2022 Priority Health Medicare Prior Authorization Criteria

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

Last updated: December 2022

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	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must first try both olanzapine and loxapine.
Indications	All FDA-approved Indications.
Off Label Uses	

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	

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	Patient has been evaluated for and does not have medication overuse headache (MOH).
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 a documented trial and failure to two of the following drugs, each from a different group (a, b, c): (a) topiramate, divalproex, valproic acid, (b) propranolol, metoprolol, and (c) amitriptyline or venlafaxine (drugs must be tried for at least 28 days each, with failure defined as an intolerance or an inability to improve the condition). For continuation of all previously approved conditions: Must provide evidence of clinical improvement (e.g., decrease in migraine days per month).
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	Patient has been evaluated for and does not have medication overuse headache (MOH).
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 a documented trial and failure to two of the following drugs, each from a different group (a, b, c): (a) topiramate, divalproex, valproic acid, (b) propranolol, metoprolol, and (c) amitriptyline or venlafaxine (drugs must be tried for at least 28 days each, with failure defined as an intolerance or an inability to improve the condition). For continuation of all previously approved conditions: Must provide evidence of clinical improvement (e.g., decrease in migraine days per month).
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	

AMVUTTRA

Products Affected

- AMVUTTRA

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with TTR stabilizers (e.g., tafamidis) or TTR-lowering agents (e.g., Tegsedi, Onpattro).
Required Medical Information	Medical records supporting the request must be provided - AND - Must have documentation of a transthyretin (TTR) mutation (e.g., V30M) - AND - Must have documentation of a baseline polyneuropathy disability (PND) score less than or equal to IIIb and/or baseline FAP Stage 1 or 2.
Age Restrictions	Must be at least 18 years of age.
Prescriber Restrictions	
Coverage Duration	1 year initial and reauthorization. Dose must align with the FDA-approved labeling.
Other Criteria	Must have documentation of clinical signs and symptoms of the condition (e.g., motor disability, peripheral/autonomic neuropathy, etc.) - AND - Patient has not had a liver transplant - AND - For reauthorization, must have a positive clinical response to Amvuttra compared to baseline (e.g., improved neuropathy symptoms, motor function, quality of life, slowing of disease progression).
Indications	All FDA-approved 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	

ARCALYST

Products Affected

- ARCALYST

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	

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	

AUBAGIO

Products Affected

- AUBAGIO

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	Must have two pre-treatment morning serum total testosterone levels taken on separate days that are less than 300 ng/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Approved if the following are met: 1) Patient is male AND 2) has pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction or decreased libido (e.g., depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis), AND 3) has been screened for prostate cancer according to current guidelines, AND 4) has a documented trial and failure (defined as an inability to improve symptoms or condition) with a generic injectable - AND - generic topical testosterone therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

AVONEX

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
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	Must not be used with another biologic drug or Lupkynis.
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. For LN, must have a confirmed diagnosis of SLE - AND - a kidney biopsy confirming class 3, 4, and/or 5 disease.
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 drugs together for at least 12 weeks each: a steroid, immunosuppressant, and/or hydroxychloroquine. FOR LUPUS NEPHRITIS: Must be receiving standard therapy for LN (e.g., mycophenolate or azathioprine plus a steroid). FOR CONTINUATION OF PREVIOUSLY APPROVED SLE REQUESTS: Must have evidence of clinical improvement since starting Benlysta. FOR CONTINUATION OF PREVIOUSLY APPROVED LUPUS NEPHRITIS REQUESTS: Must have evidence of clinical improvement including improved or stable eGFR.
Indications	All FDA-approved Indications.
Off Label Uses	

BESREMI

Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Baseline Complete blood count (CBC).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must trial and fail hydroxyurea (defined as an intolerance and/or persistence or recurrence of disease) - AND - Prescriber must follow dose recommendations per FDA-approved labeling. Once hematologic stability has been achieved with Besremi for one year, dosing interval should be expanded to every 4 weeks.
Indications	All Medically-accepted Indications.
Off Label Uses	

bexarotene

Products Affected

- *bexarotene*

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	

BEXAROTENE GEL

Products Affected

- *bexarotene*

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	

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	

CARGLUMIC ACID

Products Affected

- *carglumic acid 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	

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

COMETRIQ

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
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	

CORTROPHIN

Products Affected

- CORTROPHIN

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	Not covered for FDA-approved indications of acute gouty arthritis, severe psoriasis, and atopic dermatitis. For all covered 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-week trial of one biologic drug. For systemic dermatomyositis (polymyositis): one 12-week trial with rituximab. Continuation of previously authorized therapy requires demonstrated clinical benefit. Quantity limited to dosage as supported by the FDA-approved label. Trial of a Part B drug prior to a Part D drug applies only to beneficiaries enrolled in an MA-PD plan.
Indications	Some FDA-approved Indications Only.
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	
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 ankylosing spondylitis and non-radiographic axial spondyloarthritis (NRAS): Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one nonsteroidal anti-inflammatory drug (NSAID). For ERA: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one other systemic agent for the condition (e.g., NSAIDs, methotrexate). For all other medically-accepted indications: Must have a documented trial and failure (defined above) to one non-biologic immunomodulator for the condition (e.g. methotrexate, cyclosporine, acitretin, 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	Cosentyx 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 ERA: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one other systemic agent for the condition (e.g., NSAIDs, methotrexate). For psoriatic arthritis: Must have a documented trial and failure (defined above) to one non-biologic immunomodulator (e.g. methotrexate, leflunomide, sulfasalazine).
Indications	All Medically-accepted Indications.
Off Label Uses	

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	

CYSTARAN

Products Affected

- CYSTARAN

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 external*

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	

dihydroergotamine spray

Products Affected

- *dihydroergotamine mesylate nasal*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must try and fail (defined as inability to improve symptoms or condition) one triptan drug AND Ubrelvy or Reyvow.
Indications	All FDA-approved Indications.
Off Label Uses	

dimethyl fumarate

Products Affected

- *dimethyl fumarate oral*
- *dimethyl fumarate starter 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	

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	Initial approval: 3 months. Continuation: 1 year.
Other Criteria	Patient must first try midodrine. For continuation: Must have documentation of a positive clinical response (e.g., sustained decrease in dizziness).
Indications	All Medically-accepted Indications.
Off Label Uses	

DUPIXENT

Products Affected

- DUPIXENT

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs.
Required Medical Information	For eosinophilic esophagitis: (1) diagnosis confirmed by esophageal biopsy defined by at least 15 eosinophils per high power field (HPF), and (2) patient's current weight is at least 40 kg. For prurigo nodularis: Must have moderate to severe prurigo nodularis defined as a score of at least 7 on the Worst Itching Intensity Numerical Rating Scale (WI-NRS) and at least 20 nodular lesions.
Age Restrictions	
Prescriber Restrictions	For prurigo nodularis, must be prescribed by a dermatologist.
Coverage Duration	Authorized for 1 year. Dosing must follow the FDA-approved labeling.

PA Criteria	Criteria Details
Other Criteria	For atopic dermatitis in patients 2 years of age and older: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one medium or higher potency topical steroid (e.g., clobetasol) - AND - one topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus). For atopic dermatitis in patients younger than 2 years of age: Must have a documented trial and failure (defined above) to one medium or higher potency topical steroid (e.g., clobetasol). For asthma: Must have a documented trial and failure with 1 ICS/LABA inhaler drug in combination with 1 other asthma controller medication in the past 6 months (failure is defined as an intolerance or inability to improve the condition on required therapy for at least 4 weeks). For chronic rhinosinusitis with nasal polyp: Must have a documented trial and failure (defined as an inability to improve symptoms for least 12 weeks) with intranasal steroids - AND - Must be used in combination with an intranasal steroid. For eosinophilic esophagitis: (1) Patient must have symptoms of esophageal dysfunction - AND - (2) patient must have a documented trial and failure (defined as an intolerance or inability to achieve and maintain remission of low or mild disease activity) with one proton pump inhibitor for at least 2 months - AND - (3) must have a documented trial and failure (defined above) to one topical steroid (e.g., fluticasone, budesonide) for at least 2 months. For prurigo nodularis: Must have a documented trial and failure (defined as inability to improve the condition) to the following: one oral antihistamine and either a medium or higher potency topical steroid or a topical calcineurin inhibitor. For continuation of previously approved indications: Must have documentation demonstrating clinical benefit (e.g. decrease in exacerbations, improvement in symptoms, decrease in steroid 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	Patient has been evaluated for and does not have medication overuse headache (MOH).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a neurologist, pain specialist, or other headache specialist.
Coverage Duration	One year initial and continuation. All dosing must align with FDA-approved labeling.
Other Criteria	For migraine prevention: Must have a documented trial and failure to two of the following drugs, each from a different group (a, b, c): (a) topiramate, divalproex, valproic acid, (b) propranolol, metoprolol, and (c) amitriptyline or venlafaxine (drugs must be tried for at least 28 days each, with failure defined as an intolerance or an inability to improve the condition). For episodic cluster headache: Must have a documented trial and failure (defined as an intolerance or an inability to improve the condition) to verapamil, corticosteroids, or lithium. For continuation of all previously approved conditions: Must provide evidence of clinical improvement (e.g., decrease in migraine days per month).
Indications	All FDA-approved Indications.
Off Label Uses	

ENBREL

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML
- 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	
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 ankylosing spondylitis: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: must have a documented trial and failure (defined above) to one non-biologic immunomodulator (e.g. methotrexate, cyclosporine, acitretin). For psoriatic arthritis or rheumatoid arthritis: Must have a documented trial and failure (defined above) to one non-biologic immunomodulator (e.g. methotrexate, leflunomide, sulfasalazine). For hidradenitis suppurativa: Must have a documented trial and failure (defined above) with an 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	
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 ankylosing spondylitis: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: must have a documented trial and failure (defined above) to one non-biologic immunomodulator (e.g. methotrexate, cyclosporine, acitretin). For psoriatic arthritis or rheumatoid arthritis: Must have a documented trial and failure (defined above) to one non-biologic immunomodulator (e.g. methotrexate, leflunomide, sulfasalazine). For hidradenitis suppurativa: Must have a documented trial and failure (defined above) with an 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

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	Must not be used in combination with a PCSK9 inhibitor (e.g., Repatha), Nexletol, or Nexlizet.
Required Medical Information	Must submit most recent LDL-C level. Must submit documentation of prior therapies and responses to treatment. Confirmation of HoFH by (1) genetic testing - OR - (2) an untreated LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL with one of the following: cutaneous or tendon xanthoma before age 10 years or elevated untreated LDL-C levels consistent with HeFH in both parents (LDL-C greater than 190 mg/dL).
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or board-certified lipidologist.
Coverage Duration	One year
Other Criteria	Patient must meet the following: (1) Patient has tried a PCSK9 inhibitor (e.g., Repatha) and LDL-C remains greater than or equal to 70mg/dL - and - (2) Patient has tried one high-intensity statin (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than or equal to 20 mg daily) and LDL-C remains greater than or equal to 70mg/dL - or - (3) Patient is statin intolerant demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR failing to achieve LDL-C goal because of skeletal-muscle related symptoms that have continued despite both lowering the statin strength and attempting a different statin. For reauthorization, must also have improved and maintained an improved LDL compared to baseline.
Indications	All FDA-approved Indications.
Off Label Uses	

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	
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	

EXKIVITY

Products Affected

- EXKIVITY

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	

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	Must not be used in combination with other biologic drugs.
Required Medical Information	For initial coverage of severe eosinophilic asthma: elevated eosinophil level of greater than or equal to 150 cells/µL at therapy start, OR greater than or equal to 300 cells/µL in the previous 12 months.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and continuation. All dosing must align with FDA-approved labeling.
Other Criteria	Must have a documented trial and failure with 1 ICS/LABA inhaler drug in combination with 1 other asthma controller medication in the past 6 months (failure is defined as an intolerance or inability to improve the condition on required therapy for at least 4 weeks). For continuation of previously approved requests: Must have documented clinical benefit (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).
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	

FINGOLIMOD

Products Affected

- *fingolimod 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	

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	The following criteria must be met for initial coverage: (1) If the patient has cancer associated with LEMS, cancer must have been appropriately treated - AND - (2) patient must not have history of seizures, or an increased risk of seizures due to a condition (e.g., brain metastases) and/or medication (e.g., bupropion) - AND - (3) patient must be ambulatory - AND - (4) - for adults only, patient must have documented trial and failure (defined as an intolerance or inability to improve symptoms) to pyridostigmine. For continuation of previously approved requests: Must have documentation showing improvement or stabilization in condition using the QMG or 3TUG test.
Indications	All FDA-approved 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	

glatiramer

Products Affected

- *glatiramer acetate*

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	

GLATOPA

Products Affected

- GLATOPA

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	

GROWTH HORMONE

Products Affected

- GENOTROPIN MINIQUICK SUBCUTANEOUS PREFILLED SYRINGE
- GENOTROPIN SUBCUTANEOUS CARTRIDGE
- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR

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	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 SUBCUTANEOUS PEN-INJECTOR KIT 40 MG/0.8ML
- HUMIRA PEN-PSOR/UVEIT STARTER
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML

PA Criteria	Criteria Details
Exclusion Criteria	Humira 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 ankylosing spondylitis: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must have a documented trial and failure (defined above) to one non-biologic immunomodulator (e.g. methotrexate, cyclosporine, acitretin). For Crohns disease, psoriatic arthritis, or rheumatoid arthritis: Must have a documented trial and failure (defined above) to one non-biologic immunomodulator (e.g. azathioprine, 6-mercaptopurine, methotrexate). For hidradenitis suppurativa: Must have a documented trial and failure (defined above) with an antibiotic therapy. For uveitis: Must have a documented trial and failure (defined above) to one other agent for the condition (e.g., topical steroid, methotrexate).
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*
- *sajazir*

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of an angiotensin-converting enzyme (ACE) inhibitor is not covered.
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	6 months, initial and continuation. Limited to 3 syringes (9mls) every 30 days.
Other Criteria	For continuation: Must have documentation showing use of previously approved syringes AND a favorable clinical response (decrease in the duration of attacks, quick onset of symptom relief, resolution of symptoms, decrease in attack frequency or severity).
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 (CV) risk reduction, must have either established CV disease (e.g., coronary artery disease, heart attack, stroke) OR diabetes mellitus with 2 or more additional risk factors for CV disease (e.g., smoking, hypertension, elevated CRP) - AND - one of the following: (1) Documented trial with ezetimibe AND one high intensity statin (e.g., atorvastatin or rosuvastatin) or, if a high-intensity statin is not tolerated, one statin at the maximally tolerated dose - OR - (2) ezetimibe trial with documented statin intolerance defined as experiencing statin-related muscle symptoms during separate trials of two different statins with symptoms resolving upon discontinuation of the statin during each trial. For hypertriglyceridemia: must have tried fenofibrate 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 oral tablet 100 mg, 400 mg*

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 ORAL CAPSULE
- IMBRUVICA ORAL SUSPENSION
- IMBRUVICA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year. Dosing must follow the FDA-approved labeling.
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	

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 ORAL TABLET 1 MG, 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	

INQOVI

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Patient must first try IV decitabine. Part B before Part D Step Therapy. Applies only to beneficiaries in an MA-PD plan.
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	1 year for initial and continuation
Other Criteria	For all conditions, physician must follow dosing recommendations per FDA-approved labeling. Criteria will be applied consistent with current NCCN guidance. 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	
Required Medical Information	For initial treatment, eGFR greater than or equal to 25ml/min/1.73m2.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must try and fail (defined as an inability to improve symptoms) or intolerance to a SGLT2i (e.g., Farxiga or Jardiance) AND must be on maximally tolerated ACEI or ARB.
Indications	All FDA-approved Indications.
Off Label Uses	

KESIMPTA

Products Affected

- KESIMPTA

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	

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	

KORLYM

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	Must be prescribed by an endocrinologist.
Coverage Duration	One year
Other Criteria	For continuation of previously approved requests: Must provide documentation of improvement in hyperglycemia control with Korlym.
Indications	All FDA-approved 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	

LENALIDOMIDE

Products Affected

- *lenalidomide*

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	

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	

LEQVIO

Products Affected

- LEQVIO

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with a PCSK9 inhibitor (e.g., Repatha), Nexletol, or Nexlizet.
Required Medical Information	Must submit most recent LDL-C level. Must submit documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist, endocrinologist, or board-certified lipidologist.
Coverage Duration	One year. Limited to 3 syringes year one and 1 syringe every 6 months thereafter.
Other Criteria	Patient must meet the following: (1) Patient has tried a PCSK9 inhibitor (e.g., Repatha) and LDL-C remains greater than or equal to 70mg/dL - and - (2) Patient has tried one high-intensity statin (i.e., atorvastatin greater than or equal to 40 mg daily, rosuvastatin greater than or equal to 20 mg daily) and LDL-C remains greater than or equal to 70mg/dL - or - (3) Patient is statin intolerant demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR failing to achieve LDL-C goal because of skeletal-muscle related symptoms that have continued despite both lowering the statin strength and attempting a different statin. For reauthorization, must also have improved and maintained an improved LDL compared to baseline.
Indications	All FDA-approved 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	

LIVTENCITY

Products Affected

- LIVTENCITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Baseline CMV DNA level confirming diagnosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	8 weeks
Other Criteria	Must not be used concomitantly with other CMV antivirals (e.g., ganciclovir, valganciclovir). Dosing must follow FDA-approved labeling. Must have documented trial and failure with ganciclovir or valganciclovir. For continuation, documentation of response (e.g., CMV DNA level) must be provided.
Indications	All FDA-approved 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	

LUMIZYME

Products Affected

- LUMIZYME

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of baseline FVC and/or 6MWT values must be provided. Must provide patient's current weight and requested dose. Documentation of diagnosis confirmation by enzyme assay or genetic testing must be provided.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist in inherited metabolic disorders (e.g., genetic and metabolic specialist, neurologist, cardiologist).
Coverage Duration	One year. Dosing must follow the FDA-approved labeling.
Other Criteria	For continuation requests, must also provide documentation demonstrating improvement or stabilization in condition.
Indications	All FDA-approved 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	

LYBALVI

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	Current opioid use.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must have a documented trial and failure on two atypical antipsychotics, one of which must be aripiprazole or ziprasidone. Failure is defined as an inability to improve the condition and/or unacceptable weight gain in a patient at significant risk for weight-related morbidity and mortality (e.g., type 2 diabetes, hypertension, dyslipidemia, cardiovascular disease).
Indications	All FDA-approved Indications.
Off Label Uses	

LYNPARZA

Products Affected

- LYNPARZA 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	

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 ORAL PACKET
- MAVYRET ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have chronic hepatitis C infection.
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	

MAYZENT

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG
- MAYZENT STARTER 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	

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	

modafinil

Products Affected

- *modafinil*

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	

NEXLETOL

Products Affected

- NEXLETOL

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Juxtapid or PCSK9 inhibitors (e.g., Repatha) will not be approved.
Required Medical Information	Must submit most recent LDL-C level.
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or other physician who focuses on the treatment of CV risk management and/or lipid disorders.
Coverage Duration	One year
Other Criteria	Must have one of the following for initial approval: (1) Documented trial with ezetimibe AND one high intensity statin (e.g., atorvastatin or rosuvastatin) or, if a high-intensity statin is not tolerated, one statin at the maximally tolerated dose with failure to reach LDL-C goal - OR - (2) ezetimibe trial with documented statin intolerance defined as experiencing statin-related muscle symptoms during separate trials of two different statins with symptoms resolving upon discontinuation of the statin during each trial.
Indications	All FDA-approved Indications.
Off Label Uses	

NEXLIZET

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Juxtapid or PCSK9 inhibitors (e.g., Repatha) will not be approved.
Required Medical Information	Must submit most recent LDL-C level.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must have one of the following for initial approval: (1) Documented trial with ezetimibe AND one high intensity statin (e.g., atorvastatin or rosuvastatin) or, if a high-intensity statin is not tolerated, one statin at the maximally tolerated dose with failure to reach LDL-C goal - OR - (2) ezetimibe trial with documented statin intolerance defined as experiencing statin-related muscle symptoms during separate trials of two different statins with symptoms resolving upon discontinuation of the statin during each trial.
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

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs.
Required Medical Information	For initial coverage of severe eosinophilic asthma: elevated eosinophil level of greater than or equal to 150 cells/µL at therapy start, OR greater than or equal to 300 cells/µL in the previous 12 months. For Hypereosinophilic Syndrome (HES), must have blood eosinophil count at least 1,000 cells/mcL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 yr-Limited to 1 syringe: asthma and CRSwNP and 3 syringes (300mg):HES and EGWP per 28 days
Other Criteria	For asthma: Must have a documented trial and failure with triple therapy including an inhaled corticosteroid (ICS), long-acting beta agonist (LABA), and a long-acting antimuscarinic (LAMA) in the past 6 months (failure is defined as an intolerance or inability to improve the condition on triple therapy for at least 4 weeks). For eosinophilic granulomatosis with polyangiitis (EGWP): Must have a documented trial and failure (defined as an inability to improve symptoms) with a non-biologic immunomodulator (e.g., azathioprine, cyclophosphamide). For Hypereosinophilic Syndrome (HES): Must have had 2 flares of HES in the past year (e.g., symptoms requiring steroid or increase in steroid) - AND - Must have a documented trial and failure (defined as an inability to improve symptoms) with a generic steroid-sparing drug (e.g., methotrexate, hydroxyurea). For initial approval for chronic rhinosinusitis with nasal polyps: Must have documentation of disease persistence despite at least 8 weeks of treatment with intranasal steroids - AND - Must be used in combination with an intranasal steroid. For continuation of previously approved requests: Must have documentation showing clinical benefit (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).
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	
Required Medical Information	Confirmed diagnosis of MoCD Type A by genetic testing. Documentation of genetic testing results must be submitted.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with a physician who specializes in the treatment of inherited metabolic disorders.
Coverage Duration	12 months for initial and continuation.
Other Criteria	For continuation requests, must also provide documentation demonstrating a beneficial response to therapy compared to pretreatment baseline in one or more of the following: neurological function, gross motor function, and/or developmental milestones.
Indications	All FDA-approved Indications.
Off Label Uses	

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 125 MG/ML, 50 MG/0.4ML, 87.5 MG/0.7ML

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 ORAL PACKET 100-125 MG, 150-188 MG, 75-94 MG
- ORKAMBI ORAL TABLET

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 ORAL TABLET
- OTEZLA ORAL TABLET THERAPY PACK

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	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must first try and fail (defined as an intolerance or inability to improve the condition) with imiquimod 5% cream.
Indications	All Medically-accepted Indications.
Off Label Uses	

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	

PIRFENIDONE

Products Affected

- *pirfenidone oral tablet 267 mg, 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	

PLEGRIDY

Products Affected

- PLEGRIDY
- PLEGRIDY STARTER 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	

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	Must have a documented trial and failure with alendronate, risedronate, or ibandronate - AND - zoledronic acid. Failure is defined as intolerance, decrease in BMD, or new fracture while on therapy OR a contraindication to therapy (e.g., creatinine clearance less than 35 mL/min, inability to sit upright for 30 minutes, esophageal stricture). Part B before Part D Step Therapy. Use of 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	

PYRUKYND

Products Affected

- PYRUKYND
- PYRUKYND TAPER PACK

PA Criteria	Criteria Details
Exclusion Criteria	Not covered for a patient with any of the following: Homozygous for R479H mutation, 2 non-missense variants in PKLR gene, not regularly transfused.
Required Medical Information	Genetic testing confirming diagnosis - AND - Current hemoglobin less than or equal to 10mg/dL - AND -at least six red blood cell (RBC) transfusion episodes within the previous year.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with a hematologist.
Coverage Duration	Initial: 3 months, Continuation: 12 months
Other Criteria	For continuation: Must have documentation of a positive clinical response as determined by the prescriber.
Indications	Some FDA-approved Indications Only.
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	

RADICAVA ORS

Products Affected

- RADICAVA ORS
- RADICAVA ORS STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records supporting the request must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months. Limited to 70 mLs the first 28 days and 50 mLs every 28 days thereafter.
Other Criteria	Patient must have a diagnosis of "definite" or "probable" amyotrophic lateral sclerosis (ALS) as defined by the revised El Escorial/Arlie House criteria - AND - patient must have disease duration of less than or equal to 2 years (please provide date of diagnosis) - AND - patient must have retained most activities of daily living defined as a score of greater than or equal to 2 points on each of the 12 items of the revised ALS Functional Rating Scale (ALSFRS-R) (i.e., a minimum score of 24) - AND - patient must have normal respiratory function defined as a percent-predicted forced vital capacity (% FVC) greater than or equal to 80%. For continuation of coverage, patient must have a diagnosis of "definite" or "probable" ALS as defined by the revised El Escorial/Arlie House criteria - AND - patient must have clinical benefit from therapy as determined by the provider - AND - patient must not be dependent on invasive ventilation.
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	

REBIF

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
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	Concurrent use of Juxtapid, Praluent, Nexletol, Nexlizet will not be approved.
Required Medical Information	Must submit most recent LDL-C level. For HoFH: Must have a diagnosis of definite HoFH defined by one of the following: (1) genetic testing - OR - (2) an untreated LDL-C greater than 500 mg/dL or a treated LDL-C greater than 300 mg/dL with one of the following: cutaneous or tendon xanthoma before age 10 years OR elevated untreated LDL-C levels consistent with heterzygous FH in both parents (LDL-C greater than 190 mg/dL).
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or other physician who focuses on the treatment of CV risk management and/or lipid disorders.
Coverage Duration	One year
Other Criteria	Must have one of the following for initial approval: (1) Documented trial with ezetimibe AND one high intensity statin (e.g., atorvastatin or rosuvastatin) or, if a high-intensity statin is not tolerated, one statin at the maximally tolerated dose with failure to reach LDL-C goal - OR - (2) Documented statin intolerance defined as experiencing statin-related muscle symptoms during separate trials of two different statins with symptoms resolving upon discontinuation of the statin during each trial must be provided.
Indications	All Medically-accepted Indications.
Off Label Uses	

REPATHA PUSHTRONEX SYSTEM

Products Affected

- REPATHA PUSHTRONEX SYSTEM

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Juxtapid, Praluent, Nexletol, Nexlizet will not be approved.
Required Medical Information	Must submit most recent LDL-C level. For HoFH: Must have a diagnosis of definite HoFH defined by one of the following: (1) genetic testing - OR - (2) an untreated LDL-C greater than 500 mg/dL or a treated LDL-C greater than 300 mg/dL with one of the following: cutaneous or tendon xanthoma before age 10 years OR elevated untreated LDL-C levels consistent with heterzygous FH in both parents (LDL-C greater than 190 mg/dL).
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or other physician who focuses on the treatment of CV risk management and/or lipid disorders.
Coverage Duration	One year
Other Criteria	Must have one of the following for initial approval: (1) Documented trial with ezetimibe AND one high intensity statin (e.g., atorvastatin or rosuvastatin) or, if a high-intensity statin is not tolerated, one statin at the maximally tolerated dose with failure to reach LDL-C goal - OR - (2) Documented statin intolerance defined as experiencing statin-related muscle symptoms during separate trials of two different statins with symptoms resolving upon discontinuation of the statin during each trial must be provided.
Indications	All Medically-accepted Indications.
Off Label Uses	

REPATHA SURECLICK

Products Affected

- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Juxtapid, Praluent, Nexletol, Nexlizet will not be approved.
Required Medical Information	Must submit most recent LDL-C level. For HoFH: Must have a diagnosis of definite HoFH defined by one of the following: (1) genetic testing - OR - (2) an untreated LDL-C greater than 500 mg/dL or a treated LDL-C greater than 300 mg/dL with one of the following: cutaneous or tendon xanthoma before age 10 years OR elevated untreated LDL-C levels consistent with heterzygous FH in both parents (LDL-C greater than 190 mg/dL).
Age Restrictions	
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or other physician who focuses on the treatment of CV risk management and/or lipid disorders.
Coverage Duration	One year
Other Criteria	Must have one of the following for initial approval: (1) Documented trial with ezetimibe AND one high intensity statin (e.g., atorvastatin or rosuvastatin) or, if a high-intensity statin is not tolerated, one statin at the maximally tolerated dose with failure to reach LDL-C goal - OR - (2) Documented statin intolerance defined as experiencing statin-related muscle symptoms during separate trials of two different statins with symptoms resolving upon discontinuation of the statin during each trial must be provided.
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	

REVCOVI

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must provide trough plasma ADA activity and trough dAXP levels. Must provide patient's current weight and requested dose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year initial and continuation
Other Criteria	Provider attestation that treatment will follow FDA-approved labeling with dose adjusted to maintain trough ADA activity over 30 mmol/hr/L, trough dAXP level under 0.02 mmol/L, and/or to maintain adequate immune reconstitution based on clinical assessment of the patient.
Indications	All FDA-approved 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	Must not be used in combination with other CGRP antagonist therapy.
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	

REZUROCK

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and continuation.
Other Criteria	Other criteria will be applied consistent with current NCCN guidance. Reauthorization for GVHD: Must have documentation of clinical benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	

RINVOQ

Products Affected

- RINVOQ ORAL TABLET EXTENDED RELEASE 24 HOUR 15 MG, 30 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biological drugs.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	For NRAS, RA, PsA, AS and UC, prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For RA and PsA: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one non-biologic immunomodulator (e.g. (methotrexate, leflunomide, sulfasalazine, hydroxychloroquine). For ankylosing spondylitis (AS) and non-radiographic axial spondyloarthritis (NRAS), must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one nonsteroidal anti-inflammatory drug (NSAID). For atopic dermatitis: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one medium or higher potency topical steroid (e.g., clobetasol) or a topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) - AND - one non-biologic immunomodulator drug (e.g., methotrexate or cyclosporine). For continuation of previously approved indications for atopic dermatitis: Must have documentation demonstrating clinical benefit (e.g. decrease in exacerbations, improvement in symptoms, decrease in steroid use).
Indications	All Medically-accepted Indications.
Off Label Uses	

ROFLUMILAST

Products Affected

- *roflumilast*

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	

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	Must have clinical symptoms of LEMS (i.e., proximal lower extremity weakness) that interfere with daily activities - AND - Must provide 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	The following criteria must be met for initial approval: (1) Must not have a history of seizures, or an increased risk of seizures due to a condition (e.g., brain metastases) and/or medication (e.g., bupropion) - AND - (2) Must be ambulatory - AND - (3) If the patient has cancer associated with LEMS, cancer must have been appropriately treated. For continuation of previously approved requests: Must have documentation showing improvement or stabilization in condition using the 3TUG test.
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	

SCEMBLIX

Products Affected

- SCEMBLIX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For all indications, Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1. For PH+ CML-CP with T315I mutation, documentation confirming mutation must be provided.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with an oncologist.
Coverage Duration	1 year. Limit 60 tabs per 30 days. For CML with T315L mutation, limit to 300 tabs per 30 days.
Other Criteria	For PH+ CML-CP with T315I mutation, must submit documentation of a trial & failure (defined as disease progression, inadequate response or intolerance) of Iclusig.
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 (150 MG DOSE)
- SKYRIZI PEN
- SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE
- SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

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 psoriasis, psoriatic arthritis, and Crohn's disease: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one non-biologic immunomodulator for the condition (e.g. azathioprine, methotrexate, cyclosporine, acitretin, leflunomide, sulfasalazine).
Indications	All Medically-accepted Indications.
Off Label Uses	

SORAFENIB

Products Affected

- *sorafenib tosylate*

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	

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

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	
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	Concurrent use of an angiotensin-converting enzyme (ACE) inhibitor - AND - and other preventative therapies for HAE (e.g., Orladeyo, Haegarda) are not covered.
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	Initial approval: 6 months. Continuation approval: 12 months.
Other Criteria	For continuation: Must have documentation showing a decrease in the frequency of attacks. After the first 12 months of treatment, must attempt dosing once every 4 weeks if attack free for more than 6 months.
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	

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	

TAVNEOS

Products Affected

- TAVNEOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of the following to support the diagnosis must be provided: (1) eGFR greater than or equal to 15 mL/min/1.72 m2, (2) at least 1 major item, 3 non-major items, or 2 renal items of proteinuria and hematuria on the Birmingham Vasculitis Activity Score (BVAS) - AND - (3) positive test for either anti-PR3 or anti-MPO.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist and rheumatologist.
Coverage Duration	Initial 6 months. Continuation 12 months.
Other Criteria	Tavneos must be used as an add-on to standard therapy including cyclophosphamide, rituximab, and steroids (such as methylprednisolone or prednisone) - AND - patient must have a medical need to reduce steroid use if not previously relapsed (ie. infection, osteoporosis) - AND - patient does not currently require dialysis, have kidney transplant, or have received plasma exchange in the past 12 weeks. For continuation: Must have a reduction in the Birmingham Vasculitis Activity Score (BVAS) - AND - steroid dose.
Indications	All FDA-approved 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	Cumulative use of Tymlos and other parathyroid hormone analogs (e.g., Forteo) of more than 2 years in a lifetime is not covered.
Required Medical Information	Patient's T-score must be provided - AND - Must have ONE of the following: 1) history of fragility fractures, OR 2) a T-score of less than or equal to -2.5 at any site.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years total therapy (inclusive of all parathyroid hormone analogs)
Other Criteria	For postmenopausal osteoporosis: Must have a documented trial and failure with alendronate, risedronate, ibandronate, zoledronic acid, or Prolia - AND - Tymlos. Failure is defined as intolerance, decrease in BMD, or new fracture while on therapy OR a contraindication to therapy (e.g., creatinine clearance less than 35 mL/min, inability to sit upright for 30 minutes, esophageal stricture).
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	Two pre-treatment morning serum total testosterone levels taken on separate days that are less than 300 ng/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Approved if the following are met: 1) Patient is male AND 2) has pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction or decreased libido (e.g., depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis), AND 3) has been screened for prostate cancer according to current guidelines, AND 4) has a documented trial and failure (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product. Part B before Part D Step Therapy. 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	Two pre-treatment morning serum total testosterone levels taken on separate days that are less than 300 ng/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Approved if the following are met: 1) Patient is male AND 2) has pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction or decreased libido (e.g., depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis), AND 3) has been screened for prostate cancer according to current guidelines, AND 4) has a documented trial and failure (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product. Part B before Part D Step Therapy. 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	

TEZSPIRE

Products Affected

- TEZSPIRE

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs.
Required Medical Information	For initial coverage of severe eosinophilic asthma: elevated eosinophil level of greater than or equal to 150 cells/µL at therapy start, OR greater than or equal to 300 cells/µL in the previous 12 months. Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	1 year initial and continuation. Dosing must follow the FDA-approved labeling.
Other Criteria	For asthma: Must try and fail with 1 ICS/LABA inhaler drug in combination with 1 other asthma controller medication in the past 6 months (fail is defined as an intolerance or inability to improve the condition on required therapy for at least 4 weeks) - and - for reauthorization, must have documented clinical benefit (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).
Indications	All Medically-accepted 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	

TRUDHESA

Products Affected

- TRUDHESA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must try and fail (defined as inability to improve symptoms or condition) one triptan drug AND Ubrelvy or Reyvow.
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	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

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	Cumulative use of Tymlos and other parathyroid hormone analogs (e.g., Forteo) of more than 2 years in a lifetime is not covered.
Required Medical Information	Patient's T-score must be provided - AND - Must have ONE of the following: 1) history of fragility fractures, OR 2) a T-score of less than or equal to -2.5 at any site.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years total therapy (inclusive of all parathyroid hormone analogs)
Other Criteria	Must have a documented trial and failure with alendronate, risedronate, or ibandronate - AND - either zoledronic acid or Prolia. Failure is defined as intolerance, decrease in BMD, or new fracture while on therapy OR a contraindication to therapy (e.g., creatinine clearance less than 35 mL/min, inability to sit upright for 30 minutes, esophageal stricture).
Indications	All Medically-accepted Indications.
Off Label Uses	

TYVASO DPI

Products Affected

- TYVASO DPI MAINTENANCE KIT
- TYVASO DPI TITRATION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For PH-ILD, confirmation of diagnosis by right heart catheterization, 6-minute walk test, and medical record documentation must be provided.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist for the condition.
Coverage Duration	12 months
Other Criteria	For PH-ILD, (1) must have attestation from the provider that ILD has been optimally managed prior to use of Tyvaso, (2) only covered for PH-ILD associated with IPF or CTD, and (3) for continuation of coverage, documentation that patient has had a positive clinical response as determined by the provider and includes improvement in the 6MWD compared to baseline.
Indications	All Medically-accepted Indications.
Off Label Uses	

UBRELVY

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other CGRP antagonist therapy.
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	

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	

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	

VIJOICE

Products Affected

- VIJOICE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	All the following must be met: (1) Patient has a physician-confirmed and documented diagnosis of PROS including evidence of a mutation in the PIK3CA gene, and (2) Patient has at least one target lesion identified on imaging, and (3) Patient's baseline measurable target lesion volume is documented.
Age Restrictions	Must be at least 2 years old.
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist, vascular specialist, or geneticist.
Coverage Duration	Initial: 6 months, Reauthorization: 1 year.
Other Criteria	All the following must be met: (1) Patient's condition is severe or life-threatening and systemic treatment is deemed necessary by the treating physician, and (2) for reauthorization of previously approved requests, documentation of a positive response to therapy as determined by the provider and evidenced by at least a 20% reduction in the total measurable target lesion volume if none of the individual target lesions increased greater than or equal to 20% from baseline, no progression of non-target lesions, and no new lesions.
Indications	All FDA-approved 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	

VONJO

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Criteria will be applied consistent with current NCCN guidance.
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	

VOXZOGO

Products Affected

- VOXZOGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient's current weight. Documentation of current annualized growth velocity (AGV). Recent documentation of open epiphyses. Documentation of achondroplasias confirmed by genetic testing.
Age Restrictions	Patient is 5 to 17 years of age.
Prescriber Restrictions	Must be prescribed by or in consultation with a board-certified geneticist, endocrinologist, neurologist, orthopedic surgeon, or specialist with experience in treating achondroplasia.
Coverage Duration	One year
Other Criteria	For continuation: Must have documentation of a positive clinical response as determined by the prescriber.
Indications	All FDA-approved 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 and either an echocardiogram (ECHO) or cardiac magnetic resonance (CMR) imaging demonstrating cardiac involvement (i.e., increased left ventricular wall thickness). 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 and either an echocardiogram (ECHO) or cardiac magnetic resonance (CMR) imaging demonstrating cardiac involvement (i.e., increased left ventricular wall thickness). 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	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

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 ankylosing spondylitis: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one nonsteroidal anti-inflammatory drug (NSAID). For arthritis-related conditions in adults, must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one nonbiologic immunomodulator (e.g., methotrexate, leflunomide).
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	
Indications	All Medically-accepted 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 ankylosing spondylitis: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one nonsteroidal anti-inflammatory drug (NSAID). For other arthritis-related conditions, must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) to one nonbiologic immunomodulator (e.g., methotrexate, leflunomide).
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. Part B before Part D Step Therapy.
Indications	All Medically-accepted Indications.
Off Label Uses	

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs.
Required Medical Information	For asthma and nasal polyps: Must provide patient's current weight and baseline IgE level.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For asthma: Must have a documented trial and failure with an inhaled corticosteroid (ICS) and long-acting beta agonist (LABA) in the past 6 months (failure is defined as an intolerance or inability to improve the condition on an ICS/LABA regimen for at least 4 weeks) - AND - dose must align with FDA-approved dosing based on IgE and weight. For chronic urticaria: Must have a documented trial and failure (defined as an intolerance or inability to improve symptoms) with at least two H1 antihistamines (e.g., levocetirizine, desloratadine) - OR - one H1 antihistamine and at least 1 of the following: H2 antihistamine (e.g., famotidine), oral steroid, or leukotriene modifier. For nasal polyps: Must have a documented trial and failure (defined as an inability to improve symptoms) with daily intranasal steroids - AND - Must be used with an intranasal steroid - AND - dose must align with FDA-approved dosing based on IgE and weight. For continuation of all previously approved requests: Must have documentation showing clinical benefit (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).
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	Must first try amphetamine salts, dextroamphetamine or methylphenidate with inadequate response or intolerance. For narcolepsy, must also try either modafinil or armodafinil with inadequate response or intolerance.
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	

ZEPOSIA

Products Affected

- ZEPOSIA
- ZEPOSIA 7-DAY STARTER PACK
- ZEPOSIA STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	For ulcerative colitis: Zeposia must not be used in combination with other biological drugs.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	For ulcerative colitis: Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	One year
Other Criteria	For ulcerative colitis: Must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to Humira and Xeljanz/Xeljanz XR.
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	

ZONISADE

Products Affected

- ZONISADE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For doses above 400 mg per day, documentation confirming need for further seizure reduction is required.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	Must have tried generic zonisamide capsules with inability to swallow capsule - AND - must have tried and failed (defined as an inability to improve the condition) one other generic antiseizure medication.
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	

ZTALMY

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must provide confirmation of CDKL5 deficiency based on genetic testing - AND - patient's current weight.
Age Restrictions	Must be 2 years of age or older.
Prescriber Restrictions	Must be prescribed by a neurologist.
Coverage Duration	One year
Other Criteria	Documented therapeutic failure of at least 2 previous antiepileptic drugs.
Indications	All FDA-approved 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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