

Aldurazyme (laronidase)

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

ANTIFUNGAL

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

APTIOM

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

COSENTYX (300 MG DOSE), COSENTYX INTRAVENOUS, COSENTYX SENSOREADY (300 MG), COSENTYX SENSOREADY PEN SUBCUTANEOUS SOLUTION AUTO-INJECTOR 150 MG/ML, COSENTYX SUBCUTANEOUS, COSENTYX UNOREADY, 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 80 MG/ML, TREMFYA ONE-PRESS, TREMFYA SUBCUTANEOUS SOLUTION PREFILLED SYRINGE 100 MG/ML, XELJANZ ORAL SOLUTION, XELJANZ ORAL TABLET, XELJANZ XR

Covered Uses

Please reference the Select Autoimmune Drugs criteria document posted on [hf.org](https://www.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

BRIVIACT

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

CAMPRAL

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

capecitabine (XELODA)

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

CHORIONIC GONADOTROPIN

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
CRENESSITY

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

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

CYSTADANE

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

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

DIFICID

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

DIPENTUM

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, or b. Oral corticosteroid dependent asthma with at least 1 month of oral corticosteroid use within the last 3 months AND 2. Inadequate control of asthma symptoms after a minimum of 3 months of use of one of the following: a. Inhaled corticosteroids & long acting beta agonist, or b. Inhaled corticosteroids & long acting muscarinic antagonist. OR C) chronic rhinosinusitis with nasal polyposis.

Age Restriction

patients 6 years of age and older for atopic dermatitis, 12 years of age and older for asthma, and adults for chronic rhinosinusitis with nasal polyposis.

Prescriber Restriction

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

EXELON

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, 620 MCG/2.48ML*, 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

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

Drugs

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

Required Medical Information

Age Restriction

Prescriber Restriction

Coverage Duration

Through end of benefit year

Other Criteria

Drugs

NORDITROPIN FLEXPPO 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

IMBRUVICA (Ibrutinib)

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

ISOTRETINOIN

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

LIDODERM

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

MULTAQ

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 PLUS G6, 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

PANCRELIPASE

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

REGRANEX

Drugs
REGRANEX

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

REVLIMID (Lenalidomide)

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, 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, 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 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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

SUCRAID

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

TESTOSTERONE

Drugs

methy/TESTOSTERone 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

VIIBRYD (vilazodone)

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) I 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 inhibitor (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**, *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

XIFAXAN

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

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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<i>Phenoxybenzamine HCl Oral</i>	17	<i>Rivastigmine Tartrate</i>	27	<i>Tazarotene External Cream 0.1 %</i>	49
<i>Pirfenidone Oral Tablet 267 MG,</i>		RIVFLOZA	28	TAZORAC EXTERNAL CREAM	
<i>801 MG</i>	66	ROZLYTREK	52	0.05 %	49
PLEGRIDY INTRAMUSCULAR	41	RYBELSUS	30	TAZORAC EXTERNAL GEL	49
PLEGRIDY STARTER PACK		RYDAPT	53	TEMODAR INTRAVENOUS	53
SUBCUTANEOUS SOLUTION		SANCUSO	17	<i>Temozolomide</i>	53
AUTO-INJECTOR	41	<i>Sapropterin Dihydrochloride Oral</i>		<i>Teriparatide Subcutaneous</i>	
PLEGRIDY STARTER PACK		<i>Packet</i>	53	<i>Solution Pen-Injector 560</i>	
SUBCUTANEOUS SOLUTION		<i>Sapropterin Dihydrochloride Oral</i>		<i>MCG/2.24ML, 620 MCG/2.48ML</i>	28
PREFILLED SYRINGE	41	<i>Tablet</i>	53	<i>Testosterone Enanthate</i>	
PLEGRIDY SUBCUTANEOUS		SAVELLA	17	<i>Intramuscular Solution</i>	58
SOLUTION AUTO-INJECTOR	41	SAVELLA TITRATION PACK	17	<i>Testosterone Transdermal Gel 10</i>	
PLEGRIDY SUBCUTANEOUS		SIGNIFOR	53	<i>MG/ACT (2%), 25 MG/2.5GM (1%)</i>	57
SOLUTION PREFILLED SYRINGE	41	<i>Sildenafil Citrate Intravenous</i>	53	<i>Tetrabenazine Oral Tablet 12.5</i>	
POMALYST	53	<i>Sildenafil Citrate Oral Tablet 20 MG</i>	53	<i>MG, 25 MG</i>	53
<i>Potassium Chloride Oral Solution</i>		SIMPONI ARIA	53	THALOMID ORAL CAPSULE 100	
<i>20 MEQ/15ML (10%), 40</i>		SIMPONI SUBCUTANEOUS		MG, 50 MG	53
<i>MEQ/15ML (20%)</i>	17	SOLUTION AUTO-INJECTOR	53	<i>Tobramycin Inhalation Nebulization</i>	
PRALUENT SUBCUTANEOUS		SIMPONI SUBCUTANEOUS		<i>Solution 300 MG/4ML</i>	17
SOLUTION AUTO-INJECTOR	53	SOLUTION PREFILLED SYRINGE	53	<i>Tobramycin Inhalation Nebulization</i>	
PROLASTIN-C INTRAVENOUS		SIRTURO ORAL TABLET 100 MG	17	<i>Solution 300 MG/5ML</i>	53
SOLUTION	53	SKYRIZI INTRAVENOUS	8	<i>Tolvaptan Oral Tablet</i>	53
PROLIA SUBCUTANEOUS		SKYRIZI PEN	8	TOVIAZ	64
SOLUTION PREFILLED SYRINGE	53	SKYRIZI SUBCUTANEOUS		<i>traMADol HCl ER Oral Tablet</i>	
PROMACTA ORAL TABLET 12.5		SOLUTION CARTRIDGE	8	<i>Extended Release 24 Hour 200</i>	
MG, 25 MG, 50 MG, 75 MG	53	SKYRIZI SUBCUTANEOUS		<i>MG, 300 MG</i>	40
<i>Pyrimethamine Oral</i>	22	SOLUTION PREFILLED SYRINGE ..	8	TREMFYA ONE-PRESS	8
REBIF REBIDOSE		<i>Sodium Phenylbutyrate Oral</i>		TREMFYA SUBCUTANEOUS	
SUBCUTANEOUS SOLUTION		<i>Powder 3 GM/ITSP</i>	53	SOLUTION PREFILLED SYRINGE	
AUTO-INJECTOR	53	<i>Sodium Phenylbutyrate Oral Tablet</i>	53	100 MG/ML	8
REBIF REBIDOSE TITRATION		SOMATULINE DEPOT	53	<i>Tretinoin External</i>	49
PACK SUBCUTANEOUS		SOMAVERT	53	<i>Tretinoin Microsphere External Gel</i>	
SOLUTION AUTO-INJECTOR	53	<i>SORafenib Tosylate</i>	66	<i>0.1 %</i>	49
REBIF SUBCUTANEOUS		SOVALDI	41	<i>Tretinoin Microsphere Pump</i>	
SOLUTION PREFILLED SYRINGE	53	SPRYCEL ORAL TABLET 100		<i>External Gel 0.04 %</i>	49
REBIF TITRATION PACK		MG, 140 MG, 20 MG, 50 MG, 70		TRIKAFTA ORAL TABLET	
SUBCUTANEOUS SOLUTION		MG, 80 MG	53	THERAPY PACK	53
PREFILLED SYRINGE	53	STELARA INTRAVENOUS	8	TRULICITY SUBCUTANEOUS	
REGRANEX	48	STELARA SUBCUTANEOUS		SOLUTION AUTO-INJECTOR	30
REMICADE	64	SOLUTION 45 MG/0.5ML	8	TRUQAP ORAL TABLET 200 MG ..	28
REMODULIN INJECTION		STELARA SUBCUTANEOUS		TRYNGOLZA	59
SOLUTION 100 MG/20ML, 20		SOLUTION PREFILLED SYRINGE		TYMLOS	53
MG/20ML, 200 MG/20ML, 50		45 MG/0.5ML, 90 MG/ML	8	TYSABRI	53
MG/20ML	53	STIVARGA	53	TYVASO	53
RESTASIS	66	SUCRAID	55	TYVASO REFILL KIT	53
RETACRIT INJECTION		<i>SUNITinib Malate</i>	53	TYVASO STARTER KIT	53
SOLUTION 10000 UNIT/ML, 2000		SUNOSI	64	UPTRAVI INTRAVENOUS	53
UNIT/ML, 20000 UNIT/ML, 3000		SYMDEKO	53	UPTRAVI ORAL TABLET 1000	
UNIT/ML, 4000 UNIT/ML, 40000		SYNAGIS	28	MCG, 1200 MCG, 1400 MCG,	
UNIT/ML	53	SYNAREL	56	1600 MCG, 200 MCG, 400 MCG,	
REVLIMID ORAL CAPSULE 10		<i>Tadalafil (PAH)</i>	18	600 MCG, 800 MCG	53
MG, 15 MG, 2.5 MG, 20 MG, 25		<i>Tadalafil Oral Tablet 2.5 MG, 5 MG</i> ..	17	UPTRAVI TITRATION	53
MG, 5 MG	50	TAFINLAR ORAL CAPSULE	53	VELSIPITY	28
REVUFORJ	51	TALTZ SUBCUTANEOUS		VEMLIDY	17
REXULTI	17	SOLUTION AUTO-INJECTOR	8		

VENCLEXTA ORAL TABLET 10	
MG, 100 MG, 50 MG	53
VENCLEXTA STARTING PACK	53
VENTAVIS	53
VERZENIO	64
<i>Vigabatrin</i>	53
VIIBRYD ORAL TABLET	60
<i>Vilazodone HCl</i>	60
VIMPAT INTRAVENOUS	17
VIMPAT ORAL SOLUTION	17
VIOKACE	47
VITRAKVI ORAL CAPSULE 100	
MG, 25 MG	53
VITRAKVI ORAL SOLUTION	53
VIVITROL	61
VOQUEZNA	62
<i>Voriconazole Oral</i>	4
VOSEVI	53
VOTRIENT	53
VUMERITY	53
WAINUA	28
WEGOVY	63
XALKORI ORAL CAPSULE	53
XELJANZ ORAL SOLUTION	8
XELJANZ ORAL TABLET	8
XELJANZ XR	8
XIFAXAN ORAL TABLET 200	
MG, 550 MG	65
XOLAIR SUBCUTANEOUS	
SOLUTION PREFILLED SYRINGE	
150 MG/ML, 75 MG/0.5ML	53
XOLAIR SUBCUTANEOUS	
SOLUTION RECONSTITUTED	53
XTANDI ORAL CAPSULE	53
XTANDI ORAL TABLET 40 MG,	
80 MG	64
ZELBORAF	53
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	47
ZEPATIER	41
ZEPBOUND	67
ZEPOSIA	64
ZEPOSIA 7-DAY STARTER PACK	64
<i>Zoledronic Acid Intravenous</i>	
<i>Concentrate</i>	53
<i>Zoledronic Acid Intravenous</i>	
<i>Solution 5 MG/100ML</i>	53
ZOLINZA	53
ZYDELIG	53
ZYKADIA ORAL TABLET	53