# 2025

# Prior Authorization Criteria

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# Actimmune

**Products Affected**

- ACTIMMUNE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis, supporting imaging for osteopetrosis. Antibiotic failure if chronic granulomatous disease |
| **Age Restrictions** | Ages approved in FDA labeling/compendia |
| **Prescriber Restrictions** | Infectious Disease/Hematology-oncology/Orthopedist/rheumatologist, immunologist, endocrinologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Sulfamethoxazole/Trimethoprim and/or itraconazole failure for infections secondary to chronic granulomatous disease. Osteopetrosis must be severe malignant |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Adalimumab

**Products Affected**

- HADLIMA
- HADLIMA PUSHTOUCH

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For RA Patient must fail Methotrexate or leflunomide. For Ankylosing Spondylitis patient must fail an NSAID. For Plaque Psoriasis patient must fail 3 month trial of MTX or acitretin. 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

**Products Affected**

- *tadalafil (pah)*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Right Heart catheterization, vasoreactivity test. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Pulmonology, Cardiology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Adempas

**Products Affected**

- ADEMPAS

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | pulmonologist/cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For PAH must have tried and failed ambrisentan and tadalafil, CTPH requires failure of bosentan (based on compendial support) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Afinitor

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/neurology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Aimovig

**Products Affected**

- AIMOVIG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Ajovy

**Products Affected**

- AJOVY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology, Pain Management, Headache Specialist |
| **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 (topiramate and divalproex sodium ER). Will not be used in combination with another CGRP antagonist. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Akeega

**Products Affected**

- AKEEGA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Urology/Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Akeega is our preferred PARP + novel hormone therapy combination for BRCA positive metastatic castrate resistant prostate cancer. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Alecensa

**Products Affected**

- ALECENSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approved for ALK+ Non Small Cell Lung Cancer |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# alitretinoin (Panretin)

**Products Affected**

- PANRETIN

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

# Alunbrig

**Products Affected**

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLET THERAPY PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Ambrisentan

**Products Affected**

- *ambrisentan*

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pulmonologist or cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Pulmonary hypertension must be diagnosed by heart catheterization, an objective test of exercise ability (6 minute walk) must be submitted with referral. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Ampyra

**Products Affected**

- *dalfampridine er*

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Initial - 3 months. Renewal - 12 months |
| **Other Criteria** | For renewal, walking speed has improved from baseline. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Apokyn

**Products Affected**

- *apomorphine hcl subcutaneous*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, previous treatment history. |
| **Age Restrictions** | Ages approved in FDA labeling/compendia |
| **Prescriber Restrictions** | 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

**Products Affected**

- APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of carbamazepine and Oxcarbazepine |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Arcalyst

**Products Affected**

- ARCALYST

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | |
| **Prescriber Restrictions** | Immunologist,dermatologist,rheumatologist,cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Arikayce

**Products Affected**

- ARIKAYCE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | infectious disease, pulmonology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approve for MAC pneumonia refractory to triple therapy (ethambutol, macrolide, rifampin) and intolerance to nebulized amikacin sulfate injection |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Armodafinil/Modafinil

**Products Affected**

- *armodafinil*
- *modafinil oral*

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

# Aubagio

**Products Affected**

- *teriflunomide*

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

# Augtyro

**Products Affected**

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Metastatic NSCLC with a ROS-1 rearrangement AND Failure of crizotinib for patients without CNS metastasis OR failure of entrectinib for patients who have an NTRK fusion positive solid tumor. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Auvelity

**Products Affected**

- AUVELITY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Avonex

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of glatiramer and leflunomide |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Ayvakit

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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.<br>Diagnosis of advanced systemic mastocytosis. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# aztreonam (Cayston)

**Products Affected**

- CAYSTON

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

# Balversa

**Products Affected**

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Urology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Banzel

**Products Affected**

- RUFINAMIDE ORAL SUSPENSION
- *rufinamide oral tablet*

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

# Benlysta

**Products Affected**

- BENLYSTA SUBCUTANEOUS

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | 5 years of age and older |
| **Prescriber Restrictions** | Rheumatologist or nephrologist |
| **Coverage Duration** | Lifetime |
| **Other Criteria** | None |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Berinert

**Products Affected**

- BERINERT

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Besremi

**Products Affected**

- BESREMI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Pegasys for polycythemia vera |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Betaseron

**Products Affected**

- BETASERON SUBCUTANEOUS KIT

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

# Bosulif

**Products Affected**

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 and failure of dasatinib or nilotinib. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Braftovi

**Products Affected**

- BRAFTOVI ORAL CAPSULE 75 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of pathogenic BRAF mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progresison |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Briviact

**Products Affected**

- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | failed trial or contraindication or intolerance of Levetiracetam |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Bronchitol

**Products Affected**

- BRONCHITOL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Pulmonology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | confirmed diagnosis of cystic fibrosis. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Brukinsa

**Products Affected**

- BRUKINSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Disease progression on a covalent BTK inhibitor |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | For CLL, SLL and Waldontrom's Macroglobulinemia Brukinsa would require a trial of ibrutinib and discontinuation due to adverse effects (ie. diarrhea, nausea, stomatitis, dizziness, hypertension). Loss of drug response during an ibrutinib trial would not be acceptable criteria for approval and may indicate a c481s mutation requiring a non-covalent BTK inhibitor other than Brukinsa. Other FDA approved lymphomas such as Marginal Zone Lymphoma, Mantle cell Lymphoma, Follicular Lymphoma are covered based on FDA labeled indication. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Cabometyx

**Products Affected**

- CABOMETYX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered until disease progression. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Calquence

**Products Affected**

- CALQUENCE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months  or clinical progression |
| **Other Criteria** | For CLL and SLL Calquence would require a trial of ibrutinib and discontinuation due to adverse effects (ie. diarrhea, nausea, stomatitis, dizziness, hypertension).  Loss of drug response during an ibrutinib trial would not be acceptable criteria for approval and may indicate a c481s mutation requiring a non-covalent BTK inhibitor other than Calquence. Other FDA approved lymphomas Mantle cell Lymphoma are covered based on FDA labeled indication. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Caplyta

**Products Affected**

- CAPLYTA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | written by neurology/psychiatry |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of aripiprazole and risperidone for schizophrenia. Failure of lurasidone for bipolar depression |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Caprelsa

**Products Affected**

- CAPRELSA ORAL TABLET 100 MG, 300 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Carbaglu

**Products Affected**

- *carglumic acid oral tablet soluble*

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

# cialis

**Products Affected**

- *tadalafil oral tablet 2.5 mg, 5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | excluded from part D coverage when prescribed for treatment of erectile dysfunction |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approved for treatment of benign prostatic hyperplasia. |
| **Indications** | Some FDA-approved Indications Only. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Cinryze

**Products Affected**

- CINRYZE

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

# Cobenfy

**Products Affected**

- COBENFY
- COBENFY STARTER PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Psychiatry or Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of lurasidone and aripiprazole |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Cometriq

**Products Affected**

- COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG
- COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG
- COMETRIQ (60 MG DAILY DOSE)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | combination use with other tyrosine Kinase inhibitors. |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | oncology/hematology |
| **Coverage Duration** | 6 months or until disease progression |
| **Other Criteria** | Covered for Metastatic Thyroid Medullary Cancer |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Copiktra

**Products Affected**

- COPIKTRA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Corlanor

**Products Affected**

- CORLANOR ORAL SOLUTION
- *ivabradine hcl*

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | |
| **Prescriber Restrictions** | Cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Cotellic

**Products Affected**

- COTELLIC

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered for BRAF+ metastatic melanoma for combination use in with Zelboraf. For Histiocytosis coverage is consistent with NCCN guidelines for multiorgan or multifocal or e or unifocal a critical organ in patients who do not harbor a BRAF V600E mutation. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Cuprimine

**Products Affected**

- *penicillamine oral capsule*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | serum ceruloplasmin if used for wilson's disease |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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

**Products Affected**

- *cyclobenzaprine hcl oral tablet 10 mg, 5 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | Authorization is required for patients over 64 years of age |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 weeks for skeletal muscle spasm, 12 months for fibromyalgia |
| **Other Criteria** | For patients over 64 years of age, Physician attests they have counseled patient on risk benefit of muscle relaxers as a high risk medication and patient has been evaluated for fall risk. |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Daliresp

**Products Affected**

- *roflumilast oral tablet 250 mcg, 500 mcg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Daurismo

**Products Affected**

- DAURISMO ORAL TABLET 100 MG, 25 MG

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

# Diacomit

**Products Affected**

- DIACOMIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Diclofenac 1.5% solution

**Products Affected**

- *diclofenac sodium external solution 1.5 %*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Dificid

**Products Affected**

- DIFICID ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 10 days |
| **Other Criteria** | Recurrence after a failed taper trial of vancomycin. Taper trial 125 mg orally 4 times daily for 10 to 14 days, then 125 mg orally 2 times daily for 7 days, then 125 mg orally once daily for 7 days, then 125 mg orally every 2 to 3 days for 2 to 8 weeks. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Dronabinol

**Products Affected**

- *dronabinol*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Previous Treatment History |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Infectious disease/oncologist/gastroenterologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For HIV/Cancer related cachexia patient must fail megestrol, For Chemotherapy induced nausea, patient must fail Emend and Ondansetron. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Dupixant

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Pulmonology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Only covered for severe asthma which requires chronic maintenance oral corticosteroid use to control symptoms despite maximal guideline directed inhaler therapy. Chronic Steroid use would defined as 60 days of prednisone 5mg/day or equivalent in combination with a three month trial of Trelegy 200 or high dose OCS/LABA/LAMA combination. |
| **Indications** | Some FDA-approved Indications Only. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Emend

**Products Affected**

- *aprepitant oral capsule*
- EMEND ORAL SUSPENSION RECONSTITUTED

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Previous treatment history |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist/Surgeon |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient must fail treatment with ondansetron (PA not applicable for PONV) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Emgality

**Products Affected**

- EMGALITY
- EMGALITY (300 MG DOSE)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Emsam

**Products Affected**

- EMSAM

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, current assessment and plan, prior medication failures |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **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 |

# Enbrel

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Rheumatology/Dermatology or Specialist trained in management of prescribed condition |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Renflexis and adalimumab |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | Yes |

# Endari

**Products Affected**

- ENDARI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# entrectinib (Rozlytrek)

**Products Affected**

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG
- ROZLYTREK ORAL PACKET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Epidiolex

**Products Affected**

- EPIDIOLEX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Erivedge

**Products Affected**

- ERIVEDGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematologist/Oncologist |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | Diagnosis of metastatic basal cell carcinoma OR Diagnosis of locally advanced basal cell carcinoma that has recurred following surgery or when the patient is not a candidate for surgery and radiation |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Erleada

**Products Affected**

- ERLEADA ORAL TABLET 240 MG, 60 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Urologist, Oncologist |
| **Coverage Duration** | 12 months or until PSA progression |
| **Other Criteria** | Failure of LHRH agonist and bicalutamide for non-metastatic disease.<br>Failure of abiraterone for metastatic disease. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Esbriet

**Products Affected**

- *pirfenidone*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Eulexin

**Products Affected**

- EULEXIN

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Documentation supporting diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology, Urology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of bicalutamide |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Exjade

**Products Affected**

- *deferasirox oral tablet soluble*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | iron indices |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Fanapt

**Products Affected**

- FANAPT
- FANAPT TITRATION PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Neurology/Psychiatry |
| **Coverage Duration** | 12 months |
| **Other Criteria** | failure of lurasidone and aripiprazole for schizophrenia, for Acute treatment of manic or mixed episodes associated with bipolar I disorder failure of aripiprazole and asenapine. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Fentanyl Patch

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pain management physician/oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Fetzima

**Products Affected**

- FETZIMA
- FETZIMA TITRATION

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Fintepla

**Products Affected**

- FINTEPLA

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

# Forteo

**Products Affected**

- *teriparatide subcutaneous solution pen-injector 620 mcg/2.48ml*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Recent Bone density study previous treatment history, BMD, PTH, VITD |
| **Age Restrictions** | ages 18 and older |
| **Prescriber Restrictions** | none |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient must fail or have contraindication to IV bisphosphonates, Vitamin D (25,OH), PTH must be WNL. Cumulative treatment more than 24 months should only be considered if patient remains at or has returned to high fracture risk |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | Yes |

# Fotivda

**Products Affected**

- FOTIVDA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Fruzaqla

**Products Affected**

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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

**Products Affected**

- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of lacosamide and levetiracetam |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Gattex

**Products Affected**

- GATTEX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Gavreto

**Products Affected**

- GAVRETO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Gilenya

**Products Affected**

- *fingolimod hcl*

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

# Gilotrif

**Products Affected**

- GILOTRIF

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

# Gleostine

**Products Affected**

- GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG

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

# Glyburide

**Products Affected**

- *glyburide micronized*
- *glyburide oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | failure or contraindication to preferred glipizide and glimeperide |
| **Age Restrictions** | Prior authorization required for members 65 years or older. Automatic approval for members less than 65 years of age. |
| **Prescriber Restrictions** | |
| **Coverage Duration** | Through benefit year |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Gomekli

**Products Affected**

- GOMEKLI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Documentation supporting diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology, Neurology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Hetlioz

**Products Affected**

- *tasimelteon*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Confirmed Diagnosis of non-24 hour sleep-Wake disorder Sleep study to rule out Sleep/apnea or other contributory sleep disorders Patient must be totally blind. Covered for microdeletion syndrome Smith-Magenis syndrome. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Humira

**Products Affected**

- HUMIRA (2 PEN) SUBCUTANEOUS AUTO-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

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Dermatologist/rheumatologist/ Gastroenterologist/Ophthalmologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient must fail infliximab and a preferred biosimilar adalimumab if on formulary. Part B before Part D Step Therapy. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | Yes |

# Ibrance

**Products Affected**

- IBRANCE

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

# Icatibant

**Products Affected**

- *icatibant acetate subcutaneous solution prefilled syringe*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Allergist or Immunologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Confirmed Diagnosis of HEA,  Failure of Tranexamic acid and Danazol |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Iclusig

**Products Affected**

- ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 MG, 45 MG

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

# Idhifa

**Products Affected**

- IDHIFA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of IDH-1 mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Imbruvica

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology/ transplant specialist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Off Label and combination use must have CMS compliant compendial support that is consistent with section 10.6 in Chapter 6 of the Medicare Part D |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Imbruvica Sln

**Products Affected**

- IMBRUVICA ORAL SUSPENSION

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology/ transplant specialist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Unable to swallow or use a tablet or capsule |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Imkeldi

**Products Affected**

- *imkeldi*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematology/Oncology, Allergist, Dermatologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient unable to swallow imatinib tablet and cannot tolerate imatinib tablet dispersed in glass of water or apple juice |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Impavido

**Products Affected**

- IMPAVIDO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Infectious Disease |
| **Coverage Duration** | 28 days |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Increlex

**Products Affected**

- INCRELEX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis of severe primary IGF-1 deficieny. |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | 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 |

# Inlyta

**Products Affected**

- INLYTA ORAL TABLET 1 MG, 5 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Inqovi

**Products Affected**

- INQOVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/oncology |
| **Coverage Duration** | 12 months unless patient has disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Inrebic

**Products Affected**

- INREBIC

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | Failure of Jakafi |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Invega Sustenna

**Products Affected**

- INVEGA HAFYERA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 1092 MG/3.5ML, 1560 MG/5ML

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Iressa

**Products Affected**

- *gefitinib*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Severe hypersensitivity to gefitinib or other components. |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Patient must be at least 18 years old or older. |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approved for Non Small Cell Lung Cancer with Egfr exon 19 deletion or Exon 21 substitution. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Isotretinoin

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Itovebi

**Products Affected**

- ITOVEBI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | progression with PI3K targeted medication |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | HR-positive HER2-negative with PIK3CA mutation advanced/metastatic breast cancer and failure of endocrine therapy. This medication will be used in combination with palbociclib and fulvestrant. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# IVIG

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis, immunoglobulin studies |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For ITP must fail corticosteroids and Anti-D immunoglobulin (if indicated). For other indications must meet current LCD criteria for immunoglobulin therapy. Part B before Part D Step Therapy |
| **Indications** | All Medically-accepted Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | Yes |

# Iwilfin

**Products Affected**

- IWILFIN

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Documentation supporting high risk neuroblastoma responsive to prior lines of treatment including anti GD2 antibody therapy |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Jakafi

**Products Affected**

- JAKAFI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications, Low risk Disease |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | 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 |

# Jardiance

**Products Affected**

- JARDIANCE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | failure or allergy to Farxiga |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Jaypirca

**Products Affected**

- JAYPIRCA ORAL TABLET 100 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Indicated for third line treatment of mantle cell lymphoma after failure of a BTK inhibiting treatment. Will be approved for the patients with chronic lymphocytic leukemia or small lymphocytic lymphoma (CLL/SLL) who have received at least two prior lines of therapy, including a covalent BTK inhibitor and a BCL-2 inhibitor. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Juxtapid

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months initially, 12 months for continuation |
| **Other Criteria** | Clinical confirmation that patient has HoFH and failure of Statin and PCSK-9 therapy. Continuation of Juxtapid after 3 month trial based on LDL reduction while on therapy. If statin intolerant must fail a PCSK-9 inhibitor. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Kalydeco

**Products Affected**

- KALYDECO ORAL PACKET
- KALYDECO ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Genotyping supportive of mutation status in the FDA label |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Kerendia

**Products Affected**

- KERENDIA

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Kevzara

**Products Affected**

- KEVZARA

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Kineret

**Products Affected**

- KINERET SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For RA failure of Enbrel and Humira |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Kisqali

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Korlym

**Products Affected**

- *mifepristone oral tablet 300 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Koselugo

**Products Affected**

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | neurology/hematology/oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Diagnosis of Type 1 neurofibromatosis with symptomatic or inoperable plexiform neurofibromas |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Krazati

**Products Affected**

- KRAZATI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | Progression on another KRAS inhibitor such as sotorasib |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Presence of G12C mutation with metastatic or locally advanced Non-Small Cell Lung Cancer. Also approved in combination with cetuximab, for the treatment of adult patients with KRAS G12C-mutated locally advanced or metastatic colorectal 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 |

# Kuvan

**Products Affected**

- *sapropterin dihydrochloride oral packet*
- *sapropterin dihydrochloride oral tablet*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to dietary changes, current assessment and plan, serum phenylalanine. |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | 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 |

# Lazcluze

**Products Affected**

- LAZCLUZE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | for First line NSCLC with EGFR Exon 19 Deletion or Exon 21 L858R failure or intolerance of osimertinib (Based on NCCN preferred regimen) |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Lenvima

**Products Affected**

- LENVIMA (10 MG DAILY DOSE)
- LENVIMA (12 MG DAILY DOSE)
- LENVIMA (14 MG DAILY DOSE)
- LENVIMA (18 MG DAILY DOSE)
- LENVIMA (20 MG DAILY DOSE)
- LENVIMA (24 MG DAILY DOSE)
- LENVIMA (4 MG DAILY DOSE)
- LENVIMA (8 MG DAILY DOSE)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Lidoderm

**Products Affected**

- *lidocaine external patch 5 %*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# liraglutide (Victoza)

**Products Affected**

- *liraglutide*
- VICTOZA SUBCUTANEOUS SOLUTION PEN-INJECTOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# livtencity

**Products Affected**

- LIVTENCITY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 weeks |
| **Other Criteria** | Resistance or intolerance of valganciclovir when it it is the preferred agent, in addition can be used for CMV infection refractory to ganciclovir, cidovofovir, or foscarnet. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Lobrena

**Products Affected**

- LORBRENA ORAL TABLET 100 MG, 25 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of ALK+ mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Lokelma

**Products Affected**

- LOKELMA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 month |
| **Other Criteria** | Two elevated serum potassium levels in absence of potassium sparing medications. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Long Acting Anti-Psychotics Injections

**Products Affected**

- ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE
- INVEGA SUSTENNA INTRAMUSCULAR SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML, 156 MG/ML, 234 MG/1.5ML, 39 MG/0.25ML, 78 MG/0.5ML
- RISPERIDONE MICROSPHERES ER INTRAMUSCULAR SUSPENSION RECONSTITUTED ER 12.5 MG, 25 MG, 37.5 MG
- *risperidone microspheres er intramuscular suspension reconstituted er 50 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Neurology Psychiatry |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of two generic oral anti-psychotics in the past 12 months |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Lonsurf

**Products Affected**

- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

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

# Lotronex

**Products Affected**

- *alosetron hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Gastroenterologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of loperimide and a tricyclic antidepressant. Approved initially for 3 months continuation to 12 months if patient has improvement in symptoms. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Lumakras

**Products Affected**

- LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | Submission of molecular profile of tumor supporting KRAS G12C mutation |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Lybalvi

**Products Affected**

- LYBALVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Lynparza

**Products Affected**

- LYNPARZA ORAL TABLET 100 MG, 150 MG

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

# Lytgobi

**Products Affected**

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

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

# Mavyret

**Products Affected**

- MAVYRET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Gastroenterology, infectious disease, Hepatology |
| **Coverage Duration** | 8  weeks to 16 weeks |
| **Other Criteria** | Information supporting diagnosis,genotype,and Metavir score. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Mekinist

**Products Affected**

- MEKINIST ORAL SOLUTION RECONSTITUTED
- MEKINIST ORAL TABLET 0.5 MG, 2 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | Mutation analysis showing BRAF V600E or V600K positive, not covered for combination use with other anti-neoplastics unless FDA indication or NCCN recommended with a class 2A or greater evidence rating. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Mektovi

**Products Affected**

- MEKTOVI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of BRAF mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Metaxalone

**Products Affected**

- *metaxalone oral tablet 800 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Movantik

**Products Affected**

- MOVANTIK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12months |
| **Other Criteria** | Failure of Lactulose and lubiprostone |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Nerlynx

**Products Affected**

- NERLYNX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematologist/Oncologist |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Neupro

**Products Affected**

- NEUPRO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Ropinirole and Pramipexole |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Nexavar

**Products Affected**

- *sorafenib tosylate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | failure of sunitinib for metastatic renal cell carcinoma |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Ninlaro

**Products Affected**

- NINLARO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Northera

**Products Affected**

- *droxidopa*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Documented orthostatic hypotension or Dopamine-Beta-Hydroxylase deficiency |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Noxafil

**Products Affected**

- *posaconazole oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months |
| **Other Criteria** | Failure, resistance or contraindication to itraconazole,voriconazole |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Nubeqa

**Products Affected**

- NUBEQA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Patient has failed Xtandi for premetastatic castrate resistant prostate cancer. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Nucala

**Products Affected**

- NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 40 MG/0.4ML
- NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Nuedexta

**Products Affected**

- NUEDEXTA

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

# Nuplazid

**Products Affected**

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Nurtec

**Products Affected**

- NURTEC

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology, Pain management, headache specialist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of eletriptan and sumatriptan for abortive treatment, failure of topiramate and Aimovig for migraine prophylaxis. |
| **Indications** | Some FDA-approved Indications Only. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Odomzo

**Products Affected**

- ODOMZO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Ofev

**Products Affected**

- OFEV

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | pulmonologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of pirfenidone and 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 |

# Ogsiveo

**Products Affected**

- OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Ojemda

**Products Affected**

- OJEMDA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approved for relapsed refractory low grade glioma with BRAF v600 mutation or BRAF fusion or rearrangement. Not currently approved for firstline use |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Ojjaara

**Products Affected**

- OJJAARA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Jakafi |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Omnitrope

**Products Affected**

- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | studies establishing diagnosis of indication. |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Endocrinologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Onfi

**Products Affected**

- *clobazam oral suspension 2.5 mg/ml*
- *clobazam oral tablet*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | FDA approved Ages |
| **Prescriber Restrictions** | Restricted to Neurology |
| **Coverage Duration** | 12 Months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Onureg

**Products Affected**

- ONUREG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Opipza

**Products Affected**

- OPIPZA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology, Psychiatry |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of two generic orally disintegrating tablet (ODT) antipsychotic medications |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Opsumit

**Products Affected**

- OPSUMIT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | pulmonologist/cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of Ambrisentan and tadalafil |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Orenitram

**Products Affected**

- ORENITRAM

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Right Heart catheterization to confirm the diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# orgovyx

**Products Affected**

- ORGOVYX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Urology/Hematology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | Failure or intolerance of degaralix and leuprolide |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Orilissa

**Products Affected**

- ORILISSA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | OB/GYN |
| **Coverage Duration** | 6 months |
| **Other Criteria** | Covered for endometriosis, failure of NSAID and combinedestrogen-progestin contraceptive or progestin. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Orkambi

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | CFTR mutation analysis, spirometry |
| **Age Restrictions** | Ages approved in FDA label |
| **Prescriber Restrictions** | pulmonologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | CFTR mutation must be supported by FDA approved label such as homozygous F508-deletion |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Orserdu

**Products Affected**

- ORSERDU ORAL TABLET 345 MG, 86 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Otezla

**Products Affected**

- OTEZLA ORAL TABLET 20 MG, 30 MG
- OTEZLA ORAL TABLET THERAPY PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Documentation of active psoriatic arthritis or plaque psoriasis or Bechet's disease. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 to severe plaque psoriasis patient must fail methotrexate or Acitretin 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 |

# Pemazyre

**Products Affected**

- PEMAZYRE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Phenoxybenzamine

**Products Affected**

- *phenoxybenzamine hcl oral*

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

# Piqray

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months or until progression, |
| **Other Criteria** | HR+ ER- with PIK3CA mutation advanced/metastatic breast cancer and failure of endocrine therapy. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Pomalyst

**Products Affected**

- POMALYST

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approve for patients with multiple myeloma who have received at least two prior therapies including lenalidomide and bortezomib and have demonstrated disease progression on or within 60 days of completion of the last therapy. Covered for patients with Kaposi sarcoma. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Prevymis

**Products Affected**

- PREVYMIS ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 200 days |
| **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 to valganciclovir, has baseline leukopenia, or had failed valganciclovir. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Prolastin-C

**Products Affected**

- PROLASTIN-C INTRAVENOUS SOLUTION

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

# Prolia

**Products Affected**

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Intolerance or contraindication to injectable bisphosphonate required for coverage of prolia. Part B before Part D Step Therapy |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | Yes |

# Promacta

**Products Affected**

- PROMACTA ORAL PACKET 12.5 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist, Hepatologist/gastroenterologist, Infectious Disease |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Chronic ITP Refractory to IVIG, corticosteroids or splenectomy as per FDA approval studies not applicable to HCV related thrombocytopenia |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Pulmozyme

**Products Affected**

- PULMOZYME INHALATION SOLUTION
  2.5 MG/2.5ML

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis of cystic fibrosis current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pulmonologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered for Patients with Cystic Fibrosis. Not covered for off label indications such as asthma |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# pyrimethamine (Daraprim)

**Products Affected**

- *pyrimethamine oral*

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

# Qinlock

**Products Affected**

- QINLOCK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | hematology/oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Raldesy

**Products Affected**

- RALDESY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Unable to swallow tablets. Failure of citalopram or sertraline oral solution |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Ravicti

**Products Affected**

- RAVICTI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | hepatologist or metabolic specialist such as a endocrinologist or geneticist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Clinical Failure of Buphenyl |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Rebif

**Products Affected**

- REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of dimethyl fumarate and teriflunomide |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Repatha

**Products Affected**

- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Retacrit

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Scr, HGB, T-sat, Ferritin |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months |
| **Other Criteria** | Hemoglobin must be within FDA approved ranges for initiation and maintenance. Patient must have adequate iron stores to initiate and continue treatment. ESRD will be covered under Medicare Part B |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Retevmo

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or disease progression |
| **Other Criteria** | Diagnosis of metastatic non-small cell lung cancer or metastatic or advanced medullary thyroid carcinoma with RET alterations |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Revatio

**Products Affected**

- *sildenafil citrate oral tablet 20 mg*

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pulmonologist/Cardiologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Revlimid

**Products Affected**

- *lenalidomide*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Most recent hematology/oncology note documenting condition, regimen and setting this treatment is being used in. |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Revuforj

**Products Affected**

- REVUFORJ

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Rexulti

**Products Affected**

- REXULTI

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12months |
| **Other Criteria** | Failure of aripiprazole and lurasidone for schizophrenia or failure of combination SSRI and aripiprazole for major depressive disorder. For Alzheimer's agitation failure of quetiapine and olanzapine |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Rezlidhia

**Products Affected**

- REZLIDHIA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Rezurock

**Products Affected**

- REZUROCK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Romvimza

**Products Affected**

- ROMVIMZA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Documentation supporting diagnosis |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Rubraca

**Products Affected**

- RUBRACA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Rydapt

**Products Affected**

- RYDAPT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology/allergist |
| **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 |

# Sabril

**Products Affected**

- *vigabatrin*
- VIGPODER

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | 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 |

# Scemblix

**Products Affected**

- SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology Hematology |
| **Coverage Duration** | 12 months unless disease progression |
| **Other Criteria** | Failure of ponatinib if T315I mutation present. Failure of dasatinib for CML without T315I mutation. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Secuado

**Products Affected**

- SECUADO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Sensipar

**Products Affected**

- *cinacalcet hcl*

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Nephrologist/endocrinologist/oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For secondary hyperparathyroidism related to CKD, patient must fail active vit-D therapy/phosphate binders. ESRD use is excluded from medicare Part D and this authorization will include a determination of Part D vs Part B coverage based indication |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Signifor

**Products Affected**

- SIGNIFOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Solaraze

**Products Affected**

- *diclofenac sodium external gel 3 %*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Dermatologist, oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Somavert

**Products Affected**

- SOMAVERT

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Approved for patients with acromegaly who had an inadequate response to radiation therapy or surgery or for whom those therapies are not appropriate. Recent elevated serum IGF-1. |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Endocrinologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Sprycel

**Products Affected**

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Stelara

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | gastroenterologist/rheumatologist/dermatologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Crohns, patient must fail Entyvio and Renflexis. For plaque psoriasis, patient must fail adalimumab and Renflexis. For psoriatic arthritis, patient must fail a preferred TNF (adalimumab or infliximab) and Xeljanz. Part B before Part D Step Therapy |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | Yes |

# Stivarga

**Products Affected**

- STIVARGA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Sunosi

**Products Affected**

- SUNOSI ORAL TABLET 150 MG, 75 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Sutent

**Products Affected**

- *sunitinib malate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Symlin

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan, HA1c BG |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Endocrinologist, Internist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient BG must be non-controlled on optimal doses of insulin |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Sympazan

**Products Affected**

- SYMPAZAN

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

# Synarel

**Products Affected**

- SYNAREL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA Label |
| **Prescriber Restrictions** | |
| **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 |

# Tabloid

**Products Affected**

- TABLOID

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Tabrecta

**Products Affected**

- TABRECTA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Tafinlar

**Products Affected**

- TAFINLAR ORAL CAPSULE 50 MG, 75 MG
- TAFINLAR ORAL TABLET SOLUBLE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | Mutation analysis showing BRAF V600E or V600K positive, not covered for combination use with other anti-neoplastics unless FDA indication or NCCN recommended with a class 2A or greater evidence rating. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Tagrisso

**Products Affected**

- TAGRISSO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Taltz

**Products Affected**

- TALTZ

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Notes supporting diagnostic evidence and previous treatment history. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Rheumatology, Dermatology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Plaque Psoriasis must fail a preferred formulary subcutaneous TNF inhibitor(adalumab) and IV TNF inhibitor (Renflexis). For Psoriatic Arthritis must fail a preferred TNF agent(adalimumab/renflexis) and JAK inhibitor(Xeljanz). For Ankylosing Spondylitis must fail adalimumab and Renflexis. For non-radiographic axial spondylarthritis failure of a TNF inhibitor (adalimumab/Renflexis). Part B before Part D Step Therapy |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | Yes |

# Talzenna

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of germline BRCA mutation for breast cancer or non BRCA HRR mutations for metastatic prostate cancer |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | failure of niraparib + abiraterone (Akeega) for BRCA HRR mutations. Covered for non BRCA HRR mutations in metastatic prostate cancer. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Tarceva

**Products Affected**

- *erlotinib hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Targretin

**Products Affected**

- *bexarotene external*
- *bexarotene oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology, dermatology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | Must have failed one prior systemic therapy |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Tasigna

**Products Affected**

- TASIGNA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Covered for failure or relapse of CML when previously treated with imatinib. Covered for newly diagnosed CML patients who are Philadelphia chromosome +. Will also be covered for intolerance or adverse reaction to imatinib. Combination therapy with other tyrosine kinase inhibitors or MTOR inhibitors for CML is not supported. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Tazorac

**Products Affected**

- *tazarotene external cream 0.05 %, 0.1 %*
- TAZAROTENE EXTERNAL GEL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Previous treatment history |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **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 |

# tazverik

**Products Affected**

- TAZVERIK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Tecfidara

**Products Affected**

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

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

# Tepmetko

**Products Affected**

- TEPMETKO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | Molecular profile to support MET exon 14 skipping mutation |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Tetrabenazine

**Products Affected**

- *tetrabenazine*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology or Psychiatry |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For tardive dyskinesia causative drug must be discontinued or tried at a lower dose |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Thalomid

**Products Affected**

- THALOMID ORAL CAPSULE 100 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematologist/oncologist/infectious disease/dermatologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Tibsovo

**Products Affected**

- TIBSOVO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of IDH-1 Mutation |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Tobi Podhaler

**Products Affected**

- TOBI PODHALER

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | 6 years and older |
| **Prescriber Restrictions** | |
| **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 |

# Tracleer

**Products Affected**

- *bosentan*

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | 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 |

# Tretinoin Topical

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications, treatment of photoaging, wrinkles |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Trintellix

**Products Affected**

- TRINTELLIX

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of vilazodone and another generically available anti-depressant within past 6 months |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Truqap

**Products Affected**

- TRUQAP ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Patient has had progression on at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant therapy. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Tukysa

**Products Affected**

- TUKYSA ORAL TABLET 150 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | hematology/oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Turalio

**Products Affected**

- TURALIO ORAL CAPSULE 125 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Tykerb

**Products Affected**

- *lapatinib ditosylate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan associated studies |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | 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 |

# Ubrelvy

**Products Affected**

- UBRELVY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Uceris

**Products Affected**

- *budesonide er oral tablet extended release 24 hour*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Gastroenterologist |
| **Coverage Duration** | 8 weeks |
| **Other Criteria** | approved for 8 weeks in patients with active mild-moderate ulcerative colitis who are intolerant or have failed 1-1.5 mg/kg of oral prednisone and mesalamine |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Udenyca

**Products Affected**

- FULPHILA
- UDENYCA

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

# Uptravi

**Products Affected**

- UPTRAVI ORAL
- UPTRAVI TITRATION

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Right heart catheterization supporting diagnosis of PAH |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Pulmonology or Cardiology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | diagnosis of WHO group 1 PAH, failure of Ambrisentan and tadalafil |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Valchor

**Products Affected**

- VALCHLOR

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology or Dermatology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Valtoco

**Products Affected**

- VALTOCO 10 MG DOSE
- VALTOCO 15 MG DOSE NASAL LIQUID THERAPY PACK 2 X 7.5 MG/0.1ML
- VALTOCO 20 MG DOSE NASAL LIQUID THERAPY PACK 2 X 10 MG/0.1ML
- VALTOCO 5 MG DOSE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Vanflyta

**Products Affected**

- VANFLYTA

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

# Vascepa

**Products Affected**

- ICOSAPENT ETHYL

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Approved for patients on a statin with high cardiovascular risk and elevated triglycerides between 150-499mg/dl. Approved for hypertriglyceridemia after failure of fibrate and omega-3-acid ethyl esters. Approved for statin intolerant patients with high cardiovascular risk and elevated triglycerides between 150-499mg/dl. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Venclexta

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Medical notes supporting diagnosis. |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | approved for all FDA approved indications |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Verzenio

**Products Affected**

- VERZENIO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or clinical progresion |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Vitrakvi

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of a NTRK fusion |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **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 |

# Vizimpro

**Products Affected**

- VIZIMPRO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Evidence of EGFR mutated non-small cell lung cancer |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until Disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Vonjo

**Products Affected**

- VONJO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematology, Oncology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Voranigo

**Products Affected**

- VORANIGO

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

# Voriconazole

**Products Affected**

- *voriconazole intravenous*
- *voriconazole oral*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 3 months |
| **Other Criteria** | Covered when two of the following medications have been tried, unless resistance or contraindication precludes use, Itraconazole, fluconazole, ketoconazole. Exclusions to prerequisite medications are Invasive pulmonary aspergillosis, Scedosporium apiospermum, Fusarium |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Votrient

**Products Affected**

- *pazopanib hcl*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Vowst

**Products Affected**

- VOWST

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | gastroenterologist or Infectious disease |
| **Coverage Duration** | 3 days |
| **Other Criteria** | Approve for c. difficile infections after failure of a vancomycin taper and fidaxomicin regimen and second recurrence of CDI. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Vraylar

**Products Affected**

- VRAYLAR ORAL CAPSULE

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Psychiatry or Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Bipolar 1 disorder failure of lurasidone and quetiapine. For treatment of Schizophrenia failure of lurasidone and aripiprazole. For adjunctive treatment of major depressive disorder failure of aripiprazole and quetiapine. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Welireg

**Products Affected**

- WELIREG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Xalkori

**Products Affected**

- XALKORI ORAL CAPSULE
- XALKORI ORAL CAPSULE SPRINKLE
  150 MG, 20 MG, 50 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Diagnosis, documentation support ALK+ NSLC or ROS1 Positive for NSCLC indication. |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Hematology-oncology |
| **Coverage Duration** | 6 months |
| **Other Criteria** | Continuation will be based on lack of disease progression |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Xcopri

**Products Affected**

- XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG
- XCOPRI (350 MG DAILY DOSE)
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG
- XCOPRI ORAL TABLET THERAPY PACK

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Xdemvy

**Products Affected**

- XDEMVY

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

# Xeljanz

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Rheumatology/Gastroenterologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Rheumatoid arthritis- 3 month trial of Combination DMARD therapy in past 6 months, For Psoriatic Arthritis Patient must fail 3 month trial of MTX or LEF in past 6 months. For ulcerative colitis patient must fail azathioprine/6MP in combination with a 5-ASA compound. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Xermelo

**Products Affected**

- XERMELO

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Xgeva

**Products Affected**

- XGEVA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# Xifaxin

**Products Affected**

- XIFAXAN ORAL TABLET 550 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Notes to substantiate diagnosis of Hepatic Encephalopathy or Irritable Bowel Syndrome with Diarrhea |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 OR dicyclomine AND loperamide, approval will be limited to three 14 day treatments. Approval for hepatic encephalopathy is based on failure or intolerance of therapeutic doses of lactulose (30-45ml two to four times daily). |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Xolair

**Products Affected**

- XOLAIR

| PA Criteria | Criteria Details |
|---|---|
| **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 Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Pulmonologist, allergist, dermatologist, otolaryngologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | For Asthma patient Must Fail Combination LABA/ICS. For chronic ideopathic urticaria failure of hydroxyzine and H-2 antagonist. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Xospata

**Products Affected**

- XOSPATA

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

# Xpovio

**Products Affected**

- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 MG, 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)

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Oncology/Hematology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Xtandi

**Products Affected**

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

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 6 months or until disease progression |
| **Other Criteria** | Failure of Abiraterone for metastatic prostate cancer |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Xyrem

**Products Affected**

- *sodium oxybate*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | 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 |

# yesintek

**Products Affected**

- YESINTEK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 90 MG/ML

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | failure of methotrexate or acitretin and topical for plaque psoriasis, failure of infliximab for Crohns or Ulcerative Colitis. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Zavesca

**Products Affected**

- *miglustat*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Oncologist/Hematologist, Neurologist, Medical Geneticist, Metabolic Specialist, hepatologist |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Zejula

**Products Affected**

- ZEJULA ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | 1. Diagnosis 2. Prior treatment with platinum-based chemotherapy and response 3. Prior treatment with PARP inhibitor and response |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until progression |
| **Other Criteria** | Approve for first line maintenance for advanced epithelial, ovarian, peritoneal, fallopian cancer in patients who have platinum sensitive disease and are in a complete or partial response. Also approved for maintenance of recurrent advanced epithelial, ovarian, peritoneal, fallopian cancer in patients who have platinum sensitive disease and are in complete or partial response and have a pathogenic germline BRCA mutation. There is limited data on the use of a maintenance PARPi in patients who previously received a PARPi |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Zelboraf

**Products Affected**

- ZELBORAF

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | 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 |

# Zepatier

**Products Affected**

- ZEPATIER

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | Gentotype, Viral Load, Fibroscan/Fibrosure or liver biopsy, RAV NS5A panel |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Infectious disease, Gastroenterology/Hepatology |
| **Coverage Duration** | 12 or 16 weeks depending on RAV profile as supported by current AASLD guidelines |
| **Other Criteria** | Contraindication to GLECAPREVIR/PIBRENTASVIR |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# zileuton (Zyflo)

**Products Affected**

- *zileuton er*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Pulmonology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Uncontrolled Asthma while on maximal doses of long acting bronchodilators and inhaled corticosteroids AND montelukast. |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Zolinza

**Products Affected**

- ZOLINZA

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Medical notes supporting diagnosis, response to previous treatments, current assessment and plan |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | 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 |

# Ztalmy

**Products Affected**

- ZTALMY

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Neurology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Diagnosis of CDKl5 deficiency disorder |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Zurzuvae

**Products Affected**

- ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | Woman of childbearing age |
| **Prescriber Restrictions** | obstetrics/gynecology/psychiatry |
| **Coverage Duration** | 14 days |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Zydelig

**Products Affected**

- ZYDELIG

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Zykadia

**Products Affected**

- ZYKADIA ORAL TABLET

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | |
| **Required Medical Information** | |
| **Age Restrictions** | |
| **Prescriber Restrictions** | Hematology/Oncology |
| **Coverage Duration** | 12 months or until disease progression |
| **Other Criteria** | Restricted to use in ALK+ Non Small Cell Lung Cancer |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Zyprexa Injection

**Products Affected**

- *olanzapine intramuscular*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | |
| **Coverage Duration** | 12 months |
| **Other Criteria** | Failure of two generic anti-psychotics in the past 12 months |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

# Zytiga

**Products Affected**

- *abiraterone acetate oral tablet 250 mg*

| PA Criteria | Criteria Details |
|---|---|
| **Exclusion Criteria** | FDA labeled contraindications |
| **Required Medical Information** | Diagnosis |
| **Age Restrictions** | Ages approved in FDA labeling |
| **Prescriber Restrictions** | Oncology/urology |
| **Coverage Duration** | 12 months |
| **Other Criteria** | |
| **Indications** | All FDA-approved Indications. |
| **Off Label Uses** | |
| **Part B Prerequisite** | No |

**Index**