Priority Health

2025 Priority Health Medicare Prior Authorization Criteria

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

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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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ACTHAR

Products Affected

- ACTHAR
- ACTHAR GEL

PA Criteria	Criteria Details
Exclusion Criteria	Acthar Gel is only covered for the treatment of infantile spasms.
Required Medical Information	Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 weeks
Other Criteria	Covered for infantile spasms after trial and failure (defined as an intolerance or inability to improve the condition) with Cortrophin.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ADALIMUMAB-ADAZ

Products Affected

- *adalimumab-adaz subcutaneous solution auto-injector*
- *adalimumab-adaz subcutaneous solution prefilled syringe 20 mg/0.2ml, 40 mg/0.4ml*

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment. For approvals of shortened-interval dosing in Crohn's disease and ulcerative colitis, documentation of the following: (1) Two of the following: symptoms, imaging showing active disease, fecal calprotecin greater than 120, CRP greater than or equal to 300, and (2) inadequate drug trough levels, and (3) initial response to therapy.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.

PA Criteria	Criteria Details
Other Criteria	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For Crohn's disease: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone). For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin). For uveitis: Must try and fail (defined above) one other drug for the condition (e.g., intraocular or systemic steroids, immunomodulator drugs). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting adalimumab concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ADEMPAS

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For pulmonary arterial hypertension (PAH), confirmed diagnosis of World Health Organization (WHO) Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	For PAH, trial and failure (defined as an inability to improve the condition) with sildenafil or tadalafil. For chronic thromboembolic pulmonary hypertension (CTEPH), must be in WHO Group 4 - and - must be classified as inoperable or as persistent/recurrent after pulmonary endarterectomy.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AIMOVIG

Products Affected

- AIMOVIG

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other CGRP antagonist therapy.
Required Medical Information	For migraine prevention initial requests: (1) Must have at least four migraine days per month, AND (2) Must try and fail (defined as an intolerance or inability to improve the condition) two of the following generic migraine prevention drugs, each from a different class and each used for at least 28 days: amitriptyline, nortriptyline, venlafaxine, propranolol, metoprolol, timolol, valproic acid, divalproex, or topiramate, AND (3) Patient has been evaluated for and does not have Medication overuse headache (MOH).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 1 year. Reauth: 2 years. Dosing must align with FDA labeling.
Other Criteria	For migraine prevention reauthorization requests: Must provide documentation of a decrease in migraine days per month with use of Aimovig.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AKEEGA

Products Affected

- AKEEGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ALECENSA

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ALUNBRIG

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ambrisentan

Products Affected

- *ambrisentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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. 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. 2 years 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	
Part B Prerequisite	No

aprepitant

Products Affected

- *aprepitant oral capsule*

PA Criteria	Criteria Details
Exclusion Criteria	Aprepitant is not covered in the following situations: (1)treatment of established nausea and vomiting, and (2) for chronic continuous use.
Required Medical Information	For post-op nausea/vomiting: Provide date of surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year authorization with limit of one 30-day fill for post-op nausea/vomiting
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

APTIOM

Products Affected

- APTIOM ORAL TABLET 200 MG, 400 MG, 600 MG, 800 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ARALAST

Products Affected

- ARALAST NP INTRAVENOUS SOLUTION RECONSTITUTED 1000 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have an FEV1 less than 80 percent predicted - AND - a 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	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ARCALYST

Products Affected

- ARCALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the treatment of recurrent pericarditis: Must have documentation supporting a trial and failure (defined as inadequate response) with an NSAID in combination with colchicine.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	Initial approval for 6 months. Reauthorization for 12 months.
Other Criteria	For initial review, documentation of failure to obtain negative sputum cultures after a minimum of 6 months of a multidrug background regimen therapy for MAC lung disease must be provided. For reauthorization, documentation of a negative sputum culture obtained within the last 30 days must be provided. Criteria will be applied consistent with current ATS/IDSA guidelines.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

aripiprazole odt

Products Affected

- *aripiprazole oral tablet dispersible*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient has had prior trial with AND has a documented contraindication (e.g., dysphagia) to BOTH generic aripiprazole TABLET and generic aripiprazole oral SOLUTION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and reauthorization.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

armodafinil

Products Affected

- *armodafinil*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

asenapine

Products Affected

- *asenapine maleate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs used for at least 28 days each: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AUGTYRO

Products Affected

- AUGTYRO ORAL CAPSULE 160 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AUSTEDO

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG
- AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HOUR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG
- AUSTEDO XR PATIENT TITRATION ORAL TABLET EXTENDED RELEASE THERAPY PACK 12 & 18 & 24 & 30 MG, 6 & 12 & 24

MG

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with tetrabenazine or Ingrezza.
Required Medical Information	For tardive dyskinesia initial requests, the following documentation is required: (1) The patient's baseline Abnormal Involuntary Movement Scale (AIMS) score with date of baseline score (baseline is defined as prior to treatment with Austedo), AND (2) Trial and failure with tetrabenazine (defined as an intolerance or inadequate symptom improvement), AND either (3) the patient is using Austedo for TD that is not associated with dopamine receptor blocking, OR (4) the patient is using Austedo for TD associated with the use of dopamine receptor blocking agents and symptoms persist despite stopping or reducing the dose of the dopamine blocking agent or discontinuation or reduction of the dose of the dopamine blocking agent is not possible. For chorea associated with Huntington's disease initial requests: (1) Must provide documentation supporting a trial and failure with tetrabenazine (defined as an intolerance or inadequate symptom improvement).
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	
Coverage Duration	Initial: 1 year. Reauth: 2 years.
Other Criteria	For tardive dyskinesia (TD) reauthorization requests: (1) Must provide documentation of improvement in the patient's AIMS score compared to baseline. For chorea associated with Huntington's disease reauthorization requests: (1) Must provide documentation of improvement in chorea symptoms compared to baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AUVELITY

Products Affected

- AUVELITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	Must try and fail (defined as an inability to improve depressive symptoms after at least 4 weeks of treatment) with an SSRI or SNRI and 1 atypical antidepressant (e.g., bupropion, mirtazapine).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

AVEED

Products Affected

- AVEED

PA Criteria	Criteria Details
Exclusion Criteria	Not covered in males with late-onset (age-related) hypogonadism.
Required Medical Information	For primary and hypogonadotropic hypogonadism: Documentation of the following is required (1) Two pre-treatment serum total testosterone levels, each taken in the morning on separate days, that are less than 300 ng/dL or that are low as defined by the laboratory reference values, AND (2) Patient is male, AND (3) Pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction and decreased libido (such as depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis), AND (4) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product - and - a generic topical testosterone therapy. For gender dysphoria: Documentation of the following is required: (1) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product - and - a generic topical testosterone therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
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.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	Yes

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

AYVAKIT

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BALVERSA

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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 initial requests: 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 initial requests: 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	1 year initial. 2 years reauthorization.
Other Criteria	For SLE initial requests: Must be taking two of the following drugs together for at least 12 weeks each: a steroid, immunosuppressant, and/or hydroxychloroquine - AND - For SLE reauthorization: Must have evidence of clinical improvement with Benlysta. For lupus nephritis (LN) initial requests: Must be receiving standard therapy for LN (e.g., mycophenolate or azathioprine plus a steroid) - AND - For LN reauthorization: Must have evidence of clinical improvement with Benlysta, including improved or stable eGFR.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

BESREMI

Products Affected

- BESREMI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	Must trial and fail hydroxyurea (defined as an intolerance and/or persistence or recurrence of disease).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BETASERON

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

bexarotene

Products Affected

- *bexarotene oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BEXAROTENE GEL

Products Affected

- *bexarotene external*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must first try tazarotene.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

bosentan

Products Affected

- *bosentan*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BOSULIF

Products Affected

- BOSULIF ORAL CAPSULE 100 MG, 50 MG
- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

BRIVIACT

Products Affected

- BRIVIACT ORAL SOLUTION
- BRIVIACT ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with generic levetiracetam and at least 1 other generic anticonvulsant for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

CABOMETYX

Products Affected

- CABOMETYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

calcipotriene/betamethasone suspension

Products Affected

- *calcipotriene-betameth diprop external suspension*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure with a generic topical steroid for the scalp (such as fluocinonide solution, clobetasol solution, clobetasol shampoo) in combination with generic calcipotriene solution. Failure is defined as an inadequate response in treating the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CALQUENCE

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CAMZYOS

Products Affected

- CAMZYOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial coverage, must have (1) a diagnosis of symptomatic NYHA class II or III obstructive hypertrophic cardiomyopathy - AND - (2) a LVEF of 55% or more - AND - (3) previous trial and failure (an inability to improve symptoms), contraindication, or intolerance to beta blockers (such as metoprolol) and non-dihydropyridine calcium channel blockers (verapamil or diltiazem) at doses appropriate for obstructive hypertrophic cardiomyopathy. For reauthorization, must have (1) a LVEF of 50% or more - AND - (2) clinically significant improvement of symptoms (such as improvement in NT-proBNP, decreased shortness of breath, or an improvement in patient reported outcomes assessment).
Age Restrictions	Patient is at least 18 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with a cardiologist.
Coverage Duration	Initial: 1 year. Reauthorization: 2 years.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CAPLYTA

Products Affected

- CAPLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	For schizophrenia: 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. For depressive episodes associated with bipolar 1 disorder: Patient must have tried and failed (defined above) one of the following generic products: quetiapine or olanzapine (with fluoxetine) - AND - Patient must have tried and failed (defined above) generic lurasidone. For depressive episodes associated with bipolar 2 disorder: Patient must have tried and failed (defined above) quetiapine.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CAPRELSA

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CARGLUMIC ACID

Products Affected

- *carglumic acid oral tablet soluble*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CAYSTON

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CERDELGA

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CHOLBAM

Products Affected

- CHOLBAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial. Two years reauthorization.
Other Criteria	For reauthorization, must have clinical benefit from use of the drug as determined by the provider.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

clobazam

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
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	
Part B Prerequisite	No

COBENFY

Products Affected

- COBENFY
- COBENFY STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an inadequate response) with two generic atypical antipsychotics used for at least 28 days each.
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	Must be prescribed by, or in consultation with, a specialist for the condition being treated.
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

colistimethate sodium

Products Affected

- *colistimethate sodium (cba)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) The drug is being used intravenously (IV) or intramuscularly (IM). Administration through nebulization is not covered (CMS-approved compendia do not support inhalation/nebulization of colistimethate), AND (2) the infection is proven, or strongly suspected, to be caused by susceptible bacteria based on the following required documentation: 1) culture and susceptibility information, OR 2) local epidemiology and susceptibility patterns.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with an infectious disease specialist.
Coverage Duration	One year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

COMETRIQ

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

COPIKTRA

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CORLANOR

Products Affected

- CORLANOR ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For heart failure in adults, documentation of the following is required: (1) Patient has stable, symptomatic chronic heart failure, AND (2) Patient has an ejection fraction of 35% or less, AND (3) Patient is in sinus rhythm with a resting heart rate of at least 70 beats per minute, AND (4) Patient is currently on maximally tolerated beta-blocker therapy OR has a contraindication to beta-blocker therapy (i.e., allergy, severe COPD limiting beta blocker usage). For heart failure in children, documentation of the following is required: (1) patient has stable, symptomatic chronic heart failure due to dilated cardiomyopathy, AND (2) patient is in sinus rhythm with an elevated heart rate, AND (3) baseline heart rate (defined as prior to the use of Corlanor) has been provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year initial, 2 years reauth
Other Criteria	For reauthorization requests (adult and children), the patient is continuing to have clinical benefit from Corlanor as defined by maintenance of a decreased heart rate compared to baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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. Reauth-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. Reauthorization of previously authorized therapy requires demonstrated clinical benefit. Quantity limited to dosage as supported by the FDA-approved label.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	Yes

COSENTYX

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For ankylosing spondylitis and non-radiographic axial spondyloarthritis (NRAS): Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For ERA: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - have aggressive disease that necessitates initial biologic therapy. For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

COTELLIC

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

CYSTADROPS

Products Affected

- CYSTADROPS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

CYSTARAN

Products Affected

- CYSTARAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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, reauthorization required every 12 months thereafter
Other Criteria	Baseline timed 25-foot walk (T25FW), patient must be currently ambulatory. Reauthorization requires documentation of stability and/or improvement in walking speed.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DASATINIB

Products Affected

- *dasatinib oral tablet 100 mg, 140 mg, 20 mg, 50 mg, 70 mg, 80 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DAURISMO

Products Affected

- DAURISMO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DAYBUE

Products Affected

- DAYBUE

PA Criteria	Criteria Details
Exclusion Criteria	Patient does not have atypical or variant Rett syndrome.
Required Medical Information	Must have documentation of the following: (1) Patient's current weight, (2) diagnosis of classic/typical Rett Syndrome (RTT), AND (3) a documented mutation in the MECP2 gene.
Age Restrictions	Must be at least 2 years old.
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	One year initial and reauthorization.
Other Criteria	Initial: Must provide documentation of current Rett Syndrome Behavior Questionnaire (RSBQ) score -AND- current Clinical Global Impression-Severity score. For reauthorization: Must provide documentation confirming a positive response to therapy based on the patient's baseline RSBQ and CGIS scores.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

Diabetic Supplies

Products Affected

- *assure id insulin safety syr 29g x 1/2" 1 ml*
- BD AUTOSHIELD DUO
- *bd pen needle 29g x 12mm*
- BD PEN NEEDLE MICRO U/F
- BD PEN NEEDLE MINI U/F
- BD PEN NEEDLE NANO 2ND GEN
- BD PEN NEEDLE NANO U/F
- BD PEN NEEDLE ORIGINAL U/F
- BD PEN NEEDLE SHORT U/F
- *comfort assist insulin syringe 29g x 1/2" 1 ml*
- *cvs gauze sterile pad 2"x2"*
- *global alcohol prep ease*
- NOVOFINE PEN NEEDLE
- NOVOFINE PLUS PEN NEEDLE
- NOVOTWIST PEN NEEDLE
- *preferred plus insulin syringe 28g x 1/2" 0.5 ml*
- *reli-on insulin syringe 29g 0.3 ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	Approve if the prescriber confirms that the medical supply is being requested for a use that is directly associated with delivering insulin to the body.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DIACOMIT

Products Affected

- DIACOMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Patient has a diagnosis of seizures associated with Dravet syndrome AND (2) Patient is not currently controlled on current therapy (defined as experiencing generalized tonic clonic or clonic seizures within the past 28 days) AND (3) Patient taking concomitant clobazam therapy.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist (i.e. neurologist, epileptologist).
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

DICHLORPHENAMIDE

Products Affected

- *dichlorphenamide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

dihydroergotamine nasal spray

Products Affected

- *dihydroergotamine mesylate nasal*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation to support (1) a trial and failure (defined as inability to improve symptoms or condition) of one non-oral triptan drug (e.g., sumatriptan nasal spray or injection) AND (2) a trial and failure (defined above) of Nurtec ODT.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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 initial and reauthorization.
Other Criteria	Patient must not have pancreatic insufficiency. For reauthorization, 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	
Part B Prerequisite	No

DRIZALMA

Products Affected

- DRIZALMA SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation of a trial and failure (defined as an inability to improve the condition) with two antidepressants, one of which is duloxetine (generic Cymbalta).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

droxidopa

Products Affected

- *droxidopa*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and reauthorization.
Other Criteria	Patient must first try midodrine. For reauthorization: Must have documentation of a positive clinical response (e.g., sustained decrease in dizziness).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

DUPIXENT

Products Affected

- DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML, 300 MG/2ML
- DUPIXENT SUBCUTANEOUS SOLUTION PEN-INJECTOR 200 MG/1.14ML, 300 MG/2ML
- DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/0.67ML, 200

MG/1.14ML, 300 MG/2ML

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs or Janus Kinase Inhibitor (JAKis).
Required Medical Information	For initial coverage of asthma, documentation of the following is required: (1) Oral corticosteroid-dependent asthma - or - Eosinophilic asthma with an elevated blood eosinophil count of 150 cells per microliter or more within 6 weeks (prior to the immediate start of treatment with Dupixent) or 300 cells per microliter or more in the previous 12 months, AND (2) Trial and failure of 1 ICS/LABA inhaler in the past 6 months (failure is defined as an inability to improve the condition on the required therapy for at least 4 weeks). For reauthorization of asthma: (1) Must have documentation of clinical benefit with Dupixent compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use). For initial coverage of eosinophilic esophagitis, documentation of the following is required: (1) Confirmation of diagnosis by esophageal biopsy defined by having at least 15 eosinophils per high power field (HPF), AND (2) Patient's current weight is at least 15 kg, AND (3) Patient has symptoms of esophageal dysfunction, AND (4) Trial and failure (defined as an inability to achieve and maintain remission of low or mild disease activity) with one proton pump inhibitor for at least 2 months, AND (5) Trial and failure (defined above) with one topical steroid (e.g., fluticasone, budesonide) for at least 2 months. For reauthorization of eosinophilic esophagitis: (1) Must have documentation of a reduction in eosinophil count on endoscopic biopsy or a reduction in symptoms (e.g., less dysphagia).
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 2 years reauth. Dose must follow the FDA-approved labeling.

PA Criteria	Criteria Details
Other Criteria	For initial coverage of prurigo nodularis, documentation of the following is required: (1) Moderate to severe disease defined as a score of at least 7 on the Worst Itching Intensity Numerical Rating Scale (WI-NRS) and at least 20 nodular lesions, AND (2) Trial and failure (defined as inability to improve the condition) with one oral antihistamine, AND (3) Trial and failure (defined above) with a medium or higher potency topical steroid. For reauthorization of prurigo nodularis: (1) Must have documentation of a reduction in nodular lesion count or lesion size and/or a reduction in pruritis. For initial coverage of atopic dermatitis, documentation of the following is required: (1) Confirmation of moderate to severe atopic dermatitis, AND (2) Trial and failure (defined as an inadequate response) to one medium or higher potency topical steroid (e.g., clobetasol) - or - one topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus). For reauthorization of atopic dermatitis: (1) Must have documented clinical benefit (e.g. less exacerbations, improved symptoms, less steroid use). For initial coverage of chronic rhinosinusitis with nasal polyp, documentation of the following is required: (1) Patient has experienced 2 or more of the following symptoms for at least 12 weeks despite management: nasal congestion or obstruction, nasal drainage, reduction or loss of smell, AND (2) Patient has tried and failed (defined as an inability to improve symptoms for at least 4 weeks) an intranasal steroid, AND (3) Patient will continue to use an intranasal steroid along with Dupixent. For reauthorization of chronic rhinosinusitis with nasal polyp: (1) The patient will continue to use an intranasal steroid along with Dupixent, AND (2) Must have documentation of clinical benefit with Dupixent compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EMGALITY

Products Affected

- EMGALITY
- EMGALITY (300 MG DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other CGRP antagonist therapy.
Required Medical Information	For migraine prevention initial requests: (1) Must have at least four migraine days per month, AND (2) Must try and fail (defined as an intolerance or inability to improve the condition) two of the following generic migraine prevention drugs, each from a different class and each used for at least 28 days: amitriptyline, nortriptyline, venlafaxine, propranolol, metoprolol, timolol, valproic acid, divalproex, or topiramate, AND (3) Patient has been evaluated for and does not have Medication overuse headache (MOH). For cluster headache initial requests: (1) Must try and fail verapamil (fail is defined above), AND (2) Patient has been evaluated for and does not have Medication overuse headache (MOH).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 year. Cluster reauth: 1 year. Migraine reauth: 2 years. Dosing must align with FDA labeling.
Other Criteria	For migraine prevention reauthorization requests: Must provide documentation of a decrease in migraine days per month with use of Emgality. For cluster headache reauthorization requests: Must provide documentation of a decrease in the frequency or intensity of cluster headaches with Emgality.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EMSAM

Products Affected

- EMSAM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation supporting the trial and failure (defined as an inadequate improvement in depressive symptoms) with two of the following generic antidepressants is required: SNRIs, SSRIs, mirtazapine, or bupropion.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ENBREL

Products Affected

- ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML
- ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 25 MG/0.5ML, 50 MG/ML
- ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting Enbrel concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ENBREL MINI

Products Affected

- ENBREL MINI

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting Enbrel concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ENDARI

Products Affected

- ENDARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must try and fail hydroxyurea. Fail is defined as continuing to have pain episodes despite appropriately dosed hydroxyurea or having any intolerance to hydroxyurea.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years - 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	
Part B Prerequisite	No

ENTADFI

Products Affected

- ENTADFI

PA Criteria	Criteria Details
Exclusion Criteria	use of concomitant generic tadalafil
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	26 weeks
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	
Part B Prerequisite	No

EOHILIA

Products Affected

- EOHILIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Diagnosis of EOE confirmed by esophageal biopsy, defined as at least 15 eosinophils per high power field (HPF) - and - (2) Must have continued symptoms of EOE despite trial of a proton pump inhibitor for at least 2 months - and (3) - Trial with one topical generic corticosteroid (i.e., fluticasone, budesonide) for at least 2 months with continued symptoms.
Age Restrictions	Must be age 11 years or older.
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated (gastroenterologist, allergist)
Coverage Duration	1 year authorization with a limit of 12 weeks of treatment.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EPIDIOLEX

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

EPRONTIA

Products Affected

- EPRONTIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with generic topiramate sprinkles and at least 1 other generic anticonvulsant for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ERIVEDGE

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ERLEADA

Products Affected

- ERLEADA ORAL TABLET 240 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

erlotinib

Products Affected

- *erlotinib hcl oral tablet 100 mg, 150 mg, 25 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

EVENITY

Products Affected

- EVENITY

PA Criteria	Criteria Details
Exclusion Criteria	Cumulative use of Evenity of more than 12 months is not covered.
Required Medical Information	Must provide documentation of prior therapies and responses to treatment - AND - documentation confirming diagnosis such as T-score.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by endocrinologist.
Coverage Duration	12 months total therapy
Other Criteria	Must try and fail alendronate, risedronate, or ibandronate - AND - either zoledronic acid or Prolia. Failure is defined as intolerance, decrease in BMD in comparison to previous DEXA scan, 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	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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, reauthorization - 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 reauthorization, 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	
Part B Prerequisite	No

FABHALTA

Products Affected

- FABHALTA

PA Criteria	Criteria Details
Exclusion Criteria	Fabhalta is not covered in combination with other complement drug therapy including Soliris, Ultomiris, Empaveli. (Fabhalta has not been studied and there is no data to support use in combination with these other medications).
Required Medical Information	For initial requests for PNH: (1) Must have diagnosis confirmed by flow cytometry, - AND - (2) Must have hemolysis-associated symptoms (thrombosis, organ dysfunction, pain). For initial requests for IgAN, documentation of the following must be provided: (1) Biopsy-verified primary immunoglobulin A nephropathy (IgAN) - AND - (2) proteinuria defined as a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1 g/g - AND - (3) Trial and failure of a maximally tolerated dose of an ACE inhibitor or ARB (defined as an intolerance or an inadequate response after at least 3 months) - AND - (4) Trial and failure of Filspari (defined as an intolerance or inadequate response) - AND (5) - Patient is not currently receiving dialysis - AND - (6) Patient has not had a kidney transplant.
Age Restrictions	Patient is 18 years of age or older.
Prescriber Restrictions	For IgAN: Must be prescribed by or in consultation with a specialist for the condition.
Coverage Duration	One year initial and reauthorization.
Other Criteria	For reauthorization for PNH, must have documentation of improvement in PNH-related symptoms (e.g., fatigue, dyspnea) - AND - sustained increase in hemoglobin levels, improvement in hemolysis, or reduced transfusions compared to baseline. For IgAN reauthorization requests, must have documentation of clinical benefit that includes reduced proteinuria - AND - stabilization in the eGFR compared to baseline.
Indications	All FDA-approved Indications.
Off Label Uses	

PA Criteria	Criteria Details
Part B Prerequisite	No

FANAPT

Products Affected

- FANAPT
- FANAPT TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs that have support for the requested condition and each used for at least 28 days: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FASENRA

Products Affected

- FASENRA PEN
- FASENRA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 10 MG/0.5ML, 30 MG/ML

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, documentation of the following is required: (1) An elevated blood eosinophil count of greater than or equal to 150 cells per microliter within 6 weeks (prior to the immediate start of treatment with Fasenra) - OR - greater than or equal to 300 cells per microliter in the previous 12 months, AND (2) Trial with failure of 1 ICS/LABA inhaler in the past 6 months (failure is defined as an inability to improve the condition on the required therapy for at least 4 weeks). For reauthorization of severe eosinophilic asthma: (1) Must have documentation of clinical benefit with Fasenra compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).
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 2 years reauth. Dosing must follow the FDA-approved labeling.
Other Criteria	Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

FILSPARI

Products Affected

- *filspari*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For all requests: Medical records supporting the request must be provided, including documentation of a covered diagnosis, prior therapies, and responses to treatment. For IgAN initial requests: Must also provide (1) documentation confirming biopsy-verified primary immunoglobulin A nephropathy (IgAN) - AND - (2) documentation of a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g - AND - (3) documentation of an eGFR greater than or equal to 30 mL/min/1.73 m2.
Age Restrictions	Must be age 18 or older
Prescriber Restrictions	Must be prescribed by or in consultation with a nephrologist.
Coverage Duration	One year initial and reauthorization.
Other Criteria	For IgAN initial requests: (1) Patient must try and fail (defined as an intolerance or an inadequate response after a minimum of 3 months) with a maximally tolerated dose of an ACE inhibitor or ARB - AND - (2) Patient must try and fail (defined above) one other drug for the condition (e.g., mycophenolate, steroids, SGLT2 inhibitor, etc.) - AND (3) Patient must not be currently receiving dialysis - AND - (4) Patient has not undergone kidney transplant. For IgAN reauthorization requests: (1) Must have documentation of a reduced proteinuria - AND - no decline in eGFR compared to baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FILSUVEZ

Products Affected

- FILSUVEZ

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with Vyjuvek.
Required Medical Information	For epidermolysis bullosa initial requests: (1) Must have a diagnosis of recessive dystrophic epidermolysis bullosa (RDEB) with genetic testing confirming mutation(s), AND (2) Must have presence of open, partial thickness skin wounds, AND (3) Application is limited to open, partial thickness skin wounds only during dressing change. For epidermolysis bullosa reauthorization requests: (1) Must have presence of open, partial thickness skin wounds, AND (2) Application is limited to open, partial thickness skin wounds only during dressing change, AND (3) documentation confirming Filsuvez is providing clinical benefit must be provided (e.g. complete wound closure, decrease in wound size, reduced body surface area affected by wounds, increase in granulation tissue, decrease in pain and/or infection).
Age Restrictions	Patient must be 6 months of age or older.
Prescriber Restrictions	Must be prescribed by, or in consultation with, a dermatologist or another board-certified prescriber with qualifications to treat dystrophic epidermolysis bullosa.
Coverage Duration	3 months initial and 6 months reauthorization
Other Criteria	
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

FINGOLIMOD

Products Affected

- *fingolimod hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FINTEPLA

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with two of the following: clobazam, valproic acid, topiramate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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: 1 year. Reauthorization: 2 years.
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) - for adults only, patient must have documented trial and failure (defined as an intolerance or inability to improve symptoms) to pyridostigmine. For reauthorization: Must have documentation showing improvement or stabilization in condition using the QMG or 3TUG test.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

FOTIVDA

Products Affected

- FOTIVDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FRUZAQLA

Products Affected

- FRUZAQLA ORAL CAPSULE 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

FYCOMPA

Products Affected

- FYCOMPA ORAL SUSPENSION
- FYCOMPA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GALAFOLD

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests: (1) Patient must have a confirmed diagnosis of Fabry disease and documentation of an amenable galactosidase alpha gene variant based on in vitro assay data, AND (2) Must have an eGFR of 30 or more.
Age Restrictions	Must be at least 18 years of age.
Prescriber Restrictions	Must be prescribed by, or in consultation with, a specialist for the condition.
Coverage Duration	Two years
Other Criteria	For reauthorization: (1) Must have an eGFR of 30 or more, AND (2) Must have documentation supporting a continued response to Galafold therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GATTEX

Products Affected

- GATTEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of dependence on parenteral support for at least 12 months must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial approval is 6 months. Reauthorization: 1 year.
Other Criteria	For reauthorization: Documentation that the patient has had a sustained decreased in parenteral support from baseline as documented by an actual change in volume must be provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

GAVRETO

Products Affected

- GAVRETO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GEFITINIB

Products Affected

- *gefitinib*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GILOTRIF

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

glatiramer

Products Affected

- *glatiramer acetate subcutaneous solution prefilled syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GLATOPA

Products Affected

- GLATOPA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML, 40 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

GROWTH HORMONE

Products Affected

- NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR
- OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE
- OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED

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 reauthorization 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	
Part B Prerequisite	No

HADLIMA

Products Affected

- HADLIMA PUSHTOUCH SUBCUTANEOUS SOLUTION AUTO-INJECTOR 40 MG/0.4ML, 40 MG/0.8ML
- HADLIMA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 40 MG/0.4ML, 40 MG/0.8ML

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment. For approvals of shortened-interval dosing in Crohn's disease and ulcerative colitis, documentation of the following: (1) Two of the following: symptoms, imaging showing active disease, fecal calprotecin greater than 120, CRP greater than or equal to 300, and (2) inadequate drug trough levels, and (3) initial response to therapy.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.

PA Criteria	Criteria Details
Other Criteria	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For Crohn's disease: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone). For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin). For uveitis: Must try and fail (defined above) one other drug for the condition (e.g., intraocular or systemic steroids, immunomodulator drugs). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting adalimumab concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

Haegarda

Products Affected

- HAEGARDA

PA Criteria	Criteria Details
Exclusion Criteria	Haegarda is not covered if any of the following are met: (1) use in combination with an angiotensin-converting enzyme inhibitor (ACEI), (2) use in combination with other preventative therapies for HAE (e.g., Orladeyo, Takhyzro), and/or (3) used for the treatment of acute attacks.
Required Medical Information	Requires submission of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis.
Age Restrictions	Must be age 6 or older.
Prescriber Restrictions	Prescriber is an allergist, immunologist, hematologist, or other specialist experienced in treating HAE.
Coverage Duration	1 year initial and reauth
Other Criteria	For reauthorization: Must also have documentation showing a decrease in the frequency of attacks.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

HEMADY

Products Affected

- HEMADY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
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	
Part B Prerequisite	No

HUMIRA

Products Affected

- HUMIRA (2 PEN)
- HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML, 40 MG/0.8ML
- HUMIRA PEN SUBCUTANEOUS PEN-INJECTOR KIT
- HUMIRA SUBCUTANEOUS PREFILLED SYRINGE KIT 40 MG/0.8ML
- HUMIRA-CD/UC/HS STARTER
- HUMIRA-PED>/=40KG UC STARTER
- HUMIRA-PSORIASIS/UVEIT STARTER

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment. For approvals of shortened-interval dosing in Crohn's disease and ulcerative colitis, documentation of the following: (1) Two of the following: symptoms, imaging showing active disease, fecal calprotecin greater than 120, CRP greater than or equal to 300, and (2) inadequate drug trough levels, and (3) initial response to therapy.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.

PA Criteria	Criteria Details
Other Criteria	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For Crohn's disease: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone). For hidradenitis suppurativa: Must try and fail (defined above) one other drug for the condition (e.g., prednisone, clindamycin, erythromycin). For uveitis: Must try and fail (defined above) one other drug for the condition (e.g., intraocular or systemic steroids, immunomodulator drugs). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting adalimumab concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

HYFTOR

Products Affected

- HYFTOR

PA Criteria	Criteria Details
Exclusion Criteria	Must not be receiving systemic mTOR inhibitor therapy (e.g., everolimus).
Required Medical Information	Medical records supporting the request must be provided. Must have 3 or more facial angiofibromas.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, a dermatologist, neurologist, or geneticist.
Coverage Duration	Initial coverage: 3 months. Reauthorization: 1 year.
Other Criteria	Must not be a candidate for laser therapy or surgery. Reauthorization: Must have evidence of improvement in facial angiofibromas compared to baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IBRANCE

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

icatibant acetate

Products Affected

- *icatibant acetate subcutaneous solution prefilled syringe*
- SAJAZIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of an angiotensin-converting enzyme inhibitor (ACEI) is not covered.
Required Medical Information	Documentation of C4, C1-INH protein, and C1-INH function lab results confirming diagnosis.
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 reauthorization.
Other Criteria	For reauthorization: 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 FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ICLUSIG

Products Affected

- ICLUSIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
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	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IMBRUVICA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	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	
Part B Prerequisite	No

IMPAVIDO

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One month
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INCRELEX

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	Increlex is not covered in patients with closed epiphyses.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INLYTA

Products Affected

- INLYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

INQOVI

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must first try IV decitabine.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes

INREBIC

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must have tried and failed (defined as an intolerance or inability to improve the condition) Jakafi.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

insulin aspart

Products Affected

- *insulin aspart flexpen*
- *insulin aspart injection*
- *insulin aspart penfill*
- *insulin aspart prot & aspart*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inability to control blood glucose levels) with one of the following: Humalog, Humalog Mix, Lyumjev, or insulin lispro vials.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ISTURISA

Products Affected

- ISTURISA ORAL TABLET 1 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	Two years
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	
Part B Prerequisite	No

ivabradine

Products Affected

- *ivabradine hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For heart failure in adults, documentation of the following is required: (1) Patient has stable, symptomatic chronic heart failure, AND (2) Patient has an ejection fraction of 35% or less, AND (3) Patient is in sinus rhythm with a resting heart rate of at least 70 beats per minute, AND (4) Patient is currently on maximally tolerated beta-blocker therapy OR has a contraindication to beta-blocker therapy (i.e., allergy, severe COPD limiting beta blocker usage). For heart failure in children, documentation of the following is required: (1) patient has stable, symptomatic chronic heart failure due to dilated cardiomyopathy, AND (2) patient is in sinus rhythm with an elevated heart rate, AND (3) baseline heart rate (defined as prior to the use of ivabradine) has been provided
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial. Two years reauthorization.
Other Criteria	For reauthorization requests (adult and children), the patient is continuing to have clinical benefit from ivabradine as defined by maintenance of a decreased heart rate compared to baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

IVIG

Products Affected

- GAMMAGARD INJECTION SOLUTION 2.5 GM/25ML
- GAMMAGARD S/D LESS IGA
- GAMUNEX-C

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must provide current weight and requested dose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Dosing must follow FDA-approved labeling or have documentation supporting the dose follows accepted standards of medical practice. Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

IWILFIN

Products Affected

- IWILFIN

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	
Part B Prerequisite	No

JAKAFI

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	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	
Part B Prerequisite	No

JAYPIRCA

Products Affected

- JAYPIRCA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records supporting that the use of Jaypirca follows current NCCN recommendations must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Use of Jaypirca must follow current NCCN recommendations.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

JOENJA

Products Affected

- JOENJA

PA Criteria	Criteria Details
Exclusion Criteria	Must not use in combination with immunosuppressive medications.
Required Medical Information	Documentation of activated phosphoinositide 3-kinase delta syndrome (APDS) with PIK3CD or PIK3R1 mutation confirmed by genetic testing.
Age Restrictions	Must be at least 12 years old.
Prescriber Restrictions	Must be prescribed by or in consultation with a provider who specializes in the management of APDS.
Coverage Duration	One year initial and reauthorization.
Other Criteria	Patient must have nodal and/or extranodal lymphoproliferation, history of repeated oto-sino-pulmonary infections and/or organ dysfunction (e.g. lung, liver) - AND - for reauthorization, must provide documentation confirming a positive response to therapy.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

JYLAMVO

Products Affected

- JYLAMVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must have documentation to support a trial and failure (defined as an intolerance or inability to improve the condition) with generic methotrexate. Diagnosis will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KALYDECO

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have laboratory confirmation of ivacaftor-responsive mutation in the CFTR gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
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	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KISQALI FEMARA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KOSELUGO

Products Affected

- KOSELUGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

KRAZATI

Products Affected

- *krazati*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records supporting that the use of Krazati follows current NCCN recommendations must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Use of Krazati must follow current NCCN recommendations.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

lapatinib

Products Affected

- *lapatinib ditosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LAZCLUZE

Products Affected

- LAZCLUZE ORAL TABLET 240 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	
Part B Prerequisite	No

ledipasvir-sofosbuvir

Products Affected

- *ledipasvir-sofosbuvir*

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	Duration of therapy will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Must have documentation to support that the use of ledipasvir-sofosbuvir is consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LENALIDOMIDE

Products Affected

- *lenalidomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LENVIMA

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years. 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	
Part B Prerequisite	No

LIBERVANT

Products Affected

- LIBERVANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LIDOCAINE PATCH

Products Affected

- *lidocaine external patch 5 %*
- LIDOCAN
- LIDOCAN III

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Medically accepted indications for lidocaine 5% patch include relief of pain associated with postherpetic neuralgia (PHN), diabetic neuropathy, and cancer-related neuropathic pain.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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, valganciclovir, cidofovir or foscarnet. For reauthorization, documentation of response (e.g., CMV DNA level) must be provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

LONSURF

Products Affected

- LONSURF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LORBRENA

Products Affected

- LORBRENA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LUMAKRAS

Products Affected

- LUMAKRAS ORAL TABLET 120 MG, 240 MG, 320 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LUPRON DEPOT

Products Affected

- LUPRON DEPOT (1-MONTH) INTRAMUSCULAR KIT 3.75 MG
- LUPRON DEPOT (3-MONTH) INTRAMUSCULAR KIT 11.25 MG
- LUPRON DEPOT-PED (1-MONTH)
- LUPRON DEPOT-PED (3-MONTH)
- LUPRON DEPOT-PED (6-MONTH)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LYNPARZA

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

LYTGOBI

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MARPLAN

Products Affected

- MARPLAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation supporting the trial and failure (defined as an inadequate improvement in depressive symptoms) with two of the following generic antidepressants is required: SNRIs, SSRIs, mirtazapine, or bupropion.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

MATULANE

Products Affected

- MATULANE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Duration of therapy will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Must have documentation to support that the use of Mavyret is consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MEKINIST ORAL SOLUTION

Products Affected

- MEKINIST ORAL SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Coverage requires that the patient is unable to swallow the tablet formulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

METHYLTESTOSTERONE

Products Affected

- *methyltestosterone oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MIFEPRISTONE

Products Affected

- *mifepristone oral tablet 300 mg*

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 reauthorization of previously approved requests: Must provide documentation of improvement in hyperglycemia control with mifepristone.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

modafinil

Products Affected

- *modafinil oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

MOUNJARO

Products Affected

- MOUNJARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Only covered for the treatment of Type 2 Diabetes Mellitus.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

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	Two years
Other Criteria	Patient must not have HIV, infectious liver disease, or acquired lipodystrophy with hematologic abnormalities
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NAYZILAM

Products Affected

- NAYZILAM NASAL SOLUTION 5 MG/0.1ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

NEXLETOL

Products Affected

- NEXLETOL

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used along with PCSK9 inhibitors (e.g., Repatha), Juxtapid.
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	Two years
Other Criteria	Patient must meet the following: (1) 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) plus ezetimibe concomitantly for a minimum of 8 weeks and LDL-C remains greater than or equal to 70mg/dL or (2) Patient has tried ezetimibe and 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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NEXLIZET

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used along with PCSK9 inhibitors (e.g., Repatha), Juxtapid.
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	Two years
Other Criteria	Patient must meet the following: (1) 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) plus ezetimibe concomitantly for a minimum of 8 weeks and LDL-C remains greater than or equal to 70mg/dL or (2) Patient has tried ezetimibe and 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.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NINLARO

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

nitisinone

Products Affected

- *nitisinone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NIVESTYM

Products Affected

- NIVESTYM INJECTION SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NUBEQA

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

NUCALA

Products Affected

- NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR
- NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 40 MG/0.4ML
- NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs.
Required Medical Information	Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit. For initial coverage of severe eosinophilic asthma, documentation of the following is required: (1) An elevated blood eosinophil count of greater than or equal to 150 cells per microliter within 6 weeks (prior to the immediate start of treatment with Nucala) - OR - greater than or equal to 300 cells per microliter in the previous 12 months, AND (2) Trial with failure of 1 ICS/LABA inhaler in combination with 1 other asthma controller drug in the past 6 months (failure is defined as an inability to improve the condition on required therapy for at least 4 weeks). For reauthorization of severe eosinophilic asthma: (1) Must have documentation of clinical benefit with Nucala compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use). For initial coverage of chronic rhinosinusitis with nasal polyp, documentation of the following is required: (1) Patient has experienced 2 or more of the following symptoms for at least 12 weeks despite management: nasal congestion or obstruction, nasal drainage, reduction or loss of smell, AND (2) Patient has tried and failed (defined as an inability to improve symptoms for least 4 weeks) an intranasal steroid, AND (3) Patient will continue to use an intranasal steroid along with Nucala. For reauthorization of chronic rhinosinusitis with nasal polyp: (1) The patient will continue to use an intranasal steroid along with Nucala, AND (2) Must have documentation of clinical benefit with Nucala compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).
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 2 years reauth. Dosing must follow the FDA-approved labeling.

PA Criteria	Criteria Details
Other Criteria	For initial coverage of eosinophilic granulomatosis with polyangiitis (EGPA), documentation of the following is required: (1) Patient has non-severe disease defined as absence of life or organ-threatening manifestations, AND (2) Patient has tried and failed (defined as an intolerance or inability to improve symptoms) one traditional, non-biologic immunomodulator (e.g., azathioprine, methotrexate, mycophenolate). For reauthorization of EGPA: (1) Must have documentation of clinical benefit with Nucala compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use). For initial coverage of Hypereosinophilic Syndrome (HES), documentation of the following is required: (1) Patient has had HES for at least 6 months, AND (2) Patient has a blood eosinophil count of at least 1,000 cells per microliter, AND (3) Patient has had at least 2 HES flares in the past year defined as having symptoms requiring a steroid or an increase in a current steroid, AND (4) the provider attests that there is NO identifiable non-hematologic secondary cause of HES, AND (5) Patient has tried and failed (defined as an inability to improve symptoms) a generic steroid-sparing drug (e.g., hydroxyurea). For reauthorization of Hypereosinophilic Syndrome (HES): (1) Must have documentation of clinical benefit with Nucala compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NUEDEXTA

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records supporting the request, including documentation of the diagnosis, must be provided.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by a neurologist.
Coverage Duration	Two years
Other Criteria	Coverage requires a diagnosis of pseudobulbar affect caused by an underlying neurological condition (ex. amyotrophic lateral sclerosis, multiple sclerosis, stroke). For reauthorization, documentation that Nuedexta caused a decrease in the number of episodes of laughing or crying compared to baseline must be provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	Initial 1 year. Reauthorization 2 years
Other Criteria	For reauthorization 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	
Part B Prerequisite	No

NUPLAZID

Products Affected

- NUPLAZID ORAL CAPSULE
- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

NURTEC

Products Affected

- NURTEC

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other CGRP antagonist therapy.
Required Medical Information	For migraine prevention initial requests: (1) Must have at least four migraine days per month, AND (2) Must try and fail (defined as an intolerance or inability to improve the condition) two of the following generic migraine prevention drugs, each from a different class and each used for at least 28 days: amitriptyline, nortriptyline, venlafaxine, propranolol, metoprolol, timolol, valproic acid, divalproex, or topiramate, AND (3) Patient has been evaluated for and does not have Medication overuse headache (MOH). For treatment of acute migraine requests: Unless contraindicated per the FDA label, must try and fail (defined as inability to improve symptoms) two different triptan medications.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 1 year. Reauth: 2 years. Dosing must align with FDA labeling.
Other Criteria	For migraine prevention reauthorization requests: (1) Must provide documentation of a decrease in migraine days per month with use of Nurtec ODT.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
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	
Part B Prerequisite	No

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OFEV

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For all indications, must have documentation of High Resolution Computed Tomography (HRCT) confirming diagnosis.
Age Restrictions	
Prescriber Restrictions	Prescriber is or has consulted with a pulmonologist.
Coverage Duration	One year initial. Two years reauth. Dosing must follow the FDA-approved labeling.
Other Criteria	For idiopathic pulmonary fibrosis (IPF): Prescriber must rule out other known causes of interstitial lung disease - and - must have presence of a UIP pattern on HRCT in patients not subjected to surgical lung biopsy. For chronic fibrosing interstitial lung disease with progressive phenotype: Lung fibrosis must be at least 10% - and - Forced Vital Capacity (FVC) decline must be at least 10% - OR - at least 5% with one of the following: worsening respiratory symptoms OR worsening fibrosis on imaging. For systemic sclerosis- related interstitial lung disease (SSc-ILD): Lung fibrosis must be at least 10% - and - patient must try and fail (defined as an intolerance or inability to improve the condition) mycophenolate or cyclophosphamide at maximally tolerated doses - and - 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). For reauthorization of all indications: must have documentation of improvement in condition.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OGSIVEO

Products Affected

- OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OJEMDA

Products Affected

- OJEMDA ORAL SUSPENSION RECONSTITUTED
- OJEMDA ORAL TABLET 100 MG, 100 MG (16 PACK), 100 MG (24 PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For oral suspension, coverage requires that patient is unable to swallow the tablet formulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year. Limited to 1 box per 28 days, based on requested strength.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OJJAARA

Products Affected

- *ojjaara*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Criteria will be applied consistent with current NCCN guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ONUREG

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OPSUMIT

Products Affected

- OPSUMIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Trial and failure (defined as an inability to improve the condition) with ambrisentan or bosentan.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OPSYNVI

Products Affected

- OPSYNVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Trial and failure (defined as an inability to improve the condition) with ambrisentan or bosentan.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ORENITRAM

Products Affected

- ORENITRAM
- ORENITRAM MONTH 1
- ORENITRAM MONTH 2
- ORENITRAM MONTH 3

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Trial and failure (defined as an inability to improve the condition) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ORGOVYX

Products Affected

- ORGOVYX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an intolerance or inadequate response) with Firmagon (degarelix).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes

ORKAMBI

Products Affected

- ORKAMBI ORAL PACKET
- 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	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ORSERDU

Products Affected

- ORSERDU ORAL TABLET 345 MG, 86 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Medical records supporting that the use of Orserdu follows current NCCN recommendations must be provided.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Use of Orserdu must follow current NCCN recommendations.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OTEZLA

Products Affected

- OTEZLA ORAL TABLET
- OTEZLA ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	For PsO: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g. methotrexate, cyclosporine, acitretin). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For oral ulcers associated with Behcet's disease: Must try and fail (defined above) one other systemic therapy (e.g., colchicine, thalidomide, interferon alpha, tumor necrosis factor inhibitors) for the condition.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

OXERVATE

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	More than 8-weeks of treatment per lifetime will not be covered.
Required Medical Information	Documentation confirming diagnosis of Stage 2 (persistent epithelial defect) or stage 3 (corneal ulcer) neurotrophic keratitis such as through slit lamp examination.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation with, an ophthalmologist.
Coverage Duration	8 weeks total treatment. Dosing must follow the FDA-approved labeling.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

OZEMPIC

Products Affected

- OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML
- OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML
- OZEMPIC (2 MG/DOSE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Only covered for the treatment of Type 2 Diabetes Mellitus.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

PANRETIN

Products Affected

- PANRETIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
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	
Part B Prerequisite	No

PAZOPANIB

Products Affected

- *pazopanib hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PEMAZYRE

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

penicillamine

Products Affected

- *penicillamine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
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	
Part B Prerequisite	No

PHENOBARBITAL

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PIQRAY

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PIRFENIDONE

Products Affected

- *pirfenidone oral capsule*
- *pirfenidone oral tablet 267 mg, 801 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For all indications, must have documentation of High Resolution Computed Tomography (HRCT) confirming diagnosis.
Age Restrictions	
Prescriber Restrictions	Prescriber is or has consulted with a pulmonologist.
Coverage Duration	Two years
Other Criteria	For idiopathic pulmonary fibrosis (IPF): (1) The patient's diagnosis must be confirmed by a surgical lung biopsy or by the presence of a UIP pattern on a HRCT, and (2) the prescriber must rule out other known causes of interstitial lung disease. For reauthorization requests: Documentation of improvement in condition with use of pirfenidone must be provided.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PLEGRIDY

Products Affected

- PLEGRIDY
- PLEGRIDY STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

POMALYST

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

PREVYMIS

Products Affected

- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	200 days
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PROLASTIN-C

Products Affected

- PROLASTIN-C

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have an FEV1 less than 80 percent predicted - AND - a 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	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

PROLIA

Products Affected

- PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must first try and fail (defined as a decrease in BMD or new fracture while on therapy) an oral bisphosphonate or zoledronic acid. If intolerant or contraindicated to an oral bisphosphonate, zoledronic acid is required. Coverage is also provided if the patient has a creatinine clearance less than 35 mL/min. Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes

PROMACTA

Products Affected

- PROMACTA ORAL PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	Use of Promacta to normalize platelet counts is not covered.
Required Medical Information	Current platelet count must be provided. For ITP, initial requests: Patient has a platelet count less than 30,000/mcL - OR - less than 50,000/mcL with bleeding or one of the following risk factor(s) for bleeding: History of clinically significant bleeding at a higher platelet count, concurrent peptic ulcer disease or liver disease that increase bleeding risk, history of falling, or need for concurrent anticoagulation or anti-platelet therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	For thrombocytopenia from hepatitis C infection, initial request: The degree of thrombocytopenia is preventing the initiation of interferon therapy OR limits the ability to maintain optimal interferon based therapy. For thrombocytopenia from hepatitis C infection, reauthorization: current platelet count is less than 400 x 109/L - and - patient is responding to therapy as evidenced by increased platelet counts - and - patient continues to receive interferon based therapy. For aplastic anemia, initial requests: 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. For aplastic anemia, reauthorization: current platelet count is less than 400 x 109/L - and - patient is responding to therapy as evidenced by increased platelet counts. For ITP, initial requests: Must have inadequate response or intolerance to steroids or immunoglobulins - AND - either rituximab or splenectomy. For ITP, reauthorization: current platelet count is less than 400 x 109/L - and - patient is responding to therapy as evidenced by increased platelet counts - and - patient remains at risk for bleeding complications.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	Yes

protriptyline

Products Affected

- *protriptyline hcl*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate response) with 2 of the following generic antidepressants: SSRIs, SNRIs, bupropion, mirtazapine, or trazodone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

PURIXAN

Products Affected

- PURIXAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation to support a trial and failure with generic mercaptopurine tablet or documentation to support the patient's current inability to swallow tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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.
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, Reauthorization: 12 months
Other Criteria	For reauthorization: Must have documentation of a positive clinical response as determined by the prescriber.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

QINLOCK

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RADICAVA ORS

Products Affected

- RADICAVA ORS
- RADICAVA ORS STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
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	For initial requests, documentation of the following is required: (1) A diagnosis of definite or probable amyotrophic lateral sclerosis (ALS) as defined by the revised El Escorial/Arlie House criteria, AND (2) a diagnosis of ALS for 2 years or less (please provide date of diagnosis), AND (3) retention of most activities of daily living defined as having a baseline score of at least 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 (4) normal respiratory function defined as a percent-predicted forced vital capacity (% FVC) greater than or equal to 80%. For reauthorization requests, documentation of the following is required: (1) Radicava is slowing the progression of ALS as determined by an improved or stable ALFRS-R score or other supporting clinical documentation.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

REBIF

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REPATHA

Products Affected

- REPATHA
- REPATHA PUSHTRONEX SYSTEM
- REPATHA SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must submit most recent LDL-C level.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Patient must meet one of the following: (1) 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) plus ezetimibe concomitantly for a minimum of 8 weeks, and LDL-C remains greater than or equal to 70mg/dL - OR - (2) Patient is statin intolerant as demonstrated by experiencing statin-associated rhabdomyolysis to one statin OR has tried both rosuvastatin and atorvastatin and has experienced skeletal-muscle related symptoms on both agents which also resolved upon discontinuation.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RETEVMO

Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG
- RETEVMO ORAL TABLET 120 MG, 160 MG, 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

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	
Part B Prerequisite	No

REXULTI

Products Affected

- REXULTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For agitation in Alzheimer's disease requests: (1) Must have documentation supporting a trial and failure (defined as an inadequate response) with one generic atypical antipsychotic used for at least 28 days. For all other medically-accepted indications: (1) Must have documentation supporting a trial and failure (defined above) with two generic atypical antipsychotic drugs, used for at least 28 days each.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

REZDIFFRA

Products Affected

- REZDIFFRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests, documentation supporting the following is required: (1) A diagnosis of metabolic dysfunction-associated steatohepatitis (MASH) or nonalcoholic steatohepatitis (NASH), AND (2) a fibrosis stage of F2 or F3 confirmed by biopsy or NITs, AND (3) an NAFLD Activity Score (NAS) of at least 4, AND (4) current weight, AND (5) a provider attestation that Rezdiffra will be used in conjunction with diet and exercise as per its FDA labeling.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by, or in consultation, with a gastroenterologist or hepatologist.
Coverage Duration	One year initial and reauthorization.
Other Criteria	For reauthorization, documentation of the following is required: (1) fibrosis stage of F2 or F3 confirmed by biopsy or NITs, AND (2) documentation supporting improvement or stabilization in steatohepatitis evidenced by fibrosis score or NAFLD Activity (NAS) score.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

REZLIDHIA

Products Affected

- REZLIDHIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

RINVOQ

Products Affected

- RINVOQ LQ
- 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 biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	1 year initial (AD). 2 year initial (others). 2 year reauth (all). Dose must follow FDA labeling
Other Criteria	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis and non-radiographic axial spondyloarthritis (NRAS): Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For Crohn's disease: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone). For initial coverage of atopic dermatitis: documentation of the following is required (1) Confirmation of moderate to severe atopic dermatitis, AND (2) Trial and failure (defined as an inadequate response) to one medium or higher potency topical steroid (e.g., clobetasol) - or - one topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus). For reauthorization of atopic dermatitis: (1) Must have documented clinical benefit (e.g. less exacerbations, improved symptoms, less steroid use).
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	
Part B Prerequisite	No

RIVFLOZA

Products Affected

- RIVFLOZA SUBCUTANEOUS SOLUTION
- RIVFLOZA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 128 MG/0.8ML, 160 MG/ML

PA Criteria	Criteria Details
Exclusion Criteria	Coverage will not be provided in the following situations: (1) Patient has a history of kidney or liver transplant, AND (2) Patient will be using in combination with Oxlumo.
Required Medical Information	(1) Medical records supporting the request must be provided, AND (2) Must have a diagnosis of primary hyperoxaluria type 1 (PH1) confirmed by genetic testing of the AGXT mutation or by liver enzyme analysis, AND (3) must have preserved kidney function with an estimated glomerular filtrate rate (eGFR) of 30 mL/min/1.73m2 or more, AND (4) for reauthorization requests, must have documented clinical benefit with Rivfloza compared to baseline.
Age Restrictions	Must be 9 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with a nephrologist or urologist.
Coverage Duration	Initial: 1 year. Reauth: 2 years. Dosing must follow the FDA-approved labeling.
Other Criteria	Rivfloza vials are only covered for children 9 to 11 years old weighing less than 50 kilograms per the FDA-approved labeling.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
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 reauthorization, documentation must be provided showing a reduction in COPD exacerbations.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ROZLYTREK

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ROZLYTREK PELLET PACK

Products Affected

- ROZLYTREK ORAL PACKET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has had prior trial with AND is unable to use Rozlytrek oral capsule formulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RUBRACA

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an intolerance or inadequate response) with Lynparza.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

RUFINAMIDE

Products Affected

- *rufinamide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

RYBELSUS

Products Affected

- RYBELSUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Only covered for the treatment of Type 2 Diabetes Mellitus.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

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.
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	
Part B Prerequisite	No

SCEMBLIX

Products Affected

- SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG

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 or hematologist.
Coverage Duration	1 year. 20 mg limit to 60 tabs per 30 days. 40 mg 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	
Part B Prerequisite	No

SECUADO

Products Affected

- SECUADO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs used for at least 28 days each: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SIGNIFOR

Products Affected

- SIGNIFOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
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	
Part B Prerequisite	No

SILDENAFIL CITRATE

Products Affected

- *sildenafil citrate oral tablet 20 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SIRTURO

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SKYCLARYS

Products Affected

- SKYCLARYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of genetically confirmed diagnosis - AND - Baseline modified Friedreich's Ataxia Rating Scale (mFARS) score between 20 to 80.
Age Restrictions	Must be age 16 years or older.
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	One year initial and reauthorization
Other Criteria	Patient must be ambulatory. For reauthorization, documentation that medication is providing clinical benefit based on the patient's baseline mFARS score.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SKYRIZI

Products Affected

- SKYRIZI PEN
- SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE 180 MG/1.2ML, 360 MG/2.4ML
- SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	For Crohns disease: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SODIUM OXYBATE

Products Affected

- SODIUM OXYBATE

PA Criteria	Criteria Details
Exclusion Criteria	Patient must not be receiving sedative hypnotics with sodium oxybate. Patient must not suffer from succinic semialdehyde dehydrogenase deficiency.
Required Medical Information	Documentation of prior therapies and responses to treatment. Documentation of MSLT and polysomnography confirming diagnosis of narcolepsy.
Age Restrictions	
Prescriber Restrictions	Prescriber must be a sleep specialist or neurologist.
Coverage Duration	Two years
Other Criteria	For narcolepsy with excessive daytime sleepiness, must first try and fail (defined as an intolerance or inability to improve the condition) amphetamine salts, dextroamphetamine or methylphenidate - AND - either modafinil or armodafinil. For reauthorization requests, must provide documentation demonstrating a decrease in excessive daytime sleepiness with narcolepsy or a decrease in cataplexy episodes.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

sofosbuvir-velpatasvir

Products Affected

- *sofosbuvir-velpatasvir*

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	Duration of therapy will be applied consistent with current AASLD/IDSA guidance.
Other Criteria	Must have documentation to support that the use of sofosbuvir/velpatasvir is consistent with current AASLD/IDSA guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SOMAVERT

Products Affected

- SOMAVERT

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	
Part B Prerequisite	No

SORAFENIB

Products Affected

- *sorafenib tosylate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SPRITAM

Products Affected

- SPRITAM ORAL TABLET DISINTEGRATING SOLUBLE 1000 MG, 250 MG, 500 MG, 750 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with generic levetiracetam and at least 1 other generic anticonvulsant for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SPRYCEL

Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	For PsA in adults: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For psoriasis: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, cyclosporine, acitretin). For Crohn's disease: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, methotrexate) or a steroid (e.g., prednisone).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

STIVARGA

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SUCRAID

Products Affected

- SUCRAID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

SUNITINIB MALATE

Products Affected

- *sunitinib malate*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has had prior trial with AND has a documented contraindication (e.g. dysphagia) to BOTH generic clobazam tablet AND clobazam oral suspension.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and reauthorization.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TABRECTA

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
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	
Part B Prerequisite	No

tadalafil 20mg (Adcirca)

Products Affected

- *tadalafil (pah)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TAFINLAR

Products Affected

- TAFINLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAFINLAR TABLET FOR ORAL SUPSENSION

Products Affected

- TAFINLAR ORAL TABLET SOLUBLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Coverage requires that the patient is unable to swallow the tablet formulation.
Age Restrictions	Must be less than 18 years old.
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAGRISSO

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TALZENNA

Products Affected

- TALZENNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TASIGNA

Products Affected

- TASIGNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TASIMELTEON

Products Affected

- *tasimelteon*

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	Two years
Other Criteria	Patient must be totally blind. For reauthorization: must have documented benefit from use of tasimelteon. Not covered for a diagnosis of Smith-Magenis Syndrome (SMS).
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

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 or rheumatologist.
Coverage Duration	Initial 6 months. Reauthorization 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 reauthorization: Must have a reduction in the Birmingham Vasculitis Activity Score (BVAS) - AND - steroid dose.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

tazarotene cream

Products Affected

- *tazarotene external cream 0.1 %*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TAZVERIK

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TEPMETKO

Products Affected

- TEPMETKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TERIFLUNOMIDE

Products Affected

- *teriflunomide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TERIPARATIDE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	Cumulative use of teriparatide and other parathyroid hormone analogs (e.g., Tymlos) of more than 2 years is not covered.
Required Medical Information	Must provide documentation of prior therapies and responses to treatment - AND - documentation confirming diagnosis such as T-score.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by endocrinologist.
Coverage Duration	Two years. Dosing must follow FDA-approved labeling.
Other Criteria	Must try and fail alendronate, risedronate, or ibandronate - AND - either zoledronic acid or Prolia. Failure is defined as intolerance, decrease in BMD in comparison to previous DEXA scan, 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	
Part B Prerequisite	No

testosterone gel

Products Affected

- *testosterone transdermal gel 1.62 %, 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	Not covered in males with late-onset (age-related) hypogonadism.
Required Medical Information	For primary and hypogonadotropic hypogonadism: Documentation of the following is required (1) Two pre-treatment serum total testosterone levels, each taken in the morning on separate days, that are less than 300 ng/dL or that are low as defined by the laboratory reference values, AND (2) Patient is male, AND (3) Pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction and decreased libido (such as depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis), AND (4) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product. For gender dysphoria: Documentation of the following is required: (1) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes

testosterone solution

Products Affected

- *testosterone transdermal solution*

PA Criteria	Criteria Details
Exclusion Criteria	Not covered in males with late-onset (age-related) hypogonadism.
Required Medical Information	For primary and hypogonadotropic hypogonadism: Documentation of the following is required (1) Two pre-treatment serum total testosterone levels, each taken in the morning on separate days, that are less than 300 ng/dL or that are low as defined by the laboratory reference values, AND (2) Patient is male, AND (3) Pre-treatment clinical signs or symptoms of low testosterone other than erectile dysfunction and decreased libido (such as depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis), AND (4) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product. For gender dysphoria: Documentation of the following is required: (1) patient has tried and failed (defined as an intolerance or an inability to improve symptoms or testosterone levels) with a generic injectable testosterone product.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes

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 or Ingrezza.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	CYP2D6 genotype must be provided for doses greater than 50mg/day.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

THALOMID

Products Affected

- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TIOPRONIN

Products Affected

- *tiopronin oral tablet*
- *tiopronin oral tablet delayed release*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For approval: (1) Patient weighs at least 20 kg, (2) Patient has a diagnosis of severe homozygous cystinuria that has not responded to the conservative measures of high fluid intake, alkalinizing therapy, and diet modification including salt and protein restriction alone - and - (3) Patient will be using tiopronin in combination with the above conservative measures.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year initial and reauthorization.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
Part B Prerequisite	No

TRELSTAR

Products Affected

- TRELSTAR MIXJECT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate response) with Eligard or leuprolide 22.5 mg depot.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRETINOIN CAPSULES

Products Affected

- *tretinoin oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRIKAFTA

Products Affected

- TRIKAFTA ORAL TABLET THERAPY PACK
- TRIKAFTA ORAL THERAPY PACK

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	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

trimipramine maleate

Products Affected

- *trimipramine maleate oral*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate response) with 2 of the following generic antidepressants: SSRIs, SNRIs, bupropion, mirtazapine, or trazodone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TRULICITY

Products Affected

- TRULICITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Only covered for the treatment of Type 2 Diabetes Mellitus.
Indications	Some FDA-approved Indications Only.
Off Label Uses	
Part B Prerequisite	No

TRUQAP

Products Affected

- TRUQAP ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	For PIK3CA mutations, must first try Piqray.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TURALIO

Products Affected

- TURALIO ORAL CAPSULE 125 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

TYENNE

Products Affected

- TYENNE SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, Janus Kinase Inhibitor (JAKis), or Ofev.
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided. For systemic sclerosis- related interstitial lung disease (SSc-ILD) , must also have documentation of High Resolution Computed Tomography (HRCT) confirming diagnosis.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow FDA-approved labeling.
Other Criteria	For RA and JIA: Must have documentation supporting a trial and failure of (defined as an intolerance or inability to improve symptoms) two of the following: a preferred adalimumab product, Rinvoq, Xeljanz/Xeljanz XR, or Enbrel. For systemic sclerosis- related interstitial lung disease (SSc-ILD): Lung fibrosis must be at least 10% - and - patient must try and fail (defined as an intolerance or inability to improve the condition) mycophenolate or cyclophosphamide at maximally tolerated doses - and - 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) - and - for reauthorization, must have documentation of improvement in condition.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TYMLOS

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	Cumulative use of Tymlos and other parathyroid hormone analogs (e.g., teriparatide) of more than 2 years is not covered.
Required Medical Information	Must provide documentation of prior therapies and responses to treatment - AND - documentation confirming diagnosis such as T-score.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by endocrinologist.
Coverage Duration	Two years total (inclusive of all parathyroid hormone analogs)
Other Criteria	Must try and fail alendronate, risedronate, or ibandronate - AND - either zoledronic acid or Prolia. Failure is defined as intolerance, decrease in BMD in comparison to previous DEXA scan, 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	
Part B Prerequisite	No

TYVASO

Products Affected

- TYVASO
- TYVASO REFILL KIT
- TYVASO STARTER KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For PAH (WHO Group 1), the following are required: (1) Documentation confirming the diagnosis by right heart catheterization, AND (2) Medical records supporting the request, AND (3) documentation supporting a trial and failure (defined as an inability to improve the condition or an intolerance) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan). For reauthorization of PAH: Documentation supporting the patient has had a positive clinical response to Tyvaso compared to baseline must be provided. For PH-ILD, the following are required: (1) Documentation confirming the diagnosis by right heart catheterization, AND (2) Medical records supporting the request, AND (3) the patient's PH-ILD is associated with IPF, CTD, or combined IPF and emphysema (CPFE) is associated with ILD (PH associated with other phenotypes such as COPD is not covered based on the current 2022 ESC/ERS Guidelines). For reauthorization of PH-ILD: (1) Documentation supporting that patient has had a positive clinical response that includes an improved 6MWT compared to baseline must be provided.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist for the condition.
Coverage Duration	Two years
Other Criteria	Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

TYVASO DPI

Products Affected

- TYVASO DPI MAINTENANCE KIT
- TYVASO DPI TITRATION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For PAH (WHO Group 1), the following are required: (1) Documentation confirming the diagnosis by right heart catheterization, AND (2) Medical records supporting the request, AND (3) documentation supporting a trial and failure (defined as an inability to improve the condition or an intolerance) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan). For reauthorization of PAH: Documentation supporting the patient has had a positive clinical response to Tyvaso compared to baseline must be provided. For PH-ILD, the following are required: (1) Documentation confirming the diagnosis by right heart catheterization, AND (2) Medical records supporting the request, AND (3) the patient's PH-ILD is associated with IPF, CTD, or combined IPF and emphysema (CPFE) is associated with ILD (PH associated with other phenotypes such as COPD is not covered based on the current 2022 ESC/ERS Guidelines). For reauthorization of PH-ILD: (1) Documentation supporting that patient has had a positive clinical response that includes an improved 6MWT compared to baseline must be provided.
Age Restrictions	
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist for the condition.
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

UPTRAVI

Products Affected

- UPTRAVI
- UPTRAVI TITRATION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Trial and failure (defined as an inability to improve the condition) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan).
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VALCHLOR

Products Affected

- VALCHLOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	One year
Other Criteria	For limited/localized skin involvement, must have tried topical steroids and either topical tazarotene or topical imiquimod. For generalized skin involvement, must have tried topical steroids.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VALTOCO

Products Affected

- VALTOCO 10 MG DOSE
- VALTOCO 15 MG DOSE
- VALTOCO 20 MG DOSE
- VALTOCO 5 MG DOSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VANFLYTA

Products Affected

- VANFLYTA

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	
Part B Prerequisite	No

VENCLEXTA

Products Affected

- VENCLEXTA
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VENTAVIS

Products Affected

- VENTAVIS INHALATION SOLUTION 10 MCG/ML, 20 MCG/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1 by right heart catheterization and medical record documentation. Documentation of prior therapies and responses to treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Trial and failure (defined as an inability to improve the condition) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan). Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VERQUVO

Products Affected

- VERQUVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided. Documentation of an ejection fraction less than 45% assessed within the past 12 months must be provided.
Age Restrictions	Must be at least 18 years old.
Prescriber Restrictions	Must be prescribed by, or in consultation with, a cardiologist.
Coverage Duration	Two years
Other Criteria	Patient has symptomatic worsening chronic heart failure (NYHA class 2 to 4) - AND - has 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 - has tried and failed (defined as an intolerance or inability to improve symptoms) maximally tolerated doses of the following medications in combination: an ACEI, ARB, or ARNi (such as enalapril or Entresto) - AND - bisoprolol, carvedilol or metoprolol ER - AND - spironolactone or other diuretic.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VERSACLOZ

Products Affected

- VERSACLOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has had prior trial with AND has a documented contraindication (e.g. dysphagia) to BOTH generic clozapine tablet AND generic clozapine orally disintegrating tablet (ODT).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years.
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VERZENIO

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

vigabatrin

Products Affected

- *vigabatrin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For refractory complex partial seizures: Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 other generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

vigadrone

Products Affected

- *vigadrone*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For refractory complex partial seizures: Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 other generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VIGAFYDE

Products Affected

- VIGAFYDE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Must be 2 years of age or younger (max age 2 years).
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

vigpoder

Products Affected

- VIGPODER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For refractory complex partial seizures: Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 other generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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

VITRAKVI

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VIZIMPRO

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VONJO

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Criteria will be applied consistent with current NCCN guidance.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VORANIGO

Products Affected

- VORANIGO ORAL TABLET 10 MG, 40 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	
Part B Prerequisite	No

voriconazole

Products Affected

- *voriconazole intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VOWST

Products Affected

- VOWST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Documentation of at least 2 recurrent episodes of CDI (3 or more total CDI episodes) after failure of appropriate antibiotic treatments.
Age Restrictions	Patient must be 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	1 year. Limited to 1 treatment course (12 capsules over 3 days).
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	
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 reauthorization: Must have documentation of a positive clinical response as determined by the prescriber.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VOYDEYA

Products Affected

- VOYDEYA

PA Criteria	Criteria Details
Exclusion Criteria	Voydeya is not covered in combination with Fabhalta or Empaveli.
Required Medical Information	For initial requests: (1) Must have diagnosis of PNH confirmed by flow cytometry, (2) must be actively receiving treatment with Ultomiris/Soliris and considered stable (defined as treatment for at least 6 months) -AND- (3) Must have symptomatic extravascular hemolysis defined as: Fatigue or dyspnea - AND - Hgb less than 9.5g/dL - OR - Absolute Reticulocyte Count greater than 120 x 109/L.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	One year initial and reauthorization.
Other Criteria	For reauthorization: (1) must be actively receiving treatment with Ultomiris/Soliris, AND (2) must have documentation of improvement in EVH symptoms (e.g., fatigue, dyspnea), AND (3) must have a sustained increase in hemoglobin levels, improvement in hemolysis, or reduced transfusions compared to baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VRAYLAR

Products Affected

- VRAYLAR ORAL CAPSULE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as an inadequate response) with two of the following generic drugs that have support for the requested condition and each used for at least 28 days: aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone, or lurasidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

VYNDAMAX

Products Affected

- VYNDAMAX

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with TTR-lowering agents (e.g., Amvuttra, Onpattro).
Required Medical Information	Coverage requires documentation of the following: (1) New York Heart Association (NYHA) class 1 , 2, or 3 heart failure, AND (2) an echocardiogram (ECHO) or cardiac magnetic resonance (CMR) imaging demonstrating cardiac involvement (i.e., increased left ventricular wall thickness), AND (3) a diagnosis of transthyretin amyloid cardiomyopathy (ATTR-CM) confirmed by tissue biopsy, genetic testing, or radionuclide imaging (99mTc-PYP, 99mTc-DPD, or 99mTc-HMDP scan), AND (4) if the diagnosis was confirmed by radionuclide imaging, coverage also requires documentation of Grade 2 or 3 cardiac uptake.
Age Restrictions	Must be age 18 or older
Prescriber Restrictions	
Coverage Duration	One year initial. Two years reauthorization.
Other Criteria	Vyndamax will not be approved if the patient has primary (light-chain) amyloidosis. For reauthorization requests, coverage requires documentation of a positive clinical response to Vyndamax compared to baseline (e.g., reduced cardiovascular-related hospitalizations, improved function, improved quality of life).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

VYNDAQEL

Products Affected

- VYNDAQEL

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with TTR-lowering agents (e.g., Amvuttra, Onpattro).
Required Medical Information	Coverage requires documentation of the following: (1) New York Heart Association (NYHA) class 1 , 2, or 3 heart failure, AND (2) an echocardiogram (ECHO) or cardiac magnetic resonance (CMR) imaging demonstrating cardiac involvement (i.e., increased left ventricular wall thickness, AND (3) a diagnosis of transthyretin amyloid cardiomyopathy (ATTR-CM) confirmed by tissue biopsy, genetic testing, or radionuclide imaging (99mTc-PYP, 99mTc-DPD, or 99mTc-HMDP scan), AND (4) if the diagnosis was confirmed by radionuclide imaging, coverage also requires documentation of Grade 2 or 3 cardiac uptake.
Age Restrictions	Must be age 18 or older.
Prescriber Restrictions	
Coverage Duration	One year initial. Two years reauthorization.
Other Criteria	Vyndaqel will not be approved if the patient has primary (light-chain) amyloidosis. For reauthorization requests, coverage requires documentation of a positive clinical response to Vyndaqel compared to baseline (e.g., reduced cardiovascular-related hospitalizations, improved function, improved quality of life).
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

WAINUA

Products Affected

- WAINUA

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with tafamidis (Vyndaqel, Vyndamax), or other TTR-lowering agents (Tegsedi, Onpattro, Amvuttra).
Required Medical Information	For hereditary transthyretin-mediated amyloidosis (hATTR) with polyneuropathy, must have (1) confirmation of a transthyretin (TTR) mutation on genetic test, (2) presence of clinical signs and symptoms of the condition (e.g., motor disability, peripheral/autonomic neuropathy, etc.), and (3) documentation of a baseline FAP Stage 1 or 2.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	One year initial and reauthorization. Dosing must align with FDA-approved labeling.
Other Criteria	Patient must not have had a liver transplant. For reauthorization, must also have documentation of a positive clinical response to Wainua 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	
Part B Prerequisite	No

WELIREG

Products Affected

- WELIREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

WINREVAIR

Products Affected

- WINREVAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial requests, documentation of the following is required: (1) Must have a confirmed diagnosis of Pulmonary Arterial Hypertension (PAH), World Health Organization Group 1, by right heart catheterization, AND (2) Must have WHO functional class II or III symptoms, AND (3) Must have tried and failed (defined as an inability to improve the condition) of dual therapy with a phosphodiesterase inhibitor (e.g., sildenafil or tadalafil) AND an endothelin receptor antagonist (e.g., ambrisentan or bosentan), AND (4) Winrevair will be initiated as add on therapy to at least 2 other PAH agents (e.g. ERA, PDE5i, Prostaglandins).
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with a specialist for the condition.
Coverage Duration	One year initial. Two years reauthorization.
Other Criteria	For reauthorization requests: Documentation must be provided demonstrating that the patient has had a beneficial response to Winrevair compared to pretreatment baseline in one or more of the following: improvement in WHO functional class, risk status, or 6MWD.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XALKORI

Products Affected

- XALKORI ORAL CAPSULE
- XALKORI ORAL CAPSULE SPRINKLE 150 MG, 20 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XATMEP

Products Affected

- XATMEP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	Must try and fail (defined as an intolerance or inability to improve the condition) generic methotrexate.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XCOPRI

Products Affected

- XCOPRI (250 MG DAILY DOSE) ORAL TABLET THERAPY PACK 100 & 150 MG
- XCOPRI (350 MG DAILY DOSE)
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 25 MG, 50 MG
- XCOPRI ORAL TABLET THERAPY PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Must have documentation supporting a trial and failure (defined as inadequate seizure control) with at least 2 generic anticonvulsants for the condition.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XDEMVY

Products Affected

- XDEMVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Demodex blepharitis confirmed by the presence of mites on examination by light microscopy or presence of collarettes on slit lamp examination.
Age Restrictions	Must be at least 18 years of age.
Prescriber Restrictions	Must be prescribed by or in consultation with an optometrist or ophthalmologist.
Coverage Duration	One year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XELJANZ

Products Affected

- XELJANZ ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting Xeljanz concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XELJANZ SOLUTION

Products Affected

- XELJANZ ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting Xeljanz concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XELJANZ XR

Products Affected

- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs, Otezla, or Janus Kinase Inhibitor (JAKis).
Required Medical Information	Documentation of prior therapies and responses to treatment must be provided.
Age Restrictions	
Prescriber Restrictions	Prescriber is a specialist or has consulted with a specialist for the condition being treated.
Coverage Duration	Two years. Dosing must follow the FDA-approved labeling.
Other Criteria	For RA: Must try and fail (defined as an intolerance or inability to improve symptoms) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, hydroxychloroquine, sulfasalazine). For PsA: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., methotrexate, leflunomide, sulfasalazine). For UC: Must try and fail (defined above) one traditional non-biologic immunomodulator drug (e.g., 6-mercaptopurine, azathioprine, cyclosporine) or a steroid (e.g., prednisone). For ankylosing spondylitis: Must try and fail (defined above) one nonsteroidal anti-inflammatory drug (NSAID). For Juvenile Idiopathic Arthritis: Must try and fail (defined above) one other drug for the condition (e.g., methotrexate, sulfasalazine, NSAID) - or - the patient will be starting Xeljanz XR concurrently with methotrexate, sulfasalazine, or leflunomide - or - the patient has aggressive disease, as determined by the prescribing physician.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
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	
Part B Prerequisite	No

XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
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. Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	Yes

XIFAXAN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	For IBS-D, no more than a total of three, 14-day treatment courses are covered. Xifaxan COVERAGE FOR SMALL INTESTINAL BACTERIAL OVER-GROWTH (SIBO) IS NOT PROVIDED.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	End of plan year (all). IBS-D limited to three, 14-day treatment courses. TD limited to three days.
Other Criteria	For travelers diarrhea (TD): Coverage requires a trial and failure (defined as an intolerance or inability to improve the condition) with azithromycin. For hepatic encephalopathy: Coverage requires a trial and failure (defined above) with lactulose.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XOLAIR

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with other biologic drugs.
Required Medical Information	Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit. For initial coverage of asthma requests, documentation of the following is required: (1) A baseline IgE level of at least 30 IU/mL (baseline is defined as before treatment with Xolair or another therapy that lowers IgE levels), AND (2) a baseline (defined above) positive skin test or in vitro reactivity to a perennial aeroallergen, AND (3) Patient's current weight, AND (4) Trial and failure of 1 ICS/LABA inhaler in the past 6 months (failure is defined as an inability to improve the condition on the required therapy for at least 4 weeks). For asthma reauthorization requests: (1) Must have documentation of clinical benefit with Xolair compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use), AND (2) the patient's current weight and baseline IgE level must be provided.
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 2 years reauth. Dosing must follow the FDA-approved labeling.

PA Criteria	Criteria Details
Other Criteria	For initial coverage of food allergy requests, documentation of the following is required: (1) Patient has a diagnosis of an IgE-mediated food allergy confirmed by both a positive in vitro test for IgE to the specified foods AND a positive skin prick test to the specified foods, AND (2) Patient has a clinical history of a significant allergic reaction to the specified foods, AND (3) Patient has a baseline IgE level of at least 30 IU/mL (baseline is defined as before treatment with Xolair or another therapy that lowers IgE levels), AND (4) Xolair will be used in conjunction with a food allergen-avoidant diet, AND (5) Patient's current weight, AND (6) Patient is at least 1 year of age. For food allergy reauthorization requests: (1) Xolair must continue to be used in conjunction with a food allergen-avoidant diet, AND (2) the patient's current weight and baseline IgE level must be provided.For initial coverage of chronic urticaria requests, documentation of the following is required: (1) Patient has a confirmed diagnosis of chronic urticaria defined as urticaria occurring for more than 6 weeks, AND (2) Trial and failure (defined as an inability to improve symptoms) with one H1 antihistamine (such as levocetirizine or desloratadine). For chronic urticaria reauthorization requests: (1) Must have documentation of clinical benefit with Xolair compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use). For initial coverage of nasal polyp requests, documentation of the following is required: (1) Patient has a baseline IgE level of at least 30 IU/mL (baseline is defined as before treatment with Xolair or another therapy that lowers IgE levels), AND (2) Patient's current weight, AND (3) trial and failure (defined as an inability to improve symptoms for least 4 weeks) with an intranasal steroid, AND (4) Patient will continue to use an intranasal steroid along with Xolair. For nasal polyp reauthorization requests: (1) The patient will continue to use an intranasal steroid along with Xolair, AND (2) Must have documentation of clinical benefit with Xolair compared to baseline (e.g., decrease in exacerbations, improvement in symptoms, decrease in oral steroid use), AND (3) the patient's current weight and baseline IgE level must be provided.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

XOSPATA

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XPOVIO

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

XTANDI

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	For metastatic castration resistant prostate cancer (CRPC) AND metastatic castration-sensitive prostate cancer (CSPC): Documentation supporting a trial and failure (defined as an inadequate response or intolerance) to generic abiraterone is required.
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZEJULA

Products Affected

- ZEJULA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZELBORAF

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZEMAIRA

Products Affected

- ZEMAIRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient must have an FEV1 less than 80 percent predicted - AND - a 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	Two years
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZILBRYSQ

Products Affected

- ZILBRYSQ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 16.6 MG/0.416ML, 23 MG/0.574ML, 32.4 MG/0.81ML

PA Criteria	Criteria Details
Exclusion Criteria	Must not be used in combination with similar therapies for myasthenia gravis including immune globulins, Soliris, Ultomiris, Vyvgart/Vygart Hytrulo, or Rystiggo. (Zilbrysq has not been studied and there is no data to support use in combination with other medications used to treat MG).
Required Medical Information	For initial requests, must have: (1) Confirmed generalized myasthenia gravis that is anti-acetylcholine receptor antibody (AChR-Ab) positive - AND - (2)baseline Myasthenia Gravis Activities of Daily Living (MG-ADL) of 6 or more - AND - (3) trial and failure (defined as an intolerance or inability to improve the condition) of Vyvgart or Rystiggo - AND - (4) trial and failure (defined above) of Ultomiris. For initial and reauthorization: Medical records supporting the request must be provided.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist.
Coverage Duration	12 weeks initial. 1 year reauthorization.
Other Criteria	For reauthorization: Must have a documented response to therapy evidenced by a stable or improved MG-ADL total score from baseline.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	Yes

ZOLINZA

Products Affected

- ZOLINZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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	Two years
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	
Part B Prerequisite	No

ZTALMY

Products Affected

- ZTALMY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	(1) Must provide confirmation of CDKL5 deficiency based on genetic testing, (2) Must provide patient's current weight.
Age Restrictions	Must be 2 years of age or older.
Prescriber Restrictions	Must be prescribed by a neurologist.
Coverage Duration	Two years
Other Criteria	Must provide documentation of a trial with failure (defined as inadequate seizure control) of at least 2 previous antiepileptic drugs.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZURZUVAE

Products Affected

- ZURZUVAE ORAL CAPSULE 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Confirmation of diagnosis of postpartum depression.
Age Restrictions	Must be 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	One year. Limited to one treatment course per year.
Other Criteria	Must follow current ACOG recommendations which require the patient to be in the postpartum period (ie, within 12 months postpartum) for depression that has onset in the third trimester or within 4 weeks postpartum.
Indications	All FDA-approved Indications.
Off Label Uses	
Part B Prerequisite	No

ZYDELIG

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

ZYKADIA

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Two years
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	
Part B Prerequisite	No

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