2026

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Avmapki

Products Affected

- AVMAPKI FAKZYNJA CO-PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Indicated for the treatment of adult patients with KRAS-mutated recurrent low-grade serous ovarian cancer
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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. Diagnosis of advanced systemic mastocytosis.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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 after failure of dasatinib or nilotinib.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Calquence

Products Affected

- CALQUENCE ORAL TABLET

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Cresemba

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	hematology, infectious disease
Coverage Duration	12 weeks unless used for chronic treatment then 12 months
Other Criteria	failure or intolerance of voriconazole and posaconazole for treatment of aspergillosis.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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 and biosimilar ustekinumab
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	Yes
Prerequisite Therapy Required	No

Endari

Products Affected

- ENDARI
- *l-glutamine oral packet*

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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. Failure of abiraterone for metastatic disease.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Fanapt

Products Affected

- FANAPT
- FANAPT TITRATION PACK A

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Forteo

Products Affected

- *teriparatide subcutaneous solution pen-injector 560 mcg/2.24ml*

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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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	failure of dasatinib for patients without t315i mutation and diagnosis of CML or ALL.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Imbruvica

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Jynarque

Products Affected

- JYNARQUE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	nephrology
Coverage Duration	12 months
Other Criteria	Approved for patients with ADPKD with an eGFR greater than or equal to 25ml/min and at risk of rapid progression defined by:Mayo classes 1C, 1D, or 1E OR Age less than 55 years AND an eGFR less than 65 mL/min OR Kidney length greater than 16.5 cm in a patient aged less than 50 years OR PROPKD score greater than 6
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Kerendia

Products Affected

- KERENDIA ORAL TABLET 10 MG, 20 MG

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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	Progression on Ibrance for advanced or metastatic breast cancer.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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	Type 2 Diabetes, 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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Long Acting Anti-Psychotics Injections

Products Affected

- ABILIFY MAINTENA INTRAMUSCULAR PREFILLED SYRINGE
- ABILIFY MAINTENA INTRAMUSCULAR SUSPENSION RECONSTITUTED ER
- 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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Nexletol

Products Affected

- NEXLETOL

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

Nicotrol

Products Affected

- NICOTROL NS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Ages 18 and older
Prescriber Restrictions	
Coverage Duration	90 days
Other Criteria	Patient must be enrolled in a smoking cessation program which also incorporates behavioral support and counseling. Approved for 90 days up to twice annually.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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 and psoriatic arthritis patient must fail a preferred TNF such as adalimumab or infliximab and biosimilar ustekinumab. If injectable cant be used patient must fail Xeljanz and methotrexate or methotrexate and acitretin.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	Yes
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Promacta

Products Affected

- *eltrombopag olamine*

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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

PA Criteria	Criteria Details
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Retevmo

Products Affected

- 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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Revcovi

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Diagnosis of adenosine deaminase severe combined immunedeficiency (ADA-SCID)
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Rezdiffra

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	active hyperthyroidism or untreated hypothyroidism
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Board certified gastroenterologist or hepatolgist
Coverage Duration	12months
Other Criteria	for new starts:F2 F3 fibrosis demonstrated by liver biopsy, Magnetic resonance elastography (3.1 - 4.4 kPa), or Vibration controlled transient elastography (8-15kPA)Lack of positive ALT response after 48 week trail of liraglutide or semaglutide in conjunction with lifestyle modifications targeted to reduce weight by 5-7%AND 48 week trial of pioglitazone (in patients who also have type 2 diabetes or prediabetes and do not have class contraindications to TZDS) in conjunction with lifestyle modification targeted to reduce weight by 5-7%positive ALT response defined as 17 U/L or greater decrease in ALT Or reduction of ALT to 40 U/L or less and by at least 30% from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Stelara

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	gastroenterologist/rheumatologist/dermatologist
Coverage Duration	12 months
Other Criteria	for IBD patient must fail adalimumab and Renflexis and biosimilar ustekinumab. 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
Prerequisite Therapy Required	No

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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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 biosimilar ustekinumab. For Psoriatic Arthritis must fail a preferred TNF agent(adalimumab/renflexis) and biosimilar ustekinumab. 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
Prerequisite Therapy Required	No

Talzenna

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Tasigna

Products Affected

- *nilotinib 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	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Temazepam

Products Affected

- *temazepam oral capsule 15 mg, 30 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Chronic use of opioids
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	14 days
Other Criteria	Covered for FDA approved indication of short term treatment of insomnia covered for 14 days.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Trikafta

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patient has confirmed diagnosis of cystic fibrosis and an f508 deletion or other mutation that is confirmed amenable to Trikafta based on clinical or in vitro data.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Tyenne

Products Affected

- TYENNE SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Approved for failure or intolerance of Kevzara for overlapping indication. Approved for CART related CRS or ICANS
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Velsipity

Products Affected

- VELSIPITY

PA Criteria	Criteria Details
Exclusion Criteria	FDA labeled contraindications, combination with a targeted immunomodulator
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Gastroenterologist
Coverage Duration	12 months
Other Criteria	Failure of infliximab and vedolizumab.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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	failure of Ibrance for advanced or metastatic breast cancer
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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	Failure of Jakafi for myelofibrosis
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Vosevi

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 weeks
Other Criteria	Approved for patients who failed a prior NS5A containing regimen.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

Winrevair

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	cardiologist or pulmonologist with experience in PAH
Coverage Duration	12 months
Other Criteria	Patient is currently receiving a prostacyclin and another medication from a pharmacologic class to treat PAH such as a PDE5 inhibitor or endothelin receptor antagonist or soluble guanylate cyclase stimulator
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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	failure of ivermectin
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

yesintek

Products Affected

- YESINTEK SUBCUTANEOUS

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 IBD
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

Yonsa

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Allergy or contraindication to generic abiraterone 250mg or abiraterone 500mg
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	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
Prerequisite Therapy Required	No

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