

Drugs

abiraterone

Exclusion Criteria

Required Medical Information

The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Node-positive (N1), non-metastatic (M0) prostate cancer

No

Drugs
acitretin

Exclusion Criteria

Required Medical Information

Psoriasis: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to methotrexate or cyclosporine.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease)

No

Drugs
ACTIMMUNE

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Mycosis fungoides, Sezary syndrome.
No

Drugs

Hadlima, Hadlima PushTouch, HADLIMA(CF), HADLIMA(CF) PUSHTOUCH, HYRIMOZ, HYRIMOZ PEN, HYRIMOZ PEN CROHN'S-UC STARTER, HYRIMOZ PEN PSORIASIS STARTER, HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML- 40 MG/0.4 ML, HYRIMOZ(CF) PEN SUBCUTANEOUS PEN INJECTOR 40 MG/0.4 ML, 80 MG/0.8 ML, HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML

Exclusion Criteria

Required Medical Information

For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR 2) Intolerance or contraindication to NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, OR b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, OR c) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the BSA or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected). For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Through end of benefit year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Axial spondyloarthritis, Behcet's syndrome

No

Drugs
ADEMPAS

Exclusion Criteria

Required Medical Information

For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): PAH was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, AND 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): 1) Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR 2) Patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Agamree (Vamorolone)

Drugs
AGAMREE

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
AIMOVIG AUTOINJECTOR

Exclusion Criteria

Required Medical Information

For the preventive treatment of migraine, initial: 1) The patient experienced an inadequate treatment response with a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants OR 2) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any one of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants. For preventive treatment of migraine, continuation: The patient received at least 3 months of treatment with the requested drug, and the patient had a reduction in migraine days per month from baseline.

Age Restriction

Prescriber Restriction

Coverage Duration

Initial: 3 months, Continuation: Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
AKEEGA

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
ALECENSA

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Recurrent ALK-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC.
No

Drugs

alosetron

Exclusion Criteria

Required Medical Information

For severe diarrhea-predominant irritable bowel syndrome (IBS): 1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female, 2) chronic IBS symptoms lasting at least 6 months, 3) gastrointestinal tract abnormalities have been ruled out, AND 4) inadequate response to one conventional therapy (e.g., antispasmodics, antidepressants, antidiarrheals).

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

alpha1-proteinase inhibitor

Drugs

ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG, PROLASTIN-C INTRAVENOUS SOLUTION, ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG

Exclusion Criteria

Required Medical Information

For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema and 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry).

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
ALUNBRIG

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Recurrent ALK-positive non-small cell lung cancer (NSCLC), brain metastases from ALK-positive NSCLC, Inflammatory myofibroblastic tumor (IMT) with ALK translocation.
No

Drugs

ambrisentan

Exclusion Criteria

Required Medical Information

Pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

amphetamines

Drugs

dextroamphetamine-amphetamine oral capsule, extended release 24hr, dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg

Exclusion Criteria

Required Medical Information

- 1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR
- 2) The patient has a diagnosis of narcolepsy confirmed by a sleep study.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
ARCALYST

Exclusion Criteria

Required Medical Information

For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (new starts): 1) two or more gout flares within the previous 12 months, AND 2) inadequate response, intolerance or contraindication to maximum tolerated doses of a non-steroidal anti-inflammatory drug (NSAID) and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in patients initiating or continuing urate-lowering therapy (e.g., allopurinol) (continuation): 1) patient must have achieved or maintained a clinical benefit (i.e., a fewer number of gout attacks or fewer flare days) compared to baseline, AND 2) continued use of urate-lowering therapy concurrently with the requested drug. For recurrent pericarditis: patient must have had an inadequate response, intolerance or contraindication to maximum tolerated doses of an NSAID and colchicine.

Age Restriction

Prescriber Restriction

Coverage Duration

For prevention of gout flares: 4 months. Other: Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Prevention of gout flares in patients initiating or continuing urate-lowering therapy.

No

armodafinil

Drugs

armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg

Exclusion Criteria

Required Medical Information

1) The patient has a diagnosis of narcolepsy and the diagnosis is confirmed by sleep lab evaluation OR 2) The patient has a diagnosis of Shift Work Disorder (SWD) OR 3) The patient has a diagnosis of obstructive sleep apnea (OSA) and the diagnosis is confirmed by polysomnography.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
AUGTYRO

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG, AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG, AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG, 6 MG (14)-12 MG (14)-24 MG (14)

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Tourette's syndrome

No

Drugs
AUVELITY

Exclusion Criteria

Required Medical Information

For Major Depressive Disorder (MDD): The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to two of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
AYVAKIT

Exclusion Criteria

Required Medical Information

For myeloid and lymphoid neoplasms with eosinophilia, the patient meets all of the following criteria: 1) The disease is FIP1L1- PDGFRA rearrangement-positive, AND 2) The disease harbors a PDGFRA D842A mutation, AND 3) The disease is resistant to imatinib. For GIST, the patient meets either of the following criteria: 1) The disease harbors PDGFRA exon 18 mutation, including PDGFRA D842V mutations, OR 2) The requested drug will be used after failure on at least two Food and Drug Administration (FDA)-approved therapies in unresectable, recurrent, or metastatic disease without PDGFRA exon 18 mutation. For advanced systemic mastocytosis (AdvSM): 1) The patient has a diagnosis of advanced systemic mastocytosis including aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), and mast cell leukemia (MCL) AND 2) The patient has a platelet count of greater than or equal to 50,000/microliter (mcL).

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Myeloid and lymphoid neoplasms with eosinophilia, gastrointestinal stromal tumor (GIST) for unresectable, recurrent, or metastatic disease without platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation.

No

Drugs
BAFIERTAM

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
BALVERSA

Exclusion Criteria

Required Medical Information

For urothelial carcinoma: Disease has susceptible fibroblast growth factor receptor 3 (FGFR3) or fibroblast growth factor receptor 2 (FGFR2) genetic alterations AND the requested drug will be used as subsequent therapy for any of the following: a) locally advanced or metastatic urothelial carcinoma, b) recurrent primary carcinoma of the urethra, c) stage II urothelial carcinoma of the bladder if tumor is present following reassessment of tumor status 2-3 months after primary treatment with bladder preserving concurrent chemoradiotherapy, d) urothelial carcinoma of the bladder with metastatic or local recurrence post cystectomy, or e) urothelial carcinoma of the bladder with muscle invasive local recurrence or persistent disease in a preserved bladder.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent primary carcinoma of the urethra, recurrent or persistent urothelial carcinoma of the bladder.

No

Drugs

rufinamide oral suspension, rufinamide oral tablet 200 mg, 400 mg

Exclusion Criteria

Required Medical Information

Age Restriction

1 year of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

BENLYSTA SUBCUTANEOUS

Exclusion Criteria

For patients new to therapy: severe active central nervous system lupus.

Required Medical Information

For systemic lupus erythematosus (SLE): 1) Patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid or antimalarial) for SLE OR 2) patient is not currently receiving a stable standard therapy regimen for SLE because the patient experienced an intolerance or has a contraindication to standard therapy regimens. For lupus nephritis: 1) patient is currently receiving a stable standard therapy regimen (e.g., corticosteroid) for lupus nephritis OR 2) patient is not currently receiving a stable standard therapy regimen for lupus nephritis because the patient experienced an intolerance or has a contraindication to standard therapy regimens.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

BERINERT INTRAVENOUS KIT

Exclusion Criteria

Required Medical Information

For hereditary angioedema (HAE): The requested drug is being used for the treatment of acute angioedema attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has HAE with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.

Age Restriction

5 years of age or older

Prescriber Restriction

Prescribed by or in consultation with an immunologist, allergist, or rheumatologist

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
BESREMI

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

BETASERON SUBCUTANEOUS KIT

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

bexarotene oral

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Mycosis fungoides, Sezary syndrome, CD30-positive primary cutaneous anaplastic large cell lymphoma, CD30-positive lymphomatoid papulosis.

No

Drugs

bosentan

Exclusion Criteria

Required Medical Information

For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

BOSULIF ORAL CAPSULE 100 MG, 50 MG, BOSULIF ORAL TABLET

Exclusion Criteria

Required Medical Information

For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene, and 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I, G250E, V299L, and F317L. For CML, including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: patient has experienced resistance or intolerance to imatinib or dasatinib.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase

No

Drugs
BRAFTOVI

Exclusion Criteria

Required Medical Information

For colorectal cancer: The patient must meet both of the following criteria: 1) Tumor is positive for BRAF V600E mutation, 2) The requested drug will be used for either of the following: a) as subsequent therapy for advanced or metastatic disease, or b) as primary treatment for unresectable metachronous metastases. For cutaneous melanoma: The patient must meet all of the following criteria: 1) Tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), 2) The requested drug will be used in combination with binimetinib, and 3) The requested drug will be used for either of the following: a) unresectable or metastatic disease, or b) adjuvant systemic therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Adjuvant systemic therapy for cutaneous melanoma

No

Drugs

BRIVIACT ORAL SOLUTION, BRIVIACT ORAL TABLET

Exclusion Criteria

Required Medical Information

1) The patient has experienced an inadequate treatment response, intolerance, or contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to any of the following: Aptiom, Vimpat, Xcopri, Spritam.

Age Restriction

1 month of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Bronchitol (Mannitol)

Drugs
BRONCHITOL

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
BRUKINSA

Exclusion Criteria

Required Medical Information

For marginal zone lymphoma: 1) the requested drug is being used for the treatment of relapsed or refractory disease AND the patient has received at least one anti-CD20-based regimen OR 2) the requested drug is being used for the treatment of refractory or progressive disease AND the patient has experienced an intolerance or has a contraindication to ibrutinib.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

budesonide oral capsule, delayed, extend. release

Exclusion Criteria

Required Medical Information

For the maintenance of microscopic colitis: patient has had a clinical relapse after cessation of treatment (induction) therapy.

Age Restriction

Crohn's, treatment: 8 years of age or older

Prescriber Restriction

Coverage Duration

Microscopic colitis, maintenance: 12 months, all other indications: 3 months

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Treatment and maintenance of microscopic colitis in adults

No

buprenorphine

Drugs

buprenorphine HCl sublingual

Exclusion Criteria

Required Medical Information

The requested drug is being prescribed for the treatment of opioid use disorder AND patient meets one of the following:

1) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for treatment of opioid use disorder OR 2) The requested drug is being prescribed for induction therapy for transition from opioid use to treatment of opioid use disorder OR 3) The requested drug is being prescribed for maintenance therapy for treatment of opioid use disorder in a patient who is intolerant to naloxone.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
CABOMETYX

Exclusion Criteria

Required Medical Information

For renal cell carcinoma: The disease is advanced, relapsed, or stage IV. For non-small cell lung cancer: 1) the disease is rearranged during transfection (RET) positive AND 2) the disease is recurrent, advanced, or metastatic. For hepatocellular carcinoma: the requested drug will be used as subsequent treatment. For gastrointestinal stromal tumor (GIST): the disease is unresectable, recurrent, or metastatic AND the patient has failed on an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib). For Ewing sarcoma and osteosarcoma: the requested drug will be used as subsequent therapy. For differentiated thyroid cancer (DTC) (follicular, papillary, Hurthle cell): 1) The disease is locally advanced or metastatic disease, 2) the disease has progressed after a vascular endothelial growth factor receptor (VEGFR)-targeted therapy, AND 3) the patient is refractory to radioactive iodine therapy (RAI) or ineligible for RAI.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Non-small cell lung cancer, Ewing sarcoma, osteosarcoma, gastrointestinal stromal tumor

No

Drugs

calcipotriene scalp, calcipotriene topical ointment, ENSTILAR

Exclusion Criteria

Required Medical Information

For Treatment of Psoriasis: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to a topical steroid.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

CALQUENCE (ACALABRUTINIB MAL)

Exclusion Criteria

Required Medical Information

For gastric MALT lymphoma, non-gastric MALT lymphoma, nodal marginal zone lymphoma, and splenic marginal zone lymphoma: 1) the requested drug is being used for the treatment of refractory or progressive disease AND 2) the patient has experienced an intolerance or has a contraindication to ibrutinib. For chronic lymphocytic leukemia or small lymphocytic lymphoma: the patient has experienced an intolerance or has a contraindication to zanubrutinib or ibrutinib.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Waldenstrom macroglobulinemia, lymphoplasmacytic lymphoma, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma (noncutaneous), nodal marginal zone lymphoma, splenic marginal zone lymphoma

No

Drugs
CAPLYTA

Exclusion Criteria

Required Medical Information

For treatment of schizophrenia: 1) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone, AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following brand products: Latuda, Rexulti, Secuado, Vraylar. For treatment of depressive episodes associated with bipolar I: 1) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: olanzapine, quetiapine, AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following brand products: Latuda, Vraylar. For treatment of depressive episodes associated with bipolar II: The patient experienced an inadequate treatment response, intolerance, or contraindication to generic quetiapine.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
CAPRELSA

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.
No

Drugs

carglumic acid

Exclusion Criteria

Required Medical Information

For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic, biochemical, or genetic testing.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
CAYSTON

Exclusion Criteria

Required Medical Information

For treatment of respiratory symptoms in cystic fibrosis patients: 1) Pseudomonas aeruginosa is present in the patient's airway cultures OR 2) The patient has a history of pseudomonas aeruginosa infection or colonization in the airways.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
CERDELGA

Exclusion Criteria

Required Medical Information

For type 1 Gaucher disease (GD1): 1) The diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing, and 2) The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test, and 3) The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

clobazam oral suspension, clobazam oral tablet

Exclusion Criteria

Required Medical Information

Age Restriction

2 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

clomipramine

Exclusion Criteria

Required Medical Information

1) The requested drug is being prescribed for one of the following: a) Obsessive-Compulsive Disorder (OCD), b) Panic Disorder AND 2) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to any of the following: a) a serotonin and norepinephrine reuptake inhibitor (SNRI), b) a selective serotonin reuptake inhibitor (SSRI) OR 3) The requested drug is being prescribed for Depression AND 4) The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to two of the following: a) serotonin and norepinephrine reuptake inhibitors (SNRIs), b) selective serotonin reuptake inhibitors (SSRIs), c) mirtazapine, d) bupropion

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Depression, Panic Disorder

No

Drugs

clorazepate dipotassium

Exclusion Criteria

Required Medical Information

For all indications: The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).

Age Restriction

Prescriber Restriction

Coverage Duration

Short-term relief anxiety-1 month, Anxiety Disorders-4 months, All other Diagnoses-Plan Year

Other Criteria

This Prior Authorization only applies to patients 65 years of age or older.

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
COMETRIQ

Exclusion Criteria

Required Medical Information

For NSCLC: The requested medication is used for NSCLC when the patient's disease expresses rearranged during transfection (RET) gene rearrangements.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.

No

Drugs
COPIKTRA

Exclusion Criteria

Required Medical Information

For chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL): the patient has relapsed or refractory disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
COTELLIC

Exclusion Criteria

Required Medical Information

For adjuvant treatment of melanoma, and central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma): The patient must meet both of the following criteria: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), and 2) The requested drug will be used in combination with vemurafenib. For unresectable or metastatic melanoma: The patient must meet both of the following criteria: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), and 2) The requested drug will be used in combination with vemurafenib (with or without atezolizumab). For Histiocytic Neoplasms: The drug will be used as a single agent.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma), Erdheim-Chester disease, Rosai-Dorfman disease

No

Drugs
CYSTADROPS

Exclusion Criteria

Required Medical Information

The patient meets both of the following: 1) Diagnosis of cystinosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
CYSTAGON

Exclusion Criteria

Required Medical Information

Diagnosis of nephropathic cystinosis was confirmed by ANY of the following: 1) the presence of increased cystine concentration in leukocytes, OR 2) genetic testing, OR 3) demonstration of corneal cystine crystals by slit lamp examination.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
CYSTARAN

Exclusion Criteria

Required Medical Information

The patient meets both of the following: 1) Diagnosis of cystinosis was confirmed by ANY of the following: a) the presence of increased cystine concentration in leukocytes, OR b) genetic testing, OR c) demonstration of corneal cystine crystals by slit lamp examination, AND 2) the patient has corneal cystine crystal accumulation.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

dalfampridine

Exclusion Criteria

Required Medical Information

For multiple sclerosis, patient must meet the following: For new starts, prior to initiating therapy, patient demonstrates sustained walking impairment. For continuation of therapy: patient must have experienced an improvement in walking speed OR other objective measure of walking ability since starting the requested drug.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
DAURISMO

Exclusion Criteria

Required Medical Information

For acute myeloid leukemia: 1) the requested drug must be used in combination with cytarabine, 2) the patient is 75 years of age or older OR has comorbidities that preclude intensive chemotherapy, and 3) the requested drug will be used as treatment for induction therapy, post-induction therapy, or relapsed or refractory disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Post induction therapy following response to previous therapy with the same regimen for acute myeloid leukemia (AML).
Relapsed/refractory AML as a component of repeating the initial successful induction regimen.

No

Daybue (Trofinetide)

Drugs
DAYBUE

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
End of Benefit Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

deferasirox

Exclusion Criteria

Required Medical Information

For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

metirosine

Exclusion Criteria

Required Medical Information

The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to an alpha-adrenergic antagonist.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

desvenlafaxine

Drugs

desvenlafaxine succinate

Exclusion Criteria

Required Medical Information

Patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: a) serotonin and norepinephrine reuptake inhibitors (SNRIs), b) selective serotonin reuptake inhibitors (SSRIs), c) mirtazapine, d) bupropion

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

dexmethylphenidate

Drugs

dexmethylphenidate oral tablet 10 mg, 2.5 mg, 5 mg

Exclusion Criteria

Required Medical Information

- 1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR
- 2) The requested drug is being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Cancer-related fatigue

No

Drugs

dihydroergotamine nasal

Exclusion Criteria

Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).

Required Medical Information

The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one triptan 5-HT₁ receptor agonist.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

DIACOMIT ORAL CAPSULE 250 MG, 500 MG, DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG

Exclusion Criteria

Required Medical Information

Age Restriction

6 months of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

DIAZEPAM INTENSOL, *diazepam oral solution 5 mg/5 mL (1 mg/mL)*, *diazepam oral tablet*

Exclusion Criteria

Required Medical Information

For all indications: The prescriber must acknowledge the benefit of therapy with this prescribed medication outweighs the potential risks for the patient. (Note: The American Geriatrics Society identifies the use of this medication as potentially inappropriate in older adults, meaning it is best avoided, prescribed at reduced dosage, or used with caution or carefully monitored.) For the management of anxiety disorders: 1) The requested drug is being used concurrently with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the SSRI/SNRI becomes effective for the symptoms of anxiety, OR 2) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to AT LEAST TWO agents from the following classes: a) selective serotonin reuptake inhibitors (SSRIs), b) serotonin-norepinephrine reuptake inhibitors (SNRIs).

Age Restriction

Prescriber Restriction

Coverage Duration

Short-term relief anx-1 mo, skeletal muscle spasm-3 mo, Anx Disorders-4 mo, Other Diagnoses-PlanYR

Other Criteria

This Prior Authorization only applies to patients 65 years of age or older.

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

DOPTELET (10 TAB PACK), DOPTELET (15 TAB PACK), DOPTELET (30 TAB PACK)

Exclusion Criteria

Required Medical Information

For thrombocytopenia in patients with chronic liver disease: Untransfused platelet count prior to a scheduled procedure is less than 50,000/mcL. For chronic immune thrombocytopenia (ITP): 1) For new starts: a) Patient has had an inadequate response or is intolerant to prior therapy such as corticosteroids or immunoglobulins, AND b) Untransfused platelet count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000 to 50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes patient to trauma). 2) For continuation of therapy, platelet count response to the requested drug: a) Current platelet count is less than or equal to 200,000/mcL OR b) Current platelet count is greater than 200,000/mcL and less than or equal to 400,000/mcL and dosing will be adjusted to a platelet count sufficient to avoid clinically important bleeding.

Age Restriction

18 years of age or older

Prescriber Restriction

Coverage Duration

Chronic liver disease: 1 month, ITP initial: 6 months, ITP reauthorization: Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG

Exclusion Criteria

Required Medical Information

1) The patient has tried duloxetine capsules OR 2) The patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration).

Age Restriction

Generalized Anxiety Disorder - 7 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Cancer pain, chemotherapy-induced neuropathic pain

No

Drugs
DUAVEE

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs**DUPIXENT PEN, DUPIXENT SYRINGE****Exclusion Criteria****Required Medical Information**

For atopic dermatitis (AD), initial therapy: 1) Patient has moderate-to-severe disease, 2) Patient has had an inadequate treatment response to either a topical corticosteroid or a topical calcineurin inhibitor, OR topical corticosteroids and topical calcineurin inhibitors are not advisable for the patient. For AD, continuation of therapy: the patient achieved or maintained positive clinical response. For moderate-to-severe asthma, initial therapy: Patient meets either of the following: 1) patient is oral corticosteroid dependent and asthma remains inadequately controlled despite current treatment with both of the following medications: a) high-dose inhaled corticosteroid and b) an additional controller (long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies, OR 2) patient has a baseline blood eosinophil count of at least 150 cells per microliter and their asthma remains inadequately controlled despite current treatment with both of the following medications: a) medium-to-high-dose inhaled corticosteroid and b) additional controller (long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For moderate-to-severe asthma, continuation of therapy: asthma control has improved on treatment with the requested drug. For chronic rhinosinusitis with nasal polyposis (CRSwNP): 1) the requested drug is used as add-on maintenance treatment, AND 2) the patient has experienced an inadequate treatment response to Xhance (fluticasone).

Age Restriction

Atopic Dermatitis: 6 months of age or older, Asthma: 6 years of age or older, Chronic Rhinosinusitis with Nasal Polyposis and Prurigo Nodularis: 18 years of age or older, Eosinophilic Esophagitis: 1 year of age and older, weighing at least 15kg.

Prescriber Restriction**Coverage Duration**

AD, initial: 4 months, PN, initial: 6 months, All other: Plan Year

Other Criteria

For eosinophilic esophagitis (EoE), initial therapy: 1) diagnosis has been confirmed by esophageal biopsy, 2) patient weighs at least 15 kilograms, 3) patient experienced an inadequate treatment response, intolerance, or patient has a contraindication to a topical corticosteroid (e.g., fluticasone propionate or budesonide). For EoE, continuation of therapy: the patient achieved or maintained a positive clinical response. For prurigo nodularis (PN), initial therapy: Patient has had an inadequate treatment response to a topical corticosteroid OR topical corticosteroids are not advisable for the patient. For PN, continuation of therapy: The patient achieved or maintained a positive clinical response.

Indications

All FDA-approved Indications.

Off Label Uses**Part B Prerequisite**

No

Drugs

ELIGARD, ELIGARD (3 MONTH), ELIGARD (4 MONTH), ELIGARD (6 MONTH)

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent androgen receptor positive salivary gland tumors

No

Drugs
EMSAM

Exclusion Criteria

Required Medical Information

1) Patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: a) serotonin and norepinephrine reuptake inhibitors (SNRIs), b) selective serotonin reuptake inhibitors (SSRIs), c) mirtazapine, d) bupropion OR 2) Patient is unable to swallow oral formulations.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

ENBREL MINI, ENBREL SUBCUTANEOUS SOLUTION, ENBREL SUBCUTANEOUS SYRINGE, ENBREL SURECLICK

Exclusion Criteria

Required Medical Information

For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis (new starts only): 1) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR 2) Intolerance or contraindication to NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, OR b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, OR c) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e. at least 10% of the BSA or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected). For hidradenitis suppurativa (new starts only): patient has severe, refractory disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Hidradenitis suppurativa

No

Drugs

ENDARI, *glutamine (sickle cell)*

Exclusion Criteria

Required Medical Information

Age Restriction

5 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
EPCLUSA

Exclusion Criteria

Required Medical Information

For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases (AASLD) treatment guidelines.

Age Restriction

Prescriber Restriction

Coverage Duration

Criteria will be applied consistent with current AASLD-IDSa guidance.

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
EPIDIOLEX

Exclusion Criteria

Required Medical Information

Age Restriction

1 year of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
EPRONTIA

Exclusion Criteria

Required Medical Information

For treatment of partial-onset seizures: 1)The patient has experienced an inadequate treatment response, intolerance, or contraindication to a generic anticonvulsant AND 2) the patient has experienced an inadequate treatment response, intolerance, or contraindication to any of the following: Aptiom, Vimpat, Xcopri, Spritam. For monotherapy treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response or intolerance to topiramate tablets or capsules, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules). For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient has experienced an inadequate treatment response, intolerance, or contraindication to a generic anticonvulsant AND 2) If the patient is 4 years of age or older, the patient has experienced an inadequate treatment response, intolerance, or contraindication to Spritam or Vimpat. For the preventative treatment of migraines: 1) The patient has experienced an inadequate treatment response or intolerance to topiramate tablets or capsules, OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).

Age Restriction

Epilepsy: 2 years of age or older, Migraine: 12 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

ergotamine-caffeine

Exclusion Criteria

Coverage will be denied when used in conjunction with potent CYP3A4 inhibitors (e.g., ritonavir, nelfinavir, indinavir, erythromycin, clarithromycin).

Required Medical Information

The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least ONE triptan 5-HT₁ agonist.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
ERIVEDGE

Exclusion Criteria

Required Medical Information

Adult medulloblastoma: patient has received chemotherapy previously AND has tumor(s) with mutations in the sonic hedgehog pathway

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Adult medulloblastoma

No

Drugs
ERLEADA

Exclusion Criteria

Required Medical Information

The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

erlotinib oral tablet 100 mg, 150 mg, 25 mg

Exclusion Criteria

Required Medical Information

For NSCLC (including brain metastases from NSCLC): 1) the disease is recurrent, advanced, or metastatic and 2) the patient has sensitizing EGFR mutation-positive disease. For pancreatic cancer: the disease is locally advanced, unresectable, recurrent, or metastatic.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent non-small cell lung cancer (NSCLC), recurrent chordoma, relapsed or stage IV renal cell carcinoma (RCC), brain metastases from non-small cell lung cancer (NSCLC), recurrent pancreatic cancer.

No

Drugs

pirfenidone oral capsule, pirfenidone oral tablet 267 mg, 534 mg, 801 mg

Exclusion Criteria

Required Medical Information

For idiopathic pulmonary fibrosis (Initial Review Only): 1) a high-resolution computed tomography (HRCT) study of the chest or a lung biopsy reveals the usual interstitial pneumonia (UIP) pattern, OR 2) HRCT study of the chest reveals a result other than the UIP pattern (e.g., probable UIP, indeterminate for UIP) and the diagnosis is supported either by a lung biopsy or by a multidisciplinary discussion between at least a radiologist and pulmonologist who are experienced in idiopathic pulmonary fibrosis if a lung biopsy has not been conducted.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

everolimus (antineoplastic) oral tablet, everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg

Exclusion Criteria

Required Medical Information

For breast cancer: 1) The disease is recurrent, advanced, or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, AND 2) The requested drug is prescribed in combination with exemestane, fulvestrant, or tamoxifen, AND 3) The requested drug is used for subsequent treatment. For renal cell carcinoma: The disease is relapsed, advanced, or stage IV. For subependymal giant cell astrocytoma (SEGA): The requested drug is given as adjuvant treatment. For gastrointestinal stromal tumor: The disease is recurrent, unresectable, or metastatic AND the patient failed an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib). For symptomatic or relapsed/refractory Erdheim-Chester Disease (ECD), symptomatic or relapsed/refractory Rosai-Dorfman Disease, and Langerhans Cell Histiocytosis (LCH): the patient must have a phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha (PIK3CA) mutation.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Classic Hodgkin lymphoma, thymomas and thymic carcinomas, previously treated Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma (perivascular epithelioid cell tumors (PEComa) and lymphangiomyomatosis subtypes), gastrointestinal stromal tumors, neuroendocrine tumors of the thymus, well differentiated grade 3 neuroendocrine tumors, thyroid carcinoma (papillary, Hurthle cell, and follicular), endometrial carcinoma, histiocytic neoplasms (Rosai-Dorfman Disease, Erdheim-Chester Disease, Langerhans Cell Histiocytosis)
No

Drugs
FABHALTA

Exclusion Criteria

Required Medical Information

Vaccinate against encapsulated bacteria including *S. pneumoniae*, *N. meningitidis* and *H. influenzae* type B according to current Advisory Committee on Immunization Practices (ACIP) recommendations at least 2 weeks prior to iptacopan initiation. If urgent iptacopan treatment is necessary in a patient who is not up to date with *S. pneumoniae*, *N. meningitidis*, and *H. influenzae* type B vaccines according to ACIP recommendations, must provide antibacterial prophylaxis.

Age Restriction

Prescriber Restriction

Coverage Duration

End of Current Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

FANAPT ORAL TABLET, FANAPT ORAL TABLETS,DOSE PACK

Exclusion Criteria

Required Medical Information

For treatment of schizophrenia: 1) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: aripiprazole, asenapine, olanzapine, quetiapine, risperidone, ziprasidone AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following brand products: Latuda, Rexulti, Secuado, Vraylar.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

FASENRA, FASENRA PEN

Exclusion Criteria

Required Medical Information

For severe asthma: For initial therapy: 1) Either a) Patient has baseline blood eosinophil count of at least 150 cells per microliter OR b) Patient is dependent on systemic corticosteroids, and 2) Patient has a history of severe asthma despite current treatment with both of the following medications: a) inhaled corticosteroid and b) additional controller (long-acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For continuation of therapy: Asthma control has improved on treatment with the requested drug, as demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose.

Age Restriction

6 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

febuxostat

Exclusion Criteria

Required Medical Information

For the chronic management of hyperuricemia in a patient with gout: 1) the patient has experienced an inadequate treatment response to a maximally titrated dose of allopurinol, OR 2) the patient has experienced an intolerance to allopurinol, OR 3) the patient has a contraindication that would prohibit a trial of allopurinol.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

fentanyl patch

Drugs

fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr

Exclusion Criteria

Required Medical Information

The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26), FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG

Exclusion Criteria

Required Medical Information

The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to TWO of the following: serotonin and norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), mirtazapine, bupropion.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
FILSPARI

Exclusion Criteria

Required Medical Information

Clinical documentation that A) Patient is at risk of rapid disease progression [e.g., generally a urine protein-to-creatinine ratio (UPCR) greater than or equal to 1.5 g/g, or by other criteria such as clinical risk scoring using the International IgAN Prediction Tool] AND B) Medication will be used to reduce proteinuria AND C) Estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 meter squared AND D) Patient is on a maximized stable dose with one of an angiotensin converting enzyme (ACE) inhibitor or an angiotensin II receptor blocker (ARB) AND E) Patient has a history of failure, contraindication or intolerance to a 30-day trial of aglucocorticoid (e.g., methylprednisolone, prednisone).

Age Restriction

Prescriber Restriction

Prescribed by or in consultation with a nephrologist

Coverage Duration

Through end of benefit year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
FINTEPLA

Exclusion Criteria

Required Medical Information

Age Restriction

2 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

flucytosine

Drugs

flucytosine

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

6 weeks

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
FORTEO

Exclusion Criteria

Required Medical Information

For postmenopausal osteoporosis: patient has ONE of the following (1 or 2): 1) a history of fragility fracture, OR 2) A pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has one of the following: 1) a history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: Patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND patient meets ANY of the following: 1) patient has a history of fragility fracture, OR 2) a pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. Continuation of therapy: If the patient has received greater than or equal to 24 months of therapy with any parathyroid hormone analog: 1) The patient remains at or has returned to having a high risk for fracture, AND 2) The benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

Age Restriction

Prescriber Restriction

Coverage Duration

Initial: 24 months, Continuation: Plan Year

Other Criteria

Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
FOTIVDA

Exclusion Criteria

Required Medical Information

For advanced renal cell carcinoma: the following criteria must be met: 1) The disease is relapsed or refractory, 2) The requested drug must be used after at least two prior systemic therapies, and 3) The patient has experienced disease progression or an intolerable adverse event with a trial of cabozantinib (Cabometyx).

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Fruzaqla (fruquintinib)

Drugs
FRUZAQLA

Exclusion Criteria

Required Medical Information

Documentation of metastatic colorectal cancer.

Age Restriction

Prescriber Restriction

Oncologist

Coverage Duration

End of benefit year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

FYCOMPA ORAL SUSPENSION, FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG

Exclusion Criteria

Required Medical Information

For treatment of partial-onset seizures: 1) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic anticonvulsant AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to any of the following: Aptiom, Vimpat, Xcopri, Spritam. For adjunctive treatment of primary generalized tonic-clonic seizures: 1) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic anticonvulsant AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: Vimpat, Spritam.

Age Restriction

Partial-onset seizures: 4 years of age or older. Primary generalized tonic-clonic seizures: 12 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
GATTEX 30-VIAL

Exclusion Criteria

Required Medical Information

For short bowel syndrome (SBS) initial therapy: Adult patients were dependent on parenteral support for at least 12 months. For SBS continuation: Requirement for parenteral support has decreased from baseline while on therapy with the requested drug.

Age Restriction

Prescriber Restriction

Prescribed by or in consultation with a gastroenterologist, gastrointestinal surgeon, or nutritional support specialist.

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
GAVRETO

Exclusion Criteria

Required Medical Information

For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced, or metastatic, and 2) The tumor is rearranged during transfection (RET) fusion-positive or RET rearrangement-positive.

Age Restriction

Non-small cell lung cancer: 18 years of age or older. Medullary thyroid cancer and thyroid cancer: 12 years of age or older.

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer
No

GEFITINIB

Drugs
gefitinib

Exclusion Criteria

metastatic NSCLC whose tumors have EGFR mutations other than exon 19 deletions or exon 21 (L858R) substitution mutations.

Required Medical Information

Documented diagnosis of Metastatic non-small cell lung cancer (NSCLC) whose tumors have epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by an FDA-approved test

Age Restriction

Prescriber Restriction

Coverage Duration

Through end of benefit year.

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
GEMTESA

Exclusion Criteria

Required Medical Information

Patient must have tried and failed Myrbetriq (mirabegron) or have a contraindication to Myrbetriq including uncontrolled hypertension or a significant drug interaction.

Age Restriction

Prescriber Restriction

Coverage Duration

End of Benefit Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

fingolimod

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
GILOTRIF

Exclusion Criteria

Required Medical Information

For non-small cell lung cancer (NSCLC): Patient meets either of the following: 1) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, OR 2) Patient has sensitizing epidermal growth factor receptor (EGFR) mutation-positive disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

glatiramer subcutaneous syringe 20 mg/mL, 40 mg/mL, GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

glucagon-like peptide-1 agonists

Drugs

BYDUREON BCISE, BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML, 5 MCG/DOSE (250 MCG/ML) 1.2 ML, MOUNJARO, OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML), RYBELSUS, TRULICITY, VICTOZA 3-PAK

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Through end of benefit plan year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 450 MG, 600 MG, 750 MG, 900 MG

Exclusion Criteria

Required Medical Information

Postherpetic neuralgia: The patient has experienced an inadequate treatment response or intolerance to gabapentin immediate-release.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

GENOTROPIN, GENOTROPIN MINIQUICK

Exclusion Criteria

Pediatric patients with closed epiphyses

Required Medical Information

Pediatric growth hormone deficiency (GHD): Patient (pt) is a neonate or was diagnosed with GHD as a neonate OR meets any of the following: 1) younger than 2.5 years old (yo) with pre-treatment (pre-tx) height (ht) more than 2 standard deviations (SD) below mean and slow growth velocity OR 2) 2.5 yo or older AND one of the following: a) pre-tx 1-year ht velocity more than 2 SD below mean OR b) pre-tx ht more than 2 SD below mean and 1-year ht velocity more than 1 SD below mean, AND patient meets any of the following: 1) failed 2 pre-tx growth hormone (GH) stimulation tests (peak below 10 ng/mL), OR 2) pituitary/central nervous system (CNS) disorder (e.g., genetic defects, acquired structural abnormalities, congenital structural abnormalities) and pre-tx insulin-like growth factor-1 (IGF-1) more than 2 SD below mean. Turner syndrome: 1) Confirmed by karyotyping AND 2) pre-tx ht is less than the 5th percentile for age. Small for gestational age (SGA): 1) Birth weight (wt) less than 2500g at gestational age (GA) greater than 37 weeks, OR birth wt or length below 3rd percentile for GA or at least 2 SD below mean for GA, AND 2) did not manifest catch-up growth by age 2.

Age Restriction

SGA: 2 years of age or older

Prescriber Restriction

Prescribed by or in consultation with an endocrinologist, pediatric endocrinologist, nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, or geneticist.

Coverage Duration

Plan Year

Other Criteria

Adult GHD: Pt meets any of the following: 1) failed 2 pre-tx GH stimulation tests, OR 2) pre-tx IGF-1 more than 2 SD below mean AND failed 1 pre-tx GH stimulation test. (Note: Stimulation tests include: a) insulin tolerance test [ITT] [peak GH less than or equal to 5 ng/ml], or b) Macrilen-stimulation test [peak GH level less than 2.8ng/ml], or c) glucagon-stimulation test [GST] [peak GH level less than or equal to 3 ng/ml] for pt with a body mass index [BMI] 25-30 kg/m² and high pretest probability of GHD [e.g., acquired structural abnormalities] or BMI less than 25 kg/m², or d) GST [peak GH level less than or equal to 1 ng/ml] in pt with BMI 25-30 kg/m² and low pretest probability of GHD or BMI greater than 30 kg/m²), OR 3) organic hypothalamic-pituitary disease (e.g., suprasellar mass with previous surgery and cranial irradiation) with 3 or more pituitary hormone deficiencies AND pre-tx IGF-1 more than 2 SD below mean, OR 4) genetic or structural hypothalamic-pituitary defects, OR 5) childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS. Renewal for pediatric GHD, TS, SGA, and adult GHD: Patient is experiencing improvement.

Indications

All Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

HAEGARDA SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT

Exclusion Criteria

Required Medical Information

For hereditary angioedema: The requested drug is being used for the prevention of acute angioedema attacks. Patient has hereditary angioedema (HAE) with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has hereditary angioedema with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.

Age Restriction

6 years of age or older

Prescriber Restriction

Prescribed by or in consultation with an immunologist, allergist, or rheumatologist

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

HARVONI ORAL PELLETS IN PACKET, HARVONI ORAL TABLET 90-400 MG

Exclusion Criteria

Required Medical Information

For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases (AASLD) treatment guidelines.

Age Restriction

Prescriber Restriction

Coverage Duration

Criteria applied consistent w/ current AASLD-IDSA guidance. Reminder for 8wk option if appropriate.

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

tasimelteon

Exclusion Criteria

Required Medical Information

For Non-24-Hour Sleep-Wake Disorder: 1) for initial therapy and continuation of therapy: a) diagnosis of total blindness in both eyes (e.g., nonfunctioning retinas) and b) unable to perceive light in either eye, AND 2) if currently on therapy with the requested drug, patient must meet at least one of the following: a) increased total nighttime sleep or b) decreased daytime nap duration. For nighttime sleep disturbances in Smith-Magenis Syndrome (SMS): 1) for initial therapy and continuation therapy, the patient has a confirmed diagnosis of SMS AND 2) if currently on therapy with the requested drug, the patient experiences improvement in the quality of sleep since starting therapy.

Age Restriction

Non-24: 18 years of age or older. SMS: 16 years of age or older

Prescriber Restriction

Prescribed by or in consultation with sleep disorder specialist or neurologist

Coverage Duration

Initiation: 6 Months, Renewal: Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

HUMIRA PEN, HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, HUMIRA(CF) PEN CROHNS-UC-HS, HUMIRA(CF) PEN PEDIATRIC UC, HUMIRA(CF) PEN PSOR-UV-ADOL HS, HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 80 MG/0.8 ML, HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML, 40 MG/0.4 ML

Exclusion Criteria

Required Medical Information

For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For active ankylosing spondylitis and axial spondyloarthritis (new starts only): 1) Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR 2) Intolerance or contraindication to NSAIDs. For moderate to severe plaque psoriasis (new starts only): 1) At least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) Patient meets any of the following: a) Patient has experienced an inadequate response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, OR b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, OR c) Patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the BSA or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected). For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Axial spondyloarthritis, Behcet's syndrome

No

Drugs
IBRANCE

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Unresectable well-differentiated/dedifferentiated liposarcoma of the retroperitoneum, recurrent hormone receptor-positive human epidermal growth factor receptor 2 (HER2)-negative breast cancer
No

Drugs

icatibant, **SAJAZIR**

Exclusion Criteria

Required Medical Information

For hereditary angioedema (HAE): The requested drug is being used for the treatment of acute angioedema attacks. Patient has HAE with C1 inhibitor deficiency or dysfunction confirmed by laboratory testing OR patient has HAE with normal C1 inhibitor confirmed by laboratory testing. For patients with HAE with normal C1 inhibitor, EITHER 1) Patient tested positive for an F12, angiotensin-1, plasminogen, kininogen-1 (KNG1), heparan sulfate-glucosamine 3-O-sulfotransferase 6 (HS3ST6), or myoferlin (MYOF) gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of high-dose antihistamine therapy for at least one month.

Age Restriction

18 years of age or older

Prescriber Restriction

Prescribed by or in consultation with an immunologist, allergist, or rheumatologist

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
ICLUSIG

Exclusion Criteria

Required Medical Information

For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL), including patients who have received a hematopoietic stem cell transplant: diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, including patients who have received a hematopoietic stem cell transplant: 1) patient has accelerated or blast phase CML and no other kinase inhibitor is indicated, OR 2) patient has chronic phase CML and has experienced resistance or intolerance to at least 2 prior kinase inhibitors AND at least one of those was imatinib or dasatinib, OR 3) patient is positive for the T315I mutation.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Myeloid and/or lymphoid neoplasms with eosinophilia and FGFR1 or ABL1 rearrangement in the chronic phase or blast phase

No

Drugs
IDHIFA

Exclusion Criteria

Required Medical Information

For acute myeloid leukemia (AML) with an isocitrate dehydrogenase-2 (IDH2) mutation: 1) patient is 60 years of age or older with newly-diagnosed AML and meets one of the following: a) patient is not a candidate for intensive induction therapy, or b) patient declines intensive induction chemotherapy, OR 2) patient is 60 years of age or older and the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug OR 3) patient has relapsed or refractory AML.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Newly-diagnosed acute myeloid leukemia

No

Drugs

imatinib oral tablet 100 mg, 400 mg

Exclusion Criteria

Required Medical Information

For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), including patients who have received a hematopoietic stem cell transplant: diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: patient did not fail (excluding failure due to intolerance) prior therapy with a tyrosine kinase inhibitor. For melanoma: c-Kit mutation is positive.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), recurrent chordoma, melanoma, Kaposi sarcoma, chronic myelomonocytic leukemia, chronic graft versus host disease (cGVHD), T-cell acute lymphoblastic leukemia with ABL-class translocation, aggressive systemic mastocytosis for well-differentiated systemic mastocytosis (WDSM) or when eosinophilia is present with FIP1L1-PDGFR α fusion gene, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1, FIP1L1-PDGFR α , or PDGFR β rearrangement in the chronic phase or blast phase

No

Drugs

IMBRUVICA ORAL CAPSULE 140 MG, 70 MG, IMBRUVICA ORAL SUSPENSION, IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG

Exclusion Criteria

Required Medical Information

For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary CNS lymphoma: 1) the disease is relapsed or refractory OR 2) the requested drug is used for induction therapy as a single agent. For diffuse large B-cell lymphoma and high-grade B-cell lymphoma: the requested drug will be used as second-line or subsequent therapy. For AIDS-related B-cell lymphoma: the requested drug will be used as a single agent and as second-line or subsequent therapy for relapsed disease. For post-transplant lymphoproliferative disorders: the requested drug will be used in patients who have received prior chemoimmunotherapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Hairy cell leukemia, lymphoplasmacytic lymphoma, primary central nervous system (CNS) lymphoma, AIDS-related B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders, high-grade B-cell lymphoma
No

Drugs
INCRELEX

Exclusion Criteria

Pediatric patients with closed epiphyses

Required Medical Information

For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone (GH) gene deletion in patients who have developed neutralizing antibodies to GH, patient meets all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations (SD) below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more SD below the mean for children of the same age and gender AND 3) provocative growth hormone test showing a normal or elevated growth hormone level. For growth failure due to severe primary IGF-1 deficiency or GH gene deletion in patients who have developed neutralizing antibodies to GH, continuation of therapy: patient is experiencing improvement.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

INGREZZA, INGREZZA INITIATION PK(TARDIV), INGREZZA SPRINKLE

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

INLYTA ORAL TABLET 1 MG, 5 MG

Exclusion Criteria

Required Medical Information

For renal cell carcinoma: The disease is advanced, relapsed, or stage IV.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Thyroid carcinoma (papillary, Hurthle cell, or follicular)

No

Drugs
INQOVI

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
INREBIC

Exclusion Criteria

Required Medical Information

For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and janus kinase 2 (JAK2) rearrangement, accelerated phase myelofibrosis, blast phase myelofibrosis/acute myeloid leukemia

No

Drugs

hydrocodone bitartrate oral tablet, oral only, ext. rel. 24 hr, HYSINGLA ER, methadone oral solution, methadone oral tablet, morphine oral tablet extended release

Exclusion Criteria

Required Medical Information

The requested drug is being prescribed for pain associated with cancer, sickle cell disease, a terminal condition, or pain being managed through palliative care OR the patient meets all of the following: 1) The requested drug is being prescribed for pain severe enough to require daily, around-the-clock, long-term treatment in a patient who has been taking an opioid AND 2) The patient can safely take the requested dose based on their history of opioid use [Note: This drug should be prescribed only by healthcare professionals who are knowledgeable in the use of potent opioids for the management of chronic pain.] AND 3) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 4) This request is for continuation of therapy for a patient who has been receiving an extended-release opioid agent for at least 30 days OR the patient has taken an immediate-release opioid for at least one week.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
IRESSA

Exclusion Criteria

Required Medical Information

For non-small cell lung cancer (NSCLC): 1) disease must be metastatic, advanced, or recurrent AND 2) patient must have a sensitizing EGFR mutation.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC).
No

Drugs

ACCUTANE ORAL CAPSULE 10 MG, 20 MG, 40 MG, AMNESTEEM, CLARAVIS, isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg, ZENATANE

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Refractory acne vulgaris, severe refractory rosacea, neuroblastoma, cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), high risk for developing skin cancer (squamous cell cancers), transient acantholytic dermatosis (Grover's Disease), keratosis follicularis (Darier Disease), lamellar ichthyosis, pityriasis rubra pilaris.

No

Drugs

itraconazole oral capsule

Exclusion Criteria

Required Medical Information

The requested drug will be used orally. For the treatment of onychomycosis due to dermatophytes (*Tinea unguium*), the diagnosis has been confirmed by a fungal diagnostic test (e.g., potassium hydroxide [KOH] preparation, fungal culture, or nail biopsy).

Age Restriction

Prescriber Restriction

Coverage Duration

Disseminated/CNS histoplasmosis, Histoplasmosis/Coccidioidomycosis/CGD ppx: 12 mths. Others: 6 mths

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Coccidioidomycosis, Coccidioidomycosis prophylaxis in HIV infection, Cryptococcosis, Microsporidiosis, Talaromycosis (formerly Penicilliosis), Histoplasmosis prophylaxis in HIV infection, Invasive fungal infection prophylaxis in liver transplant, chronic granulomatous disease (CGD), and hematologic malignancy, Sporotrichosis, Pityriasis versicolor, *Tinea versicolor*, *Tinea corporis*, *Tinea cruris*, *Tinea capitis*, *Tinea manuum*, *Tinea pedis*.

No

Drugs

ivermectin oral

Exclusion Criteria

Required Medical Information

The requested drug is not being prescribed for the prevention or treatment of coronavirus disease 2019 (COVID-19).

Age Restriction

Prescriber Restriction

Coverage Duration

1 month

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Ascariasis, Cutaneous larva migrans, Mansonelliasis, Scabies, Gnathostomiasis, Pediculosis

No

Drugs

BIVIGAM, GAMMAGARD LIQUID, GAMMAGARD S-D (IGA ; 1 MCG/ML), GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %), GAMMAPLEX, GAMMAPLEX (WITH SORBITOL), GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %), OCTAGAM, PANZYGA, PRIVIGEN

Exclusion Criteria

Required Medical Information

For B-cell chronic lymphocytic leukemia (CLL): 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For bone marrow transplant/hematopoietic stem cell transplant (BMT/HSCT): 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric human immunodeficiency virus (HIV) infection: 1) serum IgG less than 400 mg/dL OR 2) history of recurrent bacterial infections. For dermatomyositis and polymyositis: 1) at least one standard first-line treatment (corticosteroid or immunosuppressant) has been tried but was unsuccessful or not tolerated OR 2) patient is unable to receive standard therapy because of a contraindication or other clinical reason. For pure red cell aplasia (PRCA): PRCA is secondary to parvovirus B19 infection.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Indications

All Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

No

Iwilfin (eflornithine)

Drugs
IWILFIN

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
JAKAFI

Exclusion Criteria

Required Medical Information

For polycythemia vera: patient had an inadequate response or intolerance to interferon therapy or hydroxyurea. For acute lymphoblastic leukemia: patient has a cytokine receptor-like factor 2 (CRLF2) mutation or a mutation associated with activation of the Janus kinase/signal transducers and activators of transcription (JAK/STAT) pathway. For CMML-2: the requested drug is used in combination with a hypomethylating agent. For BCR-ABL negative aCML: the requested drug is used as a single agent or in combination with a hypomethylating agent. For essential thrombocythemia: patient had an inadequate response or loss of response to hydroxyurea, interferon therapy, or anagrelide. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement: the disease is in chronic or blast phase.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Lower-risk myelofibrosis, accelerated phase myelofibrosis, blast phase myelofibrosis/acute myeloid leukemia, acute lymphoblastic leukemia (ALL), chronic myelomonocytic leukemia (CMML)-2, BCR-ABL negative atypical chronic myeloid leukemia (aCML), essential thrombocythemia, and myeloid, lymphoid or mixed lineage neoplasms with eosinophilia and JAK2 rearrangement

No

Drugs

JAYPIRCA ORAL TABLET 100 MG, 50 MG

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 25 MG, 5.8 MG, 50 MG, 75 MG, KALYDECO ORAL TABLET

Exclusion Criteria

Required Medical Information

For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor.

Age Restriction

1 months of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
KESIMPTA PEN

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

ketoconazole oral

Exclusion Criteria

Acute or chronic liver disease. Concurrent use with drugs that are contraindicated with ketoconazole tablets: dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, irinotecan, lurasidone, oral midazolam, alprazolam, triazolam, felodipine, nisoldipine, tolvaptan, eplerenone, lovastatin, simvastatin, or colchicine.

Required Medical Information

The potential benefits outweigh the risks of treatment with oral ketoconazole. For systemic fungal infections, the patient has any of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis. For Cushing's syndrome: the requested drug is being prescribed for a patient who cannot tolerate surgery or where surgery has not been curative.

Age Restriction

Prescriber Restriction

Coverage Duration

6 months

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Cushing's syndrome

No

Drugs
KEVZARA

Exclusion Criteria

Required Medical Information

For moderately to severely active rheumatoid arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to methotrexate (MTX) OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD. For polymyalgia rheumatica (PMR) (new starts only): 1) The patient has experienced an inadequate treatment response to corticosteroids OR 2) The patient has experienced a disease flare while attempting to taper corticosteroids.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
KINERET

Exclusion Criteria

Required Medical Information

For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance or has a contraindication to methotrexate (MTX) AND at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]).

Age Restriction

Prescriber Restriction

Coverage Duration

Through end of benefit year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG, KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent hormone receptor-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer, in combination with an aromatase inhibitor, or fulvestrant.

No

Drugs
KORLYM

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Prescribed by or in consultation with an endocrinologist

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
KOSELUGO

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of plan year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
KRAZATI

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

lapatinib

Exclusion Criteria

Required Medical Information

For breast cancer, the patient meets all the following: a) the disease is recurrent, advanced, or metastatic (including brain metastases), b) the disease is human epidermal growth factor receptor 2 (HER2)-positive, c) the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Brain metastases from human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, recurrent epidermal growth factor receptor (EGFR)-positive chordoma, HER2-amplified and RAS and BRAF wild-type colorectal cancer in combination with trastuzumab.

No

Lazcluze (lazertinib)

Drugs

LAZCLUZE ORAL TABLET 240 MG, 80 MG

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

12 months

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 12 MG/DAY (4 MG X 3), 14 MG/DAY(10 MG X 1-4 MG X 1), 18 MG/DAY (10 MG X 1-4 MG X2), 20 MG/DAY (10 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1), 4 MG, 8 MG/DAY (4 MG X 2)

Exclusion Criteria

Required Medical Information

For differentiated thyroid cancer (follicular, papillary, or Hurthle cell): disease is not amenable to radioactive iodine therapy and unresectable, locally recurrent, persistent, or metastatic. For hepatocellular carcinoma: disease is unresectable or inoperable, local, metastatic or with extensive liver tumor burden. For renal cell carcinoma, the disease is advanced, relapsed, or stage IV. For endometrial carcinoma, the patient meets ALL of the following: 1) The disease is advanced, recurrent, or metastatic, 2) The patient experienced disease progression following prior systemic therapy, AND 3) The patient is not a candidate for curative surgery or radiation.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Medullary thyroid carcinoma, recurrent endometrial carcinoma, thymic carcinoma

No

Drugs

leuprolide subcutaneous kit

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Use in combination with growth hormone for children with growth failure and advancing puberty, recurrent androgen receptor positive salivary gland tumors

No

lidocaine patches

Drugs

lidocaine topical adhesive patch, medicated 5 %

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).

No

Drugs
LIVDELZI

Exclusion Criteria

Required Medical Information

Documentation that the patients ALP was greater than or equal to 1.67-times the ULN AND total bilirubin (TB) was less than or equal to 2-times the ULN. AND Patient does not have cirrhosis with complications (e.g., Model for End Stage Liver Disease [MELD] score of 12 or greater, known esophageal varices or history of variceal bleeds, history of hepatorenal syndrome).

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
LONSURF

Exclusion Criteria

Required Medical Information

For colorectal cancer: The disease is advanced or metastatic. For gastric or gastroesophageal junction adenocarcinoma, all of the following criteria must be met: 1) The disease is unresectable locally advanced, recurrent, or metastatic, and 2) The patient has been previously treated with at least two prior lines of chemotherapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
LORBRENA

Exclusion Criteria

Required Medical Information

For recurrent, advanced, or metastatic non-small cell lung cancer: 1) Disease is anaplastic lymphoma kinase (ALK)-positive OR 2) Disease is positive for repressor of silencing (ROS)-1 rearrangement and the requested drug is being used following disease progression on crizotinib, entrectinib, or ceritinib.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Anaplastic lymphoma kinase (ALK)-positive recurrent non-small cell lung cancer (NSCLC), repressor of silencing (ROS)-1 rearrangement-positive recurrent, advanced, or metastatic NSCLC.

No

Drugs
LUMAKRAS

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

LUPRON DEPOT (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG, LUPRON DEPOT INTRAMUSCULAR SYRINGE KIT 3.75 MG

Exclusion Criteria

Required Medical Information

For uterine fibroids, patient must meet one of the following: 1) Diagnosis of anemia (e.g., hematocrit less than or equal to 30 percent and/or hemoglobin less than or equal to 10g/dL), OR 2) the requested medication will be used prior to surgery for uterine fibroids. For breast cancer, the requested drug is used for hormone receptor (HR)-positive disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Breast cancer, epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer

No

Drugs
LYNPARZA

Exclusion Criteria

Required Medical Information

For recurrent or metastatic breast cancer: the disease is BRCA 1/2-germline mutated. For prostate cancer: The patient has progressed on prior treatment with an androgen receptor-directed therapy. For epithelial ovarian, fallopian tube, or primary peritoneal cancer: The requested drug is used for maintenance therapy for stage II-IV or recurrent disease who are in complete or partial response to chemotherapy. For uterine leiomyosarcoma: 1) the requested drug is used as second-line therapy AND 2) the patient has BRCA-altered disease. For metastatic castration-resistant prostate cancer: 1) the requested drug will be used in combination with abiraterone and prednisone or prednisolone AND 2) the patient has BRCA-altered disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent HER2-negative, BRCA 1/2-germline mutated breast cancer, recurrent or metastatic HER2-positive, BRCA 1/2-germline mutated breast cancer, uterine leiomyosarcoma.

No

Drugs

LYTGABI ORAL TABLET 12 MG/DAY (4 MG X 3), 16 MG/DAY (4 MG X 4), 20 MG/DAY (4 MG X 5)

Exclusion Criteria

Required Medical Information

For cholangiocarcinoma: 1) patient has a diagnosis of unresectable, locally advanced or metastatic cholangiocarcinoma, 2) patient has received a previous treatment, AND 3) patient disease has a fibroblast growth factor receptor 2 (FGFR2) gene fusion or other rearrangement.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Extrahepatic cholangiocarcinoma

No

Drugs
MAVYRET

Exclusion Criteria

Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh [CTP] class B or C).

Required Medical Information

For hepatitis C virus (HCV): Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [CTP class B or C]), presence or absence of human immunodeficiency virus (HIV) coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases (AASLD) treatment guidelines.

Age Restriction

Prescriber Restriction

Coverage Duration

Criteria will be applied consistent with current AASLD-IDSa guidance

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

megestrol

Drugs

megestrol oral suspension 625 mg/5 mL (125 mg/mL)

Exclusion Criteria

Required Medical Information

Patient has experienced an inadequate treatment response or intolerance to megestrol 40 mg/mL oral suspension.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Cancer-related cachexia in adults

No

Drugs
MEKINIST

Exclusion Criteria

Required Medical Information

For adjuvant treatment of melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), and 2) The requested drug will be used in combination with dabrafenib. For unresectable or metastatic melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), and 2) The requested drug will be used as a single agent or in combination with dabrafenib. For brain metastases from melanoma, central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma), non-small cell lung cancer, solid tumors, and anaplastic thyroid cancer: 1) The tumor is positive for a BRAF V600E mutation, and 2) The requested drug will be used in combination with dabrafenib. For uveal melanoma, the requested drug will be used as a single agent. For low grade serous ovarian cancer and ovarian borderline epithelial tumors (low malignant potential) with invasive implants: The requested drug will be used to treat persistent or recurrent disease. For gallbladder cancer, intrahepatic cholangiocarcinoma, and extrahepatic cholangiocarcinoma: 1) The tumor is positive for a BRAF V600E mutation, 2) the disease is unresectable or metastatic, and 3) The requested drug will be used in combination with dabrafenib.

Age Restriction

One Year and Older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Langerhans cell histiocytosis, Erdheim-Chester disease, and Rosai-Dorfman disease

No

Drugs
MEKTOVI

Exclusion Criteria

Required Medical Information

For cutaneous melanoma: The patient must meet all of the following criteria: 1) Tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K), 2) The requested drug will be used in combination with encorafenib, and 3) The requested drug will be used for either of the following: a) unresectable or metastatic disease, or b) adjuvant systemic therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Adjuvant systemic therapy for cutaneous melanoma

No

methylphenidate

Drugs

methylphenidate HCl oral solution 10 mg/5 mL, 5 mg/5 mL, methylphenidate HCl oral tablet 10 mg, 20 mg, 5 mg, methylphenidate HCl oral tablet extended release, methylphenidate HCl oral tablet, chewable

Exclusion Criteria

Required Medical Information

1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR
2) The patient has a diagnosis of narcolepsy confirmed by a sleep study OR 3) The requested drug is being prescribed for the treatment of cancer-related fatigue after other causes of fatigue have been ruled out.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
miglustat

Exclusion Criteria

Required Medical Information

For type 1 Gaucher disease (GD1): The diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

modafinil

Drugs

modafinil oral tablet 100 mg, 200 mg

Exclusion Criteria

Required Medical Information

1) The patient has a diagnosis of narcolepsy and the diagnosis is confirmed by sleep lab evaluation OR 2) The patient has a diagnosis of Shift Work Disorder (SWD) OR 3) The patient has a diagnosis of obstructive sleep apnea (OSA) and the diagnosis is confirmed by polysomnography

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
MOTPOLY XR

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Through the end of the benefit year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
NERLYNX

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, brain metastases from HER2-positive breast cancer.
No

Drugs

NEXAVAR, *sorafenib*

Exclusion Criteria

Required Medical Information

For acute myeloid leukemia: the disease is FMS-like tyrosine kinase 3-internal tandem duplication (FLT3-ITD) mutation-positive AND either of the following is met (1 OR 2): 1) the requested drug will be used as maintenance therapy after hematopoietic stem cell transplant, OR 2) the requested drug is used in combination with azacitidine or decitabine for low-intensity treatment induction or post-induction therapy AND either a) the patient has a physiologic age of 60 years of age or older or b) the disease is relapsed/refractory. For thyroid carcinoma: histology is follicular, papillary, Hurthle cell or medullary. For gastrointestinal stromal tumor (GIST): the disease is unresectable, recurrent, or metastatic AND the patient has failed on an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib). For renal cell carcinoma: the patient meets ALL of the following: 1) The disease is advanced, AND 2) The patient has experienced disease progression or an intolerable adverse event with a trial of cabozantinib or axitinib. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia: 1) The disease has a FLT3 rearrangement AND 2) The disease is in chronic or blast phase.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, and solitary fibrous tumor subtypes), gastrointestinal stromal tumor, medullary thyroid carcinoma, osteosarcoma, recurrent chordoma, epithelial ovarian cancer, fallopian tube cancer, primary peritoneal cancer, lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

No

Drugs
NINLARO

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Relapsed/refractory systemic light chain amyloidosis, Waldenstrom macroglobulinemia, lymphoplasmacytic lymphoma
No

Drugs

nitisinone

Exclusion Criteria

Required Medical Information

For hereditary tyrosinemia type 1 (HT-1): Diagnosis of HT-1 is confirmed by one of the following: 1) biochemical testing (e.g., detection of succinylacetone in urine) or 2) DNA testing (mutation analysis).

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

droxidopa oral capsule 100 mg, 200 mg, 300 mg

Exclusion Criteria

Required Medical Information

For neurogenic orthostatic hypotension (nOH): Prior to initial therapy, patient has a persistent, consistent decrease in systolic blood pressure of at least 20 mmHg OR decrease in diastolic blood pressure of at least 10 mmHg within 3 minutes of standing or head-up tilt test. For continuation of therapy for nOH, patient must experience a sustained reduction in symptoms of nOH (i.e., decrease in dizziness, lightheadedness, or feeling faint). For both initial and continuation of therapy for nOH, the requested drug will be used for patients with neurogenic orthostatic hypotension associated with one of the following diagnoses: 1) primary autonomic failure due to Parkinson's disease, multiple system atrophy, or pure autonomic failure, OR 2) dopamine beta-hydroxylase deficiency, OR 3) non-diabetic autonomic neuropathy.

Age Restriction

Prescriber Restriction

Coverage Duration

3 months

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

NOXAFIL ORAL SUSPENSION

Exclusion Criteria

Required Medical Information

The requested drug will be used orally. For treatment of oropharyngeal candidiasis: patient has experienced an inadequate treatment response, intolerance, or has a contraindication to fluconazole.

Age Restriction

13 years of age or older

Prescriber Restriction

Coverage Duration

Oropharyngeal candidiasis: 1 month. All other indications: 6 months

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
NUBEQA

Exclusion Criteria

Required Medical Information

The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
NUEDEXTA

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
NUPLAZID

Exclusion Criteria

Required Medical Information

For hallucinations and delusions associated with Parkinson's disease psychosis, the diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
NURTEC ODT

Exclusion Criteria

Required Medical Information

Acute migraine treatment: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to one triptan 5-HT₁ receptor agonist. Preventive treatment of migraine: The patient meets either of the following: 1) The patient experienced an inadequate treatment response of any one of the following: antiepileptic drugs (AEDs), beta-adrenergic blocking agents, antidepressants OR 2) The patient experienced an intolerance or has a contraindication that would prohibit a trial of any one of the following: antiepileptic drugs (AEDs), beta-adrenergic blocking agents, antidepressants.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

octreotide acetate injection solution

Exclusion Criteria

Required Medical Information

For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy. For tumor control of thymomas and thymic carcinomas, the requested drug will be used for any of the following: 1) locally advanced or metastatic disease, 2) postoperatively following tumor resection.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Tumor control of thymomas and thymic carcinomas.

No

Drugs
ODOMZO

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
OFEV

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

OGSIVEO ORAL TABLET 100 MG, 150 MG, 50 MG

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
OJEMDA

Exclusion Criteria

Required Medical Information

Must confirm presence of BRAF fusion or rearrangement OR BRAF V600 mutation is present prior to treatment initiation

Age Restriction

Prescriber Restriction

Hematology/Oncology

Coverage Duration

Benefit Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
OJJAARA

Exclusion Criteria

Required Medical Information

Documentation of myelofibrosis. Patient must not have any active infections prior to initiation of therapy.

Age Restriction

Prescriber Restriction

Oncologist, Hematologist

Coverage Duration

Until end of benefit year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
ONUREG

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
OPSUMIT

Exclusion Criteria

Required Medical Information

For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) Pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
OPSYNVI

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Pulmonologist or Cardiologist

Coverage Duration
End of Benefit Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
ORGOVYX

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
ORIAHNN

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

ORKAMBI ORAL GRANULES IN PACKET, ORKAMBI ORAL TABLET

Exclusion Criteria

Required Medical Information

For cystic fibrosis (CF): The requested medication will not be used in combination with other medications containing ivacaftor.

Age Restriction

1 year of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
ORSERDU

Exclusion Criteria

Required Medical Information

Breast cancer: 1) the disease is estrogen receptor (ER) positive, human epidermal growth factor receptor 2 (HER2)-negative, and ESR1 mutated AND 2) the patient meets either of the following: a) the disease is advanced, recurrent, or metastatic AND the patient has disease progression following at least one line of endocrine therapy OR b) the disease had no response to preoperative systemic therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent hormone receptor positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer
No

Drugs

OTEZLA ORAL TABLET 20 MG, 30 MG, OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)

Exclusion Criteria

Required Medical Information

For plaque psoriasis (new starts only): Patient meets either of the following: 1) Inadequate treatment response or intolerance to ANY of the following: a) a topical therapy (e.g., topical corticosteroids, calcineurin inhibitors, vitamin D analogs), b) phototherapy (e.g., UVB, PUVA), or c) pharmacologic treatment with methotrexate, cyclosporine, or acitretin, OR 2) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
PANRETIN

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Topical treatment of cutaneous lesions in patients with non-AIDS-related Kaposi sarcoma
No

Drugs

paroxetine HCl oral suspension

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
PEGASYS

Exclusion Criteria

Required Medical Information

For chronic hepatitis C: Hepatitis C virus (HCV) confirmed by presence of hepatitis C virus HCV RNA in serum prior to starting treatment and the planned treatment regimen.

Age Restriction

Prescriber Restriction

Coverage Duration

HCV: 12-48wks. Criteria applied consistent w/current AASLD/IDSA guidance. HBV: 48wks. Other: Plan Yr

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, symptomatic lower-risk myelofibrosis), systemic mastocytosis, adult T-cell leukemia/lymphoma, mycosis fungoides/sezary syndrome, primary cutaneous CD30+ T-cell lymphoproliferative disorders, hairy cell leukemia, Erdheim-Chester disease.

No

Drugs
PEMAZYRE

Exclusion Criteria

Required Medical Information

For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 rearrangement: the disease is in chronic or blast phase.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

phenylbutyrate

Drugs

sodium phenylbutyrate

Exclusion Criteria

Required Medical Information

For urea cycle disorders (UCD): Diagnosis of UCD was confirmed by enzymatic, biochemical or genetic testing.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
PIQRAY

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, PIK3CA-mutated breast cancer in combination with fulvestrant.

No

Drugs
POMALYST

Exclusion Criteria

Required Medical Information

For multiple myeloma: The patient has previously received at least two prior therapies for multiple myeloma, including an immunomodulatory agent AND a proteasome inhibitor. For Kaposi sarcoma, patient meets one of the following: 1) patient has acquired immunodeficiency syndrome (AIDS), or 2) patient is negative for human immunodeficiency virus (HIV).

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Relapsed/refractory systemic light chain amyloidosis, primary central nervous system (CNS) lymphoma, POEMS syndrome.

No

Drugs

posaconazole oral tablet, delayed release (DRIEC)

Exclusion Criteria

Required Medical Information

The requested drug will be used orally. For prophylaxis of invasive *Aspergillus* and *Candida* infections: patient weighs greater than 40 kilograms.

Age Restriction

Treatment of Invasive Aspergillosis: 13 years of age or older, Prophylaxis of Invasive *Aspergillus* and *Candida* Infections: 2 years of age or older

Prescriber Restriction

Coverage Duration

6 months

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
PRALUENT PEN

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
PREVYMIS ORAL

Exclusion Criteria

Required Medical Information

For prophylaxis of cytomegalovirus (CMV) infection or disease: 1) the patient is CMV-seropositive, AND the patient is a recipient of an allogeneic hematopoietic stem cell transplant (HSCT), AND the requested drug will not be used beyond day 200 post-transplantation OR 2) the patient is a recipient of a kidney transplant at high risk (Donor CMV seropositive/Recipient CMV seronegative [D+/R-]) AND the requested drug will not be used beyond day 200 post-transplantation.

Age Restriction

Prescriber Restriction

Coverage Duration

6 months

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

PROCRIPT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

Exclusion Criteria

Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.

Required Medical Information

Requirements regarding hemoglobin (Hgb) values exclude values due to a recent transfusion. For initial approval: 1) for all uses except anemia due to chemotherapy or myelodysplastic syndrome (MDS): patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%), AND 2) for all uses except surgery: pretreatment (no erythropoietin treatment in previous month) Hgb is less than 10 g/dL (less than 9 g/dL for anemia in congestive heart failure), AND 3) for MDS: pretreatment serum erythropoietin level is 500 international units/L or less. For reauthorizations (patient received erythropoietin treatment in previous month) in all uses except surgery: 1) patient has received at least 12 weeks of erythropoietin therapy, AND 2) patient responded to erythropoietin therapy, AND 3) current Hgb is less than 12 g/dL, AND 4) for all uses except anemia due to chemotherapy or MDS: patient has adequate iron stores (for example, a transferrin saturation [TSAT] greater than or equal to 20%).

Age Restriction

Prescriber Restriction

Coverage Duration

16 weeks

Other Criteria

Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual (e.g., used for treatment of anemia for a patient with chronic renal failure who is undergoing dialysis, or furnished from physician's supply incident to a physician service).

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Anemia due to myelodysplastic syndromes (MDS), anemia in congestive heart failure (CHF), anemia in rheumatoid arthritis (RA), anemia due to hepatitis C treatment (ribavirin in combination with either interferon alfa or peginterferon alfa)
No

Drugs

PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG, PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

Exclusion Criteria

Required Medical Information

For chronic or persistent immune thrombocytopenia (ITP): 1) For new starts: a) Patient (pt) has had an inadequate response or is intolerant to a prior therapy such as corticosteroids or immunoglobulins, b) Untransfused platelet (plt) count at any point prior to the initiation of the requested medication is less than 30,000/mcL OR 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding (e.g., undergoing a medical or dental procedure where blood loss is anticipated, comorbidities such as peptic ulcer disease and hypertension, anticoagulation therapy, profession or lifestyle that predisposes pt to trauma) AND c) For chronic ITP only: pt has had an inadequate response or intolerance to avatrombopag. 2) For continuation of therapy, plt count response to the requested drug: a) Current plt count is less than or equal to 200,000/mcL OR b) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to a plt count sufficient to avoid clinically important bleeding. For thrombocytopenia associated with chronic hepatitis C: 1) For new starts: the requested drug is used for initiation and maintenance of interferon-based therapy. 2) For continuation of therapy: pt is receiving interferon-based therapy. For severe aplastic anemia (AA): 1) For new starts: a) Pt will use the requested drug with standard immunosuppressive therapy for first line treatment OR b) the pt had an insufficient response to immunosuppressive therapy. 2) For continuation of therapy : 1) Current plt count is 50,000-200,000/mcL OR 2) Current plt count is less than 50,000/mcL and pt has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and pt is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL to less than or equal to 400,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.

Age Restriction

Prescriber Restriction

Coverage Duration

HCV: 6mo, ITP/AA initial: 6mo, ITP reauth: Plan Year, AA reauth: APR-Plan Year, IPR-16 wks

Other Criteria

APR: adequate platelet response (greater than 50,000/mcL), IPR: inadequate platelet response (less than 50,000/mcL).

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
PULMOZYME

Exclusion Criteria

Required Medical Information

For cystic fibrosis: Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
QINLOCK

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

quetiapine oral tablet extended release 24 hr 150 mg, 200 mg, 300 mg, 400 mg, 50 mg

Exclusion Criteria

Required Medical Information

For schizophrenia, acute treatment of manic or mixed episodes associated with bipolar I disorder, both as monotherapy and as an adjunct to lithium or divalproex, the acute treatment of depressive episodes associated with bipolar disorder, maintenance treatment of bipolar I disorder, as an adjunct to lithium or divalproex, adjunctive treatment of major depressive disorder, or maintenance monotherapy treatment in bipolar I disorder: The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) olanzapine, D) quetiapine immediate-release, E) risperidone, F) ziprasidone. For all indications: If the patient is 65 years of age or older AND is using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, sertraline, clonazepam, escitalopram, alprazolam, zolpidem) with the requested drug, the prescriber determined that taking multiple central nervous system (CNS) active medications is medically necessary. [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.].

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder

No

quinine sulfate

Drugs

quinine sulfate

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

1 month

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Babesiosis, uncomplicated Plasmodium vivax malaria.

No

Drugs
RECORLEV

Exclusion Criteria

Required Medical Information

Documentation that the medication will be used for the diagnosis of endogenous hypercortisolemia associated with Cushing's syndrome AND the patient is not a candidate for surgery OR Surgery has not been curative.

Age Restriction

Beneficiary must be eighteen years of age and older.

Prescriber Restriction

Coverage Duration

Through end of benefit year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
REGRANEX

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
20 weeks

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

RELISTOR SUBCUTANEOUS SOLUTION, RELISTOR SUBCUTANEOUS SYRINGE

Exclusion Criteria

Required Medical Information

For the treatment of opioid-induced constipation in a patient with chronic non-cancer pain, including chronic pain related to prior cancer or its treatment who does not require frequent (e.g., weekly) opioid dosage escalation: 1) the patient is unable to tolerate oral medications OR 2) the patient meets one of the following criteria A) experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in a patient with chronic non-cancer pain (e.g., Movantik) OR B) the patient has a contraindication that would prohibit a trial of an oral drug indicated for opioid-induced constipation in a patient with chronic non-cancer pain (e.g., Movantik).

Age Restriction

Prescriber Restriction

Coverage Duration

4 months

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
RETEVMO

Exclusion Criteria

Required Medical Information

For non-small cell lung cancer, patient must meet all of the following: 1) The disease is recurrent, advanced or metastatic, and 2) Tumor is RET fusion-positive or RET rearrangement-positive.

Age Restriction

Must be 2 years of age or older.

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer, Langerhans Cell Histiocytosis with a RET gene fusion, symptomatic or relapsed/refractory Erdheim-Chester Disease with a RET gene fusion, symptomatic or relapsed/refractory Rosai-Dorfman Disease with a RET gene fusion.

No

Drugs

lenalidomide oral capsule 10 mg, 15 mg, 2.5 mg, 20 mg, 25 mg, 5 mg

Exclusion Criteria

Required Medical Information

For myelodysplastic syndrome (MDS): Lower risk MDS with symptomatic anemia per the Revised International Prognostic Scoring System (IPSS-R), International Prognostic Scoring System (IPSS), or World Health organization (WHO) classification-based Prognostic Scoring System (WPSS).

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, myelofibrosis-associated anemia, POEMS syndrome, myeloproliferative neoplasms, Kaposi Sarcoma, Langerhans cell histiocytosis, peripheral T-Cell lymphomas not otherwise specified, angioimmunoblastic T-cell lymphoma (AITL), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, adult T-cell leukemia/lymphoma, hepatosplenic T-cell lymphoma, primary central nervous system (CNS) lymphoma, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), acquired immunodeficiency syndrome (AIDS)-related non-germinal center diffuse large B-cell lymphoma, monomorphic post-transplant lymphoproliferative disorder, diffuse large B-cell lymphoma, multicentric Castlemans disease, high-grade B-cell lymphomas, histologic transformation of nodal marginal zone lymphoma to diffuse large B-cell lymphoma, histologic transformation of follicular lymphoma to diffuse large B-cell lymphoma.

No

Drugs
REZLIDHIA

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
REZUROCK

Exclusion Criteria

Required Medical Information

Age Restriction
12 years of age or older

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

RINVOQ LQ, RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG, 45 MG

Exclusion Criteria

Required Medical Information

For moderately to severely active rheumatoid arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance or has a contraindication to methotrexate (MTX) AND at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]). For active psoriatic arthritis (new starts only): patient has experienced an inadequate treatment response, intolerance or has a contraindication to at least one TNF inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]). For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., Humira [adalimumab]). For atopic dermatitis, continuation of therapy: the patient achieved or maintained positive clinical response. For active ankylosing spondylitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]). For non-radiographic axial spondyloarthritis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor.

Age Restriction

Atopic dermatitis: 12 years of age or older

Prescriber Restriction

Coverage Duration

Atopic dermatitis (initial): 4 months, All others: Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
ROZLYTREK

Exclusion Criteria

Required Medical Information

For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation. For ROS1-positive non-small cell lung cancer, the patient has recurrent, advanced, or metastatic disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent ROS1-positive non-small cell lung cancer (NSCLC), Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.

No

Drugs
RUBRACA

Exclusion Criteria

Required Medical Information

For metastatic castration-resistant prostate cancer with a deleterious breast cancer susceptibility gene (BRCA) mutation (germline and/or somatic): 1) patient has been treated with androgen receptor-directed therapy, 2) patient has been treated with a taxane-based chemotherapy or the patient is not fit for chemotherapy, 3) the requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy. For maintenance treatment of BRCA mutated epithelial ovarian, fallopian tube, primary peritoneal cancer: 1) the patient has advanced (stage II-IV) disease and is in complete or partial response to primary therapy or 2) the patient has recurrent disease and is in complete or partial response to platinum-based chemotherapy. For uterine leiomyosarcoma: 1) the requested drug is used as second-line therapy AND 2) the patient has BRCA-altered disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Uterine leiomyosarcoma, advanced (stage II-IV) epithelial ovarian, fallopian tube, or primary peritoneal cancer
No

Drugs
RYDAPT

Exclusion Criteria

Required Medical Information

For acute myeloid leukemia (AML): AML is FLT3 mutation-positive. For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements: the disease is in chronic or blast phase.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Relapsed or refractory acute myeloid leukemia (AML), myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FGFR1 or FLT3 rearrangements, post-induction therapy for AML, re-induction in residual disease for AML

No

Drugs

JAVYGTOR, *sapropterin*

Exclusion Criteria

Required Medical Information

For phenylketonuria (PKU): For patients who have not yet received a therapeutic trial of the requested drug, the patient's pretreatment, including before dietary management, phenylalanine level is greater than 6 mg/dL (360 micromol/L). For patients who completed a therapeutic trial of the requested drug, the patient must have experienced improvement (e.g., reduction in blood phenylalanine levels, improvement in neuropsychiatric symptoms).

Age Restriction

Prescriber Restriction

Coverage Duration

Initial: 2 months. All others: Plan Year.

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

SAVELLA ORAL TABLET, SAVELLA ORAL TABLETS,DOSE PACK

Exclusion Criteria

Required Medical Information

The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to duloxetine or pregabalin.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

SCEMBLIX ORAL TABLET 100 MG, 20 MG, 40 MG

Exclusion Criteria

Required Medical Information

For chronic myeloid leukemia (CML) in the chronic phase: 1) the diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene AND the patient meets either of the following: A) the patient has previously been treated with 2 or more tyrosine kinase inhibitors (TKIs) AND at least one of those was imatinib or dasatinib, OR B) the patient is positive for the T315I mutation.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
SIGNIFOR

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Prescribed by or in consultation with an endocrinologist

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

sildenafil (pulm.hypertension) oral tablet

Exclusion Criteria

Required Medical Information

For pulmonary arterial hypertension (PAH) (World Health Organization [WHO] Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) Pretreatment mean pulmonary arterial pressure is greater than 20 mmHg, 2) Pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) If the request is for an adult, pretreatment pulmonary vascular resistance is greater than or equal to 3 Wood units.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
SIRTURO

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Prescribed by or in consultation with an infectious disease specialist.

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
SKYCLARYS

Exclusion Criteria

Required Medical Information

Member has had a trinucleotide repeat expansion assay genetic test confirming the diagnosis of Friedreich's ataxia

Age Restriction

Age 16 years or older

Prescriber Restriction

Coverage Duration

Through end of plan year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

SKYRIZI SUBCUTANEOUS PEN INJECTOR, SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML

Exclusion Criteria

Required Medical Information

For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, or b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or c) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected). For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML), 360 MG/2.4 ML (150 MG/ML)

Exclusion Criteria

Required Medical Information

For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis, AND 2) patient meets any of the following: a) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, or b) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, or c) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10% of the body surface area or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected). For moderately to severely active Crohn's disease (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids), OR 2) Intolerance or contraindication to conventional therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
SOMAVERT

Exclusion Criteria

Required Medical Information

For acromegaly (initial): 1) patient has a high pretreatment insulin-like growth factor-1 (IGF-1) level for age and/or gender based on the laboratory reference range, and 2) patient had an inadequate or partial response to surgery or radiotherapy OR there is a clinical reason for why the patient has not had surgery or radiotherapy. For acromegaly (continuation of therapy): patient's IGF-1 level has decreased or normalized since initiation of therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

dasatinib, **SPRYCEL**

Exclusion Criteria

Required Medical Information

For chronic myeloid leukemia (CML), including patients who have received a hematopoietic stem cell transplant: 1) Diagnosis was confirmed by detection of the Philadelphia (Ph) chromosome or BCR-ABL gene, and 2) If patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L. For acute lymphoblastic leukemia (ALL), the patient has a diagnosis of one of the following: 1) Philadelphia chromosome positive ALL, including patients who have received a hematopoietic stem cell transplant: diagnosis that has been confirmed by detection of the Ph chromosome or BCR-ABL gene, and if patient experienced resistance to an alternative tyrosine kinase inhibitor, patient is negative for all of the following mutations: T315I/A, F317L/V/I/C, and V299L, OR 2) Ph-like B-ALL with ABL-class kinase fusion, OR 3) relapsed or refractory T-cell ALL with ABL-class translocation. For GIST, 1) the disease has progressed on imatinib in patients with PDGFRA D842V mutation, OR 2) the patient has failed at least 2 FDA-approved therapies (e.g., imatinib, sunitinib, regorafenib, ripretinib)

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Gastrointestinal stromal tumor (GIST), metastatic chondrosarcoma, recurrent chordoma, T-cell acute lymphoblastic leukemia (ALL), and Philadelphia (Ph)-like B-ALL, myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase

No

Stelara (Ustekinumab)

Drugs

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

Exclusion Criteria

Required Medical Information

Diagnosis of 1 of the following: A) Mod-severe Crohn disease and trial of Adalimumab and a corticosteroid OR B) Psoriatic arthritis and trial and failure of 2 or more of the following: Adalimumab, Enbrel, Xeljanz, Cosentyx, and Otezla, or C) Mod-severe chronic plaque psoriasis (affecting more than 5% of body surface area or crucial body areas such as the hands, feet, face, or genitals) and trial of 2 or more of the following: Adalimumab, Enbrel, Cosentyx, and Otezla, or D) moderately to severely active ulcerative colitis and trial of Adalimumab and corticosteroids.

Age Restriction

6 years and older for Psoriasis or Psoriatic arthritis and 18 years of age and older for all other indications

Prescriber Restriction

Gastroenterologist for Crohn disease diagnosis

Coverage Duration

6 months

Other Criteria

Negative Tuberculin test prior to therapy AND patient is free of any clinically important active infections

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
STIVARGA

Exclusion Criteria

Required Medical Information

For gastrointestinal stromal tumors: The disease is progressive, locally advanced, unresectable, or metastatic.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Progressive gastrointestinal stromal tumors (GIST), osteosarcoma, glioblastoma, angiosarcoma, retroperitoneal/intra-abdominal soft tissue sarcoma, rhabdomyosarcoma, and soft tissue sarcomas of the extremities, body wall, head and neck, advanced colorectal cancer.

No

Drugs

sunitinib malate

Exclusion Criteria

Required Medical Information

For renal cell carcinoma (RCC): 1) The disease is relapsed, advanced, or stage IV OR 2) the requested drug is being used as adjuvant treatment for patients that are at high risk of recurrent RCC following nephrectomy. For gastrointestinal stromal tumor (GIST): the disease is unresectable, recurrent, or metastatic AND the patient has failed on an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib). For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia: 1) The disease has a FLT3 rearrangement AND 2) The disease is in chronic or blast phase.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Thyroid carcinoma (follicular, medullary, papillary, and Hurthle cell), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and alveolar soft part sarcoma subtypes), recurrent chordoma, thymic carcinoma, lymphoid, myeloid, or mixed lineage neoplasms with eosinophilia

No

Drugs
SYMDEKO

Exclusion Criteria

Required Medical Information

For cystic fibrosis: The requested medication will not be used in combination with other medications containing ivacaftor.

Age Restriction

6 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
SYMPAZAN

Exclusion Criteria

Required Medical Information

Age Restriction

2 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
TABRECTA

Exclusion Criteria

Required Medical Information

For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent non-small cell lung cancer (NSCLC).

No

Drugs
TAFINLAR**Exclusion Criteria****Required Medical Information**

For brain metastases from melanoma, adjuvant treatment of melanoma, and central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma): 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), and 2) The requested drug will be used in combination with trametinib. For unresectable or metastatic melanoma: 1) The tumor is positive for a BRAF V600 activating mutation (e.g., V600E or V600K), and 2) The requested drug will be used as a single agent or in combination with trametinib. For non-small cell lung cancer: 1) The tumor is positive for a BRAF V600E mutation, and 2) The requested drug will be used as a single agent or in combination with trametinib. For thyroid carcinoma with papillary, follicular, or Hurthle histology: The tumor is positive for BRAF activating mutation (e.g., V600E or V600K). For Langerhans Cell Histiocytosis and Erdheim-Chester Disease: The disease is positive for a BRAF V600E mutation. For gallbladder cancer, extrahepatic cholangiocarcinoma, and intrahepatic cholangiocarcinoma: 1) The disease is positive for a BRAF V600E mutation and 2) The disease is unresectable or metastatic and 3) The requested drug will be used in combination with trametinib. For solid tumors:) The tumor is positive for a BRAF V600E mutation, and 2) The requested drug will be used in combination with trametinib.

Age Restriction**Prescriber Restriction****Coverage Duration**

Plan Year

Other Criteria**Indications**

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses**Part B Prerequisite**

Brain metastases from melanoma, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), central nervous system (CNS) cancer (i.e., meningioma, astrocytoma), gallbladder cancer, extrahepatic cholangiocarcinoma, intrahepatic cholangiocarcinoma, Langerhans cell histiocytosis, Erdheim-Chester disease
No

Drugs
TAGRISSO

Exclusion Criteria

Required Medical Information

For NSCLC, the requested drug is used in any of the following settings: 1) The patient meets both of the following: a) patient has metastatic, advanced, or recurrent NSCLC (including brain and/or leptomeningeal metastases from NSCLC) and b) patient has a sensitizing EGFR mutation OR 2) The patient meets both of the following: a) request is for adjuvant treatment of NSCLC following tumor resection and b) patient has EGFR mutation-positive disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent non-small cell lung cancer (NSCLC), brain metastases from sensitizing EGFR mutation-positive NSCLC, leptomeningeal metastases from EGFR mutation-positive NSCLC.

No

Drugs**TALTZ AUTOINJECTOR, TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML, 40 MG/0.5 ML, 80 MG/ML****Exclusion Criteria****Required Medical Information**

For moderate to severe plaque psoriasis (new starts only): 1) at least 3% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at the time of diagnosis AND 2) the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Otezla (apremilast), Skyrizi (risankizumab-rzaa). For active ankylosing spondylitis (new starts only): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Rinvoq (upadacitinib), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active psoriatic arthritis (PsA) (new starts only): the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following products: Enbrel (etanercept), Humira (adalimumab), Otezla (apremilast), Rinvoq (upadacitinib), Skyrizi (risankizumab-rzaa), Xeljanz (tofacitinib)/Xeljanz XR (tofacitinib extended-release). For active non-radiographic axial spondyloarthritis (new starts only): Patient meets any of the following: 1) has had an inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial or 2) has an intolerance or contraindication to NSAIDs.

Age Restriction**Prescriber Restriction****Coverage Duration**

Plan Year

Other Criteria**Indications**

All FDA-approved Indications.

Off Label Uses**Part B Prerequisite**

No

Drugs

TALZENNA ORAL CAPSULE 0.1 MG, 0.25 MG, 0.35 MG, 0.5 MG, 0.75 MG, 1 MG

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent germline breast cancer susceptibility gene (BRCA)-mutated breast cancer

No

Drugs

bexarotene topical

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Stage 2 or higher mycosis fungoides/Sezary syndrome, chronic or smoldering adult T-cell leukemia/lymphoma, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma.

No

Drugs
TASIGNA

Exclusion Criteria

Required Medical Information

For chronic myeloid leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, including patients newly diagnosed with CML and patients who have received a hematopoietic stem cell transplant: patient has experienced resistance or intolerance to imatinib or dasatinib. If patient experienced resistance to an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I, Y253H, E255K/V, and F359V/C/I mutations. For GIST, patient must have progressed on imatinib, sunitinib, and regorafenib.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST), myeloid and/or lymphoid neoplasms with eosinophilia and ABL1 rearrangement in the chronic phase or blast phase.
No

Drugs

tazarotene topical cream 0.1 %, **TAZORAC TOPICAL CREAM 0.05 %**

Exclusion Criteria

Required Medical Information

For plaque psoriasis: 1)The requested drug is being prescribed to treat less than or equal to 20 percent of the patient's body surface area (BSA) AND 2) the patient experienced an inadequate treatment response or intolerance to at least one topical corticosteroid OR has a contraindication that would prohibit a trial of topical corticosteroids.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
TAZVERIK

Exclusion Criteria

Required Medical Information

Age Restriction

Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
TEPMETKO

Exclusion Criteria

Required Medical Information

For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent non-small cell lung cancer (NSCLC).

No

Drugs

teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48mL)

Exclusion Criteria

Required Medical Information

For postmenopausal osteoporosis: patient has ONE of the following (1 or 2): 1) a history of fragility fracture, OR 2) A pre-treatment T-score of less than or equal to -2.5 or pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment Fracture Risk Assessment Tool (FRAX) fracture probability AND patient has ANY of the following: a) indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), OR b) patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy OR c) patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate. For primary or hypogonadal osteoporosis in men: patient has one of the following: 1) a history of osteoporotic vertebral or hip fracture, OR 2) pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: Patient has had an oral bisphosphonate trial of at least 1-year duration unless patient has a contraindication or intolerance to an oral bisphosphonate, AND patient meets ANY of the following: 1) patient has a history of fragility fracture, OR 2) a pre-treatment T-score of less than or equal to -2.5, OR 3) pre-treatment T-score greater than -2.5 and less than -1 with a high pre-treatment FRAX fracture probability. Continuation of therapy: If the patient has received greater than or equal to 24 months of therapy with any parathyroid hormone analog: 1) The patient remains at or has returned to having a high risk for fracture, AND 2) The benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

Age Restriction

Prescriber Restriction

Coverage Duration

Initial: 24 months, Continuation: Plan Year

Other Criteria

Patient has high FRAX fracture probability if the 10 year probability is either greater than or equal to 20 percent for any major osteoporotic fracture or greater than or equal to 3 percent for hip fracture. If glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture.

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

DEPO-TESTOSTERONE, *testosterone cypionate*

Exclusion Criteria

Required Medical Information

Primary or hypogonadotropic hypogonadism: 1) Request is for continuation of testosterone therapy and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with age-related hypogonadism (also referred to as late-onset hypogonadism) have not been established.] OR 2) Request is not for continuation of testosterone therapy and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values [Note: Safety and efficacy of testosterone products in patients with age-related hypogonadism (also referred to as late-onset hypogonadism) have not been established.].
Gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Gender Dysphoria

No

Drugs

testosterone enanthate

Exclusion Criteria

Required Medical Information

Primary or hypogonadotropic hypogonadism: 1) Request is for continuation of testosterone therapy and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with age-related hypogonadism (also referred to as late-onset hypogonadism) have not been established.] OR 2) Request is not for continuation of testosterone therapy and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values [Note: Safety and efficacy of testosterone products in patients with age-related hypogonadism (also referred to as late-onset hypogonadism) have not been established.].
Gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Gender Dysphoria

No

Drugs

tetrabenazine oral tablet 12.5 mg, 25 mg

Exclusion Criteria

Required Medical Information

For treatment of chorea associated with Huntington's disease: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine therapy. For treatment of tardive dyskinesia: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine or valbenazine therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Tic disorders, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.

No

tetracycline

Drugs

tetracycline oral capsule

Exclusion Criteria

Required Medical Information

The patient will use the requested drug orally.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

THALOMID ORAL CAPSULE 100 MG, 150 MG, 200 MG, 50 MG

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Myelofibrosis-related anemia, AIDS-related aphthous stomatitis, Kaposi sarcoma, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease., Rosai-Dorfman disease, Langerhans cell histiocytosis

No

Drugs
TIBSOVO

Exclusion Criteria

Required Medical Information

Patient has disease with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation. For acute myeloid leukemia (AML): 1) patient has newly-diagnosed AML and meets one of the following: a) 75 years of age or older, b) patient has comorbidities that preclude use of intensive induction chemotherapy, or c) patient is 60 years of age or older and declines intensive induction chemotherapy, OR 2) patient is 60 years of age or older and the requested drug will be used as post-induction therapy following response to induction therapy with the requested drug, OR 3) patient has relapsed or refractory AML. For locally advanced, unresectable, or metastatic cholangiocarcinoma: the requested drug will be used as subsequent treatment for progression on or after systemic treatment.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Conventional (grades 1-3) or dedifferentiated chondrosarcoma. Newly-diagnosed acute myeloid leukemia (AML) if 60-74 years of age and without comorbidities.

No

tobramycin

Drugs

tobramycin in 0.225 % NaCl

Exclusion Criteria

Required Medical Information

For cystic fibrosis and non-cystic fibrosis bronchiectasis, the patient must meet one of the following: 1) *Pseudomonas aeruginosa* is present in the patient's airway cultures, OR 2) the patient has a history of *Pseudomonas aeruginosa* infection or colonization in the airways.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Non-cystic fibrosis bronchiectasis

No

topical lidocaine

Drugs

lidocaine HCl mucous membrane solution 4 % (40 mg/mL), lidocaine topical ointment, lidocaine-prilocaine topical cream

Exclusion Criteria

Required Medical Information

1) The requested drug is being used for topical anesthesia, AND 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are Food and Drug Administration (FDA) approved for topical use.

Age Restriction

Prescriber Restriction

Coverage Duration

3 months

Other Criteria

Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

topical testosterone

Drugs

testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %), testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)

Exclusion Criteria

Required Medical Information

Primary or hypogonadotropic hypogonadism: 1) Request is for continuation of testosterone therapy and the patient had a confirmed low morning testosterone level according to current practice guidelines or your standard lab reference values before starting testosterone therapy [Note: Safety and efficacy of testosterone products in patients with age-related hypogonadism (also referred to as late-onset hypogonadism) have not been established.] OR 2) Request is not for continuation of testosterone therapy and the patient has at least two confirmed low morning testosterone levels according to current practice guidelines or your standard lab reference values [Note: Safety and efficacy of testosterone products in patients with age-related hypogonadism (also referred to as late-onset hypogonadism) have not been established.].
Gender dysphoria: The patient is able to make an informed decision to engage in hormone therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Gender Dysphoria

No

topical tretinoin

Drugs

tretinoin topical cream, tretinoin topical gel 0.01 %, 0.025 %

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

trientine oral capsule 250 mg, 500 mg

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
TRIKAFTA

Exclusion Criteria

Required Medical Information

For cystic fibrosis: The requested medication will not be used in combination with other medications containing ivacaftor.

Age Restriction

2 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Truqap (capivasertib)

Drugs TRUQAP

Exclusion Criteria

Required Medical Information

Documentation of locally advanced or metastatic HR-positive, HER2-negative breast cancer with a PIK3CA, AKT1, and/or PTEN-altered mutation

Age Restriction

Prescriber Restriction

Oncologist

Coverage Duration

Until end of benefit year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
TUKYSA

Exclusion Criteria

Required Medical Information

For colorectal cancer (including appendiceal adenocarcinoma): 1) the patient has advanced, unresectable, or metastatic disease AND 2) the patient has human epidermal growth factor receptor 2 (HER2)-positive disease AND 3) the patient has RAS wild-type disease AND 4) the requested drug will be used in combination with trastuzumab and 5) the patient has not previously been treated with a HER2 inhibitor.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer

No

Drugs

TURALIO ORAL CAPSULE 125 MG

Exclusion Criteria

Required Medical Information

For Langerhans Cell Histiocytosis: 1) disease has colony stimulating factor 1 receptor (CSF1R) mutation. For Erdheim-Chester Disease and Rosai-Dorfman Disease: 1) disease has CSF1R mutation AND patient has any of the following: a) symptomatic disease OR b) relapsed/refractory disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Langerhans Cell Histiocytosis, Erdheim-Chester Disease, Rosai-Dorfman Disease

No

Drugs
UBRELVY

Exclusion Criteria

Required Medical Information

Acute migraine treatment: The patient has experienced an inadequate treatment response, intolerance, or the patient has a contraindication to one triptan 5-HT₁ receptor agonist.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

budesonide oral tablet, delayed and ext. release

Exclusion Criteria

Required Medical Information

The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one 5-aminosalicylic acid (5-ASA) therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

2 months

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
UZEDY

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
VALCHLOR

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Chronic or smoldering adult T-cell leukemia/lymphoma, Stage 2 or higher mycosis fungoides/Sezary syndrome, primary cutaneous marginal zone lymphoma, primary cutaneous follicle center lymphoma, lymphomatoid papulosis, unifocal Langerhans cell histiocytosis (LCH) with isolated skin disease.
No

Drugs
VANFLYTA

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

varenicline tab

Drugs

varenicline oral tablet 0.5 mg, 1 mg, varenicline oral tablets, dose pack

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

6 months

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG, VENCLEXTA STARTING PACK

Exclusion Criteria

Required Medical Information

For acute myeloid leukemia (AML): 1) patient is 60 years of age or older OR 2) patient is less than 60 years of age with unfavorable risk genetics and TP53-mutation OR 3) patient has comorbidities that preclude use of intensive induction chemotherapy OR 4) patient has relapsed or refractory disease. For blastic plasmacytoid dendritic cell neoplasm (BPDCN): 1) patient has systemic disease being treated with palliative intent OR 2) patient has relapsed or refractory disease. For multiple myeloma: 1) the disease is relapsed or progressive AND 2) the requested drug will be used in combination with dexamethasone AND 3) patient has t(11:14) translocation. For Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma: 1) patient has previously treated disease that did not respond to primary therapy OR 2) patient has progressive or relapsed disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Mantle cell lymphoma, blastic plasmacytoid dendritic cell neoplasm (BPDCN), multiple myeloma, relapsed or refractory acute myeloid leukemia (AML), Waldenstrom macroglobulinemia/lymphoplasmacytic lymphoma, relapsed or refractory systemic light chain amyloidosis with translocation t(11:14)

No

Drugs
VERSACLOZ

Exclusion Criteria

Required Medical Information

For the treatment of a severely ill patient with schizophrenia who failed to respond adequately to standard antipsychotic treatment (i.e., treatment-resistant schizophrenia): 1) the patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) olanzapine, D) quetiapine, E) risperidone, F) ziprasidone AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following brand products: A) Latuda, B) Rexulti, C) Secuado, D) Vraylar.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
VERZENIO

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Recurrent hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer in combination with fulvestrant or an aromatase inhibitor, or as a single agent if progression on prior endocrine therapy and prior chemotherapy in the metastatic setting.
No

Drugs

vigabatrin, **VIGADRONE**

Exclusion Criteria

Required Medical Information

For complex partial seizures (CPS): patient has experienced an inadequate treatment response to at least two antiepileptic drugs for CPS.

Age Restriction

Infantile Spasms: 1 month to 2 years of age. CPS: 2 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Vigafyde (Vigabatrin)

Drugs
VIGAFYDE

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Vijoice

Drugs

VIJOICE ORAL GRANULES IN PACKET

Exclusion Criteria

Required Medical Information

**Note - Vijoice is only indicated for PIK3CA-related overgrowth spectrum (PROS), it is not indicated for breast cancer

Age Restriction

Prescriber Restriction

Coverage Duration

End of Benefit Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
VITRAKVI

Exclusion Criteria

Required Medical Information

For all neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, the disease is without a known acquired resistance mutation.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Non-metastatic neurotrophic tyrosine receptor kinase (NTRK) gene fusion-positive solid tumors, first-line treatment of NTRK gene fusion-positive solid tumors.

No

Drugs
VIZIMPRO

Exclusion Criteria

Required Medical Information

For non-small cell lung cancer (NSCLC): 1) the disease is recurrent, advanced or metastatic, and 2) the patient has sensitizing EGFR mutation-positive disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent non-small cell lung cancer (NSCLC).

No

Drugs
VONJO

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

VOQUEZNA, VOQUEZNA DUAL PAK, VOQUEZNA TRIPLE PAK

Exclusion Criteria

Required Medical Information

Patient must try and fail or have a contraindication to two(2) drugs from the proton pump inhibitor (PPI) class

Age Restriction

Prescriber Restriction

Coverage Duration

End of the Benefit Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Voranigo (vorasidenib)

Drugs

VORANIGO ORAL TABLET 10 MG, 40 MG

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

12 months

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

voriconazole

Drugs

voriconazole intravenous, voriconazole oral suspension for reconstitution, voriconazole oral tablet 200 mg, 50 mg

Exclusion Criteria

Required Medical Information

The patient will use the requested drug orally or intravenously.

Age Restriction

Prescriber Restriction

Coverage Duration

6 months

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
VOSEVI

Exclusion Criteria

Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)

Required Medical Information

For hepatitis C: Infection confirmed by presence of HCV RNA in the serum prior to starting treatment. Planned treatment regimen, genotype, prior treatment history, presence or absence of cirrhosis (compensated or decompensated [Child Turcotte Pugh class B or C]), presence or absence of HIV coinfection, presence or absence of resistance-associated substitutions where applicable, transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current American Association for the Study of Liver Diseases (AASLD) treatment guidelines.

Age Restriction

Prescriber Restriction

Coverage Duration

Criteria will be applied consistent with current AASLD-IDSa guidance.

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

pazopanib, **VOTRIENT**

Exclusion Criteria

Required Medical Information

For renal cell carcinoma: The disease is advanced, relapsed, or stage IV. For gastrointestinal stromal tumor (GIST): the disease is unresectable, recurrent, or metastatic AND the patient has failed on an FDA-approved therapy (e.g., imatinib, sunitinib, regorafenib, ripretinib). For soft tissue sarcoma (STS): The patient does not have an adipocytic soft tissue sarcoma. For uterine sarcoma: The disease is recurrent or metastatic.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma, chondrosarcoma, gastrointestinal stromal tumor.

No

Drugs

lisdexamfetamine oral capsule 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 70 mg, lisdexamfetamine oral tablet, chewable 10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, VYVANSE ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 70 MG, VYVANSE ORAL TABLET, CHEWABLE 10 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG

Exclusion Criteria

Required Medical Information

- 1) The patient has a diagnosis of Attention-Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) OR
- 2) The requested drug is being prescribed for the treatment of moderate to severe binge eating disorder (BED) in an adult.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
WAINUA

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
WELIREG

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
WINREVAIR

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Cardiologist, Pulmonologist

Coverage Duration
End of Benefit Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs

XALKORI ORAL CAPSULE, XALKORI ORAL PELLETT 150 MG, 20 MG, 50 MG

Exclusion Criteria

Required Medical Information

For NSCLC, the requested drug is used in any of the following settings: 1) the patient has recurrent, advanced or metastatic ALK-positive NSCLC, 2) the patient has recurrent, advanced or metastatic ROS-1 positive NSCLC, or 3) the patient has NSCLC with high-level MET amplification or MET exon 14 skipping mutation. For IMT, the disease is ALK-positive. For ALCL, the disease is relapsed or refractory and ALK-positive.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification or MET exon 14 skipping mutation, symptomatic or relapsed/refractory anaplastic lymphoma kinase (ALK)-fusion positive Erdheim-Chester Disease, symptomatic or relapsed/refractory (ALK)-fusion positive Rosai-Dorfman Disease, (ALK)-fusion positive Langerhans Cell Histiocytosis.

No

Drugs

XELJANZ ORAL SOLUTION, XELJANZ ORAL TABLET, XELJANZ XR

Exclusion Criteria

Required Medical Information

For moderately to severely active rheumatoid arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance or has a contraindication to methotrexate (MTX) AND at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]). For active psoriatic arthritis (new starts only): 1) patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one TNF inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]) AND 2) the requested drug is used in combination with a nonbiologic DMARD. For active ankylosing spondylitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]). For moderately to severely active ulcerative colitis (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Humira [adalimumab]). For active polyarticular course juvenile idiopathic arthritis (pcJIA) (new starts only): patient has experienced an inadequate treatment response, intolerance, or has a contraindication to at least one tumor necrosis factor (TNF) inhibitor (e.g., Enbrel [etanercept], Humira [adalimumab]).

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
XERMELO

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
XGEVA

Exclusion Criteria

Required Medical Information

For hypercalcemia of malignancy: condition is refractory to intravenous (IV) bisphosphonate therapy or there is a clinical reason to avoid IV bisphosphonate therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Coverage under Part D will be denied if coverage is available under Part A or Part B as the medication is prescribed and dispensed or administered for the individual.

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
XHANCE

Exclusion Criteria

Required Medical Information

Patient has experienced an inadequate treatment response to generic fluticasone nasal spray.

Age Restriction

18 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

XIFAXAN ORAL TABLET 550 MG

Exclusion Criteria

Required Medical Information

For irritable bowel syndrome with diarrhea (IBS-D): 1) The patient has not previously received treatment with the requested drug OR 2) The patient has previously received treatment with the requested drug AND a) the patient is experiencing a recurrence of symptoms AND b) the patient has not already received an initial 14-day course of treatment and two additional 14-day courses of treatment with the requested drug.

Age Restriction

Prescriber Restriction

Coverage Duration

Reduction in risk of overt HE recurrence: 6 Months, IBS-D: 14 Days

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

XOLAIR SUBCUTANEOUS AUTO-INJECTOR, XOLAIR SUBCUTANEOUS RECON SOLN, XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML, 75 MG/0.5 ML

Exclusion Criteria**Required Medical Information**

For allergic asthma initial therapy: 1) Patient has positive skin test (or blood test) to at least 1 perennial aeroallergen, 2) Patient has baseline IgE level greater than or equal to 30 IU/mL, and 3) Patient has inadequate asthma control despite current treatment with both of the following medications: a) Inhaled corticosteroid, and b) Additional controller (long acting beta2-agonist, long-acting muscarinic antagonist, leukotriene modifier, or sustained-release theophylline) unless patient has an intolerance or contraindication to such therapies. For allergic asthma continuation therapy only: Patient's asthma control has improved on treatment with the requested drug since initiation of therapy. For chronic idiopathic urticaria (CIU) initial therapy: 1) Patient has been evaluated for other causes of urticaria, including bradykinin-related angioedema and IL-1-associated urticarial syndromes (auto-inflammatory disorders, urticarial vasculitis), and 2) Patient has experienced a spontaneous onset of wheals, angioedema, or both, for at least 6 weeks. For CIU continuation therapy: Patient has experienced a response (e.g., improved symptoms) since initiation of therapy. For nasal polyps: 1) the requested drug is used as add-on maintenance treatment, AND 2) the patient has experienced an inadequate treatment response to Xhance (fluticasone). For IgE-Mediated Food Allergy: 1) Patient has baseline IgE level greater than or equal to 30 IU/mL

Age Restriction

For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older. For nasal polyps: 18 years of age or older. For IgE-Mediated Food Allergy: 1 year of age or older.

Prescriber Restriction**Coverage Duration**

CIU initial: 6 months. All others: Plan Year.

Other Criteria**Indications**

All FDA-approved Indications.

Off Label Uses**Part B Prerequisite**

No

Drugs
XOSPATA

Exclusion Criteria

Required Medical Information

For myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FLT3 rearrangement: the disease is in chronic or blast phase.

Age Restriction

18 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Myeloid, lymphoid, or mixed lineage neoplasms with eosinophilia and FLT3 rearrangement

No

Drugs

XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
XTANDI

Exclusion Criteria

Required Medical Information

The requested drug will be used in combination with a gonadotropin-releasing hormone (GnRH) analog or after bilateral orchiectomy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs

sodium oxybate

Exclusion Criteria

Required Medical Information

The diagnosis has been confirmed by sleep lab evaluation. EDS: 1)The patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) stimulant drug (e.g., amphetamine, dextroamphetamine, or methylphenidate) OR has a contraindication that would prohibit a trial of central nervous system (CNS) stimulant drugs (e.g., amphetamine, dextroamphetamine, or methylphenidate) [Note: Coverage of amphetamines may require prior authorization.] AND 2) If the patient is 18 years of age or older, the patient experienced an inadequate treatment response or intolerance to at least one central nervous system (CNS) wakefulness promoting drug (e.g., armodafinil) OR has a contraindication that would prohibit a trial of central nervous system (CNS) wakefulness promoting drugs (e.g., armodafinil) [Note: coverage of armodafinil may require prior authorization.].

Age Restriction

7 years of age or older

Prescriber Restriction

Prescribed by or in consultation with a sleep disorder specialist or neurologist.

Coverage Duration

Plan Year

Other Criteria

If the request is for a continuation of therapy, then the patient experienced a decrease in daytime sleepiness with narcolepsy or a decrease in cataplexy episodes with narcolepsy.

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
ZARXIO

Exclusion Criteria

Use of the requested product within 24 hours prior to or following chemotherapy.

Required Medical Information

For prophylaxis or treatment of myelosuppressive chemotherapy-induced febrile neutropenia (FN) patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, and 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

6 months

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Neutropenia in myelodysplastic syndromes (MDS), agranulocytosis, neutropenia in aplastic anemia, human immunodeficiency virus (HIV)-related neutropenia, neutropenia related to renal transplant.

No

Drugs

ZEJULA ORAL TABLET 100 MG, 200 MG, 300 MG

Exclusion Criteria

Required Medical Information

For uterine leiomyosarcoma: 1) the requested drug is used as second-line therapy AND 2) the patient has BRCA-altered disease.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

In combination with bevacizumab for persistent or recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer for platinum-sensitive disease, uterine leiomyosarcoma

No

Drugs
ZELBORAF

Exclusion Criteria

Required Medical Information

For adjuvant treatment of melanoma, and central nervous system (CNS) cancer (i.e., glioma, meningioma, astrocytoma): 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K) and 2) The requested drug will be used in combination with cobimetinib. For unresectable or metastatic melanoma: 1) The tumor is positive for BRAF V600 activating mutation (e.g., V600E or V600K) and 2) the requested drug will be used as a single agent, or in combination with cobimetinib (with or without atezolizumab). For Erdheim-Chester Disease and Langerhans Cell Histiocytosis: Tumor is positive for BRAF V600 mutation. For non-small cell lung cancer: 1) Tumor is positive for the BRAF V600E mutation, and 2) The patient has recurrent, advanced, or metastatic disease. For thyroid carcinoma: 1) Tumor is positive for BRAF mutation, and 2) Patient has radioiodine refractory follicular, Hurthle cell, or papillary thyroid carcinoma. For hairy cell leukemia: The requested drug will be used for subsequent therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Non-small cell lung cancer, hairy cell leukemia, thyroid carcinoma (i.e., papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), central nervous system cancer (i.e., glioma, meningioma, astrocytoma), adjuvant systemic therapy for cutaneous melanoma, Langerhans cell histiocytosis.

No

Drugs
ZIEXTENZO

Exclusion Criteria

Use of the requested product less than 24 hours before or after chemotherapy.

Required Medical Information

For prophylaxis of myelosuppressive chemotherapy-induced febrile neutropenia: the patient must meet both of the following: 1) Patient has a solid tumor or non-myeloid cancer, and 2) Patient is currently receiving or will be receiving treatment with myelosuppressive anti-cancer therapy.

Age Restriction

Prescriber Restriction

Coverage Duration

6 months

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Stem cell transplantation-related indications

No

Zilbrysq (Zilucoplan)

Drugs
ZILBRYSQ

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Zokinvy (Lonafarnib)

Drugs
ZOKINVY

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
ZOLINZA

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Mycosis fungoides, Sezary syndrome.
No

Drugs
ZONISADE

Exclusion Criteria

Required Medical Information

For adjunctive treatment of partial-onset seizures (i.e., focal-onset seizures): 1) The patient has experienced an inadequate treatment response, intolerance, or has a contraindication to a generic anticonvulsant AND the patient has experienced an inadequate treatment response, intolerance, or has a contraindication to any of the following: Aptiom, Xcopri, Spritam OR 2) The patient has difficulty swallowing solid oral dosage forms (e.g., tablets, capsules).

Age Restriction

16 years of age or older

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

Drugs
ZTALMY

Exclusion Criteria

Required Medical Information

Age Restriction
2 years of age or older

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
ZURZUVAE

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Indications
All FDA-approved Indications.

Off Label Uses

Part B Prerequisite
No

Drugs
ZYDELIG

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Indications
All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite
Refractory chronic lymphocytic leukemia (CLL), relapsed or refractory small lymphocytic lymphoma (SLL).
No

Drugs
ZYKADIA

Exclusion Criteria

Required Medical Information

For NSCLC: the patient has recurrent, advanced, or metastatic ALK-positive or ROS1-positive disease. For inflammatory myofibroblastic tumor: the disease is ALK-positive. For brain metastases from NSCLC: the patient has ALK-positive NSCLC.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications, Some Medically-accepted Indications.

Off Label Uses

Part B Prerequisite

Recurrent ALK-positive non-small cell lung cancer (NSCLC), recurrent, advanced, or metastatic ROS1-positive NSCLC, inflammatory myofibroblastic tumor (IMT), brain metastases from NSCLC.

No

Drugs

ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG

Exclusion Criteria

Required Medical Information

Tolerability with oral olanzapine has been established.

Age Restriction

Prescriber Restriction

Coverage Duration

Plan Year

Other Criteria

Indications

All FDA-approved Indications.

Off Label Uses

Part B Prerequisite

No

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ARCALYST	15	<i>clorazepate dipotassium</i>	47	ENSTILAR	38
<i>armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg</i>	16	<i>clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 150 mg, 200 mg, 25 mg</i>	48	EPCLUSA	73
AUGTYRO	17	COMETRIQ	49	EPIDIOLEX	74
AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG	18	COPIKTRA	50	EPRONTIA	75
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 18 MG, 24 MG, 30 MG, 36 MG, 42 MG, 48 MG, 6 MG	18	COTELLIC	51	<i>ergotamine-caffeine</i>	76
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 12-18-24-30 MG, 6 MG (14)-12 MG (14)-24 MG (14)	18	CYSTADROPS	52	ERIVEDGE	77
AUVELITY	19	CYTAGON	53	ERLEADA	78
AYVAKIT	20	CYSTARAN	54	<i>erlotinib oral tablet 100 mg, 150 mg, 25 mg</i>	79
BAFIERTAM	21	<i>dalfampridine</i>	55	<i>everolimus (antineoplastic) oral tablet</i>	81
BALVERSA	22	DASATINIB	219	<i>everolimus (antineoplastic) oral tablet for suspension 2 mg, 3 mg, 5 mg</i>	81
BENLYSTA SUBCUTANEOUS	24	DAURISMO	56	FABHALTA	82
BERINERT INTRAVENOUS KIT	25	DAYBUE	57	FANAPT ORAL TABLET	83
BESREMI	26	<i>deferasirox</i>	58	FANAPT ORAL TABLETS,DOSE PACK	83
BETASERON SUBCUTANEOUS KIT	27	DEPO-TESTOSTERONE	236	FASENRA	84
<i>bexarotene oral</i>	28	<i>desvenlafaxine succinate</i>	60	FASENRA PEN	84
<i>bexarotene topical</i>	230	<i>dexamethylphenidate oral tablet 10 mg, 2.5 mg, 5 mg</i>	61	<i>febuxostat</i>	85
BIVIGAM	125	<i>dextroamphetamine-amphetamine oral capsule,extended release 24hr</i>	14	<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	86
<i>bosentan</i>	29	<i>dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	14	FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	87
BOSULIF ORAL CAPSULE 100 MG, 50 MG	30	DIACOMIT ORAL CAPSULE 250 MG, 500 MG	63	FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 20 MG, 40 MG, 80 MG	87
BOSULIF ORAL TABLET	30	DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG	63	FILSPARI	88
BRAFTOVI	31	DIAZEPAM INTENSOL	64	<i> fingolimod</i>	99
BRIVIACT ORAL SOLUTION	32	<i>diazepam oral solution 5 mg/5 mL (1 mg/mL)</i>	64	FINTEPLA	89
BRIVIACT ORAL TABLET	32	<i>diazepam oral tablet</i>	64	<i> flucytosine</i>	90
BRONCHITOL	33	<i>dihydroergotamine nasal</i>	62	FORTEO	91
BRUKINSA	34	DOPTELET (10 TAB PACK)	65	FOTIVDA	92
<i>budesonide oral capsule, delayed, extend.release</i>	35	DOPTELET (15 TAB PACK)	65	FRUZAQLA	93
<i>budesonide oral tablet, delayed and ext.release</i>	252	DOPTELET (30 TAB PACK)	65	FYCOMPA ORAL SUSPENSION	94
<i>buprenorphine HCl sublingual</i>	36	DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 40 MG, 60 MG	66	FYCOMPA ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	94
BYDUREON BCISE	102				

GAMMAGARD LIQUID.....	125	HYRIMOZ PEN PSORIASIS		KISQALI FEMARA CO-PACK	
GAMMAGARD S-D (IGA < 1		STARTER.....	4	ORAL TABLET 200 MG/DAY(200	
MCG/ML).....	125	HYRIMOZ(CF) PEDI CROHN		MG X 1)-2.5 MG, 400	
GAMMAKED INJECTION		STARTER SUBCUTANEOUS		MG/DAY(200 MG X 2)-2.5 MG,	
SOLUTION 1 GRAM/10 ML (10 %)		SYRINGE 80 MG/0.8 ML- 40		600 MG/DAY(200 MG X 3)-2.5 MG	
.....	125	MG/0.4 ML.....	4	.....	134
GAMMAPLEX.....	125	HYRIMOZ(CF) PEN		KISQALI ORAL TABLET 200	
GAMMAPLEX (WITH SORBITOL)	125	SUBCUTANEOUS PEN		MG/DAY (200 MG X 1), 400	
GAMUNEX-C INJECTION		INJECTOR 40 MG/0.4 ML, 80		MG/DAY (200 MG X 2), 600	
SOLUTION 1 GRAM/10 ML (10 %)		MG/0.8 ML.....	4	MG/DAY (200 MG X 3).....	134
.....	125	HYRIMOZ(CF) SUBCUTANEOUS		KORLYM.....	135
GATTEX 30-VIAL.....	95	SYRINGE 10 MG/0.1 ML, 20		KOSELUGO.....	136
GAVRETO.....	96	MG/0.2 ML, 40 MG/0.4 ML.....	4	KRAZATI.....	137
<i>gefitinib</i>	97	HYSINGLA ER.....	120	<i>lapatinib</i>	138
GEMTESA.....	98	IBRANCE.....	109	LAZCLUZE ORAL TABLET 240	
GENOTROPIN.....	104	<i>icatibant</i>	110	MG, 80 MG.....	139
GENOTROPIN MINIQUICK.....	104	ICLUSIG.....	111	<i>lenalidomide oral capsule 10 mg,</i>	
GILOTRIF.....	100	IDHIFA.....	112	<i>15 mg, 2.5 mg, 20 mg, 25 mg, 5</i>	
<i>glatiramer subcutaneous syringe</i>		<i>imatinib oral tablet 100 mg, 400 mg</i>		<i>mg</i>	202
<i>20 mg/mL, 40 mg/mL</i>	101	.....	113	LENVIMA ORAL CAPSULE 10	
GLATOPA SUBCUTANEOUS		IMBRUVICA ORAL CAPSULE 140		MG/DAY (10 MG X 1), 12 MG/DAY	
SYRINGE 20 MG/ML, 40 MG/ML..	101	MG, 70 MG.....	114	(4 MG X 3), 14 MG/DAY(10 MG X	
<i>glutamine (sickle cell)</i>	72	IMBRUVICA ORAL SUSPENSION		1-4 MG X 1), 18 MG/DAY (10 MG	
GRALISE ORAL TABLET		.....	114	X 1-4 MG X2), 20 MG/DAY (10 MG	
EXTENDED RELEASE 24 HR 300		IMBRUVICA ORAL TABLET 140		X 2), 24 MG/DAY(10 MG X 2-4 MG	
MG, 450 MG, 600 MG, 750 MG,		MG, 280 MG, 420 MG.....	114	X 1), 4 MG, 8 MG/DAY (4 MG X 2)	140
900 MG.....	103	INCRELEX.....	115	<i>leuprolide subcutaneous kit</i>	141
<i>Hadlima</i>	4	INGREZZA.....	116	<i>lidocaine HCl mucous membrane</i>	
<i>Hadlima PushTouch</i>	4	INGREZZA INITIATION		<i>solution 4 % (40 mg/mL)</i>	243
HADLIMA(CF).....	4	PK(TARDIV).....	116	<i>lidocaine topical adhesive</i>	
HADLIMA(CF) PUSHTOUCH.....	4	INGREZZA SPRINKLE.....	116	<i>patch,medicated.5%</i>	142
HAEGARDA SUBCUTANEOUS		INLYTA ORAL TABLET 1 MG, 5		<i>lidocaine topical ointment</i>	243
RECON SOLN 2,000 UNIT, 3,000		MG.....	117	<i>lidocaine-prilocaine topical cream</i> ..	243
UNIT.....	105	INQOVI.....	118	<i>lisdexamfetamine oral capsule 10</i>	
HARVONI ORAL PELLETS IN		INREBIC.....	119	<i>mg, 20 mg, 30 mg, 40 mg, 50 mg,</i>	
PACKET.....	106	IRESSA.....	121	<i>60 mg, 70 mg</i>	271
HARVONI ORAL TABLET 90-400		<i>isotretinoin oral capsule 10 mg, 20</i>		<i>lisdexamfetamine oral</i>	
MG.....	106	<i>mg, 30 mg, 40 mg</i>	122	<i>tablet,chewable 10 mg, 20 mg, 30</i>	
HUMIRA PEN.....	108	<i>itraconazole oral capsule</i>	123	<i>mg, 40 mg, 50 mg, 60 mg</i>	271
HUMIRA SUBCUTANEOUS		<i>ivermectin oral</i>	124	LIVDELZI.....	143
SYRINGE KIT 40 MG/0.8 ML.....	108	IWILFIN.....	126	LONSURF.....	144
HUMIRA(CF) PEN CROHNS-UC-		JAKAFI.....	127	LORBRENA.....	145
HS.....	108	JAVYGTOR.....	209	LUMAKRAS.....	146
HUMIRA(CF) PEN PEDIATRIC UC		JAYPIRCA ORAL TABLET 100		LUPRON DEPOT (3 MONTH)	
.....	108	MG, 50 MG.....	128	INTRAMUSCULAR SYRINGE KIT	
HUMIRA(CF) PEN PSOR-UV-		KALYDECO ORAL GRANULES		11.25 MG.....	147
ADOL HS.....	108	IN PACKET 13.4 MG, 25 MG, 5.8		LUPRON DEPOT	
HUMIRA(CF) PEN		MG, 50 MG, 75 MG.....	129	INTRAMUSCULAR SYRINGE KIT	
SUBCUTANEOUS PEN		KALYDECO ORAL TABLET.....	129	3.75 MG.....	147
INJECTOR KIT 40 MG/0.4 ML, 80		KESIMPTA PEN.....	130	LYNPARZA.....	148
MG/0.8 ML.....	108	<i>ketconazole oral</i>	131	LYTGOBI ORAL TABLET 12	
HUMIRA(CF) SUBCUTANEOUS		KEVZARA.....	132	MG/DAY (4 MG X 3), 16 MG/DAY	
SYRINGE KIT 10 MG/0.1 ML, 20		KINERET.....	133	(4 MG X 4), 20 MG/DAY (4 MG X	
MG/0.2 ML, 40 MG/0.4 ML.....	108	.....		5).....	149
<i>hydrocodone bitartrate oral</i>				MAVYRET.....	150
<i>tablet,oral only,ext.rel.24.hr</i>	120			<i>megestrol oral suspension 625</i>	
HYRIMOZ.....	4			<i>mg/5 mL (125 mg/mL)</i>	151
HYRIMOZ PEN.....	4			MEKINIST.....	152
HYRIMOZ PEN CROHN'S-UC				MEKTOVI.....	153
STARTER.....	4			<i>methadone oral solution</i>	120

<i>methadone oral tablet</i>	120	PIQRAY	187	SKYRIZI SUBCUTANEOUS	
<i>methylphenidate HCl oral solution</i>		<i>pirfenidone oral capsule</i>	80	SYRINGE 150 MG/ML	216
<i>10 mg/5 mL, 5 mg/5 mL</i>	154	<i>pirfenidone oral tablet 267 mg, 534</i>		SKYRIZI SUBCUTANEOUS	
<i>methylphenidate HCl oral tablet 10</i>		<i>mg, 801 mg</i>	80	WEARABLE INJECTOR 180	
<i>mg, 20 mg, 5 mg</i>	154	POMALYST	188	MG/1.2 ML (150 MG/ML), 360	
<i>methylphenidate HCl oral tablet</i>		<i>posaconazole oral tablet, delayed</i>		MG/2.4 ML (150 MG/ML)	217
<i>extended release</i>	154	<i>release (DR/EC)</i>	189	<i>sodium oxybate</i>	285
<i>methylphenidate HCl oral</i>		PRALUENT PEN	190	<i>sodium phenylbutyrate</i>	186
<i>tablet, chewable</i>	154	PREVMIS ORAL	191	SOMAVERT	218
<i>metyrosine</i>	59	PRIVIGEN	125	<i>sorafenib</i>	159
<i>miglustat</i>	155	PROCRIT INJECTION SOLUTION		SPRYCEL	219
<i>modafinil oral tablet 100 mg, 200</i>		10,000 UNIT/ML, 2,000 UNIT/ML,		STELARA SUBCUTANEOUS	
<i>mg</i>	156	20,000 UNIT/ML, 3,000 UNIT/ML,		SOLUTION	220
<i>morphine oral tablet extended</i>		4,000 UNIT/ML, 40,000 UNIT/ML ..	192	STELARA SUBCUTANEOUS	
<i>release</i>	120	PROLASTIN-C INTRAVENOUS		SYRINGE 45 MG/0.5 ML, 90	
MOTPOLY XR	157	SOLUTION	11	MG/ML	220
MOUNJARO	102	PROMACTA ORAL POWDER IN		STIVARGA	221
NERLYNX	158	PACKET 12.5 MG, 25 MG	193	<i>sunitinib malate</i>	222
NEXAVAR	159	PROMACTA ORAL TABLET 12.5		SYMDEKO	223
NINLARO	160	MG, 25 MG, 50 MG, 75 MG	193	SYMPAZAN	224
<i>nitisinone</i>	161	PULMOZYME	194	TABRECTA	225
NOXAFIL ORAL SUSPENSION ..	163	QINLOCK	195	TAFINLAR	226
NUBEQA	164	<i>quetiapine oral tablet extended</i>		TAGRISSE	227
NUDEXTA	165	<i>release 24 hr 150 mg, 200 mg, 300</i>		TALTZ AUTOINJECTOR	228
NUPLAZID	166	<i>mg, 400 mg, 50 mg</i>	196	TALTZ SYRINGE	
NURTEC ODT	167	<i>quinine sulfate</i>	197	SUBCUTANEOUS SYRINGE 20	
OCTAGAM	125	RECORLEV	198	MG/0.25 ML, 40 MG/0.5 ML, 80	
<i>octreotide acetate injection solution</i>		REGRANEX	199	MG/ML	228
.....	168	RELISTOR SUBCUTANEOUS		TALZENNA ORAL CAPSULE 0.1	
ODOMZO	169	SOLUTION	200	MG, 0.25 MG, 0.35 MG, 0.5 MG,	
OFEV	170	RELISTOR SUBCUTANEOUS		0.75 MG, 1 MG	229
OGSIVEO ORAL TABLET 100		SYRINGE	200	TASIGNA	231
MG, 150 MG, 50 MG	171	RETEVMO	201	<i>tasimelteon</i>	107
OJEMDA	172	REZLIDHIA	203	<i>tazarotene topical cream 0.1 %</i>	232
OJJAARA	173	REZUROCK	204	TAZORAC TOPICAL CREAM 0.05	
ONUREG	174	RINVOQ LQ	205	%	232
OPSUMIT	175	RINVOQ ORAL TABLET		TAZVERIK	233
OPSYNVI	176	EXTENDED RELEASE 24 HR 15		TEPMETKO	234
ORGOVYX	177	MG, 30 MG, 45 MG	205	<i>teriparatide subcutaneous pen</i>	
ORIAHNN	178	ROZLYTREK	206	<i>injector 20 mcg/dose</i>	
ORKAMBI ORAL GRANULES IN		RUBRACA	207	<i>(620mcg/2.48mL)</i>	235
PACKET	179	<i>rufinamide oral suspension</i>	23	<i>testosterone cypionate</i>	236
ORKAMBI ORAL TABLET	179	<i>rufinamide oral tablet 200 mg, 400</i>		<i>testosterone enanthate</i>	237
ORSERDU	180	<i>mg</i>	23	<i>testosterone transdermal gel in</i>	
OTEZLA ORAL TABLET 20 MG,		RYBELSUS	102	<i>metered-dose pump 12.5 mg/ 1.25</i>	
30 MG	181	RYDAPT	208	<i>gram (1 %), 20.25 mg/1.25 gram</i>	
OTEZLA STARTER ORAL		SAJAZIR	110	<i>(1.62 %)</i>	244
TABLETS, DOSE PACK 10 MG		<i>sapropterin</i>	209	<i>testosterone transdermal gel in</i>	
(4)- 20 MG (51), 10 MG (4)-20 MG		SAVELLA ORAL TABLET	210	<i>packet 1 % (25 mg/2.5gram), 1 %</i>	
(4)-30 MG (47)	181	SAVELLA ORAL TABLETS, DOSE		<i>(50 mg/5 gram)</i>	244
OZEMPIC SUBCUTANEOUS PEN		PACK	210	<i>tetrabenazine oral tablet 12.5 mg,</i>	
INJECTOR 0.25 MG OR 0.5 MG (2		SCEMBLIX ORAL TABLET 100		<i>25 mg</i>	238
MG/3 ML), 1 MG/DOSE (4 MG/3		MG, 20 MG, 40 MG	211	<i>tetracycline oral capsule</i>	239
ML), 2 MG/DOSE (8 MG/3 ML)	102	SIGNIFOR	212	THALOMID ORAL CAPSULE 100	
PANRETIN	182	<i>sildenafil (pulm.hypertension) oral</i>		MG, 150 MG, 200 MG, 50 MG	240
PANZYGA	125	<i>tablet</i>	213	TIBSOVO	241
<i>paroxetine HCl oral suspension</i>	183	SIRTURO	214	<i>tobramycin in 0.225 % NaCl</i>	242
<i>pazopanib</i>	270	SKYCLARYS	215	<i>tretinoin topical cream</i>	245
PEGASYS	184	SKYRIZI SUBCUTANEOUS PEN		<i>tretinoin topical gel 0.01 %, 0.025</i>	
PEMAZYRE	185	INJECTOR	216	%	245

<i>trientine oral capsule 250 mg, 500 mg</i>	246	XIFAXAN ORAL TABLET 550 MG	280
TRIKAFTA	247	XOLAIR SUBCUTANEOUS	
TRULICITY	102	AUTO-INJECTOR	281
TRUQAP	248	XOLAIR SUBCUTANEOUS	
TUKYSA	249	RECON SOLN	281
TURALIO ORAL CAPSULE 125		XOLAIR SUBCUTANEOUS	
MG	250	SYRINGE 150 MG/ML, 300 MG/2	
UBRELVY	251	ML, 75 MG/0.5 ML	281
UZEDY	253	XOSPATA	282
VALCHLOR	254	XPOVIO ORAL TABLET 100	
VANFLYTA	255	MG/WEEK (50 MG X 2), 40	
<i>varenicline oral tablet 0.5 mg, 1 mg</i>	256	MG/WEEK (40 MG X 1), 40MG	
<i>varenicline oral tablets, dose pack</i>	256	TWICE WEEK (40 MG X 2), 60	
VENCLEXTA ORAL TABLET 10		MG/WEEK (60 MG X 1), 60MG	
MG, 100 MG, 50 MG	257	TWICE WEEK (120 MG/WEEK),	
VENCLEXTA STARTING PACK	257	80 MG/WEEK (40 MG X 2), 80MG	
VERSACLOZ	258	TWICE WEEK (160 MG/WEEK)	283
VERZENIO	259	XTANDI	284
VICTOZA 3-PAK	102	ZARXIO	286
<i>vigabatrin</i>	260	ZEJULA ORAL TABLET 100 MG,	
VIGADRONE	260	200 MG, 300 MG	287
VIGAFYDE	261	ZELBORAF	288
VIJOICE ORAL GRANULES IN		ZEMAIRA INTRAVENOUS	
PACKET	262	RECON SOLN 1,000 MG	11
VITRAKVI	263	ZENATANE	122
VIZIMPRO	264	ZIEXTENZO	289
VONJO	265	ZILBRYSQ	290
VOQUEZNA	266	ZOKINVY	291
VOQUEZNA DUAL PAK	266	ZOLINZA	292
VOQUEZNA TRIPLE PAK	266	ZONISADE	293
VORANIGO ORAL TABLET 10		ZTALMY	294
MG, 40 MG	267	ZURZUVAE	295
<i>voriconazole intravenous</i>	268	ZYDELIG	296
<i>voriconazole oral suspension for</i>		ZYKADIA	297
<i>reconstitution</i>	268	ZYPREXA RELPREVV	
<i>voriconazole oral tablet 200 mg, 50</i>		INTRAMUSCULAR SUSPENSION	
<i>mg</i>	268	FOR RECONSTITUTION 210 MG	298
VOSEVI	269		
VOTRIENT	270		
VYVANSE ORAL CAPSULE 10			
MG, 20 MG, 30 MG, 40 MG, 50			
MG, 60 MG, 70 MG	271		
VYVANSE ORAL			
TABLET, CHEWABLE 10 MG, 20			
MG, 30 MG, 40 MG, 50 MG, 60			
MG	271		
WAINUA	272		
WELIREG	273		
WINREVAIR	274		
XALKORI ORAL CAPSULE	275		
XALKORI ORAL PELLETT 150			
MG, 20 MG, 50 MG	275		
XELJANZ ORAL SOLUTION	276		
XELJANZ ORAL TABLET	276		
XELJANZ XR	276		
XERMELO	277		
XGEVA	278		
XHANCE	279		