maximal doses of calcitriol

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

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

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

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

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, Otolaryngolist, hematologist, or Rheumatologist

Coverage Duration
12 months

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

Indications
All FDA-approved Indications.

Off Label Uses

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

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

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

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

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

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

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

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

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

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

Drugs
PREVYMIS ORAL

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
100 days post allogenic 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

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

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

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

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

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

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

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

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 hydrophillic statin such as fluvastatin, pravastatin, rosuvastatin in the absence of fibrates or other combinations which can increase risk of myopathy or myalgia when used in combination with a statin.

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

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

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

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

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

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

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

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

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
SCEMBLIX

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

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

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

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 modafinal/armodafinal and failure of amphetamine/methylphenidate

Indications
Some FDA-approved Indications Only.

Off Label Uses

Part B Prerequisite
No

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

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

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

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

Drugs
TAGRISSO

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

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

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

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

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

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

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

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

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

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 congental or ideopathic PAH

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

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

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

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

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

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

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

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

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

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

Drugs
VERZENIO

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Hematology/Oncology

Coverage Duration
12 months or clinical progresion

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

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

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

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 ORAL CAPSULE

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

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

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

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

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

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

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

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

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

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

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 CDKl5 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

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

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