



**Select Option® Rx PDP  
(Select Option Value 2026)  
2026 Utilization Management  
Criteria: Prior Authorization**

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION  
ABOUT SOME OF THE DRUGS WE COVER IN THIS PLAN**

This document was updated on **10/15/2025**. For more recent information or other questions, please contact our Member Help Team: Select Option Rx at **1-888-678-7009** or, for TTY/TDD users, 711, seven days a week from 8 a.m. to 8 p.m. Please note that on weekends and holidays from April 1 through September 30, your call may be sent to voicemail. Or, visit **[www.ibxmedicare.com](http://www.ibxmedicare.com)** to use our *Formulary (List of Covered Drugs)* search tool or view a downloadable document.

When this document refers to “we,” “us,” or “our,” it means Independence Blue Cross. When it refers to “plan” or “our plan,” it means Select Option Rx.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2027, and from time to time during the year.

Select Option is a PDP plan with a Medicare contract. Enrollment in Select Option PDP depends on contract renewal.

Benefits underwritten by QCC Insurance Company, a subsidiary of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

## There may be restrictions to your drug coverage

Some covered drugs may have additional requirements or limits on coverage. We call this “utilization management.” These requirements and limits may include:

- **Prior Authorization (PA):** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don’t get approval, our plan may not cover the drug. Drugs that require prior authorization are listed in this document.
- **Step Therapy (ST):** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. Drugs that require step therapy are listed in *2026 Utilization Management Criteria: Step Therapy*.
- **Quantity Limits (QL):** For certain drugs, our plan limits the amount of the drug that our plan will cover. Drugs that have quantity limits are listed in the *Select Option Rx Formulary (List of Covered Drugs)*.

You can find out if your drug has any additional requirements or limits by looking in your plan *Formulary (List of Covered Drugs)*. You can also get more information about the restrictions applied to specific covered drugs by visiting [www.ibxmedicare.com](http://www.ibxmedicare.com).

You can ask our plan to make an exception to these restrictions or limits, or for a list of other similar drugs that may treat your health condition. Your *Formulary (List of Covered Drugs)* and *Evidence of Coverage* will have more information about the exception request process.

## How to use this document

This document, along with *2026 Utilization Management Criteria: Step Therapy*, is intended to be used with your *Formulary (List of Covered Drugs)*. If your prescription drug has the note “PA” in the “Requirements” column of the *Select Option Rx Formulary (List of Covered Drugs)*, you can find more information on the restriction(s) in this document.

Locate your drug in the index on page 169. The restriction information includes:

- **Prior Authorization**
  - Covered uses
  - Exclusion criteria
  - Required medical information
  - Age restrictions
  - Prescriber restrictions
  - Coverage duration
  - Other criteria

Be sure to read all the information listed for your affected drug. If you have any questions or need assistance with the information contained in this document, please call our Member Help Team: Select Option Rx at **1-888-678-7009** or, for TTY/TDD users, **711**.

## acute hae agents 2026

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### Products Affected

- BERINERT
- FIRAZYR SUBCUTANEOUS SOLUTION  
PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

## acute seizure activity agents 2026

### Products Affected

- NAYZILAM
- 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	Prescriber is a neurologist/epilepsy specialist
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# adalimumab preferred products 2026

## Products Affected

- *adalimumab-aacf (2 pen)*
- *adalimumab-aacf (2 syringe)*
- *adalimumab-aacf(cd/uc/hs strt)*
- *adalimumab-aacf(ps/uv starter)*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# adbry 2026

## Products Affected

- ADBRY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Atopic Dermatitis (AD)(Initial): (1) Diagnosis of moderate to severe AD (2) inadequate response or inability to tolerate ONE of the following: (a) one topical steroid (medium potency or higher) (b) topical tacrolimus (c) pimecrolimus cream
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(AD): Prescribed by or in consultation with a dermatologist, allergist, immunologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(AD)(Reauth): Member has had a positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# adempas 2026

## Products Affected

- ADEMPAS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(PAH, CTEPH) (Initial, Reauth): Concurrent use of phosphodiesterase inhibitors, nitrates or nitric oxide donors, pregnancy, concurrent use with other soluble guanylate cyclase stimulators (e.g. Verquvo)
<b>Required Medical Information</b>	Pulmonary Arterial Hypertension (PAH) (initial): (1) Diagnosis of PAH WHO Group I with New York Heart Association (NYHA) Functional Class II - IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less. Chronic Thromboembolic Pulmonary Hypertension (CTEPH) (initial): (1) Diagnosis of persistent/recurrent CTPH (WHO Group 4) after surgical treatment or inoperable CTEPH.
<b>Age Restrictions</b>	(PAH, CTEPH) Member is 18 years of age or older
<b>Prescriber Restrictions</b>	(PAH, CTEPH): Prescribed by or in consultation with a pulmonologist or cardiologist
<b>Coverage Duration</b>	(Initial): 6 months (Reauth):12 months
<b>Other Criteria</b>	(PAH, CPTEH) (Reauth): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# aimovig 2026

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## Products Affected

- AIMOVIG

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# allergen specific immunotherapy (sl) 2026

## Products Affected

- GRASTEK
- ODACTRA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(1) Severe, unstable or uncontrolled asthma (2) History of eosinophilic esophagitis
<b>Required Medical Information</b>	(Initial): (1) Member has a positive skin test or in vitro test for the listed allergen-specific IgE antibody. (2) Inadequate response or inability to tolerate an intranasal corticosteroid and an oral or intranasal antihistamine.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an allergist or immunologist.
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	(Reauth): (1) Member has experienced improvement in the symptoms of their allergic rhinitis or a decrease in the number of medications needed to control allergy symptoms
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# ambrisentan 2026

## Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist.
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation):12 months.
<b>Other Criteria</b>	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ampyra 2026

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## Products Affected

- AMPYRA

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# anticholinergic hrm 2026

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## Products Affected

- *chlordiazepoxide-clidinium*
- *promethazine hcl oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	2 years
Other Criteria	Subject to additional clinical review for ESRD-related use - if applicable.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# arikayce 2026

## Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(MAC): (1) Diagnosis of Mycobacterium avium complex (MAC) lung disease (2) Medication is being used as part of a combination antibacterial drug regimen (3) Used in members who have not achieved negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy
<b>Age Restrictions</b>	Member is 18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a pulmonologist or an infectious disease specialist
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# armodafinil 2026

## Products Affected

- *armodafinil*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Obstructive Sleep Apnea (OSA) (Initial) (1) Diagnosis of obstructive sleep apnea defined by ONE of the following: (A) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible) OR (B) BOTH of the following: (a) 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study is not feasible) (b) ONE of the following symptoms: Unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, breathing interruptions during sleep Narcolepsy (Initial): (1) Diagnosis of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming a sleep study is not feasible) Shift Work Disorder (SWD)(Initial):(1) Diagnosis of Shift Work Disorder confirmed by ONE of the following: (A) Symptoms of excessive sleepiness or insomnia, for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period OR (B) Sleep study demonstrating loss of a normal sleep-wake pattern (i.e. disturbed chronobiologic rhythmicity) (2) Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or sleep specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(OSA, Narcolepsy, SWD)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

PA Criteria	Criteria Details
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# austedo 2026

## Products Affected

- AUSTEDO
- AUSTEDO XR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Tardive Dyskinesia (TD)(Initial): (1) Diagnosis of TD, (2) Documentation is provided of ONE of the following: (a) Persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering or discontinuation of the offending medication, or (b) Member is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Chorea-Huntington's Disease (CHD): (1) Diagnosis of chorea associated with Huntington's disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CHD): Prescribed by or in consultation with a neurologist or a psychiatrist. (TD): Prescribed by or in consultation with a neurologist or a psychiatrist.
<b>Coverage Duration</b>	(TD)(Initial): 3 months. (TD)(Reauth): Indefinite. (CHD): Indefinite.
<b>Other Criteria</b>	(TD)(Reauth): Positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No



# auvelity 2026

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## Products Affected

- AUVELITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Major Depressive Disorder (MDD): (1) Diagnosis of major depressive disorder (MDD) (2) Inadequate response or inability to tolerate two formulary antidepressants indicated for MDD (e.g. bupropion, venlafaxine extended-release tablet or capsule, sertraline tablet, etc.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# benlysta sc 2026

## Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Member has severe active central nervous system lupus
<b>Required Medical Information</b>	Systemic Lupus Erythematosus (SLE)(initial): (1) Diagnosis of active, autoantibody-positive SLE confirmed by positive autoantibody test (e.g., antinuclear antibody test [ANA], antibodies to DNA [Anti-dsDNA], Anti-Smith [Anti-Sm]). (2) Member is receiving concurrent treatment with at least ONE of the following: steroids, antimalarials, immunosuppressants, nonsteroidal anti-inflammatory drugs (NSAIDS). Lupus Nephritis (LN): (1) Diagnosis of active lupus nephritis confirmed by kidney biopsy. (2) Member is receiving concurrent standard therapy (e.g. corticosteroids, immunosuppressants, azathioprine).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(SLE): Prescribed by or in consultation with a rheumatologist. (LN): Prescribed by or in consultation with a nephrologist or rheumatologist.
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	(SLE, LN)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# bosentan 2026

## Products Affected

- *bosentan oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation):12 months.
<b>Other Criteria</b>	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# brand antipsychotics ach 2026

## Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Trial of two generic formulary antipsychotics. Applies to new starts.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# brukinsa 2026

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## Products Affected

- BRUKINSA ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# caplyta 2026

## Products Affected

- CAPLYTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Schizophrenia: (1) Diagnosis of schizophrenia (2) Inadequate response or inability to tolerate two generic antipsychotic products (e.g. aripiprazole, olanzapine, quetiapine, paliperidone). Bipolar Depression (BD): (1) Diagnosis of bipolar depression (2) Medication will be used as monotherapy or as adjunctive therapy with lithium or valproate (3) Inadequate response or inability to tolerate two medications indicated for bipolar depression (e.g. fluoxetine, Latuda (lurasidone) quetiapine, olanzapine)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# cayston 2026

## Products Affected

- CAYSTON

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Cystic Fibrosis (CF): (1) Diagnosis of CF. (2) Evidence of Pseudomonas Aeruginosa in the lungs. (3) Susceptibility results indicating that the Pseudomonas aeruginosa is sensitive to aztreonam. (4) FEV1 between 25% and 75% of predicted, (4) Member not colonized with Burkholderia cepacia.
<b>Age Restrictions</b>	(CF): Member is 7 years of age or older
<b>Prescriber Restrictions</b>	(CF): Prescribed by or in consultation with a pulmonologist OR infectious disease specialist or Specialist affiliated with a CF care center.
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	Reauth: (1) Evidence of Pseudomonas aeruginosa in the lungs (2) Documentation of positive clinical response to therapy (e.g. improvement in lung function demonstrated by improved FEV1)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# cholbam 2026

## Products Affected

- CHOLBAM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(BASD, PD): Extrahepatic manifestations of bile acid synthesis disorders due to single enzyme defects or peroxisomal disorders including Zellweger spectrum disorders
<b>Required Medical Information</b>	Bile Acid Synthesis Disorder (BASD) (initial): (1) Diagnosis of bile acid synthesis disorder due to a single enzyme defect. Peroxisomal disorder (PD) (initial): (1) Diagnosis of peroxisomal disorder. (2) Used as adjunctive treatment. (3) Member exhibits manifestations of liver disease, steatorrhea, or complications from decreased fat soluble vitamin absorption.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(BASD, PD): Hepatologist, Gastroenterologist, Medical geneticist, other specialist that treats inborn errors of metabolism
<b>Coverage Duration</b>	(Initial): 3 months. (Reauth): Indefinite
<b>Other Criteria</b>	(BASD,PD) (Reauth): Documentation of improved liver function tests from the start of treatment.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No



# cimzia 2026

## Products Affected

- CIMZIA (2 SYRINGE)
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	Ankylosing Spondylitis (AS)(Initial): (1) Diagnosis of AS. (2) Inadequate response or inability to tolerate two of the following: (a) secukinumab (Cosentyx), (b) Adalimumab (i.e., Adalimumab-AACF), (c) etanercept (Enbrel), (d) tofacitinib (Xeljanz/Xeljanz XR), (e) upadacitinib (Rinvoq), or documentation demonstrating that a trial may be inappropriate. Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Xeljanz/Xeljanz XR (d) Rinvoq/Rinvoq LQ, (e) Skyrizi, (f) Cosentyx, (g) Ustekinumab (i.e. Yesintek), (h) Orencia, (i) Otezla OR documentation demonstrating that a trial may be inappropriate. Plaque Psoriasis (PsO)(Initial): (1) Diagnosis of moderate to severe PsO (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Skyrizi (d) Cosentyx, (e) Ustekinumab (i.e. Yesintek), (f) Otezla OR documentation demonstrating that a trial may be inappropriate. Rheumatoid Arthritis (RA): (1) Diagnosis of moderate to severe RA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Rinvoq, (d) Xeljanz/Xeljanz XR, (e) Orencia OR documentation demonstrating that a trial may be inappropriate. Crohn's Disease (CD)(Initial): (1) Diagnosis of moderate to severe CD. (2) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e., Adalimumab-AACF), (b) ustekinumab (i.e. Yesintek), (c) risankizumab (Skyrizi), (d) upadacitinib (Rinvoq) or documentation demonstrating that a trial may be inappropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CD): Prescribed by or in consultation with a gastroenterologist. (RA, AS, nr-axSpA, PJI): Prescribed by or in consultation with a rheumatologist. (PsA, PsO): prescribed by or in consultation with a dermatologist or rheumatologist.
<b>Coverage Duration</b>	12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	Non-Radiographic Axial Spondyloarthritis (nr-axSpA)(Initial): (1) Diagnosis of nr-axSpA (2) Inadequate response or inability to tolerate Rinvoq OR Cosentyx OR documentation demonstrating that a trial may be inappropriate (3) Inadequate response or inability to tolerate one NSAID (e.g. ibuprofen, meloxicam, naproxen). Polyarticular juvenile idiopathic arthritis (PJIA)(Initial): Diagnosis of active PJIA. (2) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e., Adalimumab-AACF), (b) Enbrel, (c) Xeljanz, (d) Orencia, (e) Rinvoq/Rinvoq LQ, or documentation demonstrating that a trial may be inappropriate. (AS, PsA, PsO, RA, CD, nr-axSpA, PJIA)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# cinryze 2026

## Products Affected

- CINRYZE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Part D is medically necessary when: Hereditary Angioedema (HAE)(Initial): (1) Diagnosis of hereditary angioedema (HAE) (2) For prophylaxis against HAE attacks. (3) Requested drug will not be used in combination with other products indicated for HAE prophylaxis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(HAE): Prescribed by or in consultation with an allergist, immunologist, pulmonologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Subject to Part B vs Part D review. (HAE) (Reauth): Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# cobenfy 2026

## Products Affected

- COBENFY
- COBENFY STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Schizophrenia: (1) Diagnosis of schizophrenia (2) Inadequate response or inability to tolerate TWO of the following atypical antipsychotic agents: aripiprazole, asenapine, olanzapine, paliperidone, quetiapine IR/ER, risperidone, ziprasidone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	(Schizophrenia): Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# corlanor 2026

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## Products Affected

- CORLANOR ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# cosentyx sq 2026

## Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)
- COSENTYX SUBCUTANEOUS SOLUTION  
PREFILLED SYRINGE 75 MG/0.5ML
- COSENTYX UNOREADY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(PsA, PsO, AS, nr-axSpA, ERA, HS): Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA Plaque Psoriasis (PsO)(Initial): (1) Diagnosis of moderate to severe plaque psoriasis. Ankylosing Spondylitis (AS): (1) Diagnosis of AS. (2) Inadequate response or inability to tolerate one other treatment such as NSAIDs, COX2 inhibitors or methotrexate. Non-Radiographic Axial Spondyloarthritis (nr-axSpA)(Initial): (1) Diagnosis of nr-axSpA, (2) Inadequate response or inability to tolerate two NSAIDs. Active Enthesitis-related Arthritis (ERA)(Initial): (1) Diagnosis of active enthesitis-related arthritis (ERA), (2) Inadequate response or inability to tolerate methotrexate, (3) Inadequate response or inability to tolerate at least one NSAID (e.g. ibuprofen, naproxen, meloxicam, celecoxib) Hidradenitis Suppurativa (HS)(Initial): (1) Diagnosis of HS.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PsO, HS): Prescribed by or in consultation with a dermatologist. (PsA): Prescribed by or in consultation with a rheumatologist or dermatologist. (AS, nr-axSpA, ERA): Prescribed by or in consultation with a rheumatologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(PsA, PsO, AS, nr-axSpA, ERA, HS)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# crenessity 2026

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## Products Affected

- CRENESSITY ORAL CAPSULE 100 MG, 50 MG
- CRENESSITY ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

## cresemba [oral] 2026

### Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Invasive Aspergillosis (IA): (1) For use in the treatment of invasive aspergillosis after inadequate response or inability to tolerate Voriconazole (oral Vfend). Mucormycosis (MC): (1) Diagnosis of invasive mucormycosis
<b>Age Restrictions</b>	(IA, MC): Member is 6 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist, oncologist, OR prescribed as part of chemotherapy prophylaxis protocol
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	Subject to additional clinical review for ESRD-related use - if applicable.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes



# dalfampridine 2026

## Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(Initial): Member has history of seizure or moderate to severe renal impairment (CrCL less than or equal to 50 mL/min)
<b>Required Medical Information</b>	Multiple Sclerosis (MS) (Initial): (1) Diagnosis of multiple sclerosis. (2) Confirmation that member has difficulty walking. (3) One of the following: (a) Member has expanded disability status scale (EDSS) score of less than or equal to 7 (b) Member is not restricted to using a wheelchair (if EDSS is not measured)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	(MS) (Reauth): Documentation of positive clinical response as evidenced by improvement in walking speed
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# deferasirox 2026

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## Products Affected

- *deferasirox oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

# diacomit 2026

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## Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dravet syndrome (DS): (1) Diagnosis of seizures associated with Dravet syndrome (DS), (2) Used in combination with clobazam, (3) Member weighs 7kg or more.
Age Restrictions	Member is 6 months of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# dichlorophenamide 2026

## Products Affected

- ORMALVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concomitant use of high dose Aspirin, severe pulmonary disease and hepatic insufficiency
<b>Required Medical Information</b>	Primary hyperkalemic or hypokalemic periodic paralysis (PHPP) (Initial): (1) Diagnosis of Primary hyperkalemic periodic paralysis, primary hypokalemic periodic paralysis, and related variants (e.g., Paramyotonia Congenita) (2) Member has ONE of the following: (a) a positive genetic panel for periodic paralysis or (b) positive test results for periodic paralysis to one of the following tests: (i) EMG/nerve conduction studies, (ii) Long exercise test, (iii) Muscle biopsy, or (iv) Muscle MRI.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	(Initial): 3 months (Reauth):12 months
<b>Other Criteria</b>	(PHPP)(Reauth): Member has had a positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# doptelet 2026

## Products Affected

- DOPTELET ORAL TABLET 20 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Chronic Liver Disease (CLD): (1) Diagnosis of Chronic Liver Disease (CLD) (2) Baseline platelet count less than 50,000/mcL. Member is scheduled to undergo a procedure. Chronic Immune Thrombocytopenia (ITP)(Initial): (1) Baseline platelet count less than 30,000/mcL. (2) Inadequate response or inability to tolerate one of the following: (a) corticosteroids (b) immunoglobulins (c) splenectomy (d) Rituxan (rituximab)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(ITP): Prescribed by or in consultation with hematologist/oncologist
<b>Coverage Duration</b>	(CLD): 1 month. (ITP): 12 months
<b>Other Criteria</b>	(ITP)(Continuation): (1) Positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# dupixent 2026

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# emgality 2026

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## Products Affected

- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# emsam 2026

## Products Affected

- EMSAM

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Major depressive disorder (MDD): (1) Diagnosis of major depressive disorder. (2) Inadequate response or inability to tolerate ONE SSRI or SNRI. (3) 4-5 half-lives (approximately 1 week) has elapsed after discontinuation of antidepressants without long half-lives OR at least 5 weeks has elapsed after discontinuation with antidepressants with long half-lives (e.g. fluoxetine).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes



# enbrel 2026

## 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
<b>Exclusion Criteria</b>	(RA, PsA, PJIA, PsO, AS): Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	Rheumatoid Arthritis (RA)(Initial): (1) Diagnosis of moderate to severe RA. (2) Inadequate response or inability to tolerate ONE DMARD: (e.g. Methotrexate, Hydroxychloroquine, Leflunomide, Azathioprine, Sulfasalazine). Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA. Polyarticular Juvenile Idiopathic Arthritis (PJIA): (1) Diagnosis of moderate to severe PJIA, (2) Inadequate response or inability to tolerate ONE of the following: Methotrexate, Leflunomide, Sulfasalazine. Plaque Psoriasis (PsO) (Initial): (1) Diagnosis of moderate to severe chronic PsO. Ankylosing Spondylitis (AS): (1) Diagnosis of AS, (2) Inadequate response or inability to tolerate one other treatment such as NSAIDs, COX2 inhibitors or methotrexate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, PJIA, AS): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a rheumatologist or dermatologist. (PsO): Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(RA, PsA, PJIA, PsO, AS)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# endari 2026

## Products Affected

- ENDARI
- *l-glutamine oral packet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Sickle Cell Disease (SCD)(Initial): (1) One of the following: (a) Member is using Endari with concurrent hydroxyurea therapy, OR (b) Member has an inadequate response or inability to tolerate hydroxyurea. (2) Member has had 2 or more painful sickle cell crises within the past 12 months. (3) Used to reduce acute complications of sickle cell disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(SCD): Prescribed by or in consultation with a hematologist, oncologist, or sickle cell disease management specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(SCD)(Reauth): Documentation of positive clinical response to therapy (e.g. reduction in the number of sickle cell crises)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# entyvio sq 2026

## Products Affected

- ENTYVIO PEN

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	<p>Ulcerative Colitis (UC)(Initial): (1) Diagnosis of moderately to severely active Ulcerative Colitis (2) One of the following: (A) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) ustekinumab (i.e. Yesintek), (c) upadacitinib (Rinvoq), (d) tofacitinib (Xeljanz/Xeljanz XR), (e) risankizumab (Skyrizi) OR documentation demonstrating that a trial may be inappropriate. (B) One of the following: (a) Medication will be used as a maintenance dose following two doses of Entyvio IV for induction (b) Member is currently established on Entyvio IV.</p> <p>Crohn's Disease (CD)(Initial): (1) Diagnosis of moderately to severely active CD (2) One of the following: (A) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b)Ustekinumab (i.e. Yesintek), (c) Skyrizi, (d) Rinvoq or documentation demonstrating that a trial may be inappropriate. (B) One of the following: (a) Medication will be used as a maintenance dose following two doses of Entyvio IV for induction (b) Member is currently established on Entyvio IV.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(UC, CD): Prescribed by or in consultation with a gastroenterologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(UC,CD)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	Yes

# epidiolex 2026

## Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Dravet Syndrome (DS): (1) Inadequate response or inability to tolerate ONE of the following: (a) clobazam (b) valproic acid or (c) topiramate. (2) Baseline CBC, serum transaminases and total bilirubin prior to initiating therapy. (3) Concurrent use with additional anti-epileptic(s). Lennox-Gastaut Syndrome (LGS): (1) Inadequate response or inability to tolerate ONE of the following: (a) clobazam (b) valproic acid, or (c) topiramate. (2) Baseline CBC, serum transaminases and total bilirubin prior to initiating therapy. (3) Concurrent use with additional anti-epileptic(s). Tuberous Sclerosis Complex (TSC): (1) Concurrent use with additional anti-epileptic(s). (2) Baseline CBC, serum transaminases and total bilirubin prior to initiating therapy
<b>Age Restrictions</b>	(DS, LGS, TCS): Member is 1 year of age or older
<b>Prescriber Restrictions</b>	(DS, LGS, TCS): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# esbriet 2026

## Products Affected

- *pirfenidone*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Idiopathic Pulmonary Fibrosis (IPF): (1) Diagnosis of IPF confirmed by high resolution CT scan or biopsy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(IPF): Prescribed by or in consultation a pulmonologist or lung transplant specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(REAUTH) (IPF): BOTH of the following (1) stabilization from baseline AND (2) no elevations in AST or ALT greater than 5 times upper limit of normal or greater than 3 times upper limit of normal with signs or symptoms of severe liver damage.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# eucrisa 2026

## Products Affected

- EUCRISA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis (AD): (1) Diagnosis of mild to moderate atopic dermatitis (2) Inadequate response or inability to tolerate at least TWO of the following in patients 2 years of age or older: (a) topical tacrolimus OR topical pimecrolimus, OR (b) generic, prescription medium potency or higher topical steroid, unless the affected area is sensitive (i.e., face, axillae, groin)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# fasenra 2026

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## Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No



# fintepla 2026

## Products Affected

- FINTEPLA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Dravet Syndrome (DS): Inadequate response or inability to tolerate ONE of the following: (a) clobazam, (b) valproic acid, (c) divalproex sodium, (d) topiramate. Lennox-Gastaut Syndrome (LGS): (1) Diagnosis of seizures associated with Lennox-Gastaut Syndrome (LGS) (2) Inadequate response or inability to tolerate ONE of the following: valproic acid, lamotrigine, topiramate, felbamate, clobazam.
<b>Age Restrictions</b>	(DS, LGS): Member is 2 years of age or older.
<b>Prescriber Restrictions</b>	(DS, LGS): Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Indefinite.
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# galafold 2026

## Products Affected

- GALAFOLD

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Fabry Disease (FD)(Initial): (1) Diagnosis of Fabry disease. (2) Member has amenable galactosidase alpha gene (GLA) variant based on in vitro assay data (3) Will not be used in combination with enzyme replacement therapy for FD (e.g. agalsidase beta or pegunigalsidase alfa)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(FD)(Initial, Reauth): Prescribed by or in consultation with a clinical genetics specialist OR a nephrologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(FD)(Reauth): (1) Positive clinical response to therapy (2) Will not be used in combination with enzyme replacement therapy for FD (e.g. agalsidase beta or pegunigalsidase alfa)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# gattex 2026

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## Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

# generic lidocaine transdermal patch 2026

## Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Post-Herpetic Neuralgia (PHN): (1) Diagnosis of post-herpetic neuralgia. Diabetic Peripheral Neuropathy (DPN): (1) Diagnosis of diabetic peripheral neuropathy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# generic sodium phenylbutyrate 2026

## Products Affected

- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Acute hyperammonemia. N-acetyl glutamate synthase (NAGS) deficiency
<b>Required Medical Information</b>	Urea Cycle Disorder (UCD): (1) Diagnosis of urea cycle disorder involving deficiencies of carbamoyl phosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AAS) confirmed via enzymatic, biochemical, or genetic testing. (2) Inadequate response to one of the following: Dietary protein restriction or Amino acid supplementation
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(UCD): Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders
<b>Coverage Duration</b>	Initial: 6 months Reauth: 12 months
<b>Other Criteria</b>	(Reauth) (1) Documentation of positive clinical response to therapy (e.g. plasma ammonia or amino acid levels within normal limits) (2) Will be used concomitantly with dietary protein restriction and, in some cases, dietary supplements.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# growth hormones 2026

## Products Affected

- GENOTROPIN SUBCUTANEOUS CARTRIDGE
- NUTROPIN AQ NUSPIN 10 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 20 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- NUTROPIN AQ NUSPIN 5 SUBCUTANEOUS SOLUTION PEN-INJECTOR
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) Growth Failure in Children (GFC)(Initial): (a) Diagnosis of growth hormone deficiency confirmed by one of the following: (i) Height is documented by one of the following (utilizing age and gender growth charts related to height): (A) Height is greater than 2.0 standard deviations [SD] below midparental height (B) Height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender) (ii) Growth velocity is greater than 2 SD below mean for age and gender (iii) Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed is greater than 2 years compared with chronological age), (b) documentation of bone age, (c) abnormal response from provocative testing, such as insulin-induced hypoglycemia test, levodopa, or clonidine. (2) Small for Gestational Age (SGA)(Initial): (A) Diagnosis of SGA, (B) Clinical documentation of no catch-up growth by 2 to 4 years of age. (3) Growth Failure Associated with Chronic Kidney Disease (GF-CKD) (Initial), (4) Growth failure associated with Noonan Syndrome, Prader-Willi Syndrome, Turner Syndrome or short stature homeobox-containing gene (SHOX) deficiency (Initial), (5) Diagnostically confirmed Growth Hormone Deficiency in adults (GHDA)(Initial), OR (6) Idiopathic Short Stature (ISS)(Initial): (A) Diagnosis of ISS defined by height standard deviation score (SDS) less than or equal to 2.25, (B) Documentation of growth velocity less than 25th percentile for bone age.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(All Other Indications)(Initial): Prescribed by or in consultation with an endocrinologist. (GF-CKD)(Initial) : Prescribed by or in consultation with an endocrinologist or nephrologist
<b>Coverage Duration</b>	(Initial, Continuation): 12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	(GHDA)(Continuation): Annual clinical re-evaluation by the treating endocrinologist. (GFC)(Continuation): (1) Annual clinical re-evaluation by the treating endocrinologist (SGA, ISS)(Continuation): (1) Increase in growth velocity from baseline, (2) Annual clinical re-evaluation by the treating endocrinologist. (GF-CKD)(Continuation): (1) No history of renal transplant, (2) Annual clinical re-evaluation by the treating endocrinologist. (Growth Failure Associated with Noonan Syndrome, Prader-Willi Syndrome, Turner Syndrome or Short Stature Homeobox-Containing Gene (SHOX) Deficiency)(Continuation): (1) Annual clinical re-evaluation by the treating endocrinologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# haegarda 2026

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## Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Hereditary Angioedema (HAE) (Initial): (1) Diagnosis of HAE, (2) For prophylaxis against HAE attacks. (3) Requested drug will not be used in combination with other products indicated for HAE prophylaxis.
Age Restrictions	
Prescriber Restrictions	(HAE): Prescribed by or in consultation with an allergist, immunologist, pulmonologist
Coverage Duration	12 months
Other Criteria	(HAE)(Reauth): Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No



# high dose opioids 2026

## Products Affected

- *fentanyl transdermal patch 72 hour 100 mcg/hr, 25 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 75 mcg/hr* 100 mg, 60 mg
- *methadone hcl oral tablet*
- *morphine sulfate er oral tablet extended release*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	NEW TO HIGH DOSE OPIOID THERAPY : ONE of the following (A) pain associated with cancer, (B) chronic non-cancer pain and BOTH of the following (1) member is opioid tolerant (e.g. at least one week where total daily dose is at least one of the following: 30mg of oxycodone, 60mg of oral morphine, 8mg of oral hydromorphone, 25mg of oral oxymorphone or an equianalgesic dose of another opioid) AND (2) the member has been evaluated for non-opioid prescription pharmacologic treatment prior to initiation of high dose opioid therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	Subject to additional clinical review for ESRD-related use - if applicable. CONTINUING HIGH DOSE OPIOID THERAPY (morphine equivalent dose 90mg per day or greater): ONE of the following (1) pain associated with cancer OR (2) chronic non-cancer pain and ALL (a) member's pain has been assessed within the last 6 months AND (b) member has clinically meaningful improvement in pain and functioning that outweighs risks to patient safety AND (c) member is not being treated for substance abuse
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# hrm 2026

## Products Affected

- *butalbital-acetaminophen oral tablet 50-325 mg*
- *butalbital-apap-caffeine oral capsule 50-300-40 mg*
- *butalbital-apap-caffeine oral tablet 50-325-40 mg*
- *butalbital-aspirin-caffeine oral capsule*
- *dipyridamole oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly
<b>Age Restrictions</b>	Apply if member is greater than or equal to 65 years
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	2 years
<b>Other Criteria</b>	Subject to additional clinical review for ESRD-related use - if applicable.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# hrm cyclobenzaprine 2026

## Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acute Muscle Spasms (AMS): (1) Diagnosis of Acute Muscle Spasms (AMS):(2) Prescriber attestation that drug will be used only for short periods. All Indications: Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly.
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	AMS: 1 year. All other indications: 2 years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# hrm estrogens 2026

## Products Affected

- CLIMARA PRO
- DOTTI
- *estradiol transdermal patch twice weekly*
- *estradiol transdermal patch weekly*
- JINTELI
- PREMARIN ORAL

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	ONE of the following: (1) Inadequate response or inability to tolerate vaginal estrogen preparations (e.g. vaginal tablets or cream, etc.) OR (2) Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly
<b>Age Restrictions</b>	Apply if member is greater than or equal to 65 years
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	2 years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

## hrm non benzodiazepine hypnotics 2026

### Products Affected

- *eszopiclone oral tablet 3 mg*
- *zolpidem tartrate oral tablet 10 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(Initial): Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly
<b>Age Restrictions</b>	Apply if member is greater than or equal to 65 years
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(Initial): 3 months. (Reauth): 2 years
<b>Other Criteria</b>	(Reauth): Prescriber is aware of the risk versus benefit of using the medication chronically (greater than 90 days)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

## hrm short term skeletal muscle relaxants 2026

### Products Affected

- *carisoprodol oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Acute Muscle Spasms (AMS): (1) Diagnosis of Acute Muscle Spasms (AMS):(2) Prescriber attestation that drug will be used only for short periods. All Indications: Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly.
<b>Age Restrictions</b>	Apply if member is greater than or equal to 65 years
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(AMS): 1 year. (All other indications): 2 years
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ilumya 2026

## Products Affected

- ILUMYA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(PsO): Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	Plaque Psoriasis (PsO)(Initial): (1) Diagnosis of moderate to severe PsO. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. adalimumab-AACF), (b) Enbrel, (c) Skyrizi, (d) Cosentyx, (e) Ustekinumab (i.e. Yesintek), (f) Otezla OR documentation demonstrating that a trial may be inappropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PsO): Prescribed by or in consultation with a dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Subject to Part B vs Part D review. (PsO)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# increlex 2026

## Products Affected

- INCRELEX

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(GHGD, PIGF-1D) (Initial and Continuation): Known or suspected malignancy, closed epiphyses, concurrent GH therapy
<b>Required Medical Information</b>	Growth Hormone Gene Deletion (GHGD): (Initial) (1) Diagnosis of growth hormone gene deletion who have developed neutralizing antibodies to growth hormone. Severe Primary IGF-1 Deficiency (PIGF-1D): (Initial) (1) Diagnosis of Severe primary IGF-1 deficiency AND (2) height standard deviation score less than or equal to -3.0 AND (3) basal IGF-1 standard deviation score less than or equal to -3.0 AND normal or elevated growth hormone.
<b>Age Restrictions</b>	(GHGD, PIGF-1D): Member is 2 years of age or older
<b>Prescriber Restrictions</b>	(GHGD, PIGF-1D): Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(GHGD, PIGF-1D)(CONTINUATION): (1) Documentation of increase in growth velocity from baseline AND (2) Annual clinical re-evaluation by an endocrinologist AND (3) BOTH of the following: (a) Expected adult height is not obtained (b) documentation of expected adult height goal
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No



# inhaled tobramycin 2026

## Products Affected

- TOBI PODHALER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cystic Fibrosis (CF): (1) Diagnosis of cystic fibrosis AND (2) evidence of Pseudomonas aeruginosa in the lungs (3) FEV1 between 25% and 75% of predicted, (4) Member not colonized with Burkholderia cepacia.
Age Restrictions	(CF): Member is 6 years of age or older
Prescriber Restrictions	(CF): Prescribed by or in consultation with a pulmonologist, infectious disease specialist or Specialist affiliated with a CF care center.
Coverage Duration	Remainder of contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# injectable methotrexate 2026

## Products Affected

- RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 22.5 MG/0.45ML, 30 MG/0.6ML, 7.5 MG/0.15ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Rheumatoid arthritis (RA) (Initial): (1) Diagnosis of severe, active rheumatoid arthritis (RA), (2) Inadequate response or inability to tolerate oral methotrexate. Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA, (2) Inadequate response or inability to tolerate oral methotrexate. Polyarticular juvenile idiopathic arthritis (PJIA)(Initial): (1) Diagnosis of PJIA, (2) Inadequate response or inability to tolerate oral methotrexate. Psoriasis (Initial): (1) Diagnosis of severe psoriasis, (2) Inadequate response to BOTH of the following: (a) oral methotrexate AND (b) topical steroids (e.g. clobetasol propionate cream/ointment, betamethasone cream/ointment, etc.).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, PJIA): Recommended by rheumatologist. (PSA): Recommended by a rheumatologist or dermatologist. (Psoriasis): Recommended by dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(RA, PJIA, PSA, Psoriasis) (Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# intravenous immune globulins (ivig) 2026

## Products Affected

- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(Initial): History of hypersensitivity (including anaphylaxis or severe systemic reaction) to immune globulin or any component of the preparation.
<b>Required Medical Information</b>	Part D is medically necessary when ONE of the following is present: (1) Autoimmune mucocutaneous blistering disease pemphigus vulgaris, pemphigus foliaceus, bullous pemphigoid, mucous membrane (cicatricial) pemphigoid, benign mucous membrane pemphigoid, epidermolysis bullosa acquisita and ONE of the following: (a) inadequate response or inability to tolerate conventional therapy (i.e. steroids, immunosuppressants) OR (b) rapidly progressive disease in conjunction with conventional therapy (i.e. steroids, immunosuppressants). (2) Acute Idiopathic Thrombocytopenia Purpura (ITP) and ONE of the following (a) management of acute bleeding (b) used to increase platelet count prior to surgical procedures (c) severe thrombocytopenia (platelets less than 20,000 per uL) or (d) high risk for intracerebral hemorrhage. (3) Chronic ITP and ALL of the following (a) inadequate response or inability to tolerate corticosteroids (b) duration of illness greater than 6 months (c) platelets persistently less than 20,000/ uL. (4) Chronic B-cell lymphocytic leukemia with IgG less than 600mg/dL and recurrent, serious bacterial infections requiring antibiotic therapy. (5) Hematopoietic stem cell transplant and IgG less than 400mg/dL. (6) HIV and all of the following (a) less than 14 years of age (b) evidence of qualitative or quantitative humoral immunologic defects and (c) current bacterial infection despite antimicrobial prophylaxis. (7) Solid organ transplant. (8) Chronic Inflammatory Demyelinating Polyneuritis confirmed by electrodiagnostic testing or nerve biopsy and an inadequate response or inability to tolerate corticosteroids. (9) Dermatomyositis or Polymyositis diagnosed by laboratory testing (antinuclear or myositis specific antibodies), biopsy, EMG, or MRI) and inadequate response or inability to tolerate steroids or immunosuppressants. (10) Guillain Barre syndrome with impaired function (i.e. unable to stand or walk without aid).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g. immunologist, hematologist, neurologist).

PA Criteria	Criteria Details
Coverage Duration	6 months
Other Criteria	<p>Subject to Part B vs Part D review. (11) Lambert Eaton myasthenic syndrome and an inadequate response or inability to tolerate steroids, immunosuppressants, or cholinesterase inhibitors (12) Multifocal motor neuropathy diagnosed by electrodiagnostic studies. (13) Acute exacerbations of multiple sclerosis (MS) unresponsive to steroids. (14) Myasthenia gravis and an inadequate response or inability to tolerate at least 8 weeks of standard therapy (e.g. corticosteroids, azathioprine, cyclosporine, cyclophosphamide, cholinesterase inhibitors) (15) Myasthenic crisis (16) Stiff person syndrome and an inadequate response or inability to tolerate standard therapy (e.g. muscle relaxants, benzodiazepines, and gabapentin-related medications) (17) Severe, active SLE and an inadequate response or inability to tolerate steroids (18) Kawasaki disease. (19) Infections in Low-birthweight Neonates when severe hypogammaglobulinemia (IgG greater than or equal to 400 mg/dL) is present. (20) Graves?? Ophthalmopathy (21) Immune mediated Necrotizing Myopathy when resistant to treatment with glucocorticoids and immunosuppressants (22) Graves disease (All Indications)(CONTINUATION): (1) Documentation of clinical improvement as appropriate to the diagnosis (e.g. clinical improvement in symptoms, Rankin score and Activities of Daily Living (ADL) scores, etc.)</p>
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# ivabradine 2026

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## Products Affected

- *ivabradine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# jynarque 2026

## Products Affected

- JYNARQUE ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(Autosomal Dominant Polycystic Kidney Disease (ADPKD): (Initial): (1) Diagnosis of autosomal dominant polycystic kidney disease with risk of rapidly progressing kidney disease (2) Baseline serum transaminases and bilirubin obtained prior to initiation of therapy.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist or kidney transplant specialist
<b>Coverage Duration</b>	(Initial): 3 months. (Reauth): 12 months.
<b>Other Criteria</b>	(ADPKD)(Reauth): (1) ONE of the following (a) decline in kidney function has slowed or (b) kidney pain has improved and (2) serum transaminase less than 3 times the upper limit of normal and (3) bilirubin less than 2 times upper limit of normal
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# kalydeco 2026

## Products Affected

- KALYDECO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Cystic Fibrosis (CF)(Initial): (1) Diagnosis of Cystic Fibrosis (2) One of the following: (a) Documentation of one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data, (b) If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test
<b>Age Restrictions</b>	(CF): Member is 1 month of age or older for granules. Member is 6 years of age or older for tablets
<b>Prescriber Restrictions</b>	(CF): Prescribed by or in consultation with a pulmonologist or Specialist affiliated with a CF care center
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(CF)(Reauth): Member has had a positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# kerendia 2026

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## Products Affected

- KERENDIA ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# kevzara 2026

## Products Affected

- KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/1.14ML

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	Rheumatoid arthritis (RA)(Initial): (1) Diagnosis of RA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) etanercept (Enbrel), (c) Rinvoq, (d) Xeljanz/Xeljanz XR, (e) Orencia OR documentation demonstrating that a trial may be inappropriate. Polymyalgia Rheumatica (PMR)(Initial): (1) Diagnosis of polymyalgia rheumatica (2) Inadequate response or inability to tolerate corticosteroids (e.g. prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA)(Initial): (1) Diagnosis of active polyarticular juvenile idiopathic arthritis (PJIA) (2) Member weighs at least 63 kg (3) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF) (b) Enbrel, (c) Xeljanz, (d) Orencia, (e) Rinvoq/Rinvoq LQ OR documentation demonstrating that a trial may be inappropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, PMR, PJIA): Prescribed by or in consultation with a rheumatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(RA, PMR, PJIA) (Reauth): (1) Member demonstrates positive clinical response to therapy as evidenced by at least one of the following: (a) Reduction in total active (swollen and tender) joint count from baseline or (b) Improvement in symptoms (e.g., pain, stiffness, inflammation) from baseline
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

# kineret 2026

## Products Affected

- KINERET SUBCUTANEOUS SOLUTION  
PREFILLED SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	Rheumatoid Arthritis (RA)(Initial): (1) Diagnosis of RA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. adalimumab-AACF), (b) etanercept (Enbrel), (c) Rinvog, (d) Xeljanz/Xeljanz XR, (e) Orencia OR documentation demonstrating that a trial may be inappropriate. Neonatal-Onset Multisystem Inflammatory Disease (NOMID)(Initial): (1) Diagnosis of NOMID. (2) Diagnosis has been confirmed by one of the following: (a) NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3] gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation (b) Evidence of active inflammation including both of the following: (i) clinical symptoms (e.g. rash, fever, arthralgia) (ii) elevated acute phase reactants (e.g. ESR, CRP). Deficiency of Interleukin-1 Receptor Antagonist (DIRA): (1) Diagnosis of DIRA.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, NOMID, DIRA): Prescribed by or in consultation with a rheumatologist or pediatric specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(RA, NOMID, DIRA)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# korlym 2026

## Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Pregnancy
<b>Required Medical Information</b>	Hyperglycemia in members with Cushing Syndrome (HCS)(Initial): (1) Hyperglycemia secondary to hypercortisolism in adult member with endogenous Cushing syndrome, (2) member has type 2 diabetes mellitus or glucose intolerance, (3) member has failed surgery or is not a candidate for surgery.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(HCS)(Reauth): Documentation of positive clinical response to therapy (e.g., improved, or stable glucose tolerance while on therapy)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# livtency 2026

## Products Affected

- LIVTENCY

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Cytomegalovirus (CMV): (1) Diagnosis of cytomegalovirus (CMV) infection/disease, (2) Member is a recipient of one of the following (a) Hematopoietic stem cell transplant, (b) solid organ transplant, (3) Inadequate response to a minimum 2 weeks duration or inability to tolerate one prior therapy at an appropriately indicated dose (e.g., oral valganciclovir)(4) For pediatric members 12 years of age or older, Member weighs greater than or equal to 35kg
<b>Age Restrictions</b>	(CMV): Member is 12 years of age or older
<b>Prescriber Restrictions</b>	(CMV): Prescribed by or in consultation with a provider who specializes in one of the following areas (1) transplant, (2) infectious disease (3) Oncology
<b>Coverage Duration</b>	8 weeks
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# modafinil 2026

## Products Affected

- *modafinil oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Obstructive Sleep Apnea (OSA) (Initial) (1) Diagnosis of obstructive sleep apnea defined by ONE of the following: (A) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible) OR (B) BOTH of the following: (a) 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study is not feasible) (b) ONE of the following symptoms: Unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, breathing interruptions during sleep</p> <p>Narcolepsy (Initial): (1) Diagnosis of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming a sleep study is not feasible)</p> <p>Shift Work Disorder (SWD)(Initial):(1) Diagnosis of Shift Work Disorder confirmed by ONE of the following: (A) Symptoms of excessive sleepiness or insomnia, for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period OR (B) Sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity) (2) Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia</p> <p>Fatigue due to MS (off-label) (Initial): (1) Diagnosis of multiple sclerosis (MS) (2) Member is experiencing fatigue.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist or sleep specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>(OSA, Narcolepsy, SWD)(Reauth): (1) Member demonstrates positive clinical response to therapy (MS)(Reauth): (1) Member is experiencing relief of fatigue with modafinil therapy</p>

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# nexletol/nexlizet 2026

## Products Affected

- NEXLETOL
- NEXLIZET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Heterozygous Familial Hypercholesterolemia (HeFH) OR Primary hyperlipidemia (PH). (Initial): (1) One of the following: (A) Diagnosis of HeFH, OR (B) Diagnosis of Primary hyperlipidemia (2) ONE of the following: (A) LDL-C 70 mg/dL or greater after at least 8 weeks of one low, moderate or high-intensity statin therapy and member will continue to receive statin therapy at maximally tolerated dose OR (B) Inability to tolerate statin therapy as documented by one of the following: (i) member had rhabdomyolysis or symptoms with creatine kinase (CK) exceeding 10 times the upper limit of normal (ULN) or (ii) either of the following with TWO statins: myalgia (no CK elevation) or myositis (CK less than 10 times ULN or (iii) hepatotoxicity from statin use (increased AST/ALT exceeding 3 times ULN) or (iv) liver disease documented by Child Pugh A or worse OR AST/ALT exceeding 3 times ULN for at least 6 weeks. (3) One of the following: (A) Member has been receiving at least 8 weeks of ezetimibe (Zetia) therapy as adjunct to maximally tolerated statin therapy OR (B) Member has contraindication or intolerance to ezetimibe (Zetia).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation): 12 months



PA Criteria	Criteria Details
<b>Other Criteria</b>	Established cardiovascular disease (CVD) or high risk for a CVD event but without established CVD (Initial): (1) One of the following: (A) Diagnosis of established cardiovascular disease (CVD) (e.g., coronary artery disease, symptomatic peripheral arterial disease, cerebrovascular atherosclerotic disease) OR (B) Diagnosis of a high risk for a CVD event but without established CVD [e.g., diabetes mellitus (type 1 or type 2) in females over 65 years of age or males over 60 years of age] (2) One of the following: (A) Member is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase) (B) Member has a contraindication to all statins (3) ONE of the following LDL-C values within the last 120 days (A) LDL-C greater than or equal to 55 mg/dL with ASCVD OR (B) LDL-C greater than or equal to 100 mg/dL without ASCVD (4) One of the following (A) For Nexletol, ONE of the following: (i) Member has been receiving at least 12 weeks of generic ezetimibe therapy (ii) Patient has a history of contraindication, or intolerance to ezetimibe OR (B) For Nexlizet, member has been receiving at least 12 weeks of generic ezetimibe therapy (HeFH, PH) (Continuation): (1) Positive Clinical response to therapy (e.g. reduction in LDL-C levels). (CVD) (Continuation): (1) Positive Clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# non-oral chemo agents 2026

## Products Affected

- BESREMI
- TRELSTAR MIXJECT INTRAMUSCULAR  
SUSPENSION RECONSTITUTED 11.25 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Part D is medically necessary when ANY of the following inclusion criteria is met: (1) Drug is FDA approved for indication and regimen requested, (2) The indication and regimen is classified as Category 1 or 2A by National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (3) narrative text in The American Hospital Formulary Service-Drug Information (AHFS-DI) or Clinical Pharmacology Compendium is supportive for the specific condition(s) requested, (4) The Micromedex Compendium and the strength of recommendation is listed as Class I, Class IIa, or Class IIb for the specific condition(s) requested, (5) Indication is listed in Lexi-Drugs as ??off label?? with evidence level A, (6) supported by Peer-Reviewed Medical Literature as defined in Chapter 15 Section 50.4.5 of the Medicare Benefit Policy Manual
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy. Subject to Part B vs Part D review.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

## non-preferred glp-1 agonists 2026

### Products Affected

- *exenatide*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(DM2)(Initial): (1) One of the following: (a) For members requiring ongoing treatment for type 2 diabetes mellitus, submission of medical records (e.g. chart notes) confirming diagnosis of type 2 diabetes mellitus (b) Submission of medical records (e.g. chart notes) confirming diagnosis of type 2 diabetes mellitus as evidenced by one of the following laboratory values (i) A1C greater than or equal to 6.5 percent (ii) Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL (iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test) (2) Inadequate response or inability to tolerate a minimum 90 day-supply of two of the following preferred brands: Ozempic, Trulicity, Rybelsus, Mounjaro, liraglutide
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(DM2)(Reauth): Documentation of positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

## non-preferred hepatitis c agents 2026

### Products Affected

- VOSEVI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(1) Documentation of member's Hepatitis C genotype. (2) Prescribed regimen is consistent with the current AASLD/ IDSA guidance. (3) Inability to tolerate ONE of the following when appropriate per the current AASLD/IDSA guidance: Harvoni, Epclusa, or Mavyret.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Duration will be applied consistent with AASLD/ IDSA guidance
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

## non-preferred ustekinumab sq 2026

### Products Affected

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

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	Part D is medically necessary when: Crohn's Disease (CD)(Initial): (1) Diagnosis of moderate to severe CD (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Skyrizi, (c) Rinvoq (d) Ustekinumab (i.e. Yesintek) or documentation demonstrating that a trial may be inappropriate. Ulcerative Colitis (UC)(Initial): (1) Diagnosis of moderate to severe UC. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Rinvoq, (c) Xeljanz/Xeljanz XR, (d) Skyrizi (e) Ustekinumab (i.e. Yesintek) OR documentation demonstrating that a trial may be inappropriate. Psoriatic arthritis (PsA)(Initial): (1) Diagnosis of PsA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Xeljanz/Xeljanz XR (d) Rinvoq/Rinvoq LQ, (e) Skyrizi, (f) Cosentyx, (g) Orencia, (h) Otezla, (i) Ustekinumab (i.e. Yesintek) OR documentation demonstrating that a trial may be inappropriate. Plaque psoriasis (PsO)(Initial): Diagnosis of moderate to severe PsO. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Skyrizi (d) Cosentyx, (e) Otezla, (f) Ustekinumab (i.e. Yesintek) OR documentation demonstrating that a trial may be inappropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CD, UC): prescribed by or in consultation with a Gastroenterologist. (PsO): prescribed by or in consultation with a Dermatologist. (PsA): prescribed by or in consultation with a Dermatologist or Rheumatologist
<b>Coverage Duration</b>	(CD, UC, PsA, PsO): 12 months
<b>Other Criteria</b>	(CD, UC, PsA, PsO): (Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# noxafil 2026

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## Products Affected

- *posaconazole oral tablet delayed release*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# nucala 2026

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## Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# nuedexta 2026

## Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(PBA) 1) Concomitant use with other drugs containing quinidine, quinine, or mefloquine, (2) History of Nuedexta, quinine, mefloquine or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome, (3) Known hypersensitivity to dextromethorphan (e.g., rash, hives), (4) Taking monoamine oxidase inhibitors (MAOIs) (e.g., phenelzine, selegiline, tranylcypromine) or have taken MAOIs within the preceding 14 days, (5) Presence of prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or has heart failure, (6) Receiving drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozide), (7) Has complete atrioventricular (AV) block without implanted pacemakers, or at high risk of complete AV block ]
<b>Required Medical Information</b>	Pseudobulbar Affect (PBA) (Initial): (1) Diagnosis of Pseudobulbar affect (2) Member has one of the following underlying conditions: (a) Amyotrophic lateral sclerosis (b) Multiple sclerosis (c) Alzheimer's disease (d) Parkinson's disease (e) Stroke (f) Traumatic brain injury
<b>Age Restrictions</b>	(PBA): Member is 18 years of age or older
<b>Prescriber Restrictions</b>	(PBA): Prescribed by or in consultation with a neurologist or psychiatrist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(PBA)(Reauth): (1) Documentation of clinical benefit from ongoing therapy (e.g., decrease in laughing or crying episodes)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# nuplazid 2026

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## Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# nurtec 2026

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## Products Affected

- NURTEC

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# octreotide 2026

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## Products Affected

- *octreotide acetate injection solution 200 mcg/ml, 50 mcg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

## ofev 2026

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### Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

# olumiant 2026

## Products Affected

- OLUMIANT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists, JAK inhibitors, or potent immunosuppressants such as azathioprine, cyclosporine
<b>Required Medical Information</b>	Rheumatoid arthritis (RA)(Initial): (1) Diagnosis of RA. (2) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e. adalimumab-AACF), (b) Enbrel (c) Rinvoq, (d) Xeljanz/Xeljanz XR, (e) Orencia OR documentation demonstrating that a trial may be inappropriate. Alopecia Areata (AA)(Initial): (1) Diagnosis of alopecia areata (2) Member has at least 50% scalp hair loss (3) Other causes of hair loss have been ruled out (e.g. androgenetic alopecia, trichotillomania, tinea capitis, psoriasis) (4) Inadequate response or inability to tolerate one previous treatment for alopecia areata (e.g. topical, intralesional, or systemic corticosteroids, topical immunotherapy)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA): Prescribed by or in consultation with a rheumatologist (AA): Prescribed by or in consultation with a dermatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(RA, Alopecia Areata)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# onychomycosis agents 2026

## Products Affected

- *tavaborole*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Onychomycosis: (1) Diagnosis of onychomycosis of the toenail(s) due to <i>Trichophyton rubrum</i> and <i>Trichophyton mentagrophytes</i> . (2) Diagnosis confirmed by one of the following: (a) positive potassium hydroxide (KOH) preparation, (b) culture, or (c) histology. (3) Condition is causing debility or a disruption in member's activities of daily living. (4) Inadequate response or inability to tolerate BOTH of the following: (a) oral generic terbinafine, AND (b) oral generic itraconazole OR topical generic ciclopirox.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	1 year
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# opipza 2026

## Products Affected

- OPIPZA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Schizophrenia: (1) Diagnosis of treatment of schizophrenia (2) Inadequate response or inability to tolerate aripiprazole and an additional generic formulary antipsychotic product. Major depressive disorder (MDD): (1) Diagnosis of adjunctive treatment of MDD (2) Inadequate response or inability to tolerate aripiprazole and quetiapine. Autistic disorder: (1) Diagnosis of irritability associated with autistic disorder (2) Inadequate response or inability to tolerate aripiprazole and risperidone. Tourette??s disorder: (1) Diagnosis of treatment of Tourette??s disorder (2) Inadequate response or inability to tolerate aripiprazole.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes



# oral chemo agents 2026

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## Products Affected

- *abiraterone acetate*
- ABIRTEGA
- AKEEGA
- ALECENSA
- ALUNBRIG
- AUGTYRO
- AVMAPKI FAKZYNJA CO-PACK
- AYVAKIT
- BALVERSA
- *bexarotene*
- BOSULIF ORAL CAPSULE 50 MG
- BOSULIF ORAL TABLET
- BRAFTOVI ORAL CAPSULE 75 MG
- CABOMETYX
- CALQUENCE ORAL TABLET
- CAPRELSA
- 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)
- COPIKTRA
- COTELLIC
- DANZITEN
- *dasatinib*
- DAURISMO
- ERIVEDGE
- ERLEADA
- *erlotinib hcl*
- *everolimus oral tablet 10 mg, 2.5 mg, 5 mg, 7.5 mg*
- *everolimus oral tablet soluble*
- FOTIVDA
- FRUZAQLA
- GAVRETO
- *gefitinib*
- GILOTRIF
- GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG
- GOMEKLI
- IBRANCE
- ICLUSIG
- IDHIFA
- *imatinib mesylate oral*
- IMBRUVICA ORAL CAPSULE
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG
- *imkeldi*
- INLYTA
- INQOVI
- INREBIC
- ITOVEBI
- IWILFIN
- JAKAFI
- JAYPIRCA
- KISQALI (200 MG DOSE)
- KISQALI (400 MG DOSE)
- KISQALI (600 MG DOSE)
- KOSELUGO
- KRAZATI
- *lapatinib ditosylate*
- LAZCLUZE
- *lenalidomide*
- 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)
- LONSURF
- LORBRENA
- LUMAKRAS
- LYNPARZA ORAL TABLET
- LYTGOBI (12 MG DAILY DOSE)
- LYTGOBI (16 MG DAILY DOSE)
- LYTGOBI (20 MG DAILY DOSE)
- MEKINIST
- MEKTOVI
- NERLYNX
- *nilotinib hcl*
- NINLARO
- NUBEQA
- ODOMZO

- OGSIVEO
- OJEMDA ORAL SUSPENSION RECONSTITUTED
- OJEMDA ORAL TABLET 100 MG
- OJJAARA
- ONUREG
- ORGOVYX
- ORSERDU
- *pazopanib hcl*
- PEMAZYRE
- PIQRAY (200 MG DAILY DOSE)
- PIQRAY (250 MG DAILY DOSE)
- PIQRAY (300 MG DAILY DOSE)
- POMALYST
- QINLOCK
- RETEVMO ORAL TABLET
- REVUFORJ
- REZLIDHIA
- ROMVIMZA
- ROZLYTREK
- RUBRACA
- RYDAPT
- SCEMBLIX
- *sorafenib tosylate*
- SPRYCEL
- STIVARGA
- *sunitinib malate*
- TABRECTA
- TAFINLAR
- TAGRISSO
- TALZENNA
- TASIGNA
- TAZVERIK
- TEPMETKO
- THALOMID ORAL CAPSULE 100 MG, 50 MG
- TIBSOVO
- TRUQAP ORAL TABLET 200 MG
- TUKYSA
- TURALIO ORAL CAPSULE 125 MG
- VANFLYTA
- VENCLEXTA
- VENCLEXTA STARTING PACK
- VERZENIO
- VITRAKVI
- VIZIMPRO
- VONJO
- VORANIGO
- WELIREG
- XALKORI
- XOSPATA
- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 10 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)
- XTANDI
- YONSA
- ZEJULA ORAL TABLET
- ZELBORAF
- ZOLINZA
- ZYDELIG
- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
<b>Required Medical Information</b>	Approved when ANY of the following inclusion criteria is met: (1) Drug is FDA approved for indication and regimen requested, (2) The indication and regimen is classified as Category 1 or 2A by National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (3) narrative text in The American Hospital Formulary Service-Drug Information (AHFS-DI) or Clinical Pharmacology Compendium is supportive for the specific condition(s) requested, (4) The Micromedex Compendium and the strength of recommendation is listed as Class I, Class IIa, or Class IIb for the specific condition(s) requested, (5) Indication is listed in Lexi-Drugs as ??off label?? with evidence level A, (6) supported by Peer-Reviewed Medical Literature as defined in Chapter 15 Section 50.4.5 of the Medicare Benefit Policy Manual
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# oral pah agents 2026

## Products Affected

- OPSUMIT

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation):12 months.
<b>Other Criteria</b>	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# orencia sq 2026

## Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SOLUTION  
PREFILLED SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(RA, PsA, PJIA): Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	Rheumatoid arthritis (RA)(Initial): (1) Diagnosis of RA. (2) Inadequate response or inability to tolerate one DMARD: (e.g. methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine). Psoriatic arthritis (PsA)(Initial): (1) Diagnosis of PsA. Polyarticular Juvenile idiopathic arthritis (PJIA)(Initial): (1) Diagnosis of PJIA. (2) Inadequate response or inability to tolerate one of the following: methotrexate, leflunomide, sulfasalazine.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, PJIA): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a dermatologist or rheumatologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(RA, PsA, PJIA)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# orkambi 2026

## Products Affected

- ORKAMBI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Cystic Fibrosis (CF)(Initial): (1) Diagnosis of CF, (2) One of the following: (a) Documentation that member is homozygous for the F508del mutation in the CFTR gene (b) If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene
<b>Age Restrictions</b>	(CF): Member is 1 year of age or older for granules. Member is 6 years of age or older for tablets.
<b>Prescriber Restrictions</b>	(CF): Prescribed by or in consultation with pulmonologist or Specialist affiliated with a CF care center
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(CF)(Reauth): Member has had a positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# otezla 2026

## Products Affected

- OTEZLA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Oral Ulcers Associated with Behcet's Disease (OU-BD)(Initial): (1) Diagnosis of OU-BD. Psoriatic arthritis (PsA)(Initial): (1) Diagnosis of PsA. Plaque psoriasis (PsO)(Initial): (1) Diagnosis of PsO.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PsA, OU-BD): Prescribed by or in consultation with a Rheumatologist or Dermatologist. (PsO): Prescribed by or in consultation with dermatologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(OU-BD, PsA, PsO)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

## part d vs excluded 2026

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### Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	Subject to additional clinical review for ESRD-related use - if applicable.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No



## pde inhibitor agents for pah 2026

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### Products Affected

- *tadalafil (pah)*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# praluent 2026

## Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Hyperlipidemia (HLA) (Initial): (1) Diagnosis of hyperlipidemia, (2) ONE of the following: (A) LDL-C 70 mg/dL or greater after a minimum 8-week trial of at least moderate-intensity statin therapy OR (B) Inability to tolerate statin therapy as documented by one of the following: (i) member had rhabdomyolysis or symptoms with creatine kinase (CK) exceeding 10 times the upper limit of normal (ULN) or (ii) either of the following with TWO statins: myalgia (no CK elevation) or myositis (CK less than 10 times ULN or (iii) hepatotoxicity from statin use (increased AST/ALT exceeding 3 times ULN) or (iv) liver disease documented by Child Pugh A or worse OR AST/ALT exceeding 3 times ULN for at least 6 weeks Atherosclerotic cardiovascular disease (ASCVD) (Initial): (1) Diagnosis of atherosclerotic cardiovascular disease (ASCVD) as diagnosed by either stress test, angiography, atherosclerotic event (e.g. MI, angina, stroke, claudication, carotid stenosis) or arterial intervention for atherosclerotic disease (e.g. coronary, peripheral, carotid), (2) ONE of the following: (A) LDL-C 70 mg/dL or greater after a minimum 8-week trial of at least moderate-intensity statin therapy OR (B) Inability to tolerate statin therapy as documented by one of the following: (i) member had rhabdomyolysis or symptoms with creatine kinase (CK) exceeding 10 times the upper limit of normal (ULN) or (ii) either of the following with TWO statins: myalgia (no CK elevation) or myositis (CK less than 10 times ULN or (iii) hepatotoxicity from statin use (increased AST/ALT exceeding 3 times ULN) or (iv) liver disease documented by Child Pugh A or worse OR AST/ALT exceeding 3 times ULN for at least 6 weeks
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(Initial): 6 months (Continuation): 2 years

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>Homozygous Familial Hypercholesterolemia (HoFH) (Initial): (1) Diagnosis of HoFH. (2) One of the following: (a) Untreated LDL-C greater than 500 mg/dL or (b) Treated LDL-C greater than 300 mg/dL. (3) Member is receiving other lipid-lowering therapy (e.g. statin, ezetimibe). (4) Not used in combination with Juxtapid (lomitapide). (HLA, ASVCD)(CONTINUATION): (1) Positive Clinical response to therapy (e.g. reduction in LDL-C levels).</p> <p>(HoFH)(Continuation): (1) Positive Clinical response to therapy (e.g. reduction in LDL-C levels). (2) Member continues to receive other lipid-lowering therapy (e.g. statin, ezetimibe). (3) Not used in combination with Juxtapid (lomitapide).</p>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

## preferred denosumab 2026

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### Products Affected

- JUBBONTI

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

## preferred glp-1 agonists 2026

### Products Affected

- *liraglutide*
- MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML
- OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- OZEMPIC (2 MG/DOSE)
- RYBELSUS
- TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(DM2)(Initial): (1) One of the following: (a) For members requiring ongoing treatment for type 2 diabetes mellitus, submission of medical records (e.g. chart notes) confirming diagnosis of type 2 diabetes mellitus (b) Submission of medical records (e.g. chart notes) confirming diagnosis of type 2 diabetes mellitus as evidenced by one of the following laboratory values (i) A1C greater than or equal to 6.5 percent (ii) Fasting plasma glucose (FPG) greater than or equal to 126 mg/dL (iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(DM2)(Reauth): Documentation of positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

## preferred hepatitis c agents 2026

### Products Affected

- EPCLUSA
- HARVONI
- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Documentation of member's Hepatitis C Genotype. (2) Prescribed regimen is consistent with the current AASLD/IDSA guidance.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Duration will be applied consistent with AASLD/ IDSA guidance
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

## preferred tocilizumab sq 2026

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### Products Affected

- TYENNE SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

## preferred ustekinumab sq 2026

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### Products Affected

- YESINTEK SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



# promacta 2026

## Products Affected

- *eltrombopag olamine oral tablet*
- PROMACTA ORAL TABLET

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	<p>Chronic Idiopathic Thrombocytopenic Purpura (ITP)(Initial): (1) Diagnosis of relapsed/refractory, persistent, or chronic ITP. (2) Baseline platelet count is less than 30,000/mcL. (3) Member's degree of thrombocytopenia and clinical condition increase the risk of bleeding. (4) Inadequate response or inability to tolerate ONE of the following: (a) corticosteroids, (b) immune globulin, (c) splenectomy. First-Line for Severe Aplastic Anemia(FLSAA): (1) Diagnosis of severe aplastic anemia. (2) Used for first-line treatment (i.e., member has not received prior immunosuppressive therapy). (3) Member meets at least TWO of the following: (a) absolute neutrophil count less than 500/mcL, (b) platelet count less than 20,000/mcL, (c) absolute reticulocyte count less than 60,000/mcL. (4) Used in combination with standard immunosuppressive therapy (e.g. Agam [antithymocyte globulin equine] and cyclosporine). Refractory Severe Aplastic Anemia (RSAA)(Initial): (1) Diagnosis of refractory severe aplastic anemia. (2) Member has a platelet count less than 30,000/mcL. (3) Inadequate response or inability to tolerate immunosuppressive therapy with antithymocyte globulin and cyclosporine. Chronic Hepatitis C-Associated Thrombocytopenia (HEPC-TP)(Initial): (1) Diagnosis of chronic hepatitis C-associated thrombocytopenia. (2) One of the following: (a) Planning to initiate and maintain interferon-based treatment, or (b) currently receiving interferon-based treatment.</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(ITP, FLSAA, RSAA): Prescribed by or in consultation with hematologist/oncologist. (HEPC-TP): Prescribed by or in consultation with Hematologist/oncologist, Gastroenterologist, Hepatologist, Infectious disease specialist, HIV specialist.
<b>Coverage Duration</b>	(ITP).=12mo.(FLSAA)=6mo.(RSAA)Initial=6mo.(HEPC-TP)Initial=3mo.(RSAA,HEPC-TP)Cont.=12mo.

PA Criteria	Criteria Details
<b>Other Criteria</b>	(ITP, RSAA)(Continuation): (1) Positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding. (HEPC-TP)(Continuation): (1) ONE of the following: (A) For members that started treatment with Promacta prior to initiation of treatment with interferon, both of the following: (i) Member is currently on antiviral interferon therapy for treatment of chronic hepatitis C, AND (ii) member reached a threshold platelet count that allows initiation of antiviral interferon therapy with Promacta treatment by week 9. (B) For members that started treatment with Promacta while on concomitant treatment with interferon, member is currently on antiviral interferon therapy for treatment of chronic hepatitis C.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# qualaquin 2026

## Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Use for treatment or prevention of nocturnal leg cramps
<b>Required Medical Information</b>	Uncomplicated Malaria: (1) Diagnosis of uncomplicated malaria due to (a) plasmodium falciparum malaria or (b) plasmodium vivax . (2) One of the following: (a) Both of the following: (i) treatment in areas of chloroquine-sensitive malaria (ii) Inadequate response or inability to tolerate chloroquine or hydroxychloroquine, or (b) treatment in areas of chloroquine-resistant malaria. Babesiosis: (1) Diagnosis of babesiosis.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Babesiosis: 10 days Uncomplicated Malaria: 14 Days
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# raldesy 2026

## Products Affected

- RALDESY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Major depressive disorder (MDD): (1) Diagnosis of major depressive disorder (MDD) (2) One of the following: (a) inadequate response or inability to tolerate both of the following: (i) generic formulary trazadone tablets (ii) generic formulary serotonin reuptake inhibitors (SSRI) OR (b) Member is unable to swallow tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Indefinite
Other Criteria	(All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# repatha 2026

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## Products Affected

- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# respiratory enzymes 2026

## Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(ATT): (1) IgA deficiency with known anti-IgA antibody. (2) Member is a smoker
<b>Required Medical Information</b>	Part D is medically necessary when there is documentation of: Alpha 1-antitrypsin (AAT) deficiency: (1) Submission of medical records showing diagnosis of congenital alpha1-antitrypsin deficiency as confirmed by ONE of the following: (a) PiZZ, PiZ(null) or Pi(null)(null) protein phenotypes (homozygous) OR (B) Other rare AAT disease-causing alleles associated with serum alpha1-antitrypsin (AAT) level less than 11uM/L (2) Submission of medical records showing clinical evidence of chronic emphysema without evidence of alpha 1-antitrypsin-associated liver disease (3) Member has a low serum concentration of alpha 1-antitrypsin (AAT) less than 80 mg/dL (radial immunodiffusion) or 50 mg/dl (nephelometry) or less than 11 uM/L (nephelometry) or less than 0.8 g/L (35 percent of normal)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	Subject to Part B vs Part D review.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# rexulti 2026

## Products Affected

- REXULTI

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Alzheimer's disease (AD): (1) Diagnosis of agitation associated with dementia due to Alzheimer's disease in adults. Schizophrenia: (1) Diagnosis of schizophrenia (2) Inadequate response or inability to tolerate TWO of the following: aripiprazole, quetiapine, asenapine, olanzapine, paliperidone, risperidone, ziprasidone. Major Depressive Disorder (MDD): (1) Diagnosis of major depressive disorder and as adjunctive therapy to antidepressants (2) Inadequate response or inability to tolerate aripiprazole and quetiapine
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# rezdiffra 2026

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## Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No



# rezurock 2026

## Products Affected

- REZUROCK

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Chronic graft-versus-host disease (cGVHD) (Initial): (1) Diagnosis of chronic graft-versus-host disease, (2) Inadequate response or inability to tolerate two or more lines of systemic therapy (e.g. corticosteroids, mycophenolate, etc.)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(cGVHD): Prescribed by or in consultation with one of the following (1) Hematologist, (2) Oncologist, (3) physician experienced in the management of transplant patients
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(cGVHD) (Reauth): (1) Member does not show evidence of progressive disease while on therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# rinvoq 2026

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## Products Affected

- RINVOQ

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# rinvoq lq 2026

## Products Affected

- RINVOQ LQ

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent use with any other biologic disease modifying antirheumatic drug (DMARD), other JAK inhibitors, or potent immunosuppressants (e.g. azathioprine, cyclosporine).
<b>Required Medical Information</b>	Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA, (2) Member had an inadequate response or inability to tolerate one or more TNF inhibitors (e.g. Enbrel, Adalimumab-AACF) or documentation demonstrating that a trial may be inappropriate. Polyarticular Juvenile Idiopathic Arthritis (PJIA)(Initial): (1) Diagnosis of active PJIA, (2) Inadequate response or inability to tolerate ONE of the following: Methotrexate, Leflunomide, Sulfasalazine (3) Member had an inadequate response or inability to tolerate one or more TNF inhibitors (e.g. Enbrel, Adalimumab-AACF) or documentation demonstrating that a trial may be inappropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PsA): Prescribed by or in consultation with a rheumatologist or dermatologist. (pJIA): Prescribed by or in consultation with a rheumatologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(PsA, pJIA)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# signifor 2026

## Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cushing's disease (CD)(Initial): (1) Diagnosis of (pituitary) Cushing's disease. (2) Pituitary surgery is not an option or has not been curative
Age Restrictions	
Prescriber Restrictions	(CD) Prescribed by or in consultation with an endocrinologist.
Coverage Duration	12 months
Other Criteria	(CD)(Reauth): Documentation of positive clinical response (e.g. clinically meaningful reduction in 24- hour urinary free cortisol levels, improvement in signs or symptoms of the disease)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# sildenafil 2026

## Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(PAH, RP): Documentation of concomitant nitrate use
<b>Required Medical Information</b>	Pulmonary Arterial Hypertension (PAH): (1) Diagnosis of PAH WHO Group I with New York Heart Association (NYHA) Functional Class II to IV (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less. Raynaud's Phenomenon (RP): (1) Diagnosis of secondary Raynaud's phenomenon. (2) Inadequate response or inability to tolerate a calcium channel blocker.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# simponi 2026

## Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
<b>Required Medical Information</b>	Ankylosing Spondylitis (AS)(Initial): (1) Diagnosis of AS. (2) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) etanercept (Enbrel), (c) secukinumab (Cosentyx), (d) tofacitinib (Xeljanz/Xeljanz XR), (e) upadacitinib (Rinvoq) or documentation demonstrating that a trial may be inappropriate. Psoriatic Arthritis (PsA)(Initial): (1) Diagnosis of PsA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Xeljanz/Xeljanz XR, (d) Rinvoq/Rinvoq LQ, (e) Skyrizi, (f) Cosentyx, (g) Ustekinumab (i.e. Yesintek), (h) Ocrencia, (i) Otezla OR documentation demonstrating that a trial may be inappropriate. Rheumatoid arthritis (RA)(Initial): (1) Diagnosis of moderate to severe RA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Enbrel, (c) Rinvoq, (d) Xeljanz/Xeljanz XR, (e) Ocrencia OR documentation demonstrating that a trial may be inappropriate. Ulcerative Colitis (UC)(Initial): (1) Diagnosis of moderate to severe UC. (2) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e. Adalimumab-AACF), and (b) Xeljanz/Xeljanz XR, (c) Ustekinumab (i.e. Yesintek), (d) Rinvoq, (e) Skyrizi OR documentation demonstrating that a trial may be inappropriate.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(RA, AS): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a rheumatologist or dermatologist. (UC): Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(AS, PsA, RA, UC)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# sirturo 2026

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## Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No



# skyrizi sc 2026

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## Products Affected

- SKYRIZI PEN
- SKYRIZI SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# sotatercept 2026

## Products Affected

- WINREVAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Diagnosis of PAH WHO Group I with New York Heart Association (NYHA) Functional Class II to III (2) inadequate response or inability to tolerate TWO of the following: (a) Endothelin Receptor Antagonist (bosentan, ambrisentan, macitentan) (b) Phosphodiesterase 5 inhibitor (tadalafil, sildenafil) (c) IV prostacyclin therapy (treprostinil, epoprostenol) (3) Member continues to receive other PAH therapies (e.g. ambrisentan, tadalafil)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with cardiologist or pulmonologist.
<b>Coverage Duration</b>	(Initial) 6 months (Reauth) 12 months
<b>Other Criteria</b>	(PAH)(Reauth): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# tadalafil (bph) 2026

## Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(BPH): Concurrent use of nitrates.
<b>Required Medical Information</b>	Benign prostatic hyperplasia (BPH): (1) Diagnosis of BPH. (2) Inadequate response or inability to tolerate an alpha blocker (e.g. tamsulosin, terazosin) or a 5-alpha reductase inhibitor (e.g. dutasteride, finasteride).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# taltz 2026

## Products Affected

- TALTZ

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	<p>Plaque Psoriasis (PsO)(Initial): (1) Diagnosis of moderate to severe PsO. (2) ONE of the following: (A) For members 6 to 17 years of age: an inadequate response or inability to tolerate two of the following: (a) Enbrel, (b) Cosentyx, (c) Ustekinumab (i.e. Yesintek) or documentation demonstrating that a trial may be inappropriate, OR (B) For members 18 years of age or older: an inadequate response or inability to tolerate two of the following: (a) Cosentyx (b) Enbrel (c) Adalimumab (i.e. Adalimumab-AACF) (d) Skyrizi, (e) Ustekinumab (i.e. Yesintek), (f) Otezla or documentation demonstrating that a trial may be inappropriate. Psoriatic arthritis (PsA)(Initial): (1) Diagnosis of PsA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Enbrel (b) Adalimumab(i.e. Adalimumab-AACF) (c) Cosentyx (d) Rinvoq/Rinvoq LQ (e) Skyrizi (f) Ustekinumab (i.e. Yesintek) (g) Xeljanz/Xeljanz XR, (h) Orencia, (i) Otezla OR documentation demonstrating that a trial may be inappropriate. Ankylosing spondylitis (AS)(Initial): (1) Diagnosis of AS. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) etanercept (Enbrel), (c) secukinumab (Cosentyx), (d) upadacitinib (Rinvoq), (e) tofacitinib (Xeljanz/Xeljanz XR) OR documentation demonstrating that a trial may be inappropriate. Non-Radiographic Axial Spondyloarthritis (nr-axSpA)(Initial): (1) Diagnosis of nr-axSpA. (2) Inadequate response or inability to tolerate Rinvoq OR Cosentyx OR documentation demonstrating that a trial may be inappropriate (3) Inadequate response or inability to tolerate one NSAID (e.g. ibuprofen, meloxicam, naproxen).</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PsO): Prescribed by or in consultation with a dermatologist. (PsA): Prescribed by or in consultation with a dermatologist or rheumatologist. (AS, nr-axSpA): Prescribed by or in consultation with a rheumatologist.
<b>Coverage Duration</b>	12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	(PsA, AS, nr-axSpA, PsO)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# tavneos 2026

## Products Affected

- TAVNEOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Severe Active Anti-neutrophil Cytoplasmic Autoantibody (ANCA)-associated Vasculitis (granulomatosis with polyangiitis [GPA] and microscopic polyangiitis [MPA]) (ANCA-V(GPA)(MPA))(Initial): (1) Diagnosis of Severe Active Anti-neutrophil Cytoplasmic Autoantibody (ANCA)-associated Vasculitis (granulomatosis with polyangiitis [GPA] or microscopic polyangiitis [MPA]), (2) Used as adjunct to standard therapy, and glucocorticoids (3) Member is on concurrent immunosuppressant therapy with cyclophosphamide or rituximab (Rituxan).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(ANCA-V(GPA)(MPA))Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist.
<b>Coverage Duration</b>	(Initial): 6 Months (Reauth): 1 year
<b>Other Criteria</b>	(ANCA-V(GPA)(MPA))(Reauth): (1) Positive clinical response to therapy defined as sustained remission as assessed by the Birmingham Vasculitis Activity Score (BVAS). (2) Reduction in use of glucocorticoids for treatment (3) Member is on concurrent immunosuppressant therapy with cyclophosphamide or rituximab (Rituxan).
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# teriparatide 2026

## Products Affected

- BONSITY 560 mcg/2.24ml
- FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 560 MCG/2.24ML
- *teriparatide subcutaneous solution pen-injector*

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# testosterone products 2026

## Products Affected

- testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml 12.5 mg/act (1%), 20.25 mg/1.25gm (1.62%), 20.25 mg/act (1.62%), 25 mg/2.5gm (1%), 40.5 mg/2.5gm (1.62%), 50 mg/5gm (1%)
- testosterone enanthate intramuscular solution
- testosterone transdermal gel 10 mg/act (2%),
- testosterone transdermal solution

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Delayed Puberty (DP): (1) Diagnosis of delayed puberty in male members (Applies to Testosterone Enanthate only). Breast Cancer (BC): (1) Diagnosis of inoperable breast cancer in female members (Applies to Testosterone Enanthate only) (2) Used for palliative treatment Hypogonadism (HG)(New starts only): (1) Attestation that diagnosis was initially confirmed by ALL of the following: (A) Two early morning total testosterone levels below 300 ng/dL measured on separate occasions, (B) Normal Prolactin Level, and (C) Physical or cognitive symptoms of testosterone deficiency (e.g. physical: fatigue, sleep disturbances, decreased activity, cognitive: depressive symptoms, cognitive dysfunction, loss of concentration, poor memory, irritability), (2) ONE of the following (A) negative history of prostate and breast cancer OR (B) Both of the following (i) history of prostate cancer with stable PSA less than or equal to 4ng/dL for 2 years and (ii) documentation that the risk versus benefit has been assessed.
<b>Age Restrictions</b>	(HG) Member is 12 years of age or older (applies to generic testosterone cypionate only) and member is 18 years of age or older for all other products
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(DP, BC): Indefinite (HG)(New Starts, Continuation): Indefinite
<b>Other Criteria</b>	(HG)(Continuation): ONE of the following (1) negative history of prostate and breast cancer OR (2) Both of the following (a) history of prostate cancer with stable PSA less than or equal to 4ng/dL for 2 years and (b) documentation that the risk versus benefit has been assessed
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No



PA Criteria	Criteria Details
<b>Prerequisite Therapy Required</b>	No

# tetrabenazine 2026

## Products Affected

- tetrabenazine

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Tardive Dyskinesia (TD)(Initial): (1) Diagnosis of TD, (2) Documentation is provided of ONE of the following: (a) Persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering or discontinuation of the offending medication, or (b) Member is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Tourette's Syndrome (TS): (1) Diagnosis of TS, (2) Member has tics associated with Tourette's syndrome, (3) Inadequate response or inability to tolerate haloperidol or risperidone. Chorea- Huntington's Disease (CHD): (1) Diagnosis of chorea associated with Huntington's disease
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(TS, CHD): Prescribed by or in consultation with a neurologist or a psychiatrist. (TD): Prescribed by or in consultation with a neurologist or a psychiatrist.
<b>Coverage Duration</b>	(TD)(Initial): 3 months. (TD)(Reauth): Indefinite. (TS, CHD): Indefinite.
<b>Other Criteria</b>	(TD)(Reauth): Positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# tolvaptan 2026

## Products Affected

- *tolvaptan oral tablet*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	(1) Members who are unable to sense or appropriately respond to thirst, (2) hypovolemic hyponatremia, (3) concomitant use of strong CYP3A inhibitors (4) Anuria (5) Autosomal dominant polycystic kidney disease (ADPKD)
<b>Required Medical Information</b>	Hyponatremia (HN) (1) Diagnosis of clinically significant hypervolemic or euvolemic hyponatremia. (2) One of the following: (a) serum sodium less than 125meq/L or (b) serum sodium 125-134meq/L with symptoms (e.g., nausea, vomiting, headache, lethargy, confusion, etc.) (3) Treatment has been initiated or re-initiated in a hospital setting prior to discharge within the past 30 days. (4) Inadequate response or inability to tolerate therapies to control hyponatremia (e.g., fluid restriction, diuretics, etc.).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Hyponatremia: Prescribed by or in consultation with a cardiologist, endocrinologist or nephrologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# topical chemo agents 2026

## Products Affected

- *bexarotene*
- VALCHLOR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Approved when ANY of the following inclusion criteria is met: (1) Drug is FDA approved for indication and regimen requested, (2) The indication and regimen is classified as Category 1 or 2A by National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, (3) narrative text in The American Hospital Formulary Service-Drug Information (AHFS-DI) or Clinical Pharmacology Compendium is supportive for the specific condition(s) requested, (4) The Micromedex Compendium and the strength of recommendation is listed as Class I, Class IIa, or Class IIb for the specific condition(s) requested, (5) Indication is listed in Lexi-Drugs as ??off label?? with evidence level A, (6) supported by Peer-Reviewed Medical Literature as defined in Chapter 15 Section 50.4.5 of the Medicare Benefit Policy Manual
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an oncologist or dermatologist
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

## topical retinoid products 2026

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### Products Affected

- *adapalene external gel 0.3 %*
- *tretinoin external*

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Remainder of contract year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# tracleer 2026

## Products Affected

- TRACLEER

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Documentation of a diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less. (4) Inadequate response or inability to tolerate generic bosentan.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH): Prescribed by or in consultation with a Cardiologist or Pulmonologist
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation):12 months.
<b>Other Criteria</b>	(PAH)(Continuation): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# tremfya sq 2026

## Products Affected

- TREMFYA CROHNS INDUCTION
- TREMFYA ONE-PRESS
- TREMFYA PEN SUBCUTANEOUS SOLUTION  
AUTO-INJECTOR 200 MG/2ML
- TREMFYA SUBCUTANEOUS SOLUTION  
PREFILLED SYRINGE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
<b>Required Medical Information</b>	<p>Plaque psoriasis (PsO)(Initial): (1) Diagnosis or moderate to severe PsO. (2) Inadequate response or inability to tolerate two of the following: (a) Cosentyx, (b) Enbrel, (c) Adalimumab (i.e. Adalimumab-AACF), (d) Skyrizi, (e) Ustekinumab (i.e. Yesintek) , (f) Otezla OR documentation demonstrating that a trial may be inappropriate. Psoriatic arthritis (PsA)(Initial): (1) Diagnosis of PsA, (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF) (b) Enbrel (c) Cosentyx (d) Rinvoq/Rinvoq LQ (e) Skyrizi (f) Ustekinumab (i.e. Yesintek) (g) Xeljanz/Xeljanz XR, (h) Orencia, (i) Otezla or documentation demonstrating that a trial may be inappropriate. Ulcerative colitis (UC) (Initial): (1) Diagnosis of moderately to severely active UC (2) ONE of the following: (a) Inadequate response or inability to tolerate two of the following: (i) Adalimumab (i.e. Adalimumab-AACF), (ii) ustekinumab (Stelara i.e. Yesintek), (iii) upadacitinib (Rinvoq), (iv) tofacitinib (Xeljanz/Xeljanz XR), (v) risankizumab (Skyrizi) OR documentation demonstrating that a trial may be inappropriate (b) Will be used as a maintenance dose following the intravenous induction doses. Crohn's Disease (CD)(Initial): (1) Diagnosis of moderately to severely active CD (2) One of the following: (A) Inadequate response or inability to tolerate two of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) Ustekinumab (i.e. Yesintek), (c) Skyrizi, (d) Rinvoq or documentation demonstrating that a trial may be inappropriate. (B) Will be used as a maintenance dose following the intravenous induction doses</p>
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PsO): Prescribed by or in consultation with a dermatologist. (PsA): Prescribed by or in consultation with a dermatologist or rheumatologist. (UC,CD): Prescribed by or in consultation with a gastroenterologist
<b>Coverage Duration</b>	12 months

PA Criteria	Criteria Details
<b>Other Criteria</b>	(PsO, PsA, UC, CD)(Reauth): (1) Member demonstrates positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes



# trikafta 2026

## Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Cystic Fibrosis (CF)(Initial): (1) Diagnosis of Cystic Fibrosis. (2) One of the following: (a) Documentation that member has at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by an FDA-cleared cystic fibrosis mutation test (b) A mutation in the CFTR gene that is responsive based on in vitro data. (c) If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of the F508del mutation on both alleles of the CFTR gene
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CF): Prescribed by or in consultation with a pulmonologist or Specialist affiliated with a CF care center
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(CF)(Reauth): Member has had a positive clinical response to therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# tymlos 2026

## Products Affected

- TYMLOS

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Postmenopausal Osteoporosis (PMO) (Initial): (1) Diagnosis of PMO. (2) Member has severe osteoporosis or is at a high to very high risk for fracture as defined by ONE of the following: (a) Member has a history of multiple vertebral fractures, (b) T score of the individual's bone mineral density (BMD) is at least -2.5 standard deviations below the young adult mean OR (c) history of osteoporotic fracture (i.e. Low-trauma fracture of the hip, spine, pelvis, or distal forearm, etc.) (3) Inadequate response or inability to tolerate ONE of the following: (a) bisphosphonates, (b) hormone replacement therapy, (c) selective-estrogen receptor modulators (SERMs), OR (d) Denosumab (Prolia). Osteoporosis at high risk for fracture in men (OSTm) (Initial): (1) Diagnosis of primary or hypogonadal osteoporosis (2) Both of the following: (a) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) (b) One of the following (i) History of low-trauma fracture of the hip, spine, pelvis, or distal forearm (ii) inadequate response or inability to tolerate at least one osteoporosis treatment (e.g. alendronate, risedronate, zoledronic acid, Prolia [denosumab])
<b>Age Restrictions</b>	(PMO, OSTm) Member is 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Remainder of contract year
<b>Other Criteria</b>	(PMO, OSTm)(Reauth): Cumulative lifetime therapy does not exceed 2 years
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

# tyvaso dpi 2026

## Products Affected

- TYVASO DPI MAINTENANCE KIT INHALATION  
POWDER 16 MCG, 32 MCG, 48 MCG, 64 MCG
- TYVASO DPI TITRATION KIT INHALATION  
POWDER 16 & 32 & 48 MCG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Pulmonary Arterial Hypertension (PAH) (Initial): (1) Diagnosis of pulmonary arterial hypertension (PAH) WHO Group I with New York Heart Association (NYHA) Functional Class II to IV. (2) Diagnosis confirmed by catheterization (right-heart or Swan-Ganz) or echocardiography. (3) Documentation of all the following: (a) Mean pulmonary arterial pressure is greater than 20 mm Hg. (b) Pulmonary vascular resistance (PVR) is greater than 2.0 Woods Units (WU). (c) The pulmonary capillary wedge pressure or left ventricular end-diastolic pressure is 15 mm Hg or less. Pulmonary Hypertension Associated with Interstitial Lung Disease (PH-ILD) (Initial): (1) Diagnosis of pulmonary hypertension associated with interstitial lung disease (PHILD) WHO Group 3. (2) Diagnosis confirmed by diagnostic test(s) (e.g. right heart catheterization, doppler echocardiogram, computerized tomography imaging).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAH)(PH-ILD): Prescribed by or in consultation with a Cardiologist or Pulmonologist
<b>Coverage Duration</b>	(Initial): 6 months. (Continuation): 12 months.
<b>Other Criteria</b>	(PAH)(PH-ILD)(CONTINUATION): Stabilization or improvement as evaluated by a cardiologist or pulmonologist.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ubrelvy 2026

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## Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# veozah 2026

## Products Affected

- VEOZAH

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(VMS)(Initial): (1) Diagnosis of moderate to severe vasomotor symptoms due to menopause (2) Inadequate response or inability to tolerate one of the following (a) menopausal hormone therapy (e.g. estradiol tablets) (b) non-hormonal therapy (e.g. paroxetine, venlafaxine, clonidine, etc.) (3) ONE of the following: (a) Aminotransferase is does not exceed 2 x the upper limit of normal (ULN) (b) The total bilirubin does not exceed 2 x the upper limit of normal (ULN) for the evaluating laboratory.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	(VMS)(Initial): 6 months, (Reauth): 12 months
<b>Other Criteria</b>	(VMS)(Reauth): (1) Documentation of positive clinical response to therapy (e.g. decrease in frequency and severity of vasomotor symptoms from baseline, etc.) (2) Member is not experiencing signs or symptoms that may suggest liver injury (new onset fatigue, decreased appetite, nausea, vomiting, pruritus, jaundice, pale feces, dark urine, or abdominal pain) (3) One of the following: (i) Transaminase elevations does not exceed 5 x the upper limit of normal (ULN), OR (ii) Does not exceed 3 x the ULN and the total bilirubin level does not exceed 2 x ULN.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# verquvo 2026

## Products Affected

- VERQUVO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Chronic Heart Failure (CHF) (Initial): (1) Diagnosis of chronic heart failure. (2) Member has New York Heart Association (NYHA) Class II, III, or IV symptoms (3) Ejection fraction less than 45 percent (4) One of the following: (a) Member was hospitalized for heart failure within the last 6 months (b) Member used outpatient intravenous diuretics (e.g., bumetanide, furosemide) for heart failure within the last 3 months (5) Inadequate response or inability to tolerate TWO of the following: (a) Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril) (b) Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan) (c) Angiotensin receptor-neprilysin inhibitor (ARNI) [e.g., Entresto (sacubitril and valsartan)] (d) Beta blocker (e.g. bisoprolol, carvedilol, metoprolol succinate ER) (e) Sodium-glucose co-transporter 2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin), Farxiga (dapagliflozin), Xigduo XR (dapagliflozin and metformin)] (f) Mineralocorticoid receptor antagonist (MRA) [e.g., eplerenone, spironolactone]
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CHF) (Initial): Prescribed by or in consultation with a Cardiologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(CHF) (Cont): Documentation of positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

## vigafyde solution 2026

### Products Affected

- VIGAFYDE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Infantile spasm: (1) Diagnosis of infantile spasm (2) Inadequate response or inability to tolerate Vigpoder or Vigabatrín powder for oral solution
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with neurologist/epilepsy specialist
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes



# voquezna tablets 2026

## Products Affected

- VOQUEZNA

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	(H. pylori): (1) Diagnosis of Helicobacter pylori infection (2) One of the following: (a) Used in combination with amoxicillin and clarithromycin for the treatment of H. pylori infection OR (b) Used in combination with amoxicillin for the treatment of H. pylori infection (3) An inadequate response or inability to tolerate ONE of the following: (a) Clarithromycin based therapy (e.g. clarithromycin based triple therapy, clarithromycin based concomitant therapy) OR (b) Bismuth quadruple therapy (e.g. bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI]). Erosive Esophagitis (EE): (1) ONE of the following: (a) Used for healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis OR (b) Used to maintain healing and relief of heartburn associated with erosive esophagitis (2) An inadequate response or inability to tolerate TWO of the following generic proton pump inhibitors (PPI??s): omeprazole, esomeprazole, pantoprazole, lansoprazole, rabeprazole, and dexlansoprazole.
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	H. pylori: 1 month Healing of EE: 8 weeks. Maintenance of EE: 6 month GERD: 1 month
<b>Other Criteria</b>	Heartburn with GERD: (1) Diagnosis of non-erosive Gastroesophageal Reflux Disease (GERD) (2) BOTH of the following: (a) Member has history of heartburn for at least 6 months (b) Heartburn symptoms are present for at least 4 days during any consecutive 7-day period (3) An inadequate response (minimum 8-week supply) or inability to tolerate TWO of the following generic proton pump inhibitors (PPI??s): omeprazole, esomeprazole, pantoprazole, lansoprazole, rabeprazole, and dexlansoprazole.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	

PA Criteria	Criteria Details
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# vowst 2026

## Products Affected

- VOWST

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Prevention of the recurrence of Clostridioides difficile infection (PCDI): (1) Diagnosis of recurrent Clostridioides difficile infection as defined by both of the following: (a) Presence of diarrhea defined as passage of 3 or more loose bowel movements within a 24-hour period for at least 2 consecutive days (b) a positive stool test for C. difficile toxin or toxigenic C. difficile (2) Member has a history of two or more recurrent episodes of CDI within 12 months (3) Member has completed at least 10 consecutive days of one of the following antibiotic therapies 2-4 days prior to initiating Vowst: (a) oral vancomycin (b) Difacid (fidaxomicin) (4) Member has completed the recommended bowel prep (e.g. 296mL of magnesium citrate) the day before and at least 8 hours prior to initiating Vowst (5) Previous episode of CDI is under control (e.g. less than 3 unformed or loose [i.e., Bristol Stool Scale type 6-7] stools per day for at least 2 consecutive days)
<b>Age Restrictions</b>	(PCDI): Member is 18 years of age or older
<b>Prescriber Restrictions</b>	(PCDI): Prescribed by or in consultation with gastroenterologist or infectious disease specialist
<b>Coverage Duration</b>	(PCDI): 14 days
<b>Other Criteria</b>	
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# vraylar 2026

## Products Affected

- VRAYLAR ORAL CAPSULE

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Bipolar I disorder (BD): (1) Diagnosis of bipolar I disorder (2) Inadequate response or inability to tolerate TWO of the following: aripiprazole, quetiapine, asenapine, olanzapine, paliperidone, risperidone, ziprasidone. Schizophrenia: (1) Diagnosis of schizophrenia (2) Inadequate response or inability to tolerate TWO of the following: aripiprazole, quetiapine, asenapine, olanzapine, paliperidone, risperidone, ziprasidone. Major Depressive Disorder (MDD): (1) Diagnosis of major depressive disorder and as adjunctive therapy to antidepressants (2) Inadequate response or inability to tolerate aripiprazole and quetiapine
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	Indefinite
<b>Other Criteria</b>	(All Indications): Approve if for continuation of therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# wilsons disease 2026

## Products Affected

- *trientine hcl oral capsule 500 mg*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Wilson??s disease (WD)(initial): (1) Diagnosis of Wilson??s disease (i.e., hepatolenticular degeneration) (2) Inadequate response or inability to tolerate a penicillamine product
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(WD): Prescribed by or in consultation with gastroenterologist, hepatologist, or liver transplant specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(WD) (Reauth): (1) Member demonstrates positive clinical response to therapy (e.g., reduction in 24-hour urinary copper excretion levels from baseline)
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

## xdemvy 2026

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### Products Affected

- XDEMZY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of treatment of demodex blepharitis
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist
Coverage Duration	6 weeks
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

# xeljanz 2026

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## Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

# xermelo 2026

## Products Affected

- XERMELO

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Carcinoid Syndrome Diarrhea (CSD)(Initial): (1) Diagnosis of carcinoid syndrome diarrhea, (2) Diarrhea is inadequately controlled by a stable dose of somatostatin analog (SSA) therapy (e.g. octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot]) for at least 3 months, (3) Used in combination with SSA therapy
<b>Age Restrictions</b>	(CSD): Member is 18 years of age or older
<b>Prescriber Restrictions</b>	(CSD): Prescribed by or in consultation with an Oncologist, Endocrinologist, or Gastroenterologist
<b>Coverage Duration</b>	(Initial): 12 months (Reauth): Indefinite
<b>Other Criteria</b>	(CSD)(Reauth): (1) Positive clinical response to Xermelo therapy, (2) Xermelo will continue to be used in combination with SSA therapy
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes



# xgeva 2026

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## Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	No

# xifaxan 550mg 2026

## Products Affected

- XIFAXAN ORAL TABLET 550 MG

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Prophylaxis for Hepatic Encephalopathy (HE): (1) Diagnosis of hepatic disease with risk for hepatic encephalopathy (i.e. previous episode of hepatic encephalopathy, advanced liver disease, hepatocellular carcinoma), (2) Inadequate response or inability to tolerate lactulose. Irritable Bowel Syndrome (IBS): (1) Diagnosis of irritable bowels syndrome- diarrhea, (2) Inadequate response or inability to tolerate BOTH of the following: (A) ONE of the following: (i) ONE Tricyclic antidepressant or (ii)selective serotonin reuptake inhibitor and (B) dicyclomine (3): BOTH of the following: (A) Member does not exceed 3 total courses (42 days in total) of therapy, (B) Member experiences irritable bowel syndrome with diarrhea (IBS-D) symptoms. Small Bowel Bacterial Overgrowth (SBBO)/Small Intestinal Bacterial Overgrowth (SIBO) (Initial): (1) Diagnosis of Small Bowel Bacterial Overgrowth (SBBO)/Small Intestinal Bacterial Overgrowth (SIBO).
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	:
<b>Coverage Duration</b>	(HE): Indefinite. (IBS): 2 weeks. (SBBO/SIBO): Initial and Reauth: 2 weeks.
<b>Other Criteria</b>	(SBBO/SIBO) (Reauth): (1) Documentation of Small Bowel Bacterial Overgrowth (SBBO)/Small Intestinal Bacterial Overgrowth (SIBO) recurrence following successful initial treatment
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# xolair 2026

## Products Affected

- XOLAIR

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	Concurrent therapy with any other biologic agents for asthma/allergic conditions (e.g., benralizumab [Fasenra], dupilumab [Dupixent], mepolizumab [Nucala])
<b>Required Medical Information</b>	Part D is medically necessary for: Moderate to Severe Persistent Allergic Asthma (PAA)(Initial): (1) Diagnosis of moderate to severe persistent allergic asthma (2) The individual has a positive skin test or in vitro reactivity to a perennial aeroallergen, (3) The individual has a baseline serum IgE level of between 30 IU/mL and 1300 IU/mL, (4) Inadequate response or inability to tolerate a combination of high-dose inhaled corticosteroids (ICS) with a long-acting beta-agonist (LABA). Chronic Urticaria (CU)(Initial): (1) Diagnosis of chronic urticaria (2) an inadequate response, contraindication or inability to tolerate ONE second-generation H1 antihistamine at the maximally tolerated dose in addition to ANY of the following: (a) leukotriene receptor antagonist (e.g. montelukast) (b) histamine H2-receptor antagonist (e.g. ranitidine, cimetidine, famotidine), (c) substituting to a different second- generation antihistamine, (d) systemic glucocorticosteroids or (e) cyclosporine, (3) will be used concurrently with an h1 antihistamine, unless there is contraindication or intolerance to H1 antihistamines. Nasal Polyps (NP)(Initial): (1) Diagnosis of nasal polyps. (2) Member will use concurrently with nasal corticosteroid. (3) Member had inadequate response or inability to tolerate an intranasal corticosteroid. (4) Member has a baseline serum IgE level of between 30 IU/mL and 1500 IU/mL
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(PAA): Prescribed by or in consultation with an Allergist, Immunologist, or Pulmonologist. (CU):Prescribed by or in consultation with allergist/immunologist, dermatologist. (NP): Prescribed by or in consultation with an allergist, immunologist, pulmonologist, or ENT specialist. (IMFA): Prescribed by or in consultation with an Allergist or Immunologist
<b>Coverage Duration</b>	12 months.

PA Criteria	Criteria Details
<b>Other Criteria</b>	<p>Subject to Part B vs Part D review. IgE-Mediated Food Allergy (IMFA) (initial): (1) One of the following: (A) Both of the following (i) Diagnosis of IgE-Mediated Food Allergy (ii) Clinical history of IgE Mediated Food Allergy (B) Documentation that the member has a history of severe allergic response, including anaphylaxis, following exposure to one or more foods (2) Used in conjunction with food allergen avoidance (3) Both of the following (A) Baseline (pre- Xolair treatment) serum total IgE level is greater than or equal to 30 IU/mL and less than or equal to 1850 IU/mL (B) Dosing is according to serum total IgE levels and body weight (PAA)(Reauth): (1) Documentation of positive clinical response to therapy (e.g., reduction in number of asthma exacerbations, improvement in forced expiratory volume in 1 second (FEV1), or decreased use of rescue medications). (CU)(Reauth): (1) Member's disease status has been re- evaluated since the last authorization to confirm the member's condition warrants continued treatment (2) member has experienced one or both of the following:(a) Reduction in itching severity from baseline (b) Reduction in number of hives from baseline. (NP)(Reauth): (1) Documentation of positive clinical response to therapy (e.g., reduction in nasal polyps score [NPS: 0-8 scale], improvement in nasal congestion/obstruction score [NCS: 0-3 scale]) (2) Used in combination with another agent for nasal polyps. (IMFA)(Reauth) (1) Documentation of positive clinical response to therapy (2) Used in conjunction with food allergen avoidance. (3) Dosing will continue to be based on body weight and pretreatment total IgE serum levels</p>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

# xyrem 2026

## Products Affected

- *sodium oxybate*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	CN, EDSN: Concurrent use of sedative hypnotics and alcohol
<b>Required Medical Information</b>	Cataplexy in Narcolepsy (CN)(Initial): (1) Diagnosis of cataplexy with narcolepsy, (2) Diagnosis Confirmed by Polysomnography (PSG) or Multiple sleep latency test (MSLT) or prescriber provides justification that a sleep study is not feasible. Excessive Daytime Sleepiness in Narcolepsy (EDSN)(Initial): (1) Diagnosis of EDSN (Narcolepsy Type 2), (2) Diagnosis Confirmed by Polysomnography (PSG) or Multiple sleep latency test (MSLT) or prescriber provides justification that a sleep study is not feasible and (3) Inadequate response or inability to tolerate modafinil or armodafinil. (adult use only)
<b>Age Restrictions</b>	
<b>Prescriber Restrictions</b>	(CN, EDSN): Prescribed by or in consultation with a neurologist, psychiatrist, or sleep specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(CN, EDSN)(Reauth): (1) Documentation to support the efficacy associated with the current regimen (including but not limited to reduction in the frequency of cataplexy attacks or an improvement in the Epworth sleepiness scale), (2) Member is re-evaluated every 12 months.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	Yes

## zavesca 2026

### Products Affected

- *miglustat*

PA Criteria	Criteria Details
<b>Exclusion Criteria</b>	
<b>Required Medical Information</b>	Type 1 Gaucher's Disease (T1GD)(Initial): (1) Diagnosis of mild to moderate T1GD, (2) enzyme replacement therapy is not a therapeutic option (e.g. because of allergy, hypersensitivity, or poor venous access).
<b>Age Restrictions</b>	(T1GD): Member is 18 years of age or older
<b>Prescriber Restrictions</b>	
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	(T1GD)(Reauth): Documentation of positive clinical response to therapy.
<b>Indications</b>	All Medically-accepted Indications.
<b>Off Label Uses</b>	
<b>Part B Prerequisite</b>	No
<b>Prerequisite Therapy Required</b>	No

# ztalmy 2026

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## Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

## zurzuvaе 2026

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### Products Affected

- ZURZUVAE

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW
Part B Prerequisite	No
Prerequisite Therapy Required	Yes



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