Drugs
ALDURAZYME

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information
Documented diagnosis of Mucopolysaccharidosis I (Hurler, Hurler-Scheie, or Scheie form) confirmed by and Enzyme assay demonstrating deficiency of alpha-L-iduronidase activity or DNA testing AND dose does not exceed 0.58 mg/kg/week.

Age Restriction
Greater than or equal to 6 months

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
ALHEMO

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information
Diagnosis of Hemophilia A or Hemophilia B

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
ALYFTREK

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Pulmonologist

Coverage Duration
End of Benefit Year

Other Criteria

Drugs
Itraconazole Oral, *Voriconazole Oral*

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
APTIOM

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
AQNEURSA

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
End of benefit year

Other Criteria

Drugs
ATTRUBY

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
End of benefit year

Other Criteria

Drugs
ENBREL MINI, **ENBREL SUBCUTANEOUS SOLUTION 25 MG/0.5ML**, **ENBREL SUBCUTANEOUS SOLUTION PREFILLED SYRINGE**, **ENBREL SURECLICK SUBCUTANEOUS SOLUTION AUTO-INJECTOR**, **HUMIRA (1 PEN)**, **HUMIRA (2 PEN) SUBCUTANEOUS AUTO-INJECTOR KIT 40 MG/0.4ML**, **HUMIRA (2 SYRINGE) SUBCUTANEOUS PREFILLED SYRINGE KIT 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML**, **HUMIRA-CD/UC/HS STARTER SUBCUTANEOUS AUTO-INJECTOR KIT 80 MG/0.8ML**, **HUMIRA-PSORIASIS/UVEIT STARTER SUBCUTANEOUS AUTO-INJECTOR KIT**, **KEVZARA**, **OLUMIANT**, **OTEZLA ORAL TABLET 30 MG**, **OTEZLA ORAL TABLET THERAPY PACK 10 & 20 & 30 MG**, **RINVOQ**, **SKYRIZI INTRAVENOUS**, **SKYRIZI PEN**, **SKYRIZI SUBCUTANEOUS SOLUTION CARTRIDGE**, **SKYRIZI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE**, **STELARA INTRAVENOUS**, **STELARA SUBCUTANEOUS SOLUTION 45 MG/0.5ML**, **STELARA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 45 MG/0.5ML, 90 MG/ML**, **TALTZ SUBCUTANEOUS SOLUTION AUTO-INJECTOR**, **TALTZ SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/0.25ML, 40 MG/0.5ML, 80 MG/ML**, **TREMFYA CROHNS INDUCTION SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/2ML**, **TREMFYA INTRAVENOUS**, **TREMFYA ONE-PRESS**, **TREMFYA PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 100 MG/ML, 200 MG/2ML**, **TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, 200 MG/2ML**, **XELJANZ ORAL SOLUTION**, **XELJANZ ORAL TABLET**, **XELJANZ XR**

Covered Uses
Please reference the Select Autoimmune Drugs criteria document posted on hf.org

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
AVONEX PEN INTRAMUSCULAR AUTO-INJECTOR KIT, **AVONEX PREFILLED INTRAMUSCULAR PREFILLED SYRINGE KIT**

Covered Uses
All medically accepted indications not otherwise excluded from Part D.

Exclusion Criteria
Treatment of primary progressive MS is not covered. Combination therapy with a beta interferon product, Gilenya, Aubagio, Tecfidera, Tysabri or Copaxone is not covered.

Required Medical Information
Diagnosis of relapsing forms of multiples sclerosis

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
BRIVIACT

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
AIMOVIG SUBCUTANEOUS SOLUTION AUTO-INJECTOR 140 MG/ML, 70 MG/ML, **AJOVY**, **EMGALITY**, **EMGALITY (300 MG DOSE)**

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information
Prescriber attestation of migraines and member has tried and failed two formulary alternatives for migraine prophylaxis with two different mechanism of action.

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
Acamprosate Calcium

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
Capecitabine Oral Tablet 150 MG, 500 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria

Required Medical Information
Clinical documentation of FDA approved indication for treatment.

Age Restriction
18 years and older.

Prescriber Restriction
Oncologist

Coverage Duration
Plan year

Other Criteria

Drugs
Chorionic Gonadotropin Intramuscular

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
COBENFY, **COBENFY STARTER PACK**

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
1 year

Other Criteria

Drugs
COSENTYX (300 MG DOSE), **COSENTYX INTRAVENOUS**, **COSENTYX SENSOREADY (300 MG)**, **COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML**, **COSENTYX SUBCUTANEOUS**, **COSENTYX UNOREADY**

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
CRENESSITY ORAL CAPSULE 100 MG, 50 MG, **CRENESSITY ORAL SOLUTION**

Covered Uses

Exclusion Criteria

Required Medical Information
Must be prescribed for an FDA approved indication.

Age Restriction

Prescriber Restriction

Coverage Duration
End of Benefit Year

Other Criteria

Drugs
ABRYSVO, *Adefovir Dipivoxil*, **AREXVY**, *Armodafinil*, *Asenapine Maleate*, *Azelaic Acid External*, **BELSOMRA**, *Budesonide Oral*, *Cromolyn Sodium Oral*, **EMVERM**, *Entecavir Oral Tablet 0.5 MG, 1 MG*, **EPCLUSA**, **EUCRISA**, *Exemestane*, *Febuxostat*, **FETZIMA**, **FETZIMA TITRATION**, *HYDROcodone Bitartrate ER Oral Tablet ER 24 Hour Abuse-Deterrent 100 MG, 120 MG*, *Ivermectin External Lotion*, *Lacosamide Intravenous*, *Lacosamide Oral Tablet*, *lamoTRIgine Oral Tablet Dispersible*, *Mesalamine Oral Tablet Delayed Release 800 MG*, *Modafinil Oral*, *Olopatadine HCl Ophthalmic*, *Omega-3-acid Ethyl Esters*, *Phenoxybenzamine HCl Oral*, *Potassium Chloride Oral Solution 20 MEQ/15ML (10%), 40 MEQ/15ML (20%)*, **REXULTI**, **SANCUSO**, **SAVELLA**, **SAVELLA TITRATION PACK**, **SIRTURO ORAL TABLET 100 MG**, *Tobramycin Inhalation Nebulization Solution 300 MG/4ML*, **VEMLIDY**, **VIMPAT INTRAVENOUS**, **VIMPAT ORAL SOLUTION**

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
EPIDIOLEX

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
Betaine

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
DALIRESP

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
DANZITEN

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
End of benefit year

Other Criteria

DARAPRIM

Drugs
Pyrimethamine Oral

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
DIFICID

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
DIPENTUM

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
DUPIXENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR 200 MG/1.14ML, 300 MG/2ML, **DUPIXENT SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 200 MG/1.14ML, 300 MG/2ML**

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information
Patient must have the following: A) Moderate-to-severe atopic dermatitis (eczema)AND submission of medical records (e.g. chart notes, laboratory values) documenting the following: Inadequate response, intolerance or contraindication to ONE medication in EACH of the following categories:a. Topical calcineurin inhibitor b. High potency topical corticosteroid. OR B) Moderate-to-severe asthma AND submission of medical records documenting the following: 1. Patient has ONE of the following: a. Asthma with eosinophilic phenotype with eosinophil count greater than or equal to 300 cells/mcL in the past 12 months, or b. Oral corticosteroid dependent asthma with at least 1 month of daily oral corticosteroid use within the last 3 months AND 2. Inadequate control of asthma symptoms after a minimum of 3 months of compliant use of one of the following: a. Inhaled corticosteroids & long acting beta2 agonist, or b. Inhaled corticosteroids & long acting muscarinic antagonist. OR C)Chronic rhinosinusitis with nasal polyposis (CRSwNP)AND submission of medical records (e.g. chart notes, laboratory values) documenting the following: Inadequate response, intolerance or contraindication to ONE medication in EACH of the following categories: 1. Inadequate response, intolerance or contraindication to ONE medication in EACH of the following categories: a. Nasal corticosteroid spray and b. Oral corticosteroid.

Age Restriction

Prescriber Restriction
Dermatologist or allergist/immunologist

Coverage Duration
Initial Authorization will be for 3 months. Reauthorization will be for 1 year.

Other Criteria
Renewals require submission of medical records (e.g. chart notes, laboratory values) documenting improvement of the condition.

Drugs
EMSAM

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
Rivastigmine, *Rivastigmine Tartrate*

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

FDA Approved Indication

Drugs
AGAMREE, **AUGTYRO ORAL CAPSULE 40 MG**, **BEYFORTUS**, **FABHALTA**, **FILSUVEZ**, **FRUZAQLA**, **IWILFIN**, **OGSIVEO**, **OJJAARA**, **OMVOH INTRAVENOUS**, **OMVOH SUBCUTANEOUS SOLUTION AUTO-INJECTOR**, **REZDIFFRA**, **RIVFLOZA**, **SYNAGIS**, **TASIGNA**, *Teriparatide Subcutaneous Solution Pen-Injector 560 MCG/2.24ML*, **TRUQAP ORAL TABLET 200 MG**, **VELSIPITY**, **WAINUA**

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
GEMTESA

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
End of Benefit Year

Other Criteria

Drugs
Liraglutide, **MOUNJARO SUBCUTANEOUS SOLUTION AUTO-INJECTOR**, **OZEMPIC (0.25 OR 0.5 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 2 MG/3ML**, **OZEMPIC (1 MG/DOSE) SUBCUTANEOUS SOLUTION PEN-INJECTOR 4 MG/3ML**, **OZEMPIC (2 MG/DOSE)**, **RYBELSUS**, **TRULICITY SUBCUTANEOUS SOLUTION AUTO-INJECTOR**

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria
Medication is not covered for weight loss related indications

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
NORDITROPIN FLEXPRO SUBCUTANEOUS SOLUTION PEN-INJECTOR, **OMNITROPE SUBCUTANEOUS SOLUTION CARTRIDGE**, **OMNITROPE SUBCUTANEOUS SOLUTION RECONSTITUTED**

Covered Uses
All FDA approved indications not otherwise excluded by Health Plan. Additional off-label coverage is provided for (note - some growth hormone drugs may be labeled for 1 or more of these indications): adult growth hormone deficiency, growth failure in children small for gestational age or with intrauterine growth retardation, idiopathic short stature, GH deficiency associated with Turner Syndrome, growth failure secondary to chronic renal failure/insufficiency in children who have not received a renal transplant, short stature associated with Noonan Syndrome, short bowel syndrome, and for the treatment of Prader-Willi Syndrome.

Exclusion Criteria
Coverage is not provided for constitutional delayed growth

Required Medical Information
Pediatric GHD: epiphyses must be confirmed open in patients 10 years of age and older, AND 1. diagnosis confirmed by any 2 provocative tests or by both low IGF-1 and IGFBP-3 levels in patients who meet the height related conditions of coverage, 2. diagnosis confirmed by 2 provocative tests and both low IGF-1 and IGF-BP3 in patients not meeting height related coverage conditions, or 3. 3 pituitary hormone deficiencies in pt with irreversible hypothalamic-pituitary structural lesions or panhypopituitarism. Growth failure from CRF: PGHD criteria must be met without the provocative tests or IGF-1 and IGF-BP3 related conditions. Idiopathic Short Stature: epiphyses must be confirmed as open in patients greater than or equal 10 years of age, height must be less than or equal - 2.25 sds from the mean. Small for Gestational Age: failure to manifest catch up growth by age 2 defined as birth weight, birth length, or both that are more than 2 sds mean normal values following adjustment for age and gender. Turner's syndrome and Noonan Syndrome: epiphyses must be confirmed as open and when on therapy. Adult GHD: requires either 1. a negative GH provocative test when the AGHD is due to childhood onset GHD, pituitary or hypothalamic disease, surgery or radiation therapy, or trauma, OR 2. 3 pituitary hormone deficiencies and baseline serum IGF-I levels below the age- and sex-appropriate reference range when the AGHD is due to irreversible hypothalamic-pituitary structural lesions or panhypopituitarism not acquired as a child, OR 3. 3 pituitary hormone deficiencies if adult panhypopit or irreversible hypothalamic-pituitary structural lesions are from childhood. Short bowel syndrome: when receiving specialized nutritional support.

Age Restriction
7 years of age or older for Idiopathic short stature

Prescriber Restriction
Pediatric endocrinologist for ISS

Coverage Duration
1 month for short bowel syndrome, 12 months for other indications

Other Criteria
Height related conditions of coverage: 1. height below the third percentile for their age and gender related height, 2. growth velocity subnormal greater than or equal 2 standard deviations (sds) from the age related mean, 3. delayed skeletal maturation greater than or equal 2 sds below the age/gender related mean. Renewals for PGHD, CFR, SGA, Turner's and Noonan Syndromes require growth response of greater than or equal 4.5 cm/yr (pre-pubertal) or greater than or equal 2.5 cm/yr (post-pubertal) AND open epiphyses. For pediatric patients with irreversible hypothalamic-pituitary structural lesions or panhypopituitarism coverage is renewable if the patient has had 3 pituitary hormone deficiencies. Renewals for short bowel syndrome is provided in the presence of clinical benefit (such as, decreasing the patient?s intravenous nutritional requirements). Renewals for Prader-Willi syndrome is provided if pt has increase in lean body mass or decrease in fat mass. Renewals for ISS is provided in the presence of a growth response of greater than or equal 1.5 cm/yr AND open epiphyses. Renewals for AGHD is provided in the presence of clinical benefit (e.g., increase in total lean body mass, increase in IGF-1 and IGFBP-3 levels, or increase in exercise capacity).

Drugs
HYMPAVZI

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information
Diagnosis of Hemophilia A or Hemophilia B

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
IMBRUVICA ORAL SUSPENSION

Covered Uses
All FDA-approved indications not otherwise excluded from Health Plan.

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
3 Months

Other Criteria

Drugs
Imkeldi

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
End of benefit year

Other Criteria

Drugs
ISOtretinoin Oral Capsule 10 MG, 20 MG, 30 MG, 40 MG

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
ITOVEBI

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction
Oncologist

Coverage Duration
End of Benefit Year

Other Criteria

Drugs
Lidocaine External Patch 5 %

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
LIVDELZI

Covered Uses

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 a history of a hepatic decompensation event including portal hypertension with complications, or 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

Drugs
Alosetron HCl

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
BELBUCA BUCCAL FILM 600 MCG, 750 MCG, 900 MCG, *fentaNYL Transdermal Patch 72 Hour 100 MCG/HR, 50 MCG/HR, 75 MCG/HR*, *HYDROmorphone HCl ER Oral Tablet Extended Release 24 Hour 32 MG*, *Morphine Sulfate ER Beads Oral Capsule Extended Release 24 Hour 120 MG*, *Morphine Sulfate ER Oral Capsule Extended Release 24 Hour 100 MG*, *Morphine Sulfate ER Oral Tablet Extended Release 100 MG, 200 MG, 60 MG*, *oxyMORphone HCl ER Oral Tablet Extended Release 12 Hour 20 MG, 30 MG*, *OxyMORphone HCl ER Oral Tablet Extended Release 12 Hour 40 MG*, *traMADol HCl ER Oral Tablet Extended Release 24 Hour 200 MG, 300 MG*

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
ALVESCO INHALATION AEROSOL SOLUTION 160 MCG/ACT, 80 MCG/ACT, **PLEGRIDY INTRAMUSCULAR**, **PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR**, **PLEGRIDY STARTER PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE**, **PLEGRIDY SUBCUTANEOUS SOLUTION AUTO-INJECTOR**, **PLEGRIDY SUBCUTANEOUS SOLUTION PREFILLED SYRINGE**, **SOVALDI**, **ZEPATIER**

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
MULTAQ

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
NUEDEXTA

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
NURTEC

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information
Documentation that the medication will be used for the acute treatment of migraine with or without aura in adults AND member has tried and failed two triptan therapies OR Documentation that the medication will be used for the prevention of migraine with or without aura in adults AND member has tried and failed two preventative medication alternatives

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria
Reauthorization requires documentation of medication efficacy.

Drugs
OMNIPOD 5 DEXG7G6 INTRO GEN 5, **OMNIPOD 5 DEXG7G6 PODS GEN 5**, **OMNIPOD 5 LIBRE2 G6 INTRO G5**, **OMNIPOD 5 LIBRE2 PLUS G6 PODS**, **OMNIPOD DASH INTRO (GEN 4)**, **OMNIPOD DASH PDM (GEN 4)**, **OMNIPOD DASH PODS (GEN 4)**, **OMNIPOD POD PALS**

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information
Initial therapy: 1) Member has a diagnosis of Type 1 Diabetes OR 2) Member has a diagnosis of Type 2 Diabetes AND A) Member takes 3 or more insulin injections a day (OR is currently on an insulin pump) AND B) Member checks blood glucose 3 or more times a day (OR is currently on a CGM device).

Age Restriction
None

Prescriber Restriction
Endocrinologist

Coverage Duration
12 months

Other Criteria
If request is for more than 10 pods per 30 days additional documentation is required to provide clinical rationale for higher quantity

Drugs
cloBAZam Oral Suspension 2.5 MG/ML, *cloBAZam Oral Tablet*

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
CREON, **VIOKACE**, **ZENPEP ORAL CAPSULE DELAYED RELEASE PARTICLES 10000-32000 UNIT, 15000-47000 UNIT, 20000-63000 UNIT, 25000-79000 UNIT, 3000-10000 UNIT, 40000-126000 UNIT, 5000-24000 UNIT**

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

RETINOIDS

Drugs
Adapalene External Cream, *Adapalene External Gel*, *Tazarotene External Cream 0.1 %*, **TAZORAC EXTERNAL CREAM 0.05 %**, **TAZORAC EXTERNAL GEL**, *Tretinoin External*, *Tretinoin Microsphere External Gel 0.1 %*, *Tretinoin Microsphere Pump External Gel 0.04 %*

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
REVLIMID ORAL CAPSULE 10 MG, 15 MG, 2.5 MG, 20 MG, 25 MG, 5 MG

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Pregnancy (category X)

Required Medical Information
Diagnosis of one of the following: A) Multiple myeloma used in combination with dexamethasone, or B) Diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk myelodysplastic syndromes associated with a deletion 5q cytogenetic abnormality with or without additional cytogenetic abnormalities, or C) Mantle cell lymphoma and patient's disease has relapsed or progressed after trying at least two prior therapies (Velcade and one of the following: bendamustine, cladribine, fludarabine, rituximab) AND patient is enrolled in the Revlimid REMS Program.

Age Restriction
18 years and older

Prescriber Restriction
Hematologist/oncologist. Registered in Revlimid REMS.

Coverage Duration
3 Months

Other Criteria

Drugs
REVUFORJ

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
End of benefit year

Other Criteria

Drugs
ROZLYTREK

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information
Documentation of: A)metastatic non-small cell lung cancer (NSCLC) whose tumors are ROS1-positive OR B) solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion without a known acquired resistance mutation AND are metastatic or where surgical resection is likely to result in severe morbidity AND have either progressed following treatment or have no satisfactory alternative therapy.

Age Restriction
12 years of age or older

Prescriber Restriction
Oncology

Coverage Duration
3 months

Other Criteria

Drugs
Abiraterone Acetate Oral Tablet 250 MG, 500 MG, **ACTEMRA ACTPEN**, **ACTEMRA SUBCUTANEOUS**, **ACTIMMUNE**, **ADEMPAS**, **ALECENSA**, *Ambrisentan*, **APOKYN SUBCUTANEOUS SOLUTION CARTRIDGE**, **ARANESP (ALBUMIN FREE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML**, **ARANESP (ALBUMIN FREE) INJECTION SOLUTION PREFILLED SYRINGE**, **ARCALYST**, *azaCITIDine*, **BETASERON SUBCUTANEOUS KIT**, *Bexarotene*, *Bosentan Oral Tablet*, **BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG**, **CAPRELSA ORAL TABLET 100 MG, 300 MG**, *Carglumic Acid Oral Tablet Soluble*, **CAYSTON**, **CERDELGA**, *Cinacalcet HCl Oral Tablet 30 MG, 60 MG, 90 MG*, **CINRYZE**, **COMETRIQ (100 MG DAILY DOSE) ORAL KIT 80 & 20 MG**, **COMETRIQ (140 MG DAILY DOSE) ORAL KIT 3 X 20 MG & 80 MG**, **COMETRIQ (60 MG DAILY DOSE)**, **COPAXONE SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 20 MG/ML, 40 MG/ML**, **COTELLIC**, **CYSTAGON**, **CYSTARAN**, *Dalfampridine ER*, *Decitabine*, *Deferiprone*, *Dimethyl Fumarate Oral Capsule Delayed Release 120 MG, 240 MG*, *Dimethyl Fumarate Starter Pack Oral Capsule Delayed Release Therapy Pack*, **ELIGARD**, *Eltrombopag Olamine Oral Tablet 12.5 MG, 25 MG, 50 MG, 75 MG*, **EPCLUSA**, *Epoprostenol Sodium*, **ERBITUX**, **ERIVEDGE**, **ERLEADA ORAL TABLET 60 MG**, *Erlotinib HCl Oral Tablet 100 MG, 150 MG, 25 MG*, **ESBRIET ORAL CAPSULE**, **ESBRIET ORAL TABLET 267 MG, 801 MG**, *Everolimus Oral Tablet 2.5 MG, 5 MG, 7.5 MG*, **FERRIPROX ORAL SOLUTION**, **FERRIPROX TWICE-A-DAY**, *Fingolimod HCl*, **GAZYVA**, **HARVONI**, **HEMLIBRA SUBCUTANEOUS SOLUTION 105 MG/0.7ML, 150 MG/ML, 30 MG/ML, 60 MG/0.4ML**, **HETLIOZ**, **HYQVIA**, **IBRANCE**, *Icatibant Acetate Subcutaneous Solution Prefilled Syringe*, **ICLUSIG**, **IDHIFA**, *Imatinib Mesylate Oral Tablet 100 MG, 400 MG*, **IMBRUVICA ORAL CAPSULE 140 MG, 70 MG**, **IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG**, **INCRELEX**, **INLYTA ORAL TABLET 1 MG, 5 MG**, **JAKAFI**, **KADCYLA**, **KALYDECO ORAL PACKET 25 MG, 50 MG, 75 MG**, **KALYDECO ORAL TABLET**, **KESIMPTA**, **KEYTRUDA INTRAVENOUS SOLUTION**, **KISQALI (200 MG DOSE)**, **KISQALI (400 MG DOSE)**, **KISQALI (600 MG DOSE)**, *Lapatinib Ditosylate*, **LENVIMA (10 MG DAILY DOSE)**, **LENVIMA (12 MG DAILY DOSE)**, **LENVIMA (14 MG DAILY DOSE)**, **LENVIMA (18 MG DAILY DOSE)**, **LENVIMA (20 MG DAILY DOSE)**, **LENVIMA (24 MG DAILY DOSE)**, **LENVIMA (4 MG DAILY DOSE)**, **LENVIMA (8 MG DAILY DOSE)**, *Leuprolide Acetate Injection*, **LORBRENA ORAL TABLET 100 MG, 25 MG**, **LUPRON DEPOT-PED (1-MONTH)**, **LUPRON DEPOT-PED (3-MONTH)**, **LYNPARZA ORAL TABLET**, **MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG**, **MEKINIST ORAL TABLET 0.5 MG, 2 MG**, **MIRCERA INJECTION SOLUTION PREFILLED SYRINGE 100 MCG/0.3ML, 150 MCG/0.3ML, 200 MCG/0.3ML, 30 MCG/0.3ML, 50 MCG/0.3ML, 75 MCG/0.3ML**, *mitoXANTRONE HCl*, **MYALEPT**, **NEXAVAR**, *Nitisinone Oral Capsule 10 MG, 2 MG, 5 MG*, **NIVESTYM**, **NUCALA SUBCUTANEOUS SOLUTION AUTO-INJECTOR**, **NUCALA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML**, **NUCALA SUBCUTANEOUS SOLUTION RECONSTITUTED**, *Octreotide Acetate Injection Solution 100 MCG/ML, 1000 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML*, **ODOMZO**, **ONCASPAR INJECTION**, **OPSUMIT**, **ORENITRAM**, **ORFADIN ORAL CAPSULE 20 MG**, **ORFADIN ORAL SUSPENSION**, **ORKAMBI ORAL PACKET 100-125 MG, 150-188 MG**, **ORKAMBI ORAL TABLET**, *PAZOPanib HCl*, **PEGASYS SUBCUTANEOUS SOLUTION 180 MCG/ML**, **PEGASYS SUBCUTANEOUS SOLUTION PREFILLED SYRINGE**, **POMALYST**, **PRALUENT SUBCUTANEOUS SOLUTION AUTO-INJECTOR**, **PROLASTIN-C INTRAVENOUS SOLUTION**, **PROLIA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE**, **PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG**, **REBIF REBIDOSE SUBCUTANEOUS SOLUTION AUTO-INJECTOR**, **REBIF REBIDOSE TITRATION PACK SUBCUTANEOUS SOLUTION AUTO-INJECTOR**, **REBIF SUBCUTANEOUS SOLUTION PREFILLED SYRINGE**, **REBIF TITRATION PACK SUBCUTANEOUS SOLUTION PREFILLED SYRINGE**, **REMODULIN INJECTION SOLUTION 100 MG/20ML, 20 MG/20ML, 200 MG/20ML, 50 MG/20ML**, **RETACRIT INJECTION SOLUTION 10000 UNIT/ML, 2000 UNIT/ML, 20000 UNIT/ML, 3000 UNIT/ML, 4000 UNIT/ML, 40000 UNIT/ML**, *Ribavirin Oral Capsule*, *Ribavirin Oral Tablet 200 MG*, **RYDAPT**, *Sapropterin Dihydrochloride Oral Packet*, *Sapropterin Dihydrochloride Oral Tablet*, **SIGNIFOR**, *Sildenafil Citrate Intravenous*, *Sildenafil Citrate Oral Tablet 20 MG*, **SIMPONI ARIA**, **SIMPONI SUBCUTANEOUS SOLUTION AUTO-INJECTOR**, **SIMPONI SUBCUTANEOUS SOLUTION PREFILLED SYRINGE**, *Sodium Phenylbutyrate Oral Powder 3 GM/TSP*, *Sodium Phenylbutyrate Oral Tablet*, **SOMATULINE DEPOT**, **SOMAVERT**, **SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG**, **STIVARGA**, *SUNItinib Malate*, **SYMDEKO**, **TAFINLAR ORAL CAPSULE**, **TARGRETIN EXTERNAL**, **TEMODAR INTRAVENOUS**, *Temozolomide*, *Tetrabenazine Oral Tablet 12.5 MG, 25 MG*, **THALOMID ORAL CAPSULE 100 MG, 50 MG**, *Tobramycin Inhalation Nebulization Solution 300 MG/5ML*, *Tolvaptan Oral Tablet*, **TRIKAFTA ORAL TABLET THERAPY PACK**, **TYMLOS**, **TYSABRI**, **TYVASO**, **TYVASO REFILL KIT**, **TYVASO STARTER KIT**, **UPTRAVI INTRAVENOUS**, **UPTRAVI ORAL TABLET 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG**, **UPTRAVI TITRATION**, **VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG**, **VENCLEXTA STARTING PACK**, **VENTAVIS**, *Vigabatrin*, **VITRAKVI ORAL CAPSULE 100 MG, 25 MG**, **VITRAKVI ORAL SOLUTION**, **VOSEVI**, **VOTRIENT**, **VUMERITY**, **XALKORI ORAL CAPSULE**, **XOLAIR SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 150 MG/ML, 75 MG/0.5ML**, **XOLAIR SUBCUTANEOUS SOLUTION RECONSTITUTED**, **XTANDI ORAL CAPSULE**, **ZELBORAF**, *Zoledronic Acid Intravenous Concentrate*, *Zoledronic Acid Intravenous Solution 5 MG/100ML*, **ZOLINZA**, **ZYDELIG**, **ZYKADIA ORAL TABLET**

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
SUCRAID

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
SYNAREL

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
Tadalafil (PAH), *Tadalafil Oral Tablet 2.5 MG, 5 MG*

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria
Medication used for Erectile Dysfunction are excluded from coverage.

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
methylTESTOSTERone Oral, *Testosterone Transdermal Gel 10 MG/ACT (2%), 25 MG/2.5GM (1%)*

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

TESTOSTERONE REPLACEMENT

Drugs
Testosterone Enanthate Intramuscular Solution

Covered Uses
All FDA-approved indications not otherwise excluded by Health Plan.

Exclusion Criteria
Male patients with normal or above normal testosterone levels (normal equal to 270-1070 ng/dl or 9.3-37 mmol), breast cancer in males, hypersensitivity to testosterone or any component of the product, pregnancy, known or suspected prostate cancer, use of the gel or patch in women

Required Medical Information
Statement indicating diagnosis of hypogonadism in men with pretreatment testosterone level below normal physiological value of 300 ng/dl or below normal reference level provided by the laboratory required.

Age Restriction
18 years or older

Prescriber Restriction

Coverage Duration
Through the benefit year

Other Criteria

Drugs
TRYNGOLZA

Covered Uses

Exclusion Criteria

Required Medical Information

Age Restriction
18 years of age or older

Prescriber Restriction
Endocrinologist

Coverage Duration
End of benefit year

Other Criteria

Drugs
VIIBRYD ORAL TABLET, *Vilazodone HCl*

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information
Documented trial of at least two generic antidepressants (e.g. bupropion, citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, paroxetine CR, sertraline, duloxetine, venlafaxine).

Age Restriction

Prescriber Restriction

Coverage Duration
Through end of benefit year

Other Criteria

Drugs
VIVITROL

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria

Required Medical Information
Diagnosis of 1 of the following: A) for the treatment of alcohol dependence in patients who are able to abstain from alcohol in an outpatient setting prior to initiation of treatment with Vivitrol. Patients should not be actively drinking at the time of initial Vivitrol administration or B) l is indicated for the prevention of relapse to opioid dependence, following opioid detoxification

Age Restriction
18 years of age or older

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

Drugs
VOQUEZNA

Covered Uses

Exclusion Criteria

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

Age Restriction

Prescriber Restriction

Coverage Duration
End of the Benefit Year

Other Criteria

Drugs
WEGOVY

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria
Wegovy is not covered for weight loss related indications

Required Medical Information
Documentation that the medication will be used to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke) in adults with established cardiovascular disease and either obesity or overweight. Established Cardiovascular disease is defined as prior myocardial infarction, prior stroke, or peripheral arterial disease.

Age Restriction

Prescriber Restriction
Must be prescribed by or in consultation with a cardiologist

Coverage Duration
Plan Year

Other Criteria

Drugs
Acyclovir External Ointment, **BARACLUDE ORAL SOLUTION**, **DIFICID**, **KERENDIA ORAL TABLET 10 MG, 20 MG**, *Levorphanol Tartrate Oral*, **NYVEPRIA**, *Oxiconazole Nitrate*, **REMICADE**, **SUNOSI**, **TOVIAZ**, **VERZENIO**, **XTANDI ORAL TABLET 40 MG, 80 MG**, **ZEPOSIA**, **ZEPOSIA 7-DAY STARTER PACK**

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
XIFAXAN ORAL TABLET 200 MG, 550 MG

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
Bexarotene, **EPCLUSA**, **MAYZENT STARTER PACK**, *Pirfenidone Oral Tablet 267 MG, 801 MG*, **RESTASIS**, *SORAfenib Tosylate*

Covered Uses
Must be used for an FDA Approved Indication

Exclusion Criteria

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration
Plan Year

Other Criteria

Drugs
ZEPBOUND SUBCUTANEOUS SOLUTION 10 MG/0.5ML, 2.5 MG/0.5ML, 5 MG/0.5ML, 7.5 MG/0.5ML, ZEPBOUND SUBCUTANEOUS SOLUTION AUTO-INJECTOR

Covered Uses
All FDA-approved indications not otherwise excluded from Part D.

Exclusion Criteria
Zepbound is not covered for weight loss related indications. Obesity is an excluded indication.

Required Medical Information
Obstructive Sleep Apnea (OSA): The patient must 1) Have a BMI of 30 or higher AND 2) Have a documented sleep study confirming the diagnosis of OSA AND 3) Documentation showing the patient has failed managing OSA with a CPAP device AND 4) Confirmation of moderate to severe sleep apnea as defined by an Apnea-hypopnea index (AHI) of 15 or greater.

Age Restriction

Prescriber Restriction

Coverage Duration
12 months

Other Criteria

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