Keystone 65 Rx HMO, Personal Choice 65℠ Rx PPO, Select Option® Rx PDP Plans

2027 Prior Authorization Criteria

This document contains important information about some of the drugs we cover in your health plan.

At Independence Blue Cross (IBX), we work to make sure you get the medications that are safe and right for you.

One way we do this is by asking you to use pharmacies in our network. Another way is through a process called **prior authorization**.

This document explains:

- What prior authorization is
- Which drugs it applies to
- What to do if your drug is affected

This document was last updated on 10/23/2026. For the most up-to-date information, or if you have questions, we're here to help:

- **Keystone 65 Rx**: 1-844-352-1699
- **Personal Choice 65 Rx**: 1-888-879-4293
- **Select Option Rx**: 1-888-678-7009
- **TTY/TDD**: 711

You can call **seven days a week, 8 a.m. to 8 p.m.** From April 1 through September 30, calls on weekends and holidays may go to voicemail.

You can also visit **ibxmedicare.com** to search your drug list (formulary) or view and download any other plan documents.

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What is prior authorization?

Some drugs need approval before they are covered. This is called prior authorization.

We use this process to help make sure the drug is safe, works for your condition, and is right for you.

Prior authorization means:

- You or your doctor needs to ask us before you fill the drug.
- We review the request.
- If we approve it, we will cover the drug.
- If we do not approve it, we may not cover the drug.

If you or your doctor believes this drug is the right choice for you, but it is not approved, you can ask us:

- To make an exception, or
- About other drugs that may work for you

You can find a list of drugs that require prior authorization in this document.

You can also find more details in your plan's *Formulary* (drug list) and your *Evidence of Coverage*.

How to use this document

Find your drug in the index on page **331**. Then read all the information listed for that drug.

If your drug has "PA" in the "Requirements" column of your health plan's drug formulary, you can find more details in this document.

In this document:

- "We," "us," and "our" mean Independence Blue Cross.
- "Plan" and "our plan" mean Keystone 65 Rx, Personal Choice 65 Rx, or Select Option Rx.

Independence Blue Cross offers PPO, HMO-POS, and HMO Medicare Advantage plans with a Medicare contract. Enrollment in Independence Blue Cross PPO, HMO-POS, and HMO Medicare Advantage plans depends on contract renewal. Select Option is a PDP plan with a Medicare contract. Enrollment in Select Option PDP depends on contract renewal.

Independence Blue Cross offers products through its subsidiaries and affiliates including Independence Assurance Company, Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company — independent licensees of the Blue Cross and Blue Shield Association.

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4495050 (06/26)
Group 5-tier closed IBX16995 (04/26)

ABIRATERONE 2027

Products Affected

- *abiraterone acetate*
- ABIRTEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ACETAMINOPHEN AND BUTALBITAL AND CAFFEINE HRM 2027

Products Affected

- *butalbital-apap-caffeine oral capsule*
- *butalbital-apap-caffeine oral tablet 50-325-40 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ACETAMINOPHEN AND BUTALBITAL HRM 2027

Products Affected

- *butalbital-acetaminophen oral tablet 50-325 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ACUTE HAE AGENTS 2027

Products Affected

- BERINERT

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ADALIMUMAB PREFERRED PRODUCTS 2027

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	(RA, AS, JIA, PsA, PsO, CD, UC, HS, UV): Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
Required Medical Information	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). Ankylosing Spondylitis (AS)(Initial): (1) Diagnosis of AS. (2) Inadequate response or inability to tolerate one other treatment such as NSAIDs, COX2 inhibitors or methotrexate. Polyarticular Juvenile Idiopathic Arthritis (PJIA)(Initial): (1) Diagnosis of moderate to severe PJIA. (2) Inadequate response or inability to tolerate one of the following: methotrexate, leflunomide, sulfasalazine. Psoriatic Arthritis (PsA): (1) Diagnosis of PsA. Plaque Psoriasis (PsO): (1) Diagnosis of moderate to severe chronic PsO.
Age Restrictions	
Prescriber Restrictions	(RA, JIA, AS): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a dermatologist or rheumatologist. (PsO, HS): Prescribed by or in consultation with a dermatologist. (CD, UC): Prescribed by or in consultation with a gastroenterologist. (UV): Prescribed by or in consultation with a rheumatologist or ophthalmologist.
Coverage Duration	1-year
Other Criteria	Crohn's Disease (CD) (Initial): (1) Diagnosis of moderate to severe CD. Ulcerative Colitis (UC) (Initial): (1) Diagnosis of moderate to severe UC. Hidradenitis Suppurativa (HS) (Initial): (1) Diagnosis of moderate to severe HS. Uveitis (UV): (1) Diagnosis of non-infectious intermediate, posterior, or pan-uveitis. (2) Inadequate response or inability to tolerate corticosteroids and at least one immunosuppressive drug (e.g. azathioprine, cyclosporine, methotrexate, mycophenolate). (RA, JIA, AS, PsA, PsO, HS, CD, UC, UV)(Reauth): Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.

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

ADAPALENE PRODUCTS 2027

Products Affected

- *adapalene external gel 0.3 %*

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ADBRY 2027

Products Affected

- ADBRY

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ADEMPAS 2027

Products Affected

- ADEMPAS

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

AIMOVIG 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

AKEEGA 2027

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ALECENSA 2027

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ALUNBRIG 2027

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

AMBRISENTAN 2027

Products Affected

- *ambrisentan*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ARIKAYCE 2027

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(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
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a pulmonologist or an infectious disease specialist
Coverage Duration	(Initial): 6 months (Reauth):12 months
Other Criteria	(Reauth): (1) Documentation of positive clinical response to therapy (2) Documentation that the medication will be used as part of a combination antibacterial regimen.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ARMODAFINIL 2027

Products Affected

- *armodafinil*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ASPIRIN AND BUTALBITAL AND CAFFEINE HRM 2027

Products Affected

- *butalbital-aspirin-caffeine 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

AUGTYRO 2027

Products Affected

- AUGTYRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

AUSTEDO 2027

Products Affected

- AUSTEDO & 18 & 24 & 30 MG
- AUSTEDO XR
- AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Tardive Dyskinesia (TD)(Initial): (1) Diagnosis of TD, (2) 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
Age Restrictions	
Prescriber Restrictions	(CHD): Prescribed by or in consultation with a neurologist or a psychiatrist. (TD): Prescribed by or in consultation with a neurologist or a psychiatrist.
Coverage Duration	(TD)(Initial): Months, 6 . (TD)(Reauth): Lifetime. (CHD): Lifetime
Other Criteria	(TD)(Reauth): Positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

AUVELITY 2027

Products Affected

- AUVELITY ORAL TABLET EXTENDED RELEASE 45-105 MG

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	Lifetime
Other Criteria	Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

AVMAPKI 2027

Products Affected

- AVMAPKI FAKZYNJA CO-PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

AYVAKIT 2027

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

BALVERSA 2027

Products Affected

- BALVERSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

BENLYSTA SC 2027

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Member has severe active central nervous system lupus
Required Medical Information	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).
Age Restrictions	
Prescriber Restrictions	(SLE): Prescribed by or in consultation with a rheumatologist. (LN): Prescribed by or in consultation with a nephrologist or rheumatologist.
Coverage Duration	Months, 6
Other Criteria	(SLE, LN)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

BESREMI 2027

Products Affected

- BESREMI
- BESREMI PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	(All Indications): Approve if for continuation of therapy. Subject to Part B vs Part D review.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

BEXAROTENE ORAL PRODUCTS 2027

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	Lifetime
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

BEXAROTENE TOPICAL PRODUCTS 2027

Products Affected

- *bexarotene*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	Lifetime
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

BOSENTAN 2027

Products Affected

- *bosentan*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

BOSULIF 2027

Products Affected

- BOSULIF ORAL CAPSULE 50 MG
- BOSULIF ORAL TABLET 100 MG, 500 MG
- *bosutinib oral tablet 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

BRAFTOVI 2027

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

BRAND POMALYST 2027

Products Affected

- POMALYST

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

BRUKINSA 2027

Products Affected

- BRUKINSA 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

CABOXANTINIB PRODUCTS 2027

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

CALQUENCE 2027

Products Affected

- CALQUENCE ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Approved when ALL of the following inclusion criteria are met: (1) Submission of medical records (i.e., chart notes) confirming ONE of the following: (A) Drug is FDA approved for indication and regimen requested, (B) The indication and regimen is classified as Category 1 or 2A by National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, narrative text in The American Hospital Formulary Service-Drug Information (AHFS-DI) or Clinical Pharmacology Compendium is supportive for the specific condition(s) requested, (D) The Micromedex Compendium and the strength of recommendation is listed as Class I, Class IIa, or Class IIb for the specific condition(s) requested, (E) Indication is listed in Lexi-Drugs as "off label" with evidence level A, (F) supported by Peer-Reviewed Medical Literature as defined in Chapter 15 Section 50.4.5 of the Medicare Benefit Policy Manual.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CAPLYTA 2027

Products Affected

- CAPLYTA

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

CAPRELSA 2027

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

CAYSTON 2027

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	(CF): Prescribed by or in consultation with a pulmonologist OR infectious disease specialist or Specialist affiliated with a CF care center.
Coverage Duration	1-year
Other Criteria	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)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CHLORDIAZEPOXIDE HRM 2027

Products Affected

- *chlordiazepoxide-clidinium*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly (2) Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the member
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

CHOLBAM 2027

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	(BASD, PD): Extrahepatic manifestations of bile acid synthesis disorders due to single enzyme defects or peroxisomal disorders including Zellweger spectrum disorders
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	(BASD, PD): Hepatologist, Gastroenterologist, Medical geneticist, other specialist that treats inborn errors of metabolism
Coverage Duration	(Initial): 3 months. (Reauth): 1-year
Other Criteria	(BASD,PD) (Reauth): Documentation of improved liver function tests from the start of treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

CIBINQO 2027

Products Affected

- CIBINQO

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

CIMZIA 2027

Products Affected

- CIMZIA (1 SYRINGE)
- CIMZIA (2 SYRINGE)
- CIMZIA SUBCUTANEOUS KIT 2 X 200 MG
- CIMZIA-STARTER

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
Required Medical Information	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), 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, 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, 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, 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), risankizumab (Skyrizi), (d) upadacitinib (Rinvoq) or documentation demonstrating that a trial may be inappropriate.
Age Restrictions	
Prescriber Restrictions	(CD): Prescribed by or in consultation with a gastroenterologist. (RA, AS, nr-axSpA, PJIA): Prescribed by or in consultation with a rheumatologist. (PsA, PsO): prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	1-year

PA Criteria	Criteria Details
Other Criteria	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, Xeljanz, (d) Orencia, (e) Rinvoq/Rinvoq LQ, or documentation demonstrating that a trial may be inappropriate. (AS, PsA, PsO, RA, CD, nr-axSpA, PIJA)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

COBENFY 2027

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 risperidone, ziprasidone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

COPIKTRA 2027

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

COSENTYX SQ 2027

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
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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

COTELLIC 2027

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

CRENESSITY 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

CRESEMBA ORAL 2027

Products Affected

- CRESEMBA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Invasive Aspergillosis (IA): (1) Diagnosis of invasive aspergillosis, (2) Inadequate response or inability to tolerate oral Voriconazole . Invasive Mucormycosis (MC): (1) Diagnosis of invasive mucormycosis
Age Restrictions	(IA, MC): Member is 6 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, oncologist, OR prescribed as part of chemotherapy prophylaxis protocol
Coverage Duration	Months, 6
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	Yes

DALFAMPRIDINE 2027

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	(Initial): Member has history of seizure or moderate to severe renal impairment (CrCL less than or equal to 50 mL/min)
Required Medical Information	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)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	1-year
Other Criteria	(MS) (Reauth): Documentation of positive clinical response as evidenced by improvement in walking speed
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DASATINIB PRODUCTS 2027

Products Affected

- *dasatinib*
- PHYRAGO
- SPRYCEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

DAURISMO 2027

Products Affected

- DAURISMO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

DEFERASIROX 2027

Products Affected

- *deferasirox oral tablet*
- *deferasirox oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	(NTDT, CIO-BT): (1) GFR is less than 40mL/min/1.73m, platelet counts less than 50,000/mcL, (2) Administered with other iron chelation agents
Required Medical Information	Chronic Iron Overload in Non transfusion-dependent thalassemia (NTDT) (Initial): (1) Diagnosis of Chronic iron overload in Non transfusion-dependent thalassemia syndromes, (2) liver iron concentration (LIC) of at least 5 mg of iron per gram of liver dry weight (mg Fe/g dw), (3) Serum ferritin levels consistently greater than 300 mcg/L (as demonstrated with at least two lab values within the previous two months) Chronic Iron Overload Caused by Blood Transfusions (CIO-BT)(Initial): (1) Diagnosis of chronic iron overload caused by blood transfusions (transfusional hemosiderosis). (2) Serum ferritin levels consistently greater than 1,000 mcg/L. (3) Member has required the transfusion of at least 100 mL/kg packed red blood cells
Age Restrictions	(NTDT): Member is 10 years of age or older. (CIO-BT): Member is 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	(Initial): 6 months. (Reauth): 12 months
Other Criteria	(NTDT, CIO-BT)(Reauth): Decreased serum ferritin level compared with the baseline level or reduction in LIC (liver iron concentration).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DEFLAZACORT 2027

Products Affected

- *deflazacort oral tablet*
- *jaythari oral tablet*
- KYMBEE 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

DIACOMIT 2027

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) One of the following: (a) Member is at least 18 years of age or (b) Member is 6 months of age or older and weighs 7kg or more.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Lifetime
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

DICHLORPHENAMIDE 2027

Products Affected

- ORMALVI

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

DICLOFENAC EPOLAMINE 2027

Products Affected

- *diclofenac epolamine external*

PA Criteria	Criteria Details
Exclusion Criteria	(1) Previously experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs (2) Use for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery.
Required Medical Information	Acute pain (initial): (1) Diagnosis of acute pain due to minor strains, sprains, or contusions, (2) Inadequate response or inability to tolerate at least two oral or topical non-steroidal anti-inflammatory drugs (NSAIDs)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

DIPYRIDAMOLE HRM 2027

Products Affected

- *dipyridamole oral*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

DOPTELET 2027

Products Affected

- DOPTELET ORAL TABLET 20 MG
- DOPTELET SPRINKLE

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

DULAGLUTIDE 2027

Products Affected

- TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(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 mellites 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)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	(DM2)(Reauth): Documentation of positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

DUPIXENT 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

EBGLYSS 2027

Products Affected

- EBGLYSS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis (AD)(Initial) (1) Submission of medical records (e.g. chart notes) confirming diagnosis of moderate to severe atopic dermatitis (2) One of the following: (a) Inadequate response or inability to tolerate at least one topical prescription therapy or (b) topical prescription therapy is not advisable
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Allergist/Immunologist or Dermatologist
Coverage Duration	1-year
Other Criteria	(Reauth) Member demonstrates positive clinical response to therapy (e.g., reduction i body surface area involvement, reduction in pruritus severity)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

EFINACONAZOLE PRODUCTS 2027

Products Affected

- JUBLIA

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ELTROMBOPAG 2027

Products Affected

- *eltrombopag olamine*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

EMGALITY 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

EMSAM 2027

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ENBREL 2027

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ENDARI 2027

Products Affected

- ENDARI
- *l-glutamine oral packet*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ENSACOVE 2027

Products Affected

- ENSACOVE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ENTYVIO SQ 2027

Products Affected

- ENTYVIO 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

EPCLUSA 2027

Products Affected

- EPCLUSA

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. (3) Inability to tolerate ONE of the following when appropriate per the current AASLD/IDSA guidance: generic ledipasvir-sofosbuvir, generic sofosbuvir-velpatasvir, or Mavyret.
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	Yes

EPIDIOLEX 2027

Products Affected

- EPIDIOLEX

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ERIVEDGE 2027

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ERLEADA 2027

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prostate Cancer: (1) Submission of medical records (e.g., chart notes) showing diagnosis of metastatic castration-sensitive prostate cancer (mCSPC) or non-metastatic castration-resistant prostate cancer, (2) For mCSPC, submission of medical or pharmacy records (e.g., chart notes or claims) showing an inadequate response or inability to tolerate generic abiraterone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	Approve if for continuation of therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ERLOTINIB 2027

Products Affected

- *erlotinib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ESTRADIOL HRM 2027

Products Affected

- MENOSTAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Vasomotor Symptoms: (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
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	2 years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ESTRADIOL-PROGESTIN HRM 2027

Products Affected

- CLIMARA PRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Vasomotor Symptoms: (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
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	2 years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ESTROGEN CONJUGATE HRM 2027

Products Affected

- PREMARIN ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Vasomotor Symptoms: (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
Age Restrictions	Apply if member is greater than or equal to 65 years
Prescriber Restrictions	
Coverage Duration	2 years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ESZOPICLONE HRM 2027

Products Affected

- *eszopiclone oral tablet 3 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Insomnia (Initial): (1) 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	(Initial): 3 months. (Reauth): 2 years
Other Criteria	(Reauth): Prescriber is aware of the risk versus benefit of using the medication chronically (greater than 90 days)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

EUCRISA 2027

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 members 2 years of age or older: (a) topical tacrolimus OR topical pimecrolimus, AND (b) generic, prescription medium potency or higher topical steroid, unless the affected area is sensitive (i.e., face, axillae, groin)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist, allergist or immunologist
Coverage Duration	(initial): 6 months, (reauth) 12 months
Other Criteria	(Reauth): Member demonstrates a positive response to therapy as evidenced by ONE of the following : (a) Reduction in body surface area involvement from baseline (b) Reduction in pruritus severity from baseline Improvement in quality of life from baseline
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

EVENITY 2027

Products Affected

- EVENITY

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

EVEROLIMUS PRODUCTS 2027

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

EXTENDED RELEASE METFORMIN 2027

Products Affected

- *metformin hcl er (mod)*

PA Criteria	Criteria Details
Exclusion Criteria	(1) EGFR below 30 mL/min/1.73 m2.(2) Hepatic impairment. (3) Metabolic acidosis, including diabetic ketoacidosis. (4) Used for preventing weight gain.
Required Medical Information	Diabetes Mellitus Type 2 (DM2)(Initial): (1) Diagnosis of DM2. (2) Member has a HgbA1C greater than 6.5%.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	(DM2)(Reauth): Member has had a positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

EYSUVIS 2027

Products Affected

- EYSUVIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dry Eye Disease (DED)(Initial): (1) Diagnosis of DED (2) Inadequate response or inability to tolerate a minimum of 14 days duration of therapy to 0.5% loteprednol suspension
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an ophthalmologist or optometrist.
Coverage Duration	Days, 14
Other Criteria	(DED)(Reauth): (1) Positive clinical response to therapy (e.g. improvement in dry eye symptoms).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FERRIPROX 2027

Products Affected

- *deferiprone*
- FERRIPROX ORAL TABLET 1000 MG
- FERRIPROX TWICE-A-DAY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Transfusional Iron Overload (TIO)(initial): (1) Diagnosis of transfusional iron overload due to one of the following: (a) Thalassemia syndromes, (b) sickle cell disease, other transfusion-dependent anemias. (2) Inadequate response or inability to tolerate current chelation therapy. (3) Member has Absolute Neutrophil Count (ANC) greater than 1.5 x 10^9/L.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	(TIO) (Reauth): (1) Member demonstrates positive clinical response to therapy (e.g., greater than or equal to 20% decline in serum ferritin levels from baseline). (2) ANC greater than 1.5 x 10^9/L.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FILSPARI 2027

Products Affected

- FILSPARI

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

FINTEPLA 2027

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Dravet Syndrome (DS): (1) Diagnosis of seizures associated with DS, (2) Inadequate response or inability to tolerate ONE of the following: (a) clobazam, (b) valproic acid, 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.
Age Restrictions	(DS, LGS): Member is 2 years of age or older.
Prescriber Restrictions	(DS, LGS): Prescribed by or in consultation with a neurologist.
Coverage Duration	Lifetime
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

FIRMAGON 2027

Products Affected

- FIRMAGON SUBCUTANEOUS SOLUTION RECONSTITUTED 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prostate Cancer: (1) Submission of medical records (i.e., chart notes) confirming diagnosis of advanced prostate cancer, (2) Submission of medical or pharmacy records (e.g., chart notes or claims) showing an inadequate response or inability to tolerate Eligard
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	Approve if for continuation of therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

FOTIVDA 2027

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

FRUZAQLA 2027

Products Affected

- FRUZAQLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

GALAFOLD 2027

Products Affected

- GALAFOLD

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

GATTEX 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

GAVRETO 2027

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

GEFITINIB PRODUCTS 2027

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

GENERIC LIDOCAINE TRANSDERMAL PATCH 2027

Products Affected

- *lidocaine external patch 5 %*

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

GENERIC SODIUM PHENYLBUTYRATE 2027

Products Affected

- *sodium phenylbutyrate oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	Acute hyperammonemia. N-acetyl glutamate synthase (NAGS) deficiency
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	(UCD): Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders
Coverage Duration	Initial: 6 months Reauth: 12 months
Other Criteria	(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.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

GILOTRIF 2027

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

GOCOVRI 2027

Products Affected

- GOCOVRI

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

GOMEKLI 2027

Products Affected

- GOMEKLI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

GRASTEK 2027

Products Affected

- GRASTEK

PA Criteria	Criteria Details
Exclusion Criteria	(1) Severe, unstable or uncontrolled asthma (2) History of eosinophilic esophagitis
Required Medical Information	Induced allergic rhinitis (Initial): (1) Diagnosis of induced allergic rhinitis, (2) Member has a positive skin test or in vitro test for the listed allergen-specific IgE antibody. (3) Inadequate response or inability to tolerate an intranasal corticosteroid and an oral or intranasal antihistamine.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist.
Coverage Duration	1-year
Other Criteria	(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
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

GROWTH HORMONES 2027

Products Affected

- GENOTROPIN SUBCUTANEOUS CARTRIDGE
- HUMATROPE INJECTION CARTRIDGE
- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR 10 MG/1.5ML, 15 MG/1.5ML, 5 MG/1.5ML
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE 5 MG/1.5ML

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

HAEGARDA 2027

Products Affected

- HAEGARDA

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

HARVONI 2027

Products Affected

- HARVONI

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. (3) Inability to tolerate ONE of the following when appropriate per the current AASLD/IDSA guidance: generic ledipasvir-sofosbuvir, generic sofosbuvir-velpatasvir, or Mavyret.
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	Yes

HERNEXEOS 2027

Products Affected

- HERNEXEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

HIGH DOSE OPIOIDS- FENTANYL 2027

Products Affected

- *fentanyl transdermal patch 72 hour 100 mcg/hr, 25 mcg/hr, 37.5 mcg/hr, 50 mcg/hr, 75 mcg/hr*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	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 member safety AND member is not being treated for substance abuse
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

HIGH DOSE OPIOIDS- METHADONE 2027

Products Affected

- *methadone hcl oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	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 member safety AND member is not being treated for substance abuse
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

HIGH DOSE OPIOIDS- MORPHINE 2027

Products Affected

- *morphine sulfate er oral tablet extended release*
  100 mg, 60 mg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	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 member safety AND member is not being treated for substance abuse
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

HRM CYCLOBENZAPRINE 2027

Products Affected

- *cyclobenzaprine hcl er oral capsule extended release 24 hour 15 mg*
- *cyclobenzaprine hcl oral*

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. (3) Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly (4) Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the member
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 KETOROLAC 2027

Products Affected

- *ketorolac tromethamine oral*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

HRM SHORT TERM SKELETAL MUSCLE RELAXANTS 2027

Products Affected

- *carisoprodol oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Acute, painful musculoskeletal conditions causing discomfort: (1) Diagnosis o:acute, painful musculoskeletal condition causing discomfort, (2) Prescriber attestation that drug will be used only for short periods. (3) 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

HYDROXYZINE HRM 2027

Products Affected

- *hydroxyzine hcl oral syrup 10 mg/5ml*
- *hydroxyzine hcl oral tablet*
- *hydroxyzine pamoate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly (2) Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the member
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

HYRNUO 2027

Products Affected

- HYRNUO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

IBRANCE 2027

Products Affected

- IBRANCE ORAL CAPSULE 125 MG
- IBRANCE ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

IBTROZI 2027

Products Affected

- IBTROZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ICATIBANT PRODUCTS 2027

Products Affected

- FIRAZYR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE
- *icatibant acetate 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ICLUSIG 2027

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

IDHIFA 2027

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ILUMYA 2027

Products Affected

- ILUMYA

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

IMATINIB PRODUCTS 2027

Products Affected

- *imatinib mesylate oral*
- *imkeldi*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

IMBRUVICA 2027

Products Affected

- IMBRUVICA ORAL CAPSULE
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Approved when ALL of the following inclusion criteria are met: (1) Submission of medical records (i.e., chart notes) confirming ONE of the following: (A) Drug is FDA approved for indication and regimen requested, (B) The indication and regimen is classified as Category 1 or 2A by National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, narrative text in The American Hospital Formulary Service-Drug Information (AHFS-DI) or Clinical Pharmacology Compendium is supportive for the specific condition(s) requested, (D) The Micromedex Compendium and the strength of recommendation is listed as Class I, Class IIa, or Class IIb for the specific condition(s) requested, (E) Indication is listed in Lexi-Drugs as "off label" with evidence level A, (F) supported by Peer-Reviewed Medical Literature as defined in Chapter 15 Section 50.4.5 of the Medicare Benefit Policy Manual.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

INBRIJA 2027

Products Affected

- INBRIJA

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

INCRELEX 2027

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	Known or suspected malignancy, closed epiphyses, concurrent GH therapy
Required Medical Information	Growth Hormone Gene Deletion (GHGD): (Initial) (1) Diagnosis of treatment of growth failure (2) Member with 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.
Age Restrictions	(GHGD, PIGF-1D): Member is 2 years of age or older
Prescriber Restrictions	(GHGD, PIGF-1D): Prescribed by or in consultation with an endocrinologist
Coverage Duration	1-year
Other Criteria	(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
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

INHALED TOBRAMYCIN 2027

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 80% of predicted, (4) Member not colonized with Burkholderia cepacia.
Age Restrictions	
Prescriber Restrictions	(CF): Prescribed by or in consultation with a pulmonologist, infectious disease specialist or Specialist affiliated with a CF care center.
Coverage Duration	1-year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

INJECTABLE METHOTREXATE 2027

Products Affected

- RASUVO SUBCUTANEOUS SOLUTION AUTO-INJECTOR 10 MG/0.2ML, 12.5 MG/0.25ML, 15 MG/0.3ML, 17.5 MG/0.35ML, 20 MG/0.4ML, 22.5 MG/0.45ML, 25 MG/0.5ML, 30 MG/0.6ML, 7.5 MG/0.15ML

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

INLURIYO 2027

Products Affected

- INLURIYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

INLYTA 2027

Products Affected

- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

INQOVI 2027

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

INREBIC 2027

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

INTRAVENOUS IMMUNE GLOBULINS (IVIG) 2027

Products Affected

- GAMMAGARD ERC
- GAMMAGARD INJECTION SOLUTION 10 GM/100ML, 2.5 GM/25ML, 5 GM/50ML
- GAMMAGARD S/D LESS IGA
- GAMMAKED INJECTION SOLUTION 1 GM/10ML
- GAMMAPLEX INTRAVENOUS SOLUTION 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 5 GM/50ML
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- OCTAGAM INTRAVENOUS SOLUTION 1 GM/20ML, 2 GM/20ML
- PRIVIGEN INTRAVENOUS SOLUTION 20 GM/200ML

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ISTURISA 2027

Products Affected

- ISTURISA ORAL TABLET 1 MG, 5 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ITOVEBI 2027

Products Affected

- ITOVEBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

IVABRADINE 2027

Products Affected

- *ivabradine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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) stable, symptomatic chronic heart failure (4) left ventricular ejection fraction less than or equal to 35% and (5) sinus rhythm with resting heart rate greater than or equal to 70 beats per minute. (6) Member is clinically stable for at least 4 weeks which includes 2 of the following therapies: (a) maximally tolerated doses of beta blockers or inability to tolerate beta blockers, (b) ACE inhibitors or ARBs or inability to tolerate ACE inhibitor or ARB. maximally tolerated doses of Sodium-glucose co-transporter 2 (SGLT2) inhibitor [e.g. Jardiance (empagliflozin), Farxiga (dapagliflozin), Xigduo XR (dapagliflozin and metformin)] (d) maximally tolerated doses of mineralocorticoid receptor antagonist (MRA) [e.g. eplerenone, spironolactone]. Chronic Heart Failure due to Dilated Cardiomyopathy in pediatric members ages 6 months and older (CHF-DC)(Initial): (1) Diagnosis of chronic heart failure due to dilated cardiomyopathy (2) Member is in sinus rhythm with an elevated heart rate. (3) Member has New York Heart Association (NYHA) Class II, III, or IV symptoms (4) Inadequate response or inability to tolerate a beta blocker, ACE inhibitor, or a diuretic agent (e.g., spironolactone, furosemide)
Age Restrictions	
Prescriber Restrictions	(CHF, CHF-DC): Prescribed by or in consultation with a cardiologist
Coverage Duration	1-year
Other Criteria	(CHF, CHF-DC) (Cont): Documentation of positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

IWILFIN 2027

Products Affected

- IWILFIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

JAKAFI 2027

Products Affected

- JAKAFI
- JAKAFI XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

JAYCIRCA 2027

Products Affected

- JAYPIRCA

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

JIDEYTRO 2027

Products Affected

- JIDEYTRO

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

JYNARQUE 2027

Products Affected

- *tolvaptan oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	(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) history of significant liver impairment or injury, not including uncomplicated polycystic liver disease (6) Uncorrected urinary outflow obstruction or abnormal blood sodium concentrations
Required Medical Information	(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 (3) One of the following: (a) Both of the following: Member has received tolvaptan (brand or generic Jynarque) for less than or equal to 18 months AND Alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin will be measured prior to initiation, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months of therapy OR (b) Both of the following: Member has received tolvaptan (brand or generic Jynarque) for longer than 18 months AND ALT, AST, and bilirubin will be measured at least every 3 months.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a nephrologist or kidney transplant specialist
Coverage Duration	1-year

PA Criteria	Criteria Details
Other Criteria	(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. (4) One of the following: (a) Both of the following: Member has received tolvaptan (brand or generic Jynarque) for less than or equal to 18 months AND Alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin will be measured prior to initiation, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months of therapy OR (b) Both of the following: Member has received tolvaptan (brand or generic Jynarque) for longer than 18 months AND ALT, AST, and bilirubin will be measured at least every 3 months.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

KALYDECO 2027

Products Affected

- KALYDECO

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

KERENDIA 2027

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Chronic kidney disease associated with type 2 diabetes (CKD with T2D) (Initial): (1) Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D), (2) One of the following (a) Minimum 30-day trial and member will continue therapy with ONE of the following (i) generic angiotensin-converting enzyme (ACE) inhibitor (e.g. benazepril, lisinopril), (ii) generic angiotensin II receptor blocker (ARB) (e.g. losartan, valsartan), (b) Member has contraindication or intolerance to ACE inhibitors, ARBs, or SGLT2. Heart Failure with Left Ventricular Ejection Fraction (LVEF) (initial): (1)Diagnosis of Heart Failure, (2) Member has LVEF greater than or equal to 40%, (3) Member has New York Heart Association Class II, III, or IV symptoms, (4) Member has an estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m2 (5)Member has a serum potassium level less than or equal to 5.0 mEq/L prior to initiating treatment, (6)Both of the following: (a) Member is on diuretic treatment (e.g., bumetanide, furosemide) for the management of symptoms of heart failure for at least 30 days prior to initiating treatment, (b) Member is not receiving drug in combination with spironolactone or eplerenone, (7) One of the following: (a) Member is receiving drug in combination with a sodium-glucose cotransporter-2 (SGLT2) inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]), (b) Member has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]).
Age Restrictions	
Prescriber Restrictions	(HF with LVEF): Prescribed by or in consultation with a cardiologist
Coverage Duration	1-year

PA Criteria	Criteria Details
Other Criteria	(CKD with T2D)(Reauth): (1) Documentation of positive clinical response to therapy (e.g., reduced incidence of a sustained declined in eGFR, kidney failure, or renal death). (HF with LVEF) (Reauth): (1) Member demonstrates positive clinical response to therapy and (2) one of the following: (a) Member continues to be on an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]) or (b) Member has a contraindication or intolerance to an SGLT2 inhibitor (e.g., Farxiga [dapagliflozin], Jardiance [empagliflozin]
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

KEVZARA 2027

Products Affected

- KEVZARA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- KEVZARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with any other biologic disease modifying anti-rheumatic drug (DMARD), e.g. tumor necrosis factor antagonists
Required Medical Information	Rheumatoid arthritis (RA)(Initial): (1) Diagnosis of moderately to severely active RA. (2) Inadequate response or inability to tolerate TWO of the following: (a) Adalimumab (i.e. Adalimumab-AACF), (b) etanercept (Enbrel), 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, Xeljanz, (d) Orencia, (e) Rinvoq/Rinvoq LQ OR documentation demonstrating that a trial may be inappropriate.
Age Restrictions	
Prescriber Restrictions	(RA, PMR, PJIA): Prescribed by or in consultation with a rheumatologist
Coverage Duration	1-year
Other Criteria	(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
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	Yes

KINERET 2027

Products Affected

- KINERET 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

KISQALI 2027

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

KLISYRI 2027

Products Affected

- KLISYRI (250 MG)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Actinic Keratoses: (1) Diagnosis of Actinic Keratoses (2) Inadequate response or inability to tolerate BOTH of the following generics: Topical fluorouracil and topical imiquimod
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

KOMZIFTI 2027

Products Affected

- KOMZIFTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

KORLYM 2027

Products Affected

- *mifepristone oral tablet 300 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Pregnancy
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	Months, 6
Other Criteria	(HCS)(Reauth): Documentation of positive clinical response to therapy (e.g., improved, or stable glucose tolerance while on therapy)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

KOSELUGO 2027

Products Affected

- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

KRAZATI 2027

Products Affected

- KRAZATI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

LAPATINIB PRODUCTS 2027

Products Affected

- *lapatinib ditosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

LAZCLUZE 2027

Products Affected

- LAZCLUZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

LENALIDOMIDE PRODUCTS 2027

Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

LENVATINIB PRODUCTS 2027

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

LEQEMBI IQLIK SQ 2027

Products Affected

- LEQEMBI IQLIK
- LEQEMBI IQLIK (500 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

LETAIRIS 2027

Products Affected

- LETAIRIS

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

LIFYORLI 2027

Products Affected

- LIFYORLI (125 MG DOSE) ORAL CAPSULE THERAPY PACK 1 X 25 MG & 1 X 100 MG
- LIFYORLI (150 MG DOSE) ORAL CAPSULE THERAPY PACK 2 X 25 MG & 1 X 100 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

LIRAGLUTIDE 2027

Products Affected

- *liraglutide*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

LIVTENCITY 2027

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	(CMV): Member is 12 years of age or older
Prescriber Restrictions	(CMV): Prescribed by or in consultation with a provider who specializes in one of the following areas (1) transplant, (2) infectious disease (3) Oncology
Coverage Duration	8 weeks
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

LOMUSTINE PRODUCTS 2027

Products Affected

- *lomustine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

LONSURF 2027

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

LORBRENA 2027

Products Affected

- LORBRENA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

LUMAKRAS 2027

Products Affected

- LUMAKRAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

LYNPARZA 2027

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

LYTGOBI 2027

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

MACITENTAN 2027

Products Affected

- *macitentan*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

MAVYRET 2027

Products Affected

- 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

MEKINIST 2027

Products Affected

- MEKINIST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

MEKTOVI 2027

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

METAXALONE HRM 2027

Products Affected

- *metaxalone oral tablet 400 mg, 800 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

MODAFINIL 2027

Products Affected

- *modafinil oral*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

MODEYSO 2027

Products Affected

- MODEYSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

NAYZILAM 2027

Products Affected

- NAYZILAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a neurologist/epilepsy specialist
Coverage Duration	Lifetime
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

NERLYNX 2027

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

NEURUS 2027

Products Affected

- NEREUS

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

NEXLETOL 2027

Products Affected

- NEXLETOL

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

NEXLIZET 2027

Products Affected

- NEXLIZET

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

NILOTINIB PRODUCTS 2027

Products Affected

- DANZITEN
- *nilotinib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

NINLARO 2027

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

NINTENDANIB 2027

Products Affected

- *nintedanib esylate*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

NON-PREFERRED USTEKINUMAB SQ 2027

Products Affected

- *ustekinumab 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

NOURIANZ 2027

Products Affected

- NOURIANZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Parkinson's Disease (PD) (Initial): (1) Diagnosis of Parkinson's disease. (2) concurrent use of carbidopa/levodopa containing product, (3) Member is experiencing intermittent OFF episodes, (4) member had inadequate response or inability to tolerate ONE of the following: (a) MAO-B inhibitor (e.g. rasagiline, selegiline), (b) Dopamine agonist (e.g. pramipexole, ropinirole), COMT inhibitor (e.g. entacapone)
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a neurologist.
Coverage Duration	1-year
Other Criteria	Parkinson's Disease (PD) (Reauth): (1) Member demonstrates positive response to clinical therapy (2) concurrent use of carbidopa/levodopa containing product
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NOXAFIL 2027

Products Affected

- *posaconazole oral tablet delayed release*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Treatment of invasive aspergillosis (TAI): (1) Diagnosis of TAI Prophylaxis of Invasive Aspergillus Infections (AI): (1) For use in prophylaxis of invasive Aspergillus infection due to being severely immunocompromised after inadequate response or inability to tolerate voriconazole (Vfend) Prophylaxis of Invasive Candida Infections(CI): (1) For use in prophylaxis of invasive Candida infection due to being severely immunocompromised after inadequate response or inability to tolerate voriconazole (Vfend).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist, transplant specialist, hematologist, oncologist, OR prescribed as part of chemotherapy prophylaxis protocol
Coverage Duration	1-year
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	Yes

NUBEQA 2027

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prostate Cancer: (1) Submission of medical records (e.g., chart notes) showing diagnosis of metastatic castration-sensitive prostate cancer (mCSPC) or non-metastatic castration-resistant prostate cancer, (2) For mCSPC, submission of medical or pharmacy records (e.g., chart notes or claims) showing an inadequate response or inability to tolerate generic abiraterone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	Approve if for continuation of therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

NUCALA 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

NUEDEXTA 2027

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	(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]
Required Medical Information	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 Alzheimer's disease (d) Parkinson's disease (e) Stroke (f) Traumatic brain injury
Age Restrictions	
Prescriber Restrictions	(PBA): Prescribed by or in consultation with a neurologist or psychiatrist
Coverage Duration	1-year
Other Criteria	(PBA)(Reauth): (1) Documentation of clinical benefit from ongoing therapy (e.g., decrease in laughing or crying episodes)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

NUPLAZID 2027

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Hallucinations and Delusions Associated with Parkinson Disease Psychosis (HDPDP): (1) Diagnosis of HDPDP.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

NURTEC 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

OCTREOTIDE 2027

Products Affected

- *octreotide acetate injection solution 100 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ODACTRA 2027

Products Affected

- ODACTRA

PA Criteria	Criteria Details
Exclusion Criteria	(1) Severe, unstable or uncontrolled asthma (2) History of eosinophilic esophagitis
Required Medical Information	Induced allergic rhinitis (Initial): (1) Diagnosis of induced allergic rhinitis, (2) Member has a positive skin test or in vitro test for the listed allergen-specific IgE antibody. (3) Inadequate response or inability to tolerate an intranasal corticosteroid and an oral or intranasal antihistamine.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an allergist or immunologist.
Coverage Duration	1-year
Other Criteria	(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
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ODOMZO 2027

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

OFEV 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

OGSIVEO 2027

Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

OJEMDA 2027

Products Affected

- OJEMDA ORAL SUSPENSION RECONSTITUTED
- OJEMDA ORAL TABLET 100 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

OJJAARA 2027

Products Affected

- OJJAARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

OLUMIANT 2027

Products Affected

- OLUMIANT

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ONUREG 2027

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

OPIPZA 2027

Products Affected

- OPIPZA

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ORENCIA SQ 2027

Products Affected

- ORENCIA CLICKJECT
- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent therapy with biological DMARDs or other tumor necrosis factor antagonists
Required Medical Information	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)(Initial): (1) Diagnosis of moderate to severe PJIA. (2) Inadequate response or inability to tolerate one of the following: methotrexate, leflunomide, sulfasalazine.
Age Restrictions	
Prescriber Restrictions	(RA, PJIA): Prescribed by or in consultation with a rheumatologist. (PsA): Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	1-year
Other Criteria	(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ORGOVYX 2027

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ORKAMBI 2027

Products Affected

- ORKAMBI

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ORSERDU 2027

Products Affected

- ORSERDU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

OTEZLA 2027

Products Affected

- OTEZLA
- OTEZLA XR
- OTEZLA/OTEZLA XR INITIATION PK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	(PsA, OU-BD): Prescribed by or in consultation with a Rheumatologist or Dermatologist. (PsO): Prescribed by or in consultation with dermatologist.
Coverage Duration	1-year
Other Criteria	(OU-BD, PsA, PsO)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

OXERVATE 2027

Products Affected

- OXERVATE

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

PART D VS EXCLUDED- OSPENIFENE 2027

Products Affected

- OSPHENA

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

PART D VS EXCLUDED- PRASTERONE 2027

Products Affected

- INTRAROSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
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

PART D VS EXCLUDED- VORICONAZOLE 2027

Products Affected

- *voriconazole intravenous solution reconstituted*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
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

PAZOPANIB PRODUCTS 2027

Products Affected

- *pazopanib hcl oral tablet 200 mg*
- VOTRIENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

PDE INHIBITOR AGENTS FOR PAH 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

PEMIGATINIB PRODUCTS 2027

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

PIQRAY 2027

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

PIRFENIDONE 2027

Products Affected

- *pirfenidone*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

POMALIDOMIDE 2027

Products Affected

- *pomalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

PRALUENT 2027

Products Affected

- PRALUENT SUBCUTANEOUS SOLUTION AUTO-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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

PREFERRED DENOSUMAB (XGEVA PRODUCTS) 2027

Products Affected

- OSENVELT
- WYOST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Part D is medically necessary when: Prevention of Skeletal Related Events in Multiple Myeloma or Bone Metastases from Solid Tumors (MM-BMST) : (1) For prevention of skeletal related events in multiple myeloma or bone metastases from solid tumors. Giant Cell Tumor of the Bone (GCTB): (1) Diagnosis of GCTB. (2) Member is (a) adult or (b) adolescent that is skeletally mature. (3) Tumor is unresectable or surgical resection is likely to result in severe morbidity. Hypercalcemia of Malignancy Refractory to Bisphosphonates (HCMRB): (1) Diagnosis of HCMRB
Age Restrictions	
Prescriber Restrictions	(GCTB, HCMRB): Prescribed by or in consultation with an urologist, oncologist or hematologist.
Coverage Duration	Lifetime
Other Criteria	Subject to Part B vs Part D review. (All Indications): Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

PREFERRED DENOSUMAB 2027

Products Affected

- JUBBONTI
- STOBOCLO

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

PREFERRED TOCILIZUMAB SQ 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

PREFERRED USTEKINUMAB SQ 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

PRETOMANID 2027

Products Affected

- *pretomanid*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Multidrug Resistant Tuberculosis (MDRTB): (1) Diagnosis of pulmonary extensively drug resistant (XDR), treatment-intolerant or nonresponsive MDRTB. (2) Medication will be used as part of a combination regimen with bedaquiline (Sirturo) and linezolid.
Age Restrictions	
Prescriber Restrictions	(MDR-TB): Prescribed by or in consultation with infectious disease specialist or pulmonologist
Coverage Duration	26 weeks
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

PROMETHAZINE HRM 2027

Products Affected

- *promethazine hcl oral solution 6.25 mg/5ml*
- *promethazine hcl oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Risk versus benefit has been assessed for this request of a high risk medication (HRM) in elderly (2) Prescriber acknowledges anticholinergic risks (e.g., confusion, dry mouth, blurry vision, constipation, urinary retention) and will consider lowering the dose or discontinuing medication(s) that are no longer clinically warranted for the member
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

QBREXZA 2027

Products Affected

- QBREXZA

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

QINLOCK 2027

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

QUALAQUIN 2027

Products Affected

- *quinine sulfate oral*

PA Criteria	Criteria Details
Exclusion Criteria	Use for treatment or prevention of nocturnal leg cramps
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Babesiosis: Days, 10 days Uncomplicated Malaria: 14 Days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RADICAVA 2027

Products Affected

- RADICAVA ORS STARTER KIT

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

RALDESY 2027

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	Lifetime
Other Criteria	Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

REPATHA 2027

Products Affected

- 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

RESPIRATORY ENZYMES 2027

Products Affected

- PROLASTIN-C INTRAVENOUS 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

RETEVMO 2027

Products Affected

- RETEVMO ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

REVUFORJ 2027

Products Affected

- REVUFORJ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

REXULTI 2027

Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

REZDIFFRA 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

REZLIDHIA 2027

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

REZUROCK 2027

Products Affected

- REZUROCK

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

RINVOQ 2027

Products Affected

- RINVOQ

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with any other biologic disease modifying antirheumatic drug (DMARD), other JAK inhibitors, or potent immunosuppressants (e.g. azathioprine, cyclosporine).
Required Medical Information	Rheumatoid Arthritis (RA)(Initial): (1) Diagnosis of moderate to severely active RA. (2) Member has inadequate response or inability to tolerate one DMARD: (e.g. methotrexate, hydroxychloroquine, leflunomide, azathioprine, sulfasalazine (3) Member had 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. 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. Atopic Dermatitis (AD)(Initial): (1) Submission of medical records (e.g., chart notes) showing diagnosis of refractory, moderate to severe AD, (2) Inadequate response or inability to tolerate at least one systemic drug product for the treatment of atopic dermatitis (examples include, but are not limited to Dupixent, Adbry, Ebglyss) or documentation that a trial may be inappropriate. Ulcerative Colitis (UC)(Initial): (1) Diagnosis of moderate to severe ulcerative colitis (2) One of the following: (a) Member had an inadequate response or inability to tolerate one or more TNF inhibitors (e.g. Adalimumab-AACF) (b) If TNF blockers are clinically inadvisable, an inadequate response or inability to tolerate at least one approved systemic therapy. Giant Cell Arteritis (GCA): (1) Diagnosis of GCA.
Age Restrictions	
Prescriber Restrictions	(RA, AS, nr-AxSPA, PJIA, GCA): Prescribed by or in consultation with a rheumatologist. (PsA):Prescribed by or in consultation with a rheumatologist or dermatologist. (AD): Prescribed by or in consultation with a dermatologist, allergist, immunologist. (UC, CD): Prescribed by or in consultation with a gastroenterologist.
Coverage Duration	1-year

PA Criteria	Criteria Details
Other Criteria	Ankylosing Spondylitis (AS)(Initial): (1) Diagnosis of active ankylosing spondylitis. (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. Non-radiographic axial spondylarthritis (nr-AxSPA): (1) Diagnosis of nr-AxSPA (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 (3) Inadequate response or inability to tolerate one NSAID. Crohn's Disease (CD)(Initial): (1) Diagnosis of moderately to severely active CD. (2) One of the following: (a) Member had an inadequate response or inability to tolerate one or more TNF inhibitors (e.g. Adalimumab-AACF) (b) If TNF blockers are clinically inadvisable, an inadequate response or inability to tolerate at least one approved systemic therapy. 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. (RA, PsA, AD, UC, AS, nr- AxSPA, CD, PJIA, GCA)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

RINVOQ LQ 2027

Products Affected

- RINVOQ LQ

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with any other biologic disease modifying antirheumatic drug (DMARD), other JAK inhibitors, or potent immunosuppressants (e.g. azathioprine, cyclosporine).
Required Medical Information	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.
Age Restrictions	
Prescriber Restrictions	(PsA): Prescribed by or in consultation with a rheumatologist or dermatologist. (pJIA): Prescribed by or in consultation with a rheumatologist
Coverage Duration	1-year
Other Criteria	(PsA, pJIA)(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

ROMVIMZA 2027

Products Affected

- ROMVIMZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ROZLYTREK 2027

Products Affected

- ROZLYTREK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

RUBRACA 2027

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

RYDAPT 2027

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

SCEMBLIX 2027

Products Affected

- SCEMBLIX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

SEMAGLUTIDE 2027

Products Affected

- OZEMPIC
- 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)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(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 mellites 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)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	(DM2)(Reauth): Documentation of positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SIGNIFOR 2027

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	1-year
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 2027

Products Affected

- *sildenafil citrate oral suspension reconstituted*
- *sildenafil citrate oral tablet 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

SIMPONI 2027

Products Affected

- SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- SIMPONI 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

SIRTURO 2027

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary Multi-Drug Resistant Tuberculosis (MDR-TB): (1) Diagnosis of MDR-TB due to Mycobacterium tuberculosis resistant to at least rifampin and isoniazid. (2) One of the following: (a) Member is over 18 years of age, or (b) Member weighs at least 8 kg (2) Sirturo (bedaquiline) will be administered by directly observed therapy (DOT).
Age Restrictions	
Prescriber Restrictions	(MDR-TB): Prescribed by or in consultation with infectious disease specialist or pulmonologist
Coverage Duration	24 weeks
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

SIVEXTRO IV 2027

Products Affected

- SIVEXTRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(Initial): Part D is medically necessary when documentation of a current bacterial infection and an inadequate response or inability to tolerate at least TWO drugs to which the organism is susceptible OR the requested agent is the only antibiotic to which the organism is susceptible.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist OR oncologist
Coverage Duration	Month, 1
Other Criteria	Subject to Part B vs Part D review. Subject to additional clinical review for ESRD-related use - if applicable. (REAUTH): Prescriber attests that an infectious disease consult determines that a longer duration of therapy is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SIVEXTRO ORAL 2027

Products Affected

- SIVEXTRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(Initial): Documentation of a current bacterial infection and an inadequate response or inability to tolerate TWO antibiotics to which the organism is susceptible OR the requested medication is the only antibiotic to which the organism is susceptible.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an infectious disease specialist OR oncologist
Coverage Duration	Month, 1
Other Criteria	Subject to additional clinical review for ESRD-related use - if applicable. (REAUTH): Prescriber attests that an infectious disease consult determines that a longer duration of therapy is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

SKYRIZI SC 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

SOFOSBUVIR/VELPATASVIR 2027

Products Affected

- *sofosbuvir-velpatasvir*

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

SOMAVERT 2027

Products Affected

- SOMAVERT

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

SORAFENIB PRODUCTS 2027

Products Affected

- *sorafenib tosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

SOTATERCEPT 2027

Products Affected

- WINREVAIR

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

STIVARGA 2027

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

SUNITINIB PRODUCTS 2027

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

TABRECTA 2027

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

TADALAFIL (BPH) 2027

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	(BPH): Concurrent use of nitrates.
Required Medical Information	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).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	(Reauth): (1) Member demonstrates positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TAFINLAR 2027

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

TAGRISSO 2027

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

TALTZ 2027

Products Affected

- TALTZ

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

TALZENNA 2027

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

TARPEYO 2027

Products Affected

- TARPEYO

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

TAVABOROLE PRODUCTS 2027

Products Affected

- *tavaborole*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

TAVNEOS 2027

Products Affected

- TAVNEOS

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

TEPMETKO 2027

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

TERIPARATIDE 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

TESTOSTERONE PRODUCTS 2027

Products Affected

- JATENZO
- *testosterone cypionate intramuscular solution 100 mg/ml, 200 mg/ml*
- *testosterone enanthate intramuscular solution*
- *testosterone transdermal gel 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 transdermal solution*
- XYOSTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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 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) Both of the following: (i) negative history of prostate and (ii) negative history of breast cancer OR (B) Documentation that the risk versus benefit has been assessed.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	(HG)(Continuation): ONE of the following (1) negative history of prostate and breast cancer OR (2) Documentation that the risk versus benefit has been assessed
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PA Criteria	Criteria Details
Prerequisite Therapy Required	No

TETRABENAZINE 2027

Products Affected

- *tetrabenazine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	(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.
Coverage Duration	(TD)(Initial): 6 months (TD)(Reauth): Lifetime (TS, CHD): Lifetime
Other Criteria	(TD)(Reauth): Positive clinical response to therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TEZSPIRE 2027

Products Affected

- TEZSPIRE SUBCUTANEOUS SOLUTION AUTO-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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

THALOMID 2027

Products Affected

- THALOMID ORAL CAPSULE 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

TIBSOVO 2027

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

TIRZEPATIDE 2027

Products Affected

- MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(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 mellites 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)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	(DM2)(Reauth): Documentation of positive clinical response to therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TOLVAPTAN 2027

Products Affected

- *tolvaptan (hyponatremia)*

PA Criteria	Criteria Details
Exclusion Criteria	(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)
Required Medical Information	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.).
Age Restrictions	
Prescriber Restrictions	Hyponatremia: Prescribed by or in consultation with a cardiologist, endocrinologist or nephrologist
Coverage Duration	1-year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

TOPICAL RETINOID PRODUCTS 2027

Products Affected

- *tretinoin external*

PA Criteria	Criteria Details
Exclusion Criteria	Cosmetic use
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1-year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TRACLEER 2027

Products Affected

- TRACLEER

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

TREMFYA SQ 2027

Products Affected

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

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

TRIKAFTA 2027

Products Affected

- TRIKAFTA

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

TRIPTORELIN 2027

Products Affected

- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	(All Indications): Approve if for continuation of therapy. Subject to Part B vs Part D review.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

TRUQAP 2027

Products Affected

- TRUQAP ORAL TABLET THERAPY PACK 160 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

TRYNGOLZA 2027

Products Affected

- TRYNGOLZA SUBCUTANEOUS SOLUTION AUTO-INJECTOR 80 MG/0.8ML

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

TUKYSA 2027

Products Affected

- TUKYSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

TURALIO 2027

Products Affected

- TURALIO ORAL CAPSULE 125 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

TYMLOS 2027

Products Affected

- TYMLOS

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

TYVASO DPI 2027

Products Affected

- TYVASO DPI MAINTENANCE KIT INHALATION POWDER 112 X 32MCG & 112 X64MCG, 112 X 48MCG & 112 X64MCG, 112 X 48MCG & 112 X80MCG, 16 MCG, 32 MCG, 48 MCG, 64 MCG, 80 MCG
- TYVASO DPI TITRATION KIT INHALATION POWDER 16 & 32 & 48 MCG

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

UBRELVY 2027

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

VALCHLOR 2027

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or dermatologist
Coverage Duration	Lifetime
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

VALTOCO 2027

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a neurologist/epilepsy specialist
Coverage Duration	Lifetime
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

VANFLYTA 2027

Products Affected

- VANFLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

VELSIPITY 2027

Products Affected

- VELSIPITY

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

VENCLEXTA 2027

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

VEOZAH 2027

Products Affected

- VEOZAH

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	(VMS)(Initial): 6 months, (Reauth): 12 months
Other Criteria	(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.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

VERQUVO 2027

Products Affected

- VERQUVO

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

VERZENIO 2027

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

VIGAFYDE SOLUTION 2027

Products Affected

- VIGAFYDE

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

VITRAKVI 2027

Products Affected

- VITRAKVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

VONJO 2027

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

VOQUEZNA TABLETS 2027

Products Affected

- VOQUEZNA

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

VORANIGO 2027

Products Affected

- VORANIGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

VOSEVI 2027

Products Affected

- VOSEVI

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. (3) Inability to tolerate ONE of the following when appropriate per the current AASLD/IDSA guidance: generic ledipasvir-sofosbuvir, generic sofosbuvir-velpatasvir, or Mavyret.
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	Yes

VOWST 2027

Products Affected

- VOWST

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

WEGOVY 2027

Products Affected

- WEGOVY

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

WEGOVY ORAL 2027

Products Affected

- WEGOVY

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

WELIREG 2027

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

WILSONS DISEASE 2027

Products Affected

- *trientine hcl oral capsule 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	(WD): Prescribed by or in consultation with gastroenterologist, hepatologist, or liver transplant specialist.
Coverage Duration	1-year
Other Criteria	(WD) (Reauth): (1) Member demonstrates positive clinical response to therapy (e.g., reduction in 24-hour urinary copper excretion levels from baseline)
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

XALKORI 2027

Products Affected

- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

XDEMVY 2027

Products Affected

- XDEMVY

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 2027

Products Affected

- *tofacitinib citrate er*
- *tofacitinib citrate oral*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

XERMELO 2027

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	(CSD): Prescribed by or in consultation with an Oncologist, Endocrinologist, or Gastroenterologist
Coverage Duration	2-years
Other Criteria	(CSD)(Reauth): (1) Positive clinical response to Xermelo therapy, (2) Xermelo will continue to be used in combination with SSA therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

XIFAXAN 550MG 2027

Products Affected

- XIFAXAN ORAL TABLET 550 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

XOLAIR 2027

Products Affected

- XOLAIR

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

XOSPATA 2027

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

XPOVIO 2027

Products Affected

- 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, 80 MG
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

XTANDI 2027

Products Affected

- XTANDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prostate Cancer: (1) Submission of medical records (e.g., chart notes) showing diagnosis of metastatic castration-sensitive prostate cancer (mCSPC), castration-resistant prostate cancer, or non-metastatic castration-sensitive prostate cancer with biochemical recurrence at high risk for metastasis, (2) For mCSPC, submission of medical or pharmacy records (e.g., chart notes or claims) showing an inadequate response or inability to tolerate generic abiraterone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
Other Criteria	Approve if for continuation of therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

XYREM 2027

Products Affected

- XYREM

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

XYWAV 2027

Products Affected

- XYWAV

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of sedative hypnotics and alcohol
Required Medical Information	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 modafinil or armodafinil. Idiopathic Hypersomnia (IH) (Initial): (1) Diagnosis of Idiopathic Hypersomnia as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), (2) Symptoms of excessive daytime sleepiness (e.g. nap duration of longer than 60 minutes) are present
Age Restrictions	
Prescriber Restrictions	(CN, EDSN, IH): Prescribed by or in consultation with a neurologist, psychiatrist, or sleep specialist.
Coverage Duration	1-year
Other Criteria	(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.(IH)(Reauth): (1) Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy (2) Member is re-evaluated every 12 months.
Indications	All Medically-accepted Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No
Prerequisite Therapy Required	Yes

YONSA 2027

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Approved when ALL of the following inclusion criteria are met: (1) Submission of medical records (i.e., chart notes) confirming ONE of the following: (A) Drug is FDA approved for indication and regimen requested, (B) The indication and regimen is classified as Category 1 or 2A by National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, narrative text in The American Hospital Formulary Service-Drug Information (AHFS-DI) or Clinical Pharmacology Compendium is supportive for the specific condition(s) requested, (D) The Micromedex Compendium and the strength of recommendation is listed as Class I, Class IIa, or Class IIb for the specific condition(s) requested, (E) Indication is listed in Lexi-Drugs as "off label" with evidence level A, (F) supported by Peer-Reviewed Medical Literature as defined in Chapter 15 Section 50.4.5 of the Medicare Benefit Policy Manual. (2) Submission of medical or pharmacy records (e.g., chart notes or claims) showing an inadequate response or inability to tolerate generic abiraterone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ZAVESCA 2027

Products Affected

- *miglustat*

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ZEJULA 2027

Products Affected

- ZEJULA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ZELBORAF 2027

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ZENBEXUS 2027

Products Affected

- ZENBEXUS

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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

ZOLINZA 2027

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ZTALMY 2027

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder: (1) Diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (2) Documentation of mutation in the CDKL5 gene (3) member is experiencing motor seizures (e.g. bilateral tonic, generalized tonic-clonic, bilateral clonic, atonic, focal, or bilateral tonic-clonic).
Age Restrictions	(CDKL5): Member is 2 years of age or older
Prescriber Restrictions	(CDKL5): Prescribed by or in consultation with a neurologist
Coverage Duration	Lifetime
Other Criteria	Approve if for continuation of therapy
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ZURZUVAE 2027

Products Affected

- ZURZUVAE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Postpartum depression (PPD): (1) Diagnosis of postpartum depression (PPD) (2) Onset of symptoms in the third trimester or within 4 weeks of delivery (3) Prescriber attests that the member has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence or the degree of driving impairment caused by Zurzuvae.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Days, 14
Other Criteria	Approve if for continuation of therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No
Prerequisite Therapy Required	No

ZYKADIA 2027

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	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
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Lifetime
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

ZYMFENTRA SQ 2027

Products Affected

- ZYMFENTRA (2 PEN)
- ZYMFENTRA (2 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	UNDER CMS REVIEW
Prerequisite Therapy Required	UNDER CMS REVIEW

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