PriorityHealth
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2021 Priority Health Medicare Prior Authorization Criteria

An alphabetical index by drug name appears after the drugcriteria listings.

Last updated: November 2021

abiraterone acetate

Products Affected

- *abiraterone acetate oral tablet 250 mg, 500 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ACTEMRA ACTPEN

Products Affected

- ACTEMRA ACTPEN

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not be receiving Actemra in combination with another biologic drug.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For a diagnosis of rheumatoid arthritis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic DMARD(e.g. methotrexate, leflunomide, hydroxychloroquine, sulfasalazine).
Indications	All Medically-accepted Indications.
Off Label Uses	

ACTEMRA SYRINGE

Products Affected

- ACTEMRA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not be receiving Actemra in combination with another biologic drug.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For a diagnosis of rheumatoid arthritis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic DMARD(e.g. methotrexate, leflunomide, hydroxychloroquine, sulfasalazine).
Indications	All Medically-accepted Indications.
Off Label Uses	

ACTHAR

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial-in accordance with FDA label or max of 3 mos. if unspecified in label. Continuation-1 year.
Other Criteria	For all FDA-approved indications except infantile spasms, must have a therapeutic trial of parenteral glucocorticoid. Supporting documentation for all drug trials is required demonstrating inadequate response, intolerance, or FDA labeled contraindication to therapy. For acute exacerbations of multiple sclerosis: one month trial of oral glucocorticoid. For nephrotic syndrome associated with lupus erythematosus, systemic lupus erythematosus, and inflammatory ocular disorders: one month trial of an immunosuppressant (e.g. cyclophosphamide, tacrolimus, mycophenolate mofetil, methotrexate, azathioprine). For adjunctive therapy for short-term administration rheumatic disease: 12-weeks trial of two different biologic therapies. For systemic dermatomyositis (polymyositis): 12-week trials with rituximab and IVIG. Continuation of previously authorized therapy requires demonstrated clinical benefit. Quantity limited to dosage as supported by the FDA-approved label.
Indications	All FDA-approved Indications.
Off Label Uses	

ACTIMMUNE

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient's body surface area (BSA)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ADASUVE

Products Affected

- ADASUVE

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS review
Required Medical Information	Pending CMS review
Age Restrictions	Pending CMS review
Prescriber Restrictions	Pending CMS review
Coverage Duration	Pending CMS review
Other Criteria	Pending CMS review
Indications	Pending CMS review
Off Label Uses	Pending CMS review

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For chronic thromboembolic pulmonary hypertension, must be in World Health Organziation Group 4. For pulmonary arterial hypertension, must be in World Health Organization Group 1, and patients not previously treated for pulmonary aterial hypertension must first try sildenafil (generic Revatio).
Indications	All Medically-accepted Indications.
Off Label Uses	

AFINITOR

Products Affected

- AFINITOR DISPERZ
- AFINITOR ORAL TABLET 10 MG, 2.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

AIMOVIG

Products Affected

- AIMOVIG

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with Botox (botulinum toxin) or other CGRP antagonist therapy.
Required Medical Information	Documentation supporting diagnosis, other therapies tried, and outcome. Medication overuse headache has been ruled out.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a neurologist, pain specialist, or other headache specialist.
Coverage Duration	One year
Other Criteria	For migraine prevention: must have an inadequate response, contraindication, or intolerance to two of the following migraine prevention drugs, each from a different class and tried for at least 28 days each: topiramate, divalproex, valproic acid, propranolol, metoprolol, amitriptyline, and venlafaxine. For continuation: must provide evidence of significant clinical improvement.
Indications	All FDA-approved Indications.
Off Label Uses	

AJOVY

Products Affected

- AJOVY

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with Botox (botulinum toxin) or other CGRP antagonist therapy
Required Medical Information	Documentation supporting diagnosis, other therapies tried, and outcome. Medication overuse headache has been ruled out.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a neurologist, pain specialist, or other headache specialist.
Coverage Duration	One year
Other Criteria	For migraine prevention: must have an inadequate response, contraindication, or intolerance to two of the following migraine prevention drugs, each from a different class and tried for at least 28 days each: topiramate, divalproex, valproic acid, propranolol, metoprolol, amitriptyline, and venlafaxine. For continuation: must provide evidence of significant clinical improvement.
Indications	All FDA-approved Indications.
Off Label Uses	

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ALUNBRIG

Products Affected

- ALUNBRIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ARALAST

Products Affected

- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a predicted FEV1 value between 30 and 65% and have serum AAT level less than 11 micromoles per liter (80 milligrams per deciliter if measured by radial immunodiffusion or 50 milligrams per deciliter if measure by nephelometry)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ARIKAYCE

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial review, sputum culture supporting the diagnosis of Mycobacterium avium complex (MAC) lung disease must be submitted. For continuation, documentation of negative sputum culture obtained within the last 30 days must be provided.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Initial approval for 6 months. Continuation for 12 months.
Other Criteria	For initial review, documentation of failure to obtain a negative sputum cultures after a minimum of 6 months of a multidrug background regimen therapy for MAC lung disease must be provided. Criteria will be applied consistent with current ATS/IDSA guidelines.
Indications	All FDA-approved Indications.
Off Label Uses	

armodafinil

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

Auryxia

Products Affected

- AURYXIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For a diagnosis of hyperphosphatemia in patients with chronic kidney disease (CKD) on dialysis, must first try and fail calcium acetate.
Indications	All FDA-approved Indications.
Off Label Uses	

AUSTEDO

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with tetrabenazine, Ingrezza, a monoamine oxidase inhibitor (MAOI), or reserpine.
Required Medical Information	For diagnosis of tardive dyskinesia (TD), baseline documentation of Abnormal Involuntary Movement Scale (AIMS) score must be provided.
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	
Coverage Duration	Initial approval for 6 months, continuation for one year.
Other Criteria	For diagnosis of tardive dyskinesia (TD), must have moderate or severe TD, indicated by minimum AIMS score of 3 on item 8 (severity of abnormal movements). For continuation, documentation of improvement in chorea symptoms for Huntingtons disease or improvement in AIMS score compared to baseline for TD.
Indications	All Medically-accepted Indications.
Off Label Uses	

AVEED

Products Affected

- AVEED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Subnormal serum total testosterone concentration must be less than 300 ng/dL, on more than one occasion in the past year.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must be male. Patient must have prior use of a generic injectable and generic topical testosterone, for a minimum of two months. Patient must have clinical symptoms and signs consistent with androgen deficiency. Men over age 50 years (or over 40 years who have a family history or are African-American) must be screened for prostate cancer before starting therapy and routinely while on therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

AYVAKIT

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

BALVERSA

Products Affected

- BALVERSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

BENLYSTA

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	For all FDA-approved indications, Benlysta must not be used with another biologic drug.
Required Medical Information	For SLE, must have a SELENA-SLEDAI score of 6 or more before starting Benlysta AND either an anti-dsDNA antibody greater than 30 IU/ml or ANA greater than 1:80.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a specialist in treating the condition or have consulted with a specialist.
Coverage Duration	One year
Other Criteria	For SLE, must be taking two of the following together for at least 12 weeks each: steroid, immunosuppressant, and hydroxychloroquine. For LN, must have active proliferative and/or membranous lupus nephritis (class 3, 4, or 5) AND continue to receive standard maintenance therapy with mycophenolate or azathioprine (or if contraindicated, another standard drug such as tacrolimus) plus steroid. For continuation of SLE, must have evidence of clinical improvement since starting Benlysta. For continuation of LN, must have evidence of clinical improvement including improved or stable eGFR.
Indications	All FDA-approved Indications.
Off Label Uses	

BERINERT

Products Affected

- BERINERT

PA Criteria	Criteria Details
Exclusion Criteria	Patient is on an angiotensin-converting enzyme (ACE) inhibitor.
Required Medical Information	For HAE Type I or II, documentation of C4, C1-INH protein, and C1-INH function lab results. Patient's weight.
Age Restrictions	Must be age 5 or older.
Prescriber Restrictions	Prescriber is an allergist, immunologist, hematologist, or other specialist experienced in treating HAE.
Coverage Duration	Limited to one fill of 20 units/kg (supplied in 500 unit vials).
Other Criteria	Patient has attacks either affecting upper airways, involving the face, neck, or abdomen, or resulting in debilitation or dysfunction. Patient has received training for self-administration. Each additional fill requires documentation of the patients use of the previous supply of Berinert, as well as documentation of symptom relief with use.
Indications	All FDA-approved Indications.
Off Label Uses	

BOSULIF

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

BRAFTOVI

Products Affected

- BRAFTOVI ORAL CAPSULE 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have documentation of BRAF V600 mutation status.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

BRUKINSA

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

CABOMETYX

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

CALQUENCE

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

CAPLYTA

Products Affected

- CAPLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must have tried and failed (defined as taking the medication as prescribed without an adequate response or with intolerance) two of the following generic atypical antipsychotics: aripiprazole, ziprasidone, olanzapine, risperidone, quetiapine.
Indications	All FDA-approved Indications.
Off Label Uses	

CAPRELSA

Products Affected

- CAPRELSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

CARBAGLU

Products Affected

- CARBAGLU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

CAYSTON

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CHOLBAM

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For continuation, must provide documentation showing the patient has met 2 of the following laboratory criteria or 1 laboratory criterion plus a body weight increase by 10% (or stability at greater than the 50th percentile): (1) AST or ALT less than 50 U/L (or baseline levels reduced by 80%) (2) total bilirubin less than 1 mg/dL, and (3) no evidence of cholestasis on liver biopsy.
Indications	All Medically-accepted Indications.
Off Label Uses	

clobazam

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must first try one generic anticonvulsant. Clobazam suspension may only be used in patients where tablets are contraindicated (e.g., dysphagia).
Indications	All FDA-approved Indications.
Off Label Uses	

clomiphene citrate

Products Affected

- *clomiphene citrate oral*

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS review
Required Medical Information	Pending CMS review
Age Restrictions	Pending CMS review
Prescriber Restrictions	Pending CMS review
Coverage Duration	Pending CMS review
Other Criteria	Pending CMS review
Indications	Pending CMS review
Off Label Uses	Pending CMS review

COMETRIQ

Products Affected

- COMETRIQ (100 MG DAILY DOSE)
- COMETRIQ (140 MG DAILY DOSE)
- COMETRIQ (60 MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

COPIKTRA

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

COSENTYX

Products Affected

- COSENTYX (300 MG DOSE)
- COSENTYX SENSOREADY (300 MG)

PA Criteria	Criteria Details
Exclusion Criteria	Cosentyx must not be used in combination with other biological drugs.
Required Medical Information	For a diagnosis of ankylosing spondylitis, must have a BASDAI score of at least 4.
Age Restrictions	Must be age 18 or older
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For a diagnosis of ankylosing spondylitis and non-radiographic axial spondyloarthritis (NRAS), must first have presence of disease for at least 4 weeks and a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For a diagnosis of psoriasis, must have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, cyclosporine, acitretin). For a diagnosis of psoriatic arthritis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, leflunomide, sulfasalazine).
Indications	All Medically-accepted Indications.
Off Label Uses	

COSENTYX 75MG/0.5ML

Products Affected

- COSENTYX SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 75 MG/0.5ML

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS review
Required Medical Information	Pending CMS review
Age Restrictions	Pending CMS review
Prescriber Restrictions	Pending CMS review
Coverage Duration	Pending CMS review
Other Criteria	Pending CMS review
Indications	Pending CMS review
Off Label Uses	Pending CMS review

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

CRINONE

Products Affected

- CRINONE VAGINAL GEL 8 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

CYSTADROPS

Products Affected

- CYSTADROPS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DALFAMPRIDINE ER

Products Affected

- *dalfampridine er*

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not have history of seizure and creatinine clearance must be greater than 50 ml per min.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial approval for 12 weeks, recertification required every 12 months therafter
Other Criteria	Baseline timed 25-foot walk (T25FW), patient must be currently ambulatory. Continuation stability and/or improvement in walking speed.
Indications	All Medically-accepted Indications.
Off Label Uses	

DALIRESP

Products Affected

- DALIRESP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have an FEV1 less than 50%. Patient must have had more than one COPD exacerbation in the past year.
Age Restrictions	Must be age 18 or older
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must have tried and failed triple therapy with an inhaled corticosteroid (ICS), long-acting beta agonist (LABA), and a long-acting antimuscarinic (LAMA) in the past 6 months (failure is defined as no improvement, a worsening of the condition, or an intolerance after trying triple therapy at the maximum dosages for at least 4 weeks consistently). For continuation, documentation must be provided showing a reduction in COPD exacerbations.
Indications	All Medically-accepted Indications.
Off Label Uses	

DAURISMO

Products Affected

- DAURISMO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

DIACOMIT

Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

diclofenac epolamine patch

Products Affected

- *diclofenac epolamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DOJOLVI

Products Affected

- DOJOLVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must provide documentation supporting the diagnosis (e.g., medical records).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patient must not have pancreatic insufficiency. For continuation, patient must have clinically significant benefit compared to baseline (e.g., reduced hospitalizations, myopathy, cardiac symptoms, muscle weakness, etc.).
Indications	All FDA-approved Indications.
Off Label Uses	

droxidopa

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two weeks
Other Criteria	Patient must first try midodrine.
Indications	All Medically-accepted Indications.
Off Label Uses	

DUPIXENT

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorized for 1 year. Limited to 4 syringes the first month, 2 syringes per month thereafter.
Other Criteria	For atopic dermatitis, must have trial and inadequate response to one medium or higher potency topical steroid (e.g., clobetasol, halobetasol, fluocinonide) - and - one topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus). For asthma, must be used as an add-on to current maintenance ICS/LABA inhaler, or if contraindicated or not tolerated, another maintenance medication for the condition. For chronic rhinosinusitis with nasal polyp (CRSwNP), documentation of disease persistence for at least 12 weeks despite sino-nasal surgery or treatment with systemic and intranasal corticosteroids - and - must be used in combination with an intranasal steroid. For all conditions, Dupixent must not be used in combination with other monoclonal antibodies (e.g., Xolair, Nucala). For continuation, Dupixent must not be used in combination with other monoclonal antibodies and patient must have documented clinical benefit from therapy (e.g. decrease in exacerbation frequency, improvement in asthma symptoms, or decrease in oral corticosteroid use).
Indications	All Medically-accepted Indications.
Off Label Uses	

EMGALITY

Products Affected

- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with Botox (botulinum toxin) or other CGRP antagonist therapy.
Required Medical Information	Documentation supporting diagnosis, other therapies tried, and outcome. Medication overuse headache has been ruled out.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a neurologist, pain specialist, or other headache specialist.
Coverage Duration	One year
Other Criteria	For migraine prevention: must have an inadequate response, contraindication, or intolerance to two of the following migraine prevention drugs, each from a different class and tried for at least 28 days each: topiramate, divalproex, valproic acid, propranolol, metoprolol, amitriptyline. For migraine prevention: Emgality is limited to two 120mg/mL injections the first month, then one 120mg/mL injection every 30 days thereafter. For episodic cluster headache: must have an inadequate response, contraindication, or intolerance to verapamil, corticosteroids, or lithium. For continuation of all conditions: must provide evidence of significant clinical improvement.
Indications	All FDA-approved Indications.
Off Label Uses	

ENBREL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Enbrel must not be used in combination with other biological drugs.
Required Medical Information	For diagnosis of ankylosing spondylitis, must have presence of active disease for at least 4 weeks, BASDAI score of at least 4.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For a diagnosis of ankylosing spondylitis, must first have presence of disease for at least 4 weeks and a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For a diagnosis of psoriasis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, cyclosporine, acitretin). For a diagnosis of psoriatic arthritis or rheumatoid arthritis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, leflunomide, sulfasalazine). For a diagnosis of hidradenitis suppurativa, must first have a documented trial and failure (defined as an inability to improve symptoms) with systemic or topical antibiotic therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

ENBREL MINI

Products Affected

- ENBREL MINI

PA Criteria	Criteria Details
Exclusion Criteria	Enbrel must not be used in combination with other biological drugs.
Required Medical Information	For diagnosis of ankylosing spondylitis, must have presence of active disease for at least 4 weeks, BASDAI score of at least 4.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For a diagnosis of ankylosing spondylitis, must first have presence of disease for at least 4 weeks and a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For a diagnosis of psoriasis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, cyclosporine, acitretin). For a diagnosis of psoriatic arthritis or rheumatoid arthritis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, leflunomide, sulfasalazine). For a diagnosis of hidradenitis suppurativa, must first have a documented trial and failure (defined as an inability to improve symptoms) with systemic or topical antibiotic therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

ENSPRYNG

Products Affected

- ENSPRYNG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NMOSD, must provide documentation of anti-aquaporin-4 (AQP4) antibody positive status in chart notes or medical records.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	One year - 3 syringes in month one, 1 syringe per month thereafter
Other Criteria	Patient must have had at least one attack requiring rescue therapy in the last year or two attacks requiring rescue therapy in the last 2 years.
Indications	All FDA-approved Indications.
Off Label Uses	

EPCLUSA

Products Affected

- EPCLUSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist.
Coverage Duration	12 weeks
Other Criteria	Criteria will be applied consistent with current AASLD-IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	

EPIDIOLEX

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ERLEADA

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

erlotinib

Products Affected

- *erlotinib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ESBRIET

Products Affected

- ESBRIET ORAL CAPSULE
- *esbriet oral tablet 267 mg*
- ESBRIET ORAL TABLET 801 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have presence of a UIP pattern on HRCT in patients not subjected to surgical lung biopsy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Prescriber must rule out other known causes of interstitial lung disease.
Indications	All Medically-accepted Indications.
Off Label Uses	

EVENITY

Products Affected

- EVENITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient's T-score must be provided
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months total therapy
Other Criteria	For diagnosis of postmenopausal osteoporosis, the following criteria must be met: documented therapeutic trial with failure, contraindication, or intolerance (defined as creatinine clearance less than 35 mL/min, inability to remain upright for 30 minutes after dose, esophageal stricture (known stricture or dysphagia), significant decrease in BMD after at least one year of therapy, or new fracture while on therapy) to alendronate, risedronate, or ibandronate AND documented therapeutic trial with failure, contraindication, or intolerance (defined as significant decrease in BMD after at least one year of therapy, or new fracture while on therapy) to zoledronic acid (generic Reclast) or Prolia.
Indications	All Medically-accepted Indications.
Off Label Uses	

everolimus

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

EVKEEZA

Products Affected

- EVKEEZA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off Label Uses	Pending CMS Review

EVRYSDI

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For spinal muscular atrophy (SMA), documentation of the genetic test confirming the diagnosis must be provided.
Age Restrictions	Patient must be 2 months of age or older.
Prescriber Restrictions	Must be prescribed by a neurologist or in consultation with a neurologist with experience treating SMA.
Coverage Duration	Initial - 12 months, continuation - 12 months
Other Criteria	Patient must not be receiving concurrent Spinraza or have previously received or be planning to receive gene therapy for SMA (Zolgensma). For continuation, must provide documentation showing a clinically significant improvement in SMA symptoms (e.g., progression, stabilization, decreased decline in motor function) compared to the predicted and natural trajectory of the disease.
Indications	All FDA-approved Indications.
Off Label Uses	

FARYDAK

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	48 weeks
Other Criteria	Limited to 6 capsules for every 21-day cycle. Covered for 16 cycles when approved.
Indications	All Medically-accepted Indications.
Off Label Uses	

FASENRA

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For initial approval, Fasenra must be used as an add-on to current maintenance treatment with an ICS/LABA inhaler or, if contraindicated or not tolerated, another maintenance medication for the condition. Must not be used in combination with other monoclonal antibodies (e.g., Xolair, Nucala). For continuation, must not be used in combination with other monoclonal antibodies, and patient must have documented clinical benefit from therapy (e.g., decrease in exacerbation frequency, improvement in asthma symptoms, or decrease in oral corticosteroid use). First year is limited to 1 syringe every 4 weeks for 3 months, then 1 syringe every 8 weeks thereafter. Subsequent years are limited to 1 syringe every 8 weeks.
Indications	All Medically-accepted Indications.
Off Label Uses	

fentanyl citrate transmucosal

Products Affected

- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Patient must be age 16 or over
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must first try two short-acting oral opioids (e.g., oxycodone, morphine sulfate, hydromorphone).
Indications	All FDA-approved Indications.
Off Label Uses	

FINTEPLA

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

Firdapse

Products Affected

- FIRDAPSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have clinical symptoms of LEMS (i.e., proximal extremity weakness) that interfere with daily activities. Must provide a baseline disease severity score using the Quantitative Myasthenia Gravis (QMG) or the Triple-Timed Up-And-Go (3TUG) test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial approval for 4 weeks. Subsequent approvals will be for 12 months.
Other Criteria	For initial approval, patient must have tried and failed pyridostigmine (fail is defined as taking the medication as prescribed and at an appropriate dose for the condition). If the patient has a cancer diagnosis associated with LEMS, the cancer must have been appropriately treated. Patient must not have history of seizures nor have conditions (e.g., no active brain metastases) or be taking medications (e.g., bupropion, clozapine, fluoroquinolones) that increase the risk of seizures. Patient must be ambulatory. For continuation, patient must show improvement or stabilization in condition from baseline using the QMG or 3TUG test and/or other measures per providers attestation.
Indications	All FDA-approved Indications.
Off Label Uses	

FORTEO

Products Affected

- FORTEO SUBCUTANEOUS SOLUTION PEN-INJECTOR 620 MCG/2.48ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient's T-score must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years total therapy
Other Criteria	For diagnosis of postmenopausal osteoporosis, the following criteria must be met: documented therapeutic trial with failure, contraindication, or intolerance to one antiresorptive therapy (defined as creatinine clearance less than 35 mL/min, inability to remain upright for 30 minutes after dose, esophageal stricture [known stricture or dysphagia], significant decrease in BMD after at least one year of therapy, or new fracture while on therapy to alendronate, risedronate, ibandronate OR significant decrease in BMD after at least one year of therapy or new fracture while on therapy to Prolia or zoledronic acid) AND documented therapeutic trial with failure, contraindication, or intolerance (defined as significant decrease in BMD after at least one year of therapy or new fracture while on therapy) to Tymlos. For diagnosis of osteoporosis (primary or hypogonadal, or due to corticosteroids) the following criteria must be met: documented therapeutic trial with failure, contraindication, or intolerance (defined as creatinine clearance less than 35 mL/min, inability to remain upright for 30 minutes after dose, esophageal stricture (known stricture or dysphagia), significant decrease in BMD after at least one year of therapy, or new fracture while on therapy) to alendronate, risedronate, or ibandronate AND documented therapeutic trial with failure, contraindication, or intolerance (defined as significant decrease in BMD after at least one year of therapy, or new fracture while on therapy) to zoledronic acid (generic Reclast) or Prolia.

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off Label Uses	

FOTIVDA

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For advanced renal cell carcinoma, must have clear-cell histology.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

GALAFOLD

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a confirmed diagnosis of Fabry disease and documentation of an amenable galactosidase alpha gene variant based on in vitro assay data.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Patient must not be taking Galafold in combination with enzyme replacement therapy (ERT), such as Fabrazyme.
Indications	All Medically-accepted Indications.
Off Label Uses	

GATTEX

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial approval is 6 months. Susbequent approval for one year.
Other Criteria	Patient must be dependent on parenteral support for 12 months or greater. Continuation requires documentation of clinical benefit from Gattex (e.g., reduction in parenteral support, sustained response after reduction, etc.).
Indications	All Medically-accepted Indications.
Off Label Uses	

GAVRETO

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

GLASSIA

Products Affected

- GLASSIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a predicted FEV1 value between 30 and 65% and have serum AAT level less than 11 micromoles per liter (80 milligrams per deciliter if measured by radial immunodiffusion or 50 milligrams per deciliter if measure by nephelometry)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GROWTH HORMONE

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FOR CHILDREN: must submit an untreated growth velocity curve with a minimum of 1 year of growth data showing a growth velocity of less that 10th % for bone age and gender, growth plates must be open, bone age must be a minimum of 1 year behind chronological age (unless GHD is related to pituitary surgery, radiation therapy, or with precocious puberty), must have a documented GH deficiency via 2 growth hormone stimulation tests below 10ng/ml or GH stimulation test level less than 15 ng/ml + IGF-1 and IGF-PB3 levels below normal for bone age and sex, decreased muscle tone by exam. FOR ADULTS with a diagnosis of GHD: Must have confirmation of GHD by meeting one of the following: (1) A suboptimal response using an appropriate GH-stimulation test, (2) Child-onset GHD with confirmed persistent GHD, or (3) patient has all the following: (a) documented pituitary or hypothalamic disease (e.g., brain tumor with previous brain irradiation), (b)greater than or equal to 3 pituitary hormone deficiencies (thyroid-stimulating hormone (TSH), corticotropin (ACTH), and gonadotropins), and (c) low insulin-like growth factor-1 (IGF-1). If IGF-1 value is indeterminate, a suboptimal response on an appropriate GH-stimulation test required.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by an endocrinologist, gastroenterologist, or nephrologist.
Coverage Duration	One year

PA Criteria	Criteria Details
Other Criteria	FOR CHILDREN: Diagnosis of Growth Hormone Deficiency-height must be less than the 5th% fir age/sex. Diagnosis of Turner's syndrome-height must be less than 10th%. Diagnosis of Pre-transplant chronic renal insufficiency-height must be less than 5th% for age/sex and patient must be receiving weekly dialysis or SCR less than 2 mg/dL. FOR CHILDREN: must not have constitutional growth delay, or acute or chronic catabolic illness. FOR ADULTS, the following conditions are not covered: treatment of reduced growth hormone related to aging, Turner's syndrome or cystinosis. For continuation in adults and children: Above normal IGF-1 level requires provider attestation that dose will be decreased and therapy will be managed to obtain a level within normal range.
Indications	All Medically-accepted Indications.
Off Label Uses	

HEMADY

Products Affected

- HEMADY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	For the duration of the multiple myeloma treatment, up to one year
Other Criteria	Patient must try and fail dexamethasone oral tablet (generic Decadron) for current multiple myeloma treatment. Fail is defined as having an intolerance to an inability to improve the condition.
Indications	All Medically-accepted Indications.
Off Label Uses	

HETLIOZ

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be prescribed by a sleep specialist or a neurologist.
Coverage Duration	One year
Other Criteria	Patient must be totally blind. For continuation: must have documented benefit from use of Hetlioz. Not covered for a diagnosis of Smith-Magenis Syndrome (SMS).
Indications	Some FDA-approved Indications Only.
Off Label Uses	

HUMIRA

Products Affected

- HUMIRA PEDIATRIC CROHNS START SUBCUTANEOUS PREFILLED SYRINGE KIT 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.4ML, 40 MG/0.8ML, 80 MG/0.8ML
- HUMIRA PEN-CD/UC/HS STARTER
- HUMIRA PEN-PEDIATRIC UC START
- HUMIRA PEN-PS/UV/ADOL HS START
- HUMIRA PEN-PSOR/UVEIT STARTER
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	Humira must not be used in combination with other biological drugs.
Required Medical Information	For diagnosis of ankylosing spondylitis, must have presence of active disease for at least 4 weeks, BASDAI score of at least 4.
Age Restrictions	Must be 2 years of age or older
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For a diagnosis of ankylosing spondylitis, must first have presence of disease for at least 4 weeks and a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one nonsteroidal anti-inflammatory drug (NSAID). For a diagnosis of psoriasis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, cyclosporine, acitretin). For a diagnosis of Crohns disease, psoriatic arthritis, rheumatoid arthritis, or ulcerative colitis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. azathioprine, 6-mercaptopurine, methotrexate). For a diagnosis of hidradenitis suppurativa, must first have a documented trial and failure (defined as an inability to improve symptoms) with systemic or topical antibiotic therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

icatibant acetate

Products Affected

- *icatibant acetate*

PA Criteria	Criteria Details
Exclusion Criteria	Patient is on an angiotensin-converting enzyme (ACE) inhibitor
Required Medical Information	For HAE Type I or II, documentation of C4, C1-INH protein, and C1-INH function lab results.
Age Restrictions	Must be age 18 or older
Prescriber Restrictions	Prescriber is an allergist, immunologist, hematologist, or other specialist experienced in treating HAE.
Coverage Duration	Approved for three syringes (9ml) every 15 days
Other Criteria	Patient has attacks either affecting upper airways, involving the face, neck, or abdomen, or resulting in debilitation or dysfunction. Patient has received training for self-administration. Each additional fill requires documentation of the patients use of the previous supply of icatibant acetate, as well as documentation of symptom relief with use.
Indications	All Medically-accepted Indications.
Off Label Uses	

ICLUSIG

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ICOSAPENT ETHYL

Products Affected

- *icosapent ethyl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For severe hypertriglyceridemia, laboratory confirmation of a baseline triglyceride level of at least 500 mg/dL prior to starting icosapent ethyl. For reducing the risk of myocardial infarction (MI), stroke, coronary revascularization, and unstable angina requiring hospitalization, laboratory confirmation of a baseline triglyceride level of at least 150mg/dL prior to starting icosapent ethyl.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For cardiovascular risk reduction, must have either established cardiovascular disease (e.g., coronary artery disease, heart attack, stroke) OR diabetes mellitus with 2 or more additional risk factors for cardiovascular disease (e.g., smoking, hypertension, elevated CRP) - and - must be used with maximally tolerated statin therapy. Statin trials are not required for patients who have tried, but are unable to tolerate a statin at any dose and have provider attestation certifying statin intolerance. For hypertriglyceridemia: must have tried omega-3-acid ethyl esters for at least 12 weeks with an inability to lower triglycerides below 150mg/dL.
Indications	All Medically-accepted Indications.
Off Label Uses	

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of IDH2 (isocitrate dehydrogenase-2) mutation must be submitted.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

imatinib mesylate

Products Affected

- *imatinib mesylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorized for one year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

IMBRUVICA

Products Affected

- IMBRUVICA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For GVHD, must fail one systemic corticosteroid and one immunosuppressant (tacrolimus, cyclosporine). Failure is defined as disease progression, inability to taper steroid dose, or failure to improve after one month of therapy and/or treatment-related toxicity. For GVHD, continuation requires no disease progression of chronic GVHD, recurrence of malignancy, or unacceptable toxicity.
Indications	All Medically-accepted Indications.
Off Label Uses	

IMIPRAMINE

Products Affected

- *imipramine hcl oral*
- *imipramine pamoate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IMPAVIDO

Products Affected

- *impavido*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Four weeks
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

INGREZZA

Products Affected

- INGREZZA

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with tetrabenazine or Austedo.
Required Medical Information	Baseline documentation of Abnormal Involuntary Movement Scale (AIMS) score must be provided.
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	
Coverage Duration	Initial approval is 6 months, continuation for one year.
Other Criteria	For diagnosis of tardive dyskinesia (TD), must have moderate or severe TD, indicated by minimum AIMS score of 3 on item 8 (severity of abnormal movements). For continuation, documentation of improvement compared to baseline AIMS score.
Indications	All Medically-accepted Indications.
Off Label Uses	

INLYTA

Products Affected

- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

INQOVI

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

INREBIC

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Baseline platelet count of 50 X 109 cells/L or greater
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial approval 6 months with continuation approval for 12 months
Other Criteria	Patient must be resistant, intolerant, or have a contraindication to Jakafi. Patient must not currently have thiamine deficiency. For continuation, patient must have experienced a 35% reduction in spleen volume (approximately a 50% reduction in spleen size on palpation).
Indications	All FDA-approved Indications.
Off Label Uses	

IRESSA

Products Affected

- IRESSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ISTURISA

Products Affected

- ISTURISA ORAL TABLET 1 MG, 10 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have failed pituitary surgery or have a contraindication to pituitary surgery.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	Must be prescribed by an endocrinologist
Coverage Duration	One year
Other Criteria	Patient must have tried and failed two of the following: ketoconzaole, Lysodren, cabergoline, and/or Signifor/LAR.
Indications	All FDA-approved Indications.
Off Label Uses	

IVIG

Products Affected

- BIVIGAM INTRAVENOUS SOLUTION 5 GM/50ML
- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA
- GAMUNEX-C INJECTION SOLUTION 1 GM/10ML
- PANZYGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For myeofibrosis and polycythemia vera: Complete blood count (CBC) prior to initiating therapy (platelet count greater than 50 x 10(9)/L)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Myelofibrosis/PV: 12 months, GVHD: 6 months
Other Criteria	For all conditions, physician must follow dosing recommendations per FDA-approved labeling. For GVHD, must have disease progression after at least 3-5 days steroid treatment or no response after 7 days therapy - and - must have a trial, or medical contraindication to therapy with mycophenolate mofetil or have tried one other therapy. After 6 months of treatment in responders who have discontinued therapeutic doses of corticosteroids, taper Jakafi dose unless medically contraindicated. For continuation of all conditions, must have had improvement in condition with use of Jakafi.
Indications	All Medically-accepted Indications.
Off Label Uses	

KALYDECO

Products Affected

- KALYDECO ORAL PACKET
- KALYDECO ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have laboratory confirmation of ivacaftor-responsive mutation in the CFTR gene.
Age Restrictions	Patient must be age 4 months or older.
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

KERENDIA

Products Affected

- KERENDIA

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS review.
Required Medical Information	Pending CMS review.
Age Restrictions	Pending CMS review.
Prescriber Restrictions	Pending CMS review.
Coverage Duration	Pending CMS review.
Other Criteria	Pending CMS review.
Indications	Pending CMS review.
Off Label Uses	Pending CMS review.

KEVEYIS

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

KISQALI

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

KISQALI FEMARA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

KOSELUGO

Products Affected

- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

lapatinib

Products Affected

- *lapatinib ditosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ledipasvir-sofosbuvir

Products Affected

- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Must first try Epclusa. Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	

LENVIMA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

LIDOCAINE PATCH

Products Affected

- *lidocaine external patch 5 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

LORBRENA

Products Affected

- LORBRENA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of ALK-positive mutation must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

LUMAKRAS

Products Affected

- LUMAKRAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

LUPKYNIS

Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with a biologic drug for the condition (e.g., Benlysta, rituximab) is not covered.
Required Medical Information	Confirmed diagnosis of SLE - AND - a kidney biopsy confirming class 3, 4, and/or 5 disease.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a nephrologist or rheumatologist.
Coverage Duration	12 months initial and continuation.
Other Criteria	For initial requests, tried and failed (defined as an inability to improve kidney function) Benlysta and a generic calcineurin inhibitor (e.g., tacrolimus or cyclosporine) - AND -be receiving standard therapy for LN (e.g., mycophenolate or azathioprine plus a corticosteroid). For continuation of previously approved requests, must have laboratory evidence of response to Lupkynis defined as a urinary protein creatinine ratio less than 0.5 mg/mg and improved or stable eGFR.
Indications	All FDA-approved Indications.
Off Label Uses	

LYNPARZA

Products Affected

- LYNPARZA ORAL TABLET 100 MG, 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

MATULANE

Products Affected

- MATULANE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

MAVENCLAD

Products Affected

- MAVENCLAD (10 TABS)
- MAVENCLAD (4 TABS)
- MAVENCLAD (5 TABS)
- MAVENCLAD (6 TABS)
- MAVENCLAD (7 TABS)
- MAVENCLAD (8 TABS)
- MAVENCLAD (9 TABS)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years total therapy
Other Criteria	Patient must first try glatiramer. Patient must not have concurrent use with other MS disease modifying drugs. Patient must not have clinically isolated syndrome (CIS).
Indications	All Medically-accepted Indications.
Off Label Uses	

MAVYRET

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have chronic hepatitis C infection. Must be age 12 or older or weigh 45kg or more.
Age Restrictions	Must be age 12 or older.
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist.
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Must first try Epclusa. Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	

MEKINIST

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

MEKTOVI

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have documentation of BRAF V600 mutation status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

METHYLTESTOSTERONE

Products Affected

- *methyltestosterone oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

MYALEPT

Products Affected

- MYALEPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Laboratory confirmed leptin deficiency. Must have one of the following: triglyceride level more than 200mg/dL or diabetes mellitus.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must not have HIV, infectious liver disease, or acquired lipodystrophy with hematologic abnormalities
Indications	All Medically-accepted Indications.
Off Label Uses	

NATPARA

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have two consecutive calcium levels less than 8.9
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

NERLYNX

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months total therapy
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

NEXAVAR

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

NEXLETOL

Products Affected

- NEXLETOL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must submit most recent LDL cholesterol (LDL-C) laboratory report. For HeFH, must confirm diagnosis by genetic testing, WHO Dutch Lipid Network or Simon-Broome criteria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must first try ezetimibe and one high intensity statin medication (e.g., atorvastatin 40 mg daily or higher dose and rosuvastatin 20 mg daily or higher) or, if a high-intensity statin is not tolerated, one statin at the maximally tolerated dose and be unable to reach LDL-C goal. Statin trial is not required for patients who have tried, but are unable to tolerate a statin at any dose and have provider attestation certifying statin intolerance. Must not be used in combination with PCSK9s.
Indications	All FDA-approved Indications.
Off Label Uses	

NEXLIZET

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must submit most recent LDL cholesterol (LDL-C) laboratory report. For HeFH, must confirm diagnosis by genetic testing, WHO Dutch Lipid Network or Simon-Broome criteria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must first try ezetimibe and one high intensity statin medication (e.g., atorvastatin 40 mg daily or higher dose and rosuvastatin 20 mg daily or higher) or, if a high-intensity statin is not tolerated, one statin at the maximally tolerated dose and be unable to reach LDL-C goal. Statin trial is not required for patients who have tried, but are unable to tolerate a statin at any dose and have provider attestation certifying statin intolerance. Must not be used in combination with PCSK9s.
Indications	All FDA-approved Indications.
Off Label Uses	

NIVESTYM

Products Affected

- NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

NUBEQA

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

NUCALA

Products Affected

- NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For severe eosinophilic asthma, peripheral blood eosinophil count must be provided. For Hypereosinophilic Syndrome (HES), must have blood eosinophil count at least 1,000 cells/mcL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial approval for 12 months, continuation for 12 months
Other Criteria	For initial approval for severe eosinophilic asthma, Nucala must be used as add-on to current maintenance treatment with an ICS/LABA inhaler or, if contraindicated or not tolerated, another maintenance medication for the condition. For a diagnosis of severe eosinophilic asthma, Nucala is limited to one syringe every 28 days. For a diagnosis of eosinophilic granulomatosis with polyangiitis, must have first tried one systemic non-biologic disease modifying drug (e.g., azathioprine, cyclophosphamide). For a diagnosis of eosinophilic granulomatosis with polyangiitis up to three syringes every 28 days will be authorized. Nucala must not be used in combination with other monoclonal antibodies (e.g., Xolair, Fasenra). For continuation, all initial requirements must be met and patient must have documented clinical benefit from therapy. For initial approval for Hypereosinophilic Syndrome (HES), must have been diagnosed with HES for at least 6 months with at least 2 flares in the past year (e.g., signs or symptoms or increased eosinophils requiring an increase in steroid dose or addition of another therapy) and must have tried and failed one generic, steroid-sparing therapy (e.g., methotrexate, hydroxyurea). For continuation, must have clinical improvement in condition on Nucala (e.g., reduction in flares, reduced steroid dosing, etc.) compared to previous steroid-sparing therapy.
Indications	All Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be prescribed by a neurologist
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NULIBRY

Products Affected

- NULIBRY

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off Label Uses	Pending CMS Review

NUPLAZID

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OCALIVA

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have one of the following: alkaline phosphatase level greater than or equal to 1.67 times the upper limit of normal, or total bilirubin greater than or equal to 1 times the upper limit of normal but less than 2 times the upper limit of normal.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must have received 12 months of ursodiol therapy and have had an inadequate response or be intolerant to ursodiol.
Indications	All Medically-accepted Indications.
Off Label Uses	

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For idiopathic pulmonary fibrosis (IPF), must have presence of a UIP pattern on HRCT in patients not subjected to surgical lung biopsy. For systemic sclerosis related Interstitial Lung Disease (SSc-ILD), diagnosis must be confirmed by HRCT.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For IPF, provider must rule out other known causes of interstitial lung disease. For SSc-ILD, fibrotic disease in the lung must be at least 10%, Forced Vital Capacity (FVC) must be at least 40% of predicted normal - and - SSc disease onset (defined by first non-Raynaud symptom) must be within the 7 past years. Must have disease progression (e.g., greater than or equal to 10 percent decline in FVC or DLCO) on trials of mycophenolate mofetil and cyclophosphamide at maximally tolerated doses, or have medical contraindication to treatment. Provider must attest that the patient is being adequately treated for any complications of SSc (e.g.,pulmonary hypertension) and comorbid disease (e.g., chronic obstructive pulmonary disease - COPD). For chronic fibrosing ILDs, must have a progressive phenotype.
Indications	All Medically-accepted Indications.
Off Label Uses	

ONUREG

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For diagnosis of pulmonary aterial hypertension, must be in World Health Organization Group category 1.
Indications	All Medically-accepted Indications.
Off Label Uses	

ORENCIA

Products Affected

- ORENCIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Orencia must not be used in combination with other biological products.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For a diagnosis of psoriatic arthritis or rheumatoid arthritis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, leflunomide, hydroxychloroquine, sulfasalazine).
Indications	All Medically-accepted Indications.
Off Label Uses	

ORENCIA CLICKJECT

Products Affected

- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Exclusion Criteria	Orencia Clickject must not be used in combination with other biological drugs.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For a diagnosis of psoriatic arthritis or rheumatoid arthritis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, leflunomide, hydroxychloroquine, sulfasalazine).
Indications	All Medically-accepted Indications.
Off Label Uses	

ORENITRAM

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must first try generic Revatio (sildenafil).
Indications	All Medically-accepted Indications.
Off Label Uses	

ORGOVYX

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	When approved, a loading dose of 360 mg (32 tablets) is authorized the first month of treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	

ORKAMBI

Products Affected

- ORKAMBI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have laboratory confirmation of homozygous F508del mutation in the cystic fibrosis transmembrane regulator (CFTR) gene
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ORLADEYO

Products Affected

- ORLADEYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must submit documentation of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis.
Age Restrictions	Must be age 12 or older.
Prescriber Restrictions	Prescriber must be an allergist, immunologist, hematologist, or other specialist experienced in treating HAE.
Coverage Duration	Initial approval: 6 months. Continuation approval: 12 months.
Other Criteria	Patient must have attacks either affecting upper airways, involving the face, neck, or abdomen, or resulting in debilitation or dysfunction. Patient must not be on an angiotensin-converting enzyme (ACE) inhibitor. Orladeyo must not be used in combination with other prophylactic therapies for HAE (e.g., Takhzyro). For continuation, must provide documentation showing a decrease in the frequency of acute attacks while on Orladeyo.
Indications	All FDA-approved Indications.
Off Label Uses	

OTEZLA

Products Affected

- OTEZLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For a diagnosis of psoriasis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, cyclosporine, acitretin). For psoriatic arthritis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, leflunomide, sulfasalazine). For oral ulcers associated with Behcet's disease, must have tried one other systemic therapy (e.g., colchicine, thalidomide, interferon alpha, tumor necrosis factor inhibitors).
Indications	All Medically-accepted Indications.
Off Label Uses	

OXERVATE

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation confirming diagnosis must be submitted.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	8 weeks total treatment
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

PANRETIN

Products Affected

- PANRETIN

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS Review
Required Medical Information	Pending CMS Review
Age Restrictions	Pending CMS Review
Prescriber Restrictions	Pending CMS Review
Coverage Duration	Pending CMS Review
Other Criteria	Pending CMS Review
Indications	Pending CMS Review
Off Label Uses	Pending CMS Review

PEMAZYRE

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year - dose and frequency must align with FDA label
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

penicillamine

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For cystinuria, documentation that treatment with conservative measures (e.g. high fluid intake, sodium and protein restriction, urinary alkalization) were ineffective, not tolerated, or contraindicated. Quantity limited to dosage as supported by the FDA-approved label.
Indications	All FDA-approved Indications.
Off Label Uses	

pentamidine

Products Affected

- *pentamidine isethionate inhalation*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CD4 lymphocyte count. For patients 30 days to 1 year of age, was the patient born to a mother known to be HIV-infected? Is HIV seropostive or infected? For patients 2 years of age ond older, has the patient experienced at least one episode of PCP?
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must have therapeutic trial of Co-trimoxazole (trimethoprim/sulfamethoxazole).
Indications	All Medically-accepted Indications.
Off Label Uses	

PERSERIS

Products Affected

- PERSERIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must be stable on or be able to tolerate an oral risperidone dose of 3 to 4 mg/day. For Perseris 120 mg, the patient must try and fail Rispderal Consta (fail means the drug was tried at an equivalent dose to currently requested Perseris, but the condition did not improve or patient had an intolerance).
Indications	All Medically-accepted Indications.
Off Label Uses	

PHENOBARBITAL

Products Affected

- *phenobarbital oral elixir*
- *phenobarbital oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

PIQRAY

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated, advanced or metastatic breast cancer, documentation of evidence confirming mutations must be submitted.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

PRETOMANID

Products Affected

- PRETOMANID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	26 weeks
Other Criteria	Must be used in combination with linezolid and Sirturo.
Indications	All FDA-approved Indications.
Off Label Uses	

PREVYMIS

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	100 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

PROLASTIN-C

Products Affected

- PROLASTIN-C INTRAVENOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a predicted FEV1 value between 30 and 65% and have serum AAT level less than 11 micromoles per liter (80 milligrams per deciliter if measured by radial immunodiffusion or 50 milligrams per deciliter if measure by nephelometry).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PROLIA

Products Affected

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For diagnosis of post-menopausal osteoporosis and for males with diagnosis of osteoporosis, must have a therapeutic trial with one oral bisphosphonate (e.g., alendronate, risedronate, ibandronate) and zoledronic acid. For diagnosis of prophylaxis of post-menopausal osteoporosis, must have a therapeutic trial with one oral bisphosphonate (e.g., alendronate, risedronate, ibandronate) and zoledronic acid. Applies only to beneficiaries enrolled in an MA-PD plan.
Indications	All Medically-accepted Indications.
Off Label Uses	

PROMACTA

Products Affected

- PROMACTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Current platelet count
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For chronic ITP, must first try IVIG or immunoglobulin. For thrombocytopenia from hepatitis C infection, must also use interferon-based therapy. For aplastic anemia, must be used with standard immunosuppressive therapy (antithymocyte globulin and cyclosporine) for first-line treatment or must have had an insufficient response to cyclosporine or cyclosporine modified for second-line or subsequent treatment.
Indications	All Medically-accepted Indications.
Off Label Uses	

QELBREE

Products Affected

- QELBREE ORAL CAPSULE EXTENDED RELEASE 24 HOUR 100 MG, 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must first try both atomoxetine and clonidine ER.
Indications	All FDA-approved Indications.
Off Label Uses	

QINLOCK

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

RAVICTI

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

RAYALDEE

Products Affected

- RAYALDEE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Serum total 25-hydroxyvitamin D level must be less than 30 ng/mL (must be submitted to Priority Health).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must have chronic kidney disease (CKD) stage 3 or 4.
Indications	All Medically-accepted Indications.
Off Label Uses	

RELISTOR

Products Affected

- RELISTOR ORAL
- RELISTOR SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not have mechanical gastrointestinal obstruction.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 months
Other Criteria	Must try and fail (defined as an inadequate response or intolerance) to lactulose and polyethylene glycol (Miralax).
Indications	All Medically-accepted Indications.
Off Label Uses	

REPATHA

Products Affected

- REPATHA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must submit most recent LDL cholesterol (LDL-C) laboratory report. For HeFH or HoFH, must confirm diagnosis by genetic testing, WHO Dutch Lipid Network or Simon-Broome criteria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must first try one high intensity statin medication (e.g., daily atorvastatin 40 mg or higher or rosuvastatin 20 mg or higher) or, if a high-intensity statin is not tolerated, at least two statins at the maximally tolerated dose and be unable to reach LDL-C goal (e.g., less than 70 mg/dL for very high risk disease). Statins trials are not required for patients who have tried, but are unable to tolerate a statin at any dose and have provider attestation certifying statin intolerance. Must not be used in combination with Nexletol or Nexlizet.
Indications	All Medically-accepted Indications.
Off Label Uses	

REPATHA PUSHTRONEX SYSTEM

Products Affected

- REPATHA PUSHTRONEX SYSTEM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must submit most recent LDL cholesterol (LDL-C) laboratory report. For HeFH or HoFH, must confirm diagnosis by genetic testing, WHO Dutch Lipid Network or Simon-Broome criteria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must first try one high intensity statin medication (e.g., daily atorvastatin 40 mg or higher or rosuvastatin 20 mg or higher) or, if a high-intensity statin is not tolerated, at least two statins at the maximally tolerated dose and be unable to reach LDL-C goal (e.g., less than 70 mg/dL for very high risk disease). Statins trials are not required for patients who have tried, but are unable to tolerate a statin at any dose and have provider attestation certifying statin intolerance. Must not be used in combination with Nexletol or Nexlizet.
Indications	All Medically-accepted Indications.
Off Label Uses	

REPATHA SURECLICK

Products Affected

- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must submit most recent LDL cholesterol (LDL-C) laboratory report. For HeFH or HoFH, must confirm diagnosis by genetic testing, WHO Dutch Lipid Network or Simon-Broome criteria.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must first try one high intensity statin medication (e.g., daily atorvastatin 40 mg or higher or rosuvastatin 20 mg or higher) or, if a high-intensity statin is not tolerated, at least two statins at the maximally tolerated dose and be unable to reach LDL-C goal (e.g., less than 70 mg/dL for very high risk disease). Statins trials are not required for patients who have tried, but are unable to tolerate a statin at any dose and have provider attestation certifying statin intolerance. Must not be used in combination with Nexletol or Nexlizet.
Indications	All Medically-accepted Indications.
Off Label Uses	

RETEVMO

Products Affected

- RETEVMO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

REVLIMID

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

REYVOW

Products Affected

- REYVOW ORAL TABLET 100 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Unless contraindicated per the FDA label, trial and failure (defined as intolerance or an inability to improve symptoms) with two different triptan medications. Reyvow will not be covered for migraine prevention. Quantities to treat more than 4 migraines per month are not covered.
Indications	All FDA-approved Indications.
Off Label Uses	

RINVOQ

Products Affected

- RINVOQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must have tried and failed one oral DMARD (e.g. methotrexate) or one injectable DMARD (e.g. Humira).
Indications	All Medically-accepted Indications.
Off Label Uses	

ROZLYTREK

Products Affected

- ROZLYTREK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of NTRK gene fusion must be submitted for NTRK gene fusion positive solid tumors. Documentation of ROS 1 mutation testing must be submitted for ROS1 positive non-small cell lung cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

RUFINAMIDE

Products Affected

- *rufinamide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RUZURGI

Products Affected

- RUZURGI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have clinical symptoms of LEMS(i.e., proximal lower extremity weakness) that interfere with daily activities. If the patient has a cancer diagnosis associated with LEMS, the cancer must have been appropriately treated. Must provide a baseline disease severity score using the Triple-Timed Up-And-Go (3TUG) test.
Age Restrictions	Patient must be between the ages of 6 and 16 years.
Prescriber Restrictions	
Coverage Duration	Initial approval for 3 months. Subsequent approvals for 12 months.
Other Criteria	Patient must not have history of seizures nor have conditions (e.g., no active brain metastases) or be taking medications (e.g., bupropion, clozapine, fluoroquinolones) that increase the risk of seizures. Patient must be ambulatory. For continuation, patient must show improvement or stabilization in condition from baseline using the 3TUG test and/or other measures per provider's attestation.
Indications	All FDA-approved Indications.
Off Label Uses	

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of acute myeloid leukemia (AML), patient must have FLT3 mutation-positive disease as detected by an FDA-approved test.
Age Restrictions	Must be age 18 or older
Prescriber Restrictions	
Coverage Duration	One year. For AML, limited to 6 cycles.
Other Criteria	For diagnosis of AML, patient must be using Rydapt in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation chemotherapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

SAMSCA

Products Affected

- SAMSCA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	Treatment must be initiated in an inpatient setting.
Indications	All Medically-accepted Indications.
Off Label Uses	

SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS SOLUTION RECONSTITUTED 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must be too ill for pituitary surgery or patient must have had surgery that failed to completely removed the tumor. Patient must have a documented trial with ketoconazole to reduce cortisol secretion.
Indications	All Medically-accepted Indications.
Off Label Uses	

SIKLOS

Products Affected

- SIKLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SILDENAFIL CITRATE

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For pulmonary arterial hypertension (PAH), patient must have a PAH classification that meets World Health Organization (WHO) Group 1 criteria.
Indications	All Medically-accepted Indications.
Off Label Uses	

SIVEXTRO

Products Affected

- SIVEXTRO ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Culture and sensitivity results showing the patient's infection is not susceptible to alternative antibiotic treatments.
Age Restrictions	
Prescriber Restrictions	Prescriber must be an infectious disease specialist or have consulted with an infectious disease specialist.
Coverage Duration	6 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

SKYRIZI

Products Affected

- SKYRIZI
- SKYRIZI (150 MG DOSE)
- SKYRIZI PEN

PA Criteria	Criteria Details
Exclusion Criteria	Skyrizi must not be used in combination with other biological drugs.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For diagnosis of psoriasis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, cyclosporine, acitretin). When authorized, up to 150mg (two 75mg syringes) will be covered at weeks 0 and 4, followed by 150mg (two 75mg syringes) every 12 weeks for maintenance dosing.
Indications	All Medically-accepted Indications.
Off Label Uses	

SPRYCEL

Products Affected

- SPRYCEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

STELARA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Stelara must not be used in combination with other biological drugs.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For all medically accepted indications, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to two of the following: Humira, Rinvoq, Skyrizi, Actemra, Cosentyx, Otezla, Xeljanz, Xeljanz XR, Orencia or Enbrel.
Indications	All Medically-accepted Indications.
Off Label Uses	

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

SUNITINIB MALATE

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For diagnosis of gastrointestinal stromal tumor, patient must have a trial with imatinib (Gleevec).
Indications	All Medically-accepted Indications.
Off Label Uses	

SYLATRON

Products Affected

- SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG, 600 MCG

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not have autoimmune hepatitis, hepatic decompensation, or sever neuropsychiatric disorders.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Sylatron administration must begin within 84 days after cutaneous lesion is removed with documentation of adequate surgical margins and complete regional lymphadenectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	

SYMDEKO

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have laboratory confirmation of homozygous F508del mutation or have at least one tezacaftor/ivacaftor-responsive mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	Must be age 6 or older.
Prescriber Restrictions	
Coverage Duration	One year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Must be age 2 years or older.
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must first try and fail generic clobazam.
Indications	All FDA-approved Indications.
Off Label Uses	

SYNRIBO

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Authorized for one year.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TABRECTA

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tadalafil 2.5mg and 5mg (Cialis)

Products Affected

- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must have tried and failed either 6 months of finasteride or 3 months of dutasteride and must have tried and failed 28 days of alfuzosin, doxazosin, tamsulosin, or terazosin.
Indications	All Medically-accepted Indications.
Off Label Uses	

tadalafil 20mg (Adcirca)

Products Affected

- *tadalafil (pah)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For pulmonary arterial hypertension (PAH), patient must have a PAH classification that meets World Health Organization (WHO) Group 1 criteria.
Indications	All FDA-approved Indications.
Off Label Uses	

TAFINLAR

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have laboratory confirmation of epidermal growth factor receptor T790M mutation, or exon 19 deletion or exon 21 (L858R) substitution mutations
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TAKHZYRO

Products Affected

- TAKHZYRO

PA Criteria	Criteria Details
Exclusion Criteria	Patient is on an angiotensin-converting enzyme (ACE) inhibitor.
Required Medical Information	Patient has attacks either affecting upper airways, involving the face, neck, or abdomen, or resulting in debilitation or dysfunction. Requires submission of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis.
Age Restrictions	Must be age 12 or older.
Prescriber Restrictions	Prescriber is an allergist, immunologist, hematologist, or other specialist experienced in treating HAE.
Coverage Duration	Limited to 300mg (one vial) every 2 weeks. Duration of each authorization is limited to 6 months.
Other Criteria	Documentation that on-demand/acute therapy (e.g. Firazyr, Berinert, Kalibtor) did not provide adequate symptom control.
Indications	All FDA-approved Indications.
Off Label Uses	

TALZENNA

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TARGRETIN

Products Affected

- TARGRETIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must first try tazarotene.
Indications	All Medically-accepted Indications.
Off Label Uses	

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TAZVERIK

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TEGSEDI

Products Affected

- TEGSEDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For hereditary transthyretin-mediated (hATTR) amyloidosis with polyneuropathy, diagnosis confirmed by the following: documented transthyretin (TTR) mutation (e.g., V30M) by genetic testing AND documented amyloid deposits in biopsy tissue. Must provide documentation of one of the following: Baseline polyneuropathy disability (PND) score less than or equal to IIIb or baseline FAP Stage 1 or 2. Patient must have a platelet count of greater than or equal to 100 x 109/L. Patient must have a urine protein to creatinine ratio (UPCR) less than 1,000 mg/g.
Age Restrictions	Must be age 18 or older
Prescriber Restrictions	
Coverage Duration	12 months on initial and continuation requests
Other Criteria	Patient must present with clinical signs and symptoms of the condition (e.g., motor disability, peripheral/autonomic neuropathy, etc.). Patient must not be receiving Tegsedi in combination with tafamidis (Vyndaqel, Vyndamax) or Onpattro. For continuation, patient must show clinical benefit from Tegsedi (e.g., improved neuropathy symptoms, slowing of disease progression).
Indications	All Medically-accepted Indications.
Off Label Uses	

TEPMETKO

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, must provide documentation of a MET exon 14 skipping alteration.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TERIPARATIDE

Products Affected

- TERIPARATIDE (RECOMBINANT)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patients T-score must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years total therapy
Other Criteria	For diagnosis of postmenopausal osteoporosis, the following criteria must be met: documented therapeutic trial with failure, contraindication, or intolerance to one antiresorptive therapy (defined as creatinine clearance less than 35 mL/min, inability to remain upright for 30 minutes after dose, esophageal stricture [known stricture or dysphagia], significant decrease in BMD after at least one year of therapy, or new fracture while on therapy to alendronate, risedronate, ibandronate OR significant decrease in BMD after at least one year of therapy or new fracture while on therapy to Prolia or zoledronic acid). For diagnosis of osteoporosis (primary or hypogonadal, or due to corticosteroids) the following criteria must be met: documented therapeutic trial with failure, contraindication, or intolerance (defined as creatinine clearance less than 35 mL/min, inability to remain upright for 30 minutes after dose, esophageal stricture (known stricture or dysphagia), significant decrease in BMD after at least one year of therapy, or new fracture while on therapy) to alendronate, risedronate, or ibandronate AND documented therapeutic trial with failure, contraindication, or intolerance (defined as significant decrease in BMD after at least one year of therapy, or new fracture while on therapy) to zoledronic acid (generic Reclast) or Prolia.
Indications	All Medically-accepted Indications.
Off Label Uses	

testosterone gel

Products Affected

- *testosterone transdermal gel 10 mg/act (2%), 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%)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Subnormal serum total testosterone concentration must be less than 300 ng/dL, on more than one occasion in the past year.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must be male. Patient must have clinical symptoms and signs consistent with androgen deficiency. Men over age 50 years (or over 40 years who have a family history or are African-American) must be screened for prostate cancer before starting therapy and routinely while on therapy. Patient must have a documented trial and failure (defined as an intolerance or an inability to improve symptoms or testosterone levels after 2 months of therapy) to a generic injectable testosterone product. Trial with injectable testosterone applies only to members who are enrolled in a MAPD plan.
Indications	All Medically-accepted Indications.
Off Label Uses	

testosterone solution

Products Affected

- *testosterone transdermal solution*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Subnormal serum total testosterone concentration must be less than 300 ng/dL, on more than one occasion in the past year.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must be male. Patient must have clinical symptoms and signs consistent with androgen deficiency. Men over age 50 years (or over 40 years who have a family history or are African-American) must be screened for prostate cancer before starting therapy and routinely while on therapy. Patient must have a documented trial and failure (defined as an intolerance or an inability to improve symptoms or testosterone levels after 2 months of therapy) to a generic injectable testosterone product. Trial with injectable testosterone applies only to members who are enrolled in a MAPD plan.
Indications	All Medically-accepted Indications.
Off Label Uses	

tetrabenazine

Products Affected

- *tetrabenazine oral tablet 12.5 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with Austedo.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year.
Other Criteria	CYP2D6 genotype must be provided for doses greater than 50mg/day.
Indications	All FDA-approved Indications.
Off Label Uses	

THALOMID

Products Affected

- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TIBSOVO

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have documentation of IDH1 mutation status
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

tolvaptan

Products Affected

- *tolvaptan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	30 days
Other Criteria	Treatment must be initiated in an inpatient setting.
Indications	All Medically-accepted Indications.
Off Label Uses	

TRETINOIN CAPSULES

Products Affected

- *tretinoin oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TRIKAFTA

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For diagnosis of cystic fibrosis, must provide documentation of a F508del mutation or at least one mutation responsive to Trikafta.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

trimipramine

Products Affected

- *trimipramine maleate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TRUSELTIQ

Products Affected

- TRUSELTIQ (100MG DAILY DOSE)
- TRUSELTIQ (125MG DAILY DOSE)
- TRUSELTIQ (50MG DAILY DOSE)
- TRUSELTIQ (75MG DAILY DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS review
Required Medical Information	Pending CMS review
Age Restrictions	Pending CMS review
Prescriber Restrictions	Pending CMS review
Coverage Duration	Pending CMS review
Other Criteria	Pending CMS review
Indications	Pending CMS review
Off Label Uses	Pending CMS review

TUKYSA

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TURALIO

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must provide medical records supporting the patient's diagnosis and confirming functional limitation and not amenable to surgery
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient's T-score must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years total therapy (inclusive of all parathyroid hormone analogs)
Other Criteria	For diagnosis of postmenopausal osteoporosis, the following criteria must be met: documented therapeutic trial with failure, contraindication, or intolerance (defined as creatinine clearance less than 35 mL/min, inability to remain upright for 30 minutes after dose, esophageal stricture (known stricture or dysphagia), significant decrease in BMD after at least one year of therapy, or new fracture while on therapy) to alendronate, risedronate, or ibandronate AND documented therapeutic trial with failure, contraindication, or intolerance (defined as significant decrease in BMD after at least one year of therapy, or new fracture while on therapy) to zoledronic acid (generic Reclast) or Prolia.
Indications	All Medically-accepted Indications.
Off Label Uses	

UBRELVY

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Unless contraindicated per the FDA label, trial and failure (defined as intolerance or an inability to improve symptoms) with two different triptan medications. Ubrelvy will not be covered for migraine prevention. Quantities to treat more than 8 migraines per month are not covered.
Indications	All FDA-approved Indications.
Off Label Uses	

UKONIQ

Products Affected

- UKONIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

UPTRAVI

Products Affected

- UPTRAVI INTRAVENOUS
- UPTRAVI ORAL TABLET
- UPTRAVI ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have World Health Organization (WHO) group 1 classification of pulmonary arterial hypertension.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must have tried one of the following: topical corticosteroids, topical chemotherapy such as BiCNU an mechlorethamine), topical retinoids, or topical imiquimod.
Indications	All Medically-accepted Indications.
Off Label Uses	

VASCEPA

Products Affected

- VASCEPA ORAL CAPSULE 0.5 GM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For severe hypertriglyceridemia, laboratory confirmation of a baseline triglyceride level of at least 500 mg/dL prior to starting Vascepa. For reducing the risk of myocardial infarction (MI), stroke, coronary revascularization, and unstable angina requiring hospitalization, laboratory confirmation of a baseline triglyceride level of at least 150mg/dL prior to starting Vascepa.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For cardiovascular risk reduction, must have either established cardiovascular disease (e.g., coronary artery disease, heart attack, stroke) OR diabetes mellitus with 2 or more additional risk factors for cardiovascular disease (e.g., smoking, hypertension, elevated CRP) - and - must be used with maximally tolerated statin therapy. Statin trials are not required for patients who have tried, but are unable to tolerate a statin at any dose and have provider attestation certifying statin intolerance. For hypertriglyceridemia: must have tried omega-3-acid ethyl esters for at least 12 weeks with an inability to lower triglycerides below 150mg/dL.
Indications	All Medically-accepted Indications.
Off Label Uses	

VENCLEXTA

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

VERQUVO

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Ejection fraction less than 45% within the past 12 months.
Age Restrictions	Must be at least 18 years old.
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist.
Coverage Duration	One year
Other Criteria	Must have chronic NYHA class 2 - 4 heart failure - AND - have been hospitalized for heart failure in the past 6 months or treated with outpatient IV diuretic therapy for heart failure in the past 3 months - AND - tried and failed (defined as an intolerance or inability to improve symptoms) maximally tolerated doses of the following medications in combination: (a) an ACEI, ARB or Entresto, (b) bisoprolol, carvedilol or metoprolol ER, and (c) spironolactone or other diuretic.
Indications	All FDA-approved Indications.
Off Label Uses	

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

VITRAKVI

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of NTRK gene fusion must be submitted.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

VIZIMPRO

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of laboratory report confirming EGFR exon 19 deletion or exon 21 L858R mutation must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

VOTRIENT

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

VYNDAMAX

Products Affected

- VYNDAMAX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of transthyretin amyloid cardiomyopathy (ATTR-CM) must be confirmed by tissue biopsy, genetic testing, or radionuclide imaging (99mTc-PYP, 99mTc-DPD, or 99mTc-HMDP scan) (documentation must be provided). Diagnosis by radionuclide imaging requires all of the following to be met (documentation must be provided): Grade 2 or 3 cardiac uptake on radionuclide imaging, echocardiogram (ECHO) or cardiac magnetic resonance (CMR) imaging demonstrating cardiac involvement (i.e., increased left ventricular wall thickness), absence of monoclonal protein identified in serum and urine immunofixation (IFE) and serum free light chain (sFLC) assay. Patient must have clinical symptoms or cardiomyopathy and heart failure (e.g., dyspnea, edema, angina).
Age Restrictions	Must be age 18 or older
Prescriber Restrictions	
Coverage Duration	12 months on initial and continuation requests
Other Criteria	Vyndamax will not be approved if the patient has primary (light-chain) amyloidosis or if Vyndamax is being used with Onpattro or Tegsedi. For continuation: must continue to meet initial criteria - and - have had a positive clinical response to Vyndamax compared to baseline evidenced by objective (e.g., reduced cardiovascular-related hospitalizations, cardiac function) and subjective measures (e.g., function, quality of life).
Indications	All FDA-approved Indications.
Off Label Uses	

VYNDAQEL

Products Affected

- VYNDAQEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of transthyretin amyloid cardiomyopathy (ATTR-CM) must be confirmed by tissue biopsy, genetic testing, or radionuclide imaging (99mTc-PYP, 99mTc-DPD, or 99mTc-HMDP scan) (documentation must be provided). Diagnosis by radionuclide imaging requires all of the following to be met (documentation must be provided): Grade 2 or 3 cardiac uptake on radionuclide imaging, echocardiogram (ECHO) or cardiac magnetic resonance (CMR) imaging demonstrating cardiac involvement (i.e., increased left ventricular wall thickness), absence of monoclonal protein identified in serum and urine immunofixation (IFE) and serum free light chain (sFLC) assay. Patient must have clinical symptoms or cardiomyopathy and heart failure (e.g., dyspnea, edema, angina).
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	
Coverage Duration	12 months on initial and continuation requests
Other Criteria	Vyndaqel will not be approved if the patient has primary (light-chain) amyloidosis or if Vyndaqel is being used with Onpattro or Tegsedi. For continuation: must continue to meet initial criteria - and - have had a positive clinical response to Vyndaqel compared to baseline evidenced by objective (e.g., reduced cardiovascular-related hospitalizations, cardiac function) and subjective measures (e.g., function, quality of life).
Indications	All FDA-approved Indications.
Off Label Uses	

WELIREG

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	Pending CMS review.
Required Medical Information	Pending CMS review.
Age Restrictions	Pending CMS review.
Prescriber Restrictions	Pending CMS review.
Coverage Duration	Pending CMS review.
Other Criteria	Pending CMS review.
Indications	Pending CMS review.
Off Label Uses	Pending CMS review.

XALKORI

Products Affected

- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

XATMEP

Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XELJANZ

Products Affected

- XELJANZ ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Xeljanz must not be used in combination with other biological drugs.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For a diagnosis of psoriatic arthritis, rheumatoid arthritis, or ulcerative colitis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. azathioprine, 6-mercaptopurine, methotrexate, leflunomide). For a diagnosis of ulcerative colitis, induction dosing is limited to 16 weeks. Induction and maintenance dosing must be applied consistent with the FDA-approved label. For a diagnosis of polyarticular juvenile idiopathic arthritis (PJIA), must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. methotrexate, leflunomide, sulfasalazine).
Indications	All Medically-accepted Indications.
Off Label Uses	

XELJANZ SOLUTION

Products Affected

- XELJANZ ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biological drugs.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For a diagnosis of polyarticular juvenile idiopathic arthritis (PJIA), must have a trial and failure (defined as an inability to improve symptoms or an intolerance) to one non-biologic immunomodulator (e.g. methotrexate, leflunomide, sulfasalazine) AND to Xeljanz tablet if weight is 40 kilograms or more. Dosing must follow the FDA-approved labeling for all indications
Indications	All FDA-approved Indications.
Off Label Uses	

XELJANZ XR

Products Affected

- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	Xeljanz XR must not be used in combination with other biological drugs.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For a diagnosis of psoriatic arthritis, rheumatoid arthritis, or ulcerative colitis, must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g. azathioprine, 6-mercaptopurine, methotrexate, leflunomide). For a diagnosis of ulcerative colitis, induction dosing is limited to 16 weeks. Induction and maintenance dosing must be applied consistent with the FDA-approved label.
Indications	All Medically-accepted Indications.
Off Label Uses	

XERMELO

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must be experiencing 4 or more bowel movements per day.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must have been receiving stable dose SSA therapy (either long-acting release (LAR), depot, or infusion pump) for at least 3 months.
Indications	All Medically-accepted Indications.
Off Label Uses	

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For all medically-accepted indications (except for Giant Cell Tumor of the bone, and for bone metastases from breast, prostate, and lung cancer), must first try zoledronic acid. Trial with zoledronic acid applies only to members enrolled in an MA-PD (Medicare Advantage Prescription Drug) plan.
Indications	All Medically-accepted Indications.
Off Label Uses	

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must provide baseline IgE level and current weight.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For diagnosis of asthma, patient's symptoms must be inadequately controlled with an ICS/LABA inhaler or, if contraindicated or not tolerated, another maintenance medication for the condition. Must not be used in combination with other monoclonal antibodies (e.g., Fasenra, Nucala). For diagnosis of chronic urticaria, patient must first try two or more H1 antihistamines, or patient must first try one H1 antihistamine and one or more of the following: H2 antihistamines, oral corticosteroids, or leukotriene modifiers. For diagnosis of nasal polyps, patient must have disease persistence for at least 4 weeks despite daily treatment with intranasal steroids, and patient must use Xolair in combination with an intranasal steroid. For continuation, must not be used in combination with other biologic drugs (e.g., Dupixent, Nucala), patient must have a decrease in nasal polyp and congestion symptoms, and the patient's current weight must be provided. Dosing must follow the FDA-approved dosing based on baseline IgE and current weight.
Indications	All Medically-accepted Indications.
Off Label Uses	

XOSPATA

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of laboratory report confirming FLT3 mutation must be submitted.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

XPOVIO

Products Affected

- XPOVIO (100 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 50 MG
- XPOVIO (40 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 40 MG
- XPOVIO (40 MG TWICE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 40 MG
- XPOVIO (60 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 60 MG
- XPOVIO (60 MG TWICE WEEKLY)
- XPOVIO (80 MG ONCE WEEKLY) ORAL TABLET THERAPY PACK 20 MG, 40 MG
- XPOVIO (80 MG TWICE WEEKLY)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

XTANDI

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

XYREM ORAL

Products Affected

- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not be receiving sedative hypnotics with Xyrem. Patient must not suffer from succinic semialdehyde dehydrogenase deficiency.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a sleep specialist, neurologist, or pulmonologist.
Coverage Duration	One year
Other Criteria	For narcolepsy with excessive daytime sleepiness, must first try amphetamine salts, dextroamphetamine or methylphenidate - AND - either modafinil or armodafinil with inadequate response or intolerance.
Indications	All FDA-approved Indications.
Off Label Uses	

XYWAV

Products Affected

- XYWAV

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not be receiving sedative hypnotics with Xywav. Patient must not suffer from succinic semialdehyde dehydrogenase deficiency.
Required Medical Information	Confirmation of diagnosis by polysomnography. For a diagnosis of idiopathic hypersomnia, must also exclude other common causes of excessive sleepiness (e.g., insufficient sleep, depression, medications, sleep-related breathing disorders).
Age Restrictions	
Prescriber Restrictions	Prescriber must be a sleep specialist, neurologist, or pulmonologist.
Coverage Duration	One year
Other Criteria	UNDER CMS REVIEW
Indications	All FDA-approved Indications.
Off Label Uses	

ZEJULA

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ZEMAIRA

Products Affected

- ZEMAIRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have a predicted FEV1 value between 30 and 65% and have serum AAT level less than 11 micromoles per liter (80 milligrams per deciliter if measured by radial immunodiffusion or 50 milligrams per deciliter if measure by nephelometry).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ZEPATIER

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Prescriber must be a gastroenterologist, hepatologist, or infectious disease specialist.
Coverage Duration	Criteria will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Must first try Epclusa. Criteria will be applied consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For diagnosis of primary cutaneous T-cell lymphoma, patient must have prior use of two of the following systemic therapies: a retinoid (bexarotene, all-trans retinoic acid, isotretinoin, acitretin), an interferon (IFN-alpha, IFN-gamma), methotrexate, or extracorporeal photopheresis.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZORBTIVE

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Four weeks only
Other Criteria	Patient must be receiving TPN in conjunction with Zorbtive.
Indications	All Medically-accepted Indications.
Off Label Uses	

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

ZYKADIA

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

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