2020 Prior Authorization Criteria

Updated 12/01/2020

ABIRATERONE

Products Affected

- Abiraterone Acetate
- Zytiga Oral Tablet 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Node-positive (N1), non-metastatic (M0) prostate cancer

ACITRETIN

Products Affected

- Acitretin

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Prevention of non-melanoma skin cancers in high risk individuals, Lichen planus, Keratosis follicularis (Darier Disease).

ACTIMMUNE

Products Affected

- Actimmune

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Mycosis fungoides, Sezary syndrome, atopic dermatitis.

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For pulmonary arterial hypertension (PAH) (WHO Group 1): PAH was confirmed by right heart catheterization. For chronic thromboembolic pulmonary hypertension (CTEPH) (WHO Group 4): Patient has persistent or recurrent CTEPH after pulmonary endarterectomy (PEA), OR patient has inoperable CTEPH with the diagnosis confirmed by right heart catheterization AND by computed tomography (CT), magnetic resonance imaging (MRI), or pulmonary angiography. For new starts only (excluding recurrent/persistent CTEPH after PEA): 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 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 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AFINITOR

Products Affected

- Afinitor Disperz
- Afinitor Oral Tablet 10 MG
- Everolimus Oral Tablet 2.5 MG, 5 MG, 7.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For breast cancer: 1) The disease is recurrent or metastatic hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, and 2) The requested medication is prescribed in combination with exemestane, fulvestrant, or tamoxifen, and 3) The patient has received endocrine therapy within 1 year. For renal cell carcinoma: 1) The disease is relapsed, metastatic or unresectable, and 2) For disease that is of predominantly clear cell histology, disease has progressed on prior therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Classical Hodgkin lymphoma, thymomas and thymic carcinomas, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, soft tissue sarcoma subtypes: perivascular epithelioid cell tumors (PEComa), lymphangioleiomyomatosis, gastrointestinal stromal tumors, neuroendocrine tumor of the thymus, thyroid carcinoma (papillary, Hurthle cell, and follicular), endometrial carcinoma

AIMOVIG

Products Affected

- Aimovig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) 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, OR 2) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 3) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial 3 months, Reauthorization Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALDURAZYME

Products Affected

- Aldurazyme

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For mucopolysaccharidosis I: diagnosis was confirmed by an enzyme assay demonstrating a deficiency of alpha-L-iduronidase enzyme activity or by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALECENSA

Products Affected

- Alecensa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer, brain metastases from ALK-positive non-small cell lung cancer.

ALOSETRON

Products Affected

- Alosetron HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for a biological female or a person that self-identifies as a female with a diagnosis of severe diarrhea-predominant irritable bowel syndrome (IBS) AND 2) Chronic IBS symptoms lasting at least 6 months AND 3) Gastrointestinal tract abnormalities have been ruled out AND 4) Inadequate response to conventional therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALPHA1-PROTEINASE INHIBITOR

Products Affected

- Aralast NP Intravenous Solution Reconstituted 1000 MG, 500 MG
- Prolastin-C
- Zemaira

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For alpha1-proteinase inhibitor deficiency: Patient must have 1) clinically evident emphysema, 2) pretreatment serum alpha1-proteinase inhibitor level less than 11 micromol/L (80 mg/dL by radial immunodiffusion or 50 mg/dL by nephelometry), and 3) pretreatment post-bronchodilation forced expiratory volume in 1 second (FEV1) greater than or equal to 25 percent and less than or equal to 80 percent of predicted.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For brain metastases from NSCLC: disease is ALK-positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive non-small cell lung cancer (NSCLC), brain metastases from NSCLC.

ANADROL

Products Affected

- Anadrol-50

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Cachexia associated with AIDS (HIV-wasting)

APOKYN

Products Affected

- Apokyn Subcutaneous Solution Cartridge

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For prevention of gout flares in members initiating or continuing urate-lowering therapy (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 non-steroidal anti-inflammatory drugs and colchicine, AND 3) concurrent use with urate-lowering therapy. For prevention of gout flares in members initiating or continuing urate-lowering therapy (continuation): 1) member 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.
Age Restrictions	
Prescriber Restrictions	
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	Prevention of gout flares in patients initiating or continuing urate-lowering therapy.

ARMODAFINIL

Products Affected

- Armodafinil

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is Shift Work Disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ATYPICAL ANTIPSYCHOTICS

Products Affected

- Fanapt
- Fanapt Titration Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Coverage will be denied if request is for an indication excluded from Part D.
Indications	All FDA-approved Indications.
Off Label Uses	

AUSTEDO

Products Affected

- Austedo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AVASTIN

Products Affected

- Avastin

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
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	Breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity.

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

B VS. D

Products Affected

- Abelcet
- Abraxane
- Acetylcysteine Inhalation
- Acyclovir Sodium Intravenous Solution
- Adriamycin Intravenous Solution
- Albuterol Sulfate Inhalation
- Alimta
- AmBisome
- Aminosyn II Intravenous Solution 10 %
- Aminosyn-PF Intravenous Solution 7 %
- Amphotericin B Intravenous
- Aprepitant
- AzaCITIDine
- azaTHIOprine Oral
- Bendeka
- Brovana
- Budesonide Inhalation Suspension 0.25 MG/2ML, 0.5 MG/2ML
- Calcitonin (Salmon)
- Calcitriol Intravenous Solution 1 MCG/ML
- Calcitriol Oral
- CARBOplatin Intravenous Solution
- Cinacalcet HCl
- CISplatin Intravenous Solution 100 MG/100ML, 200 MG/200ML, 50 MG/50ML
- Clinimix/Dextrose (4.25/10)
- Clinimix/Dextrose (4.25/5)
- Clinimix/Dextrose (5/15)
- Clinimix/Dextrose (5/20)
- Clinisol SF
- Clinolipid
- Cromolyn Sodium Inhalation
- Cyclophosphamide Injection
- Cyclophosphamide Intravenous
- Cyclophosphamide Oral Capsule
- CycloSPORINE Intravenous
- CycloSPORINE Modified
- CycloSPORINE Oral Capsule
- Cytarabine Injection Solution
- Depo-Provera Intramuscular Suspension 400 MG/ML
- Diphtheria-Tetanus Toxoids DT
- DOCEtaxel CONCENTRATE 80 MG/4ML Intravenous
- DOCEtaxel Intravenous Concentrate 160 MG/8ML, 200 MG/10ML
- DOCEtaxel Intravenous Concentrate 20 MG/ML, 80 MG/4ML
- DOCEtaxel Intravenous Solution 160 MG/16ML, 20 MG/2ML
- DOCEtaxel Intravenous Solution 80 MG/8ML
- DOCEtaxel Solution 160 MG/16ML Intravenous
- DOCEtaxel Solution 20 MG/2ML Intravenous
- DOCEtaxel SOLUTION 80 MG/8ML Intravenous
- Doxercalciferol Oral
- DOXOrubicin HCl Intravenous Solution
- DOXOrubicin HCl Liposomal
- Dronabinol
- Emend Oral Suspension Reconstituted
- Engerix-B Injection
- EpiRUBicin HCl Intravenous Solution 200 MG/100ML, 50 MG/25ML
- Etoposide Intravenous Solution 100 MG/5ML, 500 MG/25ML
- Everolimus Oral Tablet 0.25 MG, 0.5 MG, 0.75 MG
- Fluorouracil Intravenous
- FreAmine HBC
- FreAmine III Intravenous Solution 10 %
- Fulvestrant
- GamaSTAN S/D
- Ganciclovir Sodium Intravenous Solution Reconstituted
- Gemcitabine HCl Intravenous Solution 1 GM/26.3ML, 2 GM/52.6ML, 200 MG/5.26ML
- Gemcitabine HCl Intravenous Solution Reconstituted
- Gengraf Oral Capsule 100 MG, 25 MG
- Gengraf Oral Solution
- Granisetron HCl Oral
- Heparin Sodium (Porcine) Injection Solution 1000 UNIT/ML, 10000 UNIT/ML, 20000 UNIT/ML, 5000

UNIT/ML
- Hepatamine
- HumuLIN R U-500 (CONCENTRATED)
- HYDROmorphone HCl PF Injection Solution 10 MG/ML, 50 MG/5ML, 500 MG/50ML
- Ibandronate Sodium
- Imovax Rabies
- Intralipid Intravenous Emulsion 20 %
- Intralipid Intravenous Emulsion 30 %
- Intron A
- Ipratropium Bromide Inhalation
- Ipratropium-Albuterol
- Irinotecan HCl
- Kadcyla
- Leucovorin Calcium Injection Solution 500 MG/50ML
- Leucovorin Calcium Injection Solution Reconstituted
- Levalbuterol HCl Inhalation
- LevOCARNitine Oral Solution
- LevOCARNitine Oral Tablet
- Lidocaine HCl (PF) Injection Solution 0.5 %, 1 %, 1.5 %
- Lidocaine HCl Injection Solution 0.5 %, 1 %, 2 %
- Methotrexate Sodium (PF) Injection Solution 1 GM/40ML, 250 MG/10ML, 50 MG/2ML
- Methotrexate Sodium Injection Solution 250 MG/10ML, 50 MG/2ML
- Methotrexate Sodium Injection Solution Reconstituted
- Morphine Sulfate (PF) Injection Solution 10 MG/ML, 2 MG/ML, 4 MG/ML, 5 MG/ML, 8 MG/ML
- Morphine Sulfate (PF) Intravenous Solution 10 MG/ML, 4 MG/ML
- Morphine Sulfate (PF) Intravenous Solution 2 MG/ML, 8 MG/ML
- Morphine Sulfate (PF) SOLUTION 10 MG/ML Intravenous
- Morphine Sulfate (PF) SOLUTION 4 MG/ML Intravenous
- Morphine Sulfate (PF) SOLUTION 8 MG/ML Intravenous
- Morphine Sulfate Intravenous Solution 1 MG/ML
- Mycophenolate Mofetil
- Mycophenolate Sodium
- NephrAmine
- Nulojix
- Nutrilipid
- Oxaliplatin Intravenous Solution 100 MG/20ML, 50 MG/10ML
- Oxaliplatin Intravenous Solution Reconstituted
- PACLitaxel Intravenous Concentrate 100 MG/16.7ML, 150 MG/25ML, 30 MG/5ML, 300 MG/50ML
- Pamidronate Disodium Intravenous Solution 30 MG/10ML, 90 MG/10ML
- Pamidronate Disodium Intravenous Solution 6 MG/ML
- Pamidronate Disodium Intravenous Solution Reconstituted
- Paricalcitol Oral
- Pentamidine Isethionate Inhalation
- Perforomist
- Plenamine
- Premasol Intravenous Solution 10 %
- Procalamine
- Prograf Oral Packet
- Prosol
- RabAvert
- Recombivax HB
- SandIMMUNE Oral Solution
- Sirolimus Oral
- Tacrolimus Oral
- Taxotere Intravenous Concentrate 80 MG/4ML
- TDVAX
- Tenivac
- Toposar Intravenous Solution 1 GM/50ML, 100 MG/5ML
- TPN Electrolytes Intravenous Concentrate
- Travasol
- Trexall
- TrophAmine Intravenous Solution 10 %
- vinCRIStine Sulfate Intravenous
- Vinorelbine Tartrate
- Xatmep
- Zoledronic Acid Intravenous Concentrate
- Zoledronic Acid Intravenous Solution
- Zortress

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	N/A
Other Criteria	This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.
Indications	All Medically-accepted Indications.
Off Label Uses	

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BANZEL

Products Affected

- Banzel

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	1 year of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BENLYSTA

Products Affected

- Benlysta

PA Criteria	Criteria Details
Exclusion Criteria	Severe active lupus nephritis. Severe active central nervous system lupus.
Required Medical Information	For systemic lupus erythematosus (SLE): 1) Patient is currently receiving standard therapy (e.g., corticosteroids, azathioprine, leflunomide, methotrexate, mycophenolate mofetil, hydroxychloroquine, non-steroidal anti-inflammatory drugs) for SLE OR 2) patient is not currently receiving standard therapy for SLE because patient tried and had an inadequate response or intolerance to standard therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BERINERT

Products Affected

- Berinert

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For hereditary angioedema (HAE): patient has hereditary angioedema 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, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BETASERON

Products Affected

- Betaseron Subcutaneous Kit

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BEXAROTENE

Products Affected

- Bexarotene
- Targretin External

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Mycosis fungoides, Sezary syndrome (capsules only), primary cutaneous CD30-positive T-cell lymphoproliferative disorder types: primary cutaneous anaplastic large cell lymphoma (capsules only) and lymphomatoid papulosis (capsules only), chronic or smoldering adult T-cell leukemia/lymphoma (gel only), primary cutaneous B-cell lymphoma types: primary cutaneous marginal zone lymphoma (gel only) and primary cutaneous follicle center lymphoma (gel only).

BOSENTAN

Products Affected

- Bosentan

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For pulmonary arterial hypertension (PAH) (WHO Group 1): Diagnosis was confirmed by right heart catheterization. For PAH new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BOSULIF

Products Affected

- Bosulif

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL): Diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML: 1) Patient received a hematopoietic stem cell transplant, OR 2) Patient has accelerated or blast phase CML, OR 3) Patient has chronic phase CML (includes newly diagnosed) and meets one of the following conditions: a) high or intermediate risk for disease progression, or b) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Relapsed or refractory Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL).

BRAFTOVI

Products Affected

- Braftovi Oral Capsule 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRIVIACT

Products Affected

- Briviact

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	4 years of age or older (tablets and oral solution).
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRUKINSA

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BUPRENORPHINE

Products Affected

- Buprenorphine HCl Sublingual

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for the treatment of opioid dependence AND 2) The patient is pregnant or breastfeeding, and the requested drug is being prescribed for induction therapy and/or subsequent maintenance therapy for opioid dependence treatment OR 3) The requested drug is being prescribed for induction therapy for transition from opioid use to opioid dependence treatment OR 4) The requested drug is being prescribed for maintenance therapy for opioid dependence treatment in a patient who is intolerant to naloxone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma: The disease is relapsed, unresectable, or metastatic. For non-small cell lung cancer: The disease is rearranged during transfection (RET) positive.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Non-small cell lung cancer

CALCIPOTRIENE

Products Affected

- Calcipotriene External Cream
- Calcipotriene External Ointment
- Calcipotriene External Solution
- Calcipotriene-Betameth Diprop External Suspension
- Calcitrene
- Enstilar

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for the treatment of psoriasis AND 2) The patient experienced an inadequate treatment response, intolerance, or contraindication to a generic topical steroid.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CAPRELSA

Products Affected

- Caprelsa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC: the requested medication is used for NSCLC with RET gene rearrangements.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell.

CARBAGLU

Products Affected

- Carbaglu

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For N-acetylglutamate synthase (NAGS) deficiency: Diagnosis of NAGS deficiency was confirmed by enzymatic or genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CAYSTON

Products Affected

- Cayston

PA Criteria	Criteria Details
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 Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CERDELGA

Products Affected

- Cerdelga

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing. The patient's CYP2D6 metabolizer status has been established using an FDA-cleared test. The patient is a CYP2D6 extensive metabolizer, an intermediate metabolizer, or a poor metabolizer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CEREZYME

Products Affected

- Cerezyme Intravenous Solution Reconstituted 400 UNIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Gaucher disease was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Type 3 Gaucher disease

CLOBAZAM

Products Affected

- CloBAZam

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CLOMIPRAMINE

Products Affected

- ClomiPRAMINE HCl Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for one of the following: the treatment of Obsessive-Compulsive Disorder (OCD) or Panic Disorder AND 2) The patient has experienced an inadequate treatment response, intolerance, or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI), mirtazapine OR 3) The requested drug is being prescribed for the treatment of Depression AND 4) The patient has experienced an inadequate treatment response, intolerance, or contraindication to one of the following: a generic selective serotonin reuptake inhibitor (SSRI), a generic serotonin and norepinephrine reuptake inhibitor (SNRI) , mirtazapine, bupropion
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Depression, Panic Disorder

CLORAZEPATE

Products Affected

- Clorazepate Dipotassium

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For adjunctive therapy in the management of partial seizures OR 3) Symptomatic relief in acute alcohol withdrawal OR 4) For the short-term relief of the symptoms of anxiety AND 5) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. 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.
Indications	All FDA-approved Indications.
Off Label Uses	

CLOZAPINE ODT

Products Affected

- CloZAPine Oral Tablet Dispersible

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

COMETRIQ

Products Affected

- Cometriq (100 MG Daily Dose) Oral Kit 80 & 20 MG
- Cometriq (140 MG Daily Dose) Oral Kit 3 x 20 MG & 80 MG
- Cometriq (60 mg Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC: The requested medication is used for NSCLC with RET gene rearrangements.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Non-small cell lung cancer (NSCLC), differentiated thyroid carcinoma: papillary, follicular, and Hurthle cell

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For melanoma (including brain metastases): 1) The disease is unresectable or metastatic, 2) The disease is positive for the BRAF V600E or V600K mutation, AND 3) The requested medication will be used in combination with vemurafenib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Brain metastases from melanoma

CYSTAGON

Products Affected

- Cystagon

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For nephropathic cystinosis: Diagnosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CYSTARAN

Products Affected

- Cystaran

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For treatment of corneal cystine crystal accumulation in patients with cystinosis: 1) Diagnosis of cystinosis was confirmed by the presence of increased cystine concentration in leukocytes or by genetic testing, and 2) The patient has corneal cystine crystal accumulation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DALFAMPRIDINE

Products Affected

- Dalfampridine ER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For multiple sclerosis new starts: Prior to initiating therapy, patient demonstrates sustained walking impairment. For multiple sclerosis continuation of therapy: Patient must have experienced an improvement in walking speed or other objective measure of walking ability since starting the requested medication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DEFERASIROX

Products Affected

- Deferasirox Granules
- Deferasirox Oral Tablet
- Jadenu Oral Tablet 180 MG
- Jadenu Sprinkle

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DEMSER

Products Affected

- Demser
- metyroSINE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DESVENLAFAXINE

Products Affected

- Desvenlafaxine Succinate ER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following: a generic serotonin and norepinephrine reuptake inhibitor (SNRI), a generic selective serotonin reuptake inhibitor (SSRI), mirtazapine, bupropion
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DHE NASAL

Products Affected

- Dihydroergotamine Mesylate Nasal

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one triptan 5-HT1 receptor agonist
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DIAZEPAM

Products Affected

- Diazepam Oral Concentrate
- DiazePAM Oral Solution 5 MG/5ML
- diazePAM Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) For the management of anxiety disorders, the requested drug is being used with a selective serotonin reuptake inhibitor (SSRI) or serotonin-norepinephrine reuptake inhibitor (SNRI) until the antidepressant becomes effective for the symptoms of anxiety OR the patient has experienced an inadequate treatment response, intolerance or contraindication to a selective serotonin reuptake inhibitor (SSRI) or a serotonin-norepinephrine reuptake inhibitor (SNRI) OR 2) For symptomatic relief in acute alcohol withdrawal OR 3) For use as an adjunct for the relief of skeletal muscle spasms OR 4) For adjunctive therapy in the treatment of convulsive disorders OR 5) For the short-term relief of the symptoms of anxiety AND 6) The benefit of therapy with the prescribed medication outweighs the potential risk in a patient 65 years of age or older.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Short-term relief anxiety-1 Month, Anxiety Disorders-4 Months, All other Diagnoses-Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. 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
Indications	All FDA-approved Indications.
Off Label Uses	

DRIZALMA

Products Affected

- Drizalma Sprinkle

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient has tried duloxetine capsules or the patient is unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration)
Age Restrictions	GAD - 7 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Cancer pain, chemotherapy-induced neuropathic pain

EMGALITY

Products Affected

- Emgality

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for the preventive treatment of migraine in an adult patient AND 2) 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, OR 3) The patient experienced an inadequate treatment response with a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants, OR 4) The patient experienced an intolerance or has a contraindication that would prohibit a 4-week trial of any of the following: Antiepileptic drugs (AEDs), Beta-adrenergic blocking agents, Antidepressants OR 1) The requested drug is being prescribed for the treatment of episodic cluster headaches in an adult patient AND 2) The patient received the requested drug for at least 3 weeks of treatment and had a reduction in weekly cluster headache attack frequency from baseline OR 3) The patient experienced an inadequate treatment response, intolerance, or contraindication to a triptan medication (i.e., 5-HT1 receptor agonist).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial 3 months, Reauthorization Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EMSAM

Products Affected

- Emsam

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Patient experienced an inadequate treatment response, intolerance, or contraindication to any of the following antidepressants: bupropion, trazodone, mirtazapine, serotonin norepinephrine reuptake inhibitors (SNRIs), selective serotonin reuptake inhibitors (SSRIs), tricyclic or tetracyclic antidepressants OR 2) Patient is unable to swallow oral formulations.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENBREL

Products Affected

- Enbrel Mini
- Enbrel Subcutaneous Solution 25 MG/0.5ML
- Enbrel Subcutaneous Solution Prefilled Syringe
- Enbrel Subcutaneous Solution Reconstituted
- Enbrel SureClick Subcutaneous Solution Auto-Injector

PA Criteria	Criteria Details
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 (e.g., tofacitinib). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to MTX OR 2) Inadequate response or intolerance to a prior biologic DMARD. For active ankylosing spondylitis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For chronic moderate to severe plaque psoriasis (new starts only): 1) At least 5% 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 DMARD as first-line therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Severe, refractory hidradenitis suppurativa.

ENDARI

Products Affected

- Endari

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	5 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EPCLUSA

Products Affected

- Epclusa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For chronic 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, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EPO

Products Affected

- Procrit

PA Criteria	Criteria Details
Exclusion Criteria	Patients receiving chemotherapy with curative intent. Patients with myeloid cancer.
Required Medical Information	For all uses except surgery: Pretreatment (no erythropoietin treatment in previous month) hemoglobin (Hgb) is less than 10 g/dL (less than 9 g/dL for anemia in congested heart failure only). Additional requirements for primary MF, post-polycythemia vera MF, post-essential thrombocythemia MF: 1) Patient has symptomatic anemia. 2) For initial therapy, pretreatment serum erythropoietin level is less than 500mU/mL. For surgery: 1) Patient is scheduled for elective, noncardiac, nonvascular surgery. 2) Pretreatment Hgb is greater than 10 but not more than 13 g/dL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	16 weeks
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 (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). Coverage includes use in anemia in patients whose religious beliefs forbid blood transfusions. Requirements regarding Hgb values exclude values due to a recent transfusion. For reauthorizations (patient received erythropoietin in previous month): 1) For all uses except surgery, there is an increase in Hgb of at least 1 g/dL after at least 12 weeks of therapy. 2) For anemia in chronic kidney disease, MDS, CHF, RA, HIV, hepatitis C treatment, primary MF, post-polycythemia vera MF, post-essential thrombocythemia MF, or patients whose religious beliefs forbid blood transfusions: current Hgb is less than or equal to 12 g/dL. 3) For anemia due to myelosuppressive cancer chemotherapy: current Hgb is less than 11 g/dL.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	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), anemia in primary myelofibrosis (MF), post-polycythemia vera MF, and post-essential thrombocythemia MF. Cancer patients who are undergoing palliative treatment.

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
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 Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ESBRIET

Products Affected

- Esbriet

PA Criteria	Criteria Details
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 Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FABRAZYME

Products Affected

- Fabrazyme

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of Fabry disease was confirmed by an enzyme assay demonstrating a deficiency of alpha-galactosidase enzyme activity or by genetic testing, or the patient is a symptomatic obligate female carrier.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FARYDAK

Products Affected

- Farydak Oral Capsule 10 MG, 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FASENRA

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
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 at optimized doses: a) inhaled corticosteroid and b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained release theophylline). 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 Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FENTANYL PATCH

Products Affected

- FentaNYL Transdermal Patch 72 Hour 100 MCG/HR, 25 MCG/HR, 50 MCG/HR, 75 MCG/HR
- fentaNYL Transdermal Patch 72 Hour 12 MCG/HR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) 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 2) 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 3) 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 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FETZIMA

Products Affected

- Fetzima
- Fetzima Titration

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Patient experienced an inadequate treatment response, intolerance, or contraindication to two generic alternatives from the following drug classes: selective serotonin reuptake inhibitors (SSRIs) or serotonin-norepinephrine reuptake inhibitors (SNRIs).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FINTEPLA

Products Affected

- Fintepla

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FIRAZYR

Products Affected

- Icatibant Acetate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The requested drug is being used for the treatment 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 a) Patient tested positive for an F12, angiopoietin-1, or plasminogen gene mutation OR b) Patient has a family history of angioedema or the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FORTEO

Products Affected

- Forteo Subcutaneous Solution Pen-Injector

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following (1. or 2.): 1) A history of fragility fractures, OR 2) A pre-treatment T-score of less than or equal to -2.5 or osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -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 (e.g., injectable bisphosphonate or antiresorptive agent) OR c) Member 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) a pre-treatment T-score of less than or equal to -2.5, OR 3) osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment FRAX fracture probability. For glucocorticoid-induced osteoporosis: 1) 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 2) Patient has one of the following: a) a history of fragility fracture, OR b) a pre-treatment T-score of less than or equal to -2.5, OR c) osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -1) with a high pre-treatment FRAX fracture probability.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide)

PA Criteria	Criteria Details
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 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	

FYCOMPA

Products Affected

- Fycompa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Partial-onset seizures: 4 years of age or older, PRIMARY generalized tonic-clonic seizures: 12 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GATTEX

Products Affected

- Gattex

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For short bowel syndrome (SBS) initial therapy: Patient was 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 medication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GAVRETO

Products Affected

- Gavreto

PA Criteria	Criteria Details
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 Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Recurrent or advanced rearranged during transfection (RET) rearrangement-positive non-small cell lung cancer

GILENYA

Products Affected

- Gilenya Oral Capsule 0.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer (NSCLC): Patient meets either of the following: A) Patient has metastatic squamous NSCLC that progressed after platinum-based chemotherapy, or B) Patient has a known sensitizing EGFR mutation. For brain metastases from NSCLC, patient has a known sensitizing EGFR mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Brain metastases from non-small cell lung cancer.

GLATIRAMER

Products Affected

- Glatiramer Acetate
- Glatopa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	First clinical episode of multiple sclerosis.

GRALISE

Products Affected

- Gralise
- Gralise Starter

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GROWTH HORMONE

Products Affected

- Genotropin
- Genotropin MiniQuick

PA Criteria	Criteria Details
Exclusion Criteria	Pediatric patients with closed epiphyses (except in patients with PWS).
Required Medical Information	Pediatric GHD: 1) Younger than 2.5 yrs old, when applicable: a) Pre-treatment (pre-tx) height (ht) more than 2 SD below mean and slow growth velocity. 2) 2.5 yrs old or older: 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. Pediatric GHD: 1) Failed 2 stimulation tests (peak below 10 ng/mL) prior to starting treatment, OR 2) Pituitary/CNS disorder (eg, genetic defects, CNS tumors, congenital structural abnormalities) and pre-tx IGF-1 more than 2 SD below mean, OR 3) Patient is a neonate or was diagnosed with GHD as a neonate. TS: 1) Confirmed by karyotyping AND 2) Pre-treatment height is less than the 5th percentile for age. SGA: 1) Birth weight (wt) below 2500g at gestational age (GA) more 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. Adult GHD: 1) Failed 2 stimulation tests (peak below 5 ng/mL) or test with Macrilen (peak below 2.8 ng/ml) prior to starting tx, OR 2) Structural abnormality of the hypothalamus/pituitary AND 3 or more pituitary hormone deficiencies, OR 3) Childhood-onset GHD with congenital (genetic or structural) abnormality of the hypothalamus/pituitary/CNS, OR 4) Low pre-tx IGF-1 and failed 1 stimulation test prior to starting tx.
Age Restrictions	SGA: 2 years of age or older
Prescriber Restrictions	Endocrinologist, pediatric endocrinologist, pediatric nephrologist, infectious disease specialist, gastroenterologist/nutritional support specialist, geneticist.
Coverage Duration	Plan Year
Other Criteria	Renewal for pediatric GHD, TS, SGA, and adult GHD: patient is experiencing improvement.
Indications	All Medically-accepted Indications.
Off Label Uses	

HAEGARDA

Products Affected

- Haegarda

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For hereditary angioedema (HAE): The requested drug is being used for the prevention 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, angiopoietin-1, or plasminogen gene mutation OR 2) Patient has a family history of angioedema and the angioedema was refractory to a trial of antihistamine for at least one month.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HARVONI

Products Affected

- Harvoni

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For chronic 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, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
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	

HERCEPTIN

Products Affected

- Herceptin

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: 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	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.

HERCEPTIN HYLECTA

Products Affected

- Herceptin Hylecta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
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	

HERZUMA

Products Affected

- Herzuma

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: 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	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
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 both eyes, 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initiation: 6 Months, Renewal: Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK MEDICATION

Products Affected

- Cyproheptadine HCl Oral
- Digitek Oral Tablet 250 MCG
- Digox Oral Tablet 250 MCG
- Digoxin Oral Solution
- Digoxin Oral Tablet 250 MCG
- GuanFACINE HCl ER
- Scopolamine

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (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.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Indications	All FDA-approved Indications.
Off Label Uses	

HRM-ANTICONVULSANTS

Products Affected

- PHENobarbital Oral Elixir
- PHENobarbital Oral Tablet
- PHENobarbital Sodium Injection

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (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.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.
Indications	All FDA-approved Indications.
Off Label Uses	

HRM-ANTIPARKINSON

Products Affected

- Benztropine Mesylate Oral
- Trihexyphenidyl HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (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.) EPS (extrapyramidal symptoms): 1) The patient has not tried the non-HRM alternative drug amantadine AND 2) The patient has a contraindication to the non-HRM alternative drug amantadine AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) The patient has tried the non-HRM alternative drug amantadine AND 5) The patient experienced an inadequate treatment response OR intolerance to the non-HRM alternative drug amantadine AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. Parkinson's: 1) The patient has tried two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole have been tried. AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following non-HRM alternative drugs: amantadine, carbidopa/levodopa, pramipexole, or ropinirole AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

HRM-HYDROXYZINE

Products Affected

- HydrOXYzine HCl Oral Syrup
- hydrOXYzine HCl Oral Tablet
- hydrOXYzine Pamoate Oral Capsule 25 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (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 anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release have been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline, or venlafaxine extended-release AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) If being requested for pruritus, prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient.
Indications	All FDA-approved Indications.
Off Label Uses	

HRM-HYDROXYZINE INJ

Products Affected

- HydrOXYzine HCl Intramuscular

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (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.) Alcohol Withdrawal Syndrome: 1) The patient has not tried one of the following alternative drugs: clorazepate or lorazepam AND 2) The patient has a contraindication to one of the following alternative drugs: clorazepate or lorazepam AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) The patient has tried one of the following alternative drugs: clorazepate or lorazepam AND 5) The patient experienced an inadequate treatment response OR intolerance to one of the following alternative drugs: clorazepate or lorazepam AND 6) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient. Anxiety: 1) The patient has tried two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 2) The patient experienced an inadequate treatment response OR intolerance to two of the following alternative drugs: buspirone, duloxetine, escitalopram, sertraline or venlafaxine extended-release AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient OR 4) If being requested for nausea/vomiting, prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

HRM-HYPNOTICS

Products Affected

- Zolpidem Tartrate Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (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.) 1) The patient has a contraindication to two of the following non-HRM alternative drugs: doxepin (3mg or 6mg) and trazodone AND 2) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 3) One non-HRM alternative drug doxepin (3mg or 6mg) or trazodone has been tried AND 4) The patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM alternative drugs: doxepin (3mg or 6mg) or trazodone AND 5) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
Indications	All FDA-approved Indications.
Off Label Uses	

HRM-PROMETHAZINE

Products Affected

- Promethazine HCl Injection
- Promethazine HCl Oral Syrup
- Promethazine HCl Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (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.) Rhinitis: 1) The patient has tried one of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 2) The patient experienced an inadequate treatment response OR intolerance to one of the following non-HRM alternative drugs: levocetirizine, azelastine nasal, fluticasone nasal, or flunisolide nasal AND 3) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 4) The requested drug is being prescribed for urticaria AND 5) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 6) The drug is being requested for antiemetic therapy in postoperative patients or motion sickness AND 7) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient OR 8) The requested drug is being prescribed for any of the following: allergic conjunctivitis, dermatographism, allergic reaction to blood or plasma, sedation, adjunct therapy with analgesics for postoperative pain, angioedema, or adjunct therapy with epinephrine for anaphylaxis after acute symptoms are controlled AND 9) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweighs the potential risks for this patient.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

HRM-SKELETAL MUSCLE RELAXANTS

Products Affected

- Cyclobenzaprine HCl Oral Tablet 10 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	This Prior Authorization requirement only applies to patients 70 years of age or older. (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.) Prescriber must acknowledge that the benefit of therapy with this prescribed medication outweigh the potential risks for this patient.
Indications	All FDA-approved Indications.
Off Label Uses	

HUMIRA

Products Affected

- Humira Pediatric Crohns Start Subcutaneous Prefilled Syringe Kit 80 MG/0.8ML, 80 MG/0.8ML & 40MG/0.4ML
- Humira Pen Subcutaneous Pen-Injector Kit
- Humira Pen-CD/UC/HS Starter
- Humira Pen-Ps/UV/Adol HS Start
- Humira Subcutaneous Prefilled Syringe Kit

PA Criteria	Criteria Details
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 (e.g., tofacitinib). For moderately to severely active polyarticular juvenile idiopathic arthritis (new starts only): 1) Inadequate response, intolerance or contraindication to MTX OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% 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, b) Pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, c) Patient has severe psoriasis that warrants a biologic DMARD as first-line therapy. 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, aminosalicylates), OR 2) Intolerance or contraindication to conventional therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	

PA Criteria	Criteria Details
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Axial spondyloarthritis.

HYPNOTIC BENZODIAZEPINES

Products Affected

- Temazepam Oral Capsule 15 MG, 7.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This Prior Authorization requirement only applies to patients 65 years of age or older. (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.) 1) One non-HRM (non-High Risk Medication) alternative drug doxepin (3mg or 6mg) or trazodone has been tried AND 2) The patient experienced an inadequate treatment response OR intolerance to one non-HRM (non-High Risk Medication) alternative drug doxepin (3mg or 6mg) or trazodone OR 3) The patient has a contraindication to two non-HRM (non-High Risk Medication) alternative drugs doxepin (3mg or 6mg) and trazodone AND 4)The benefit of therapy with this prescribed medication outweighs the potential risk in a patient 65 years of age or older APPLIES TO GREATER THAN CUMULATIVE 90 DAYS OF THERAPY PER YEAR.
Indications	All FDA-approved Indications.
Off Label Uses	

IBRANCE

Products Affected

- Ibrance

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Well-differentiated/dedifferentiated liposarcoma.

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Follow-up therapy after hematopoietic stem cell transplant (HSCT) for CML and ALL patients.

IDHIFA

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IMATINIB

Products Affected

- Imatinib Mesylate

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For chronic myeloid leukemia (CML) or Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), 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 Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Desmoid tumors, pigmented villonodular synovitis/tenosynovial giant cell tumor (PVNS/TGCT), chordoma, melanoma, and AIDS-related Kaposi sarcoma.

IMBRUVICA

Products Affected

- Imbruvica

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For mantle cell lymphoma: 1) the requested drug will be used in a patient who has received at least one prior therapy, OR 2) the requested drug will be used in combination with rituximab as pretreatment to induction therapy with RHyperCVAD (cyclophosphamide, vincristine, doxorubicin, and dexamethasone) regimen. For gastric MALT lymphoma and non-gastric MALT lymphoma: 1) disease is recurrent, refractory, or progressive, AND 2) the requested drug will be used as second-line or subsequent therapy. For hairy cell leukemia: the requested drug will be used as a single agent for disease progression. For primary central nervous system lymphoma: the disease is relapsed or refractory disease. For nodal marginal zone lymphoma or splenic marginal zone lymphoma: 1) disease is refractory or progressive, AND 2) the requested drug will be used as second-line or subsequent therapy. For histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma: the requested drug will be used in patients who have received prior chemoimmunotherapy. For diffuse large B-cell lymphoma: 1) disease is progressive or refractory AND 2) 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 second-line or subsequent therapy for relapsed disease. For post-transplant lymphoproliferative disorders: 1) the disease is partially responsive, persistent, or progressive AND 2) the requested drug will be used in patients who have received prior chemoimmunotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Gastric mucosa-associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, hairy cell leukemia, and lymphoplasmacytic lymphoma, follicular lymphoma, primary central nervous system lymphoma, AIDS-related B-cell lymphoma, histologic transformation of marginal zone lymphoma to diffuse large B-cell lymphoma, diffuse large B-cell lymphoma, post-transplant lymphoproliferative disorders.

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For growth failure due to severe primary insulin-like growth factor-1 (IGF-1) deficiency or growth hormone gene deletion in patients who have developed neutralizing antibodies to growth hormone, must meet all of the following prior to beginning therapy with the requested drug (new starts only): 1) height 3 or more standard deviations below the mean for children of the same age and gender AND 2) basal IGF-1 level 3 or more standard deviations 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For renewal, patient is experiencing improvement.
Indications	All FDA-approved Indications.
Off Label Uses	

INGREZZA

Products Affected

- Ingrezza

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INLYTA

Products Affected

- Inlyta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma, the disease is relapsed, metastatic, or unresectable.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Papillary, Hurthle cell, or follicular thyroid carcinoma.

INQOVI

Products Affected

- Inqovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IR BEFORE ER

Products Affected

- Hysingla ER
- Methadone HCl Intensol
- Methadone HCl Oral Solution
- Methadone HCl Oral Tablet
- Morphine Sulfate ER Oral Tablet Extended Release
- Nucynta ER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) 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 2) 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 3) 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 4) The patient has been evaluated and the patient will be monitored for the development of opioid use disorder AND 5) The 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 severe continuous pain and the patient has received an immediate-release opioid for at least one week
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer (NSCLC) (including brain metastases from NSCLC), patient has a known sensitizing EGFR mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Brain metastases from non-small cell lung cancer.

ISOTRETINOIN

Products Affected

- Amnesteem
- Claravis
- ISOtretinoin Oral
- Myorisan
- Zenatane

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Refractory acne, 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.

ITRACONAZOLE

Products Affected

- Itraconazole Oral Capsule

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	If for the treatment of onychomycosis due to tinea, the diagnosis has been confirmed by a fungal diagnostic test.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Coccidioidomycosis, Cryptococcosis, Microsporidiosis, Penicilliosis, Sporotrichosis, Pityriasis versicolor/Tinea versicolor, Tinea corporis/Tinea cruris, Tinea capitis, Tinea manuum/Tinea pedis.

IVIG

Products Affected

- Bivigam Intravenous Solution 5 GM/50ML
- Flebogamma DIF Intravenous Solution 10 GM/100ML, 10 GM/200ML, 2.5 GM/50ML, 20 GM/200ML, 20 GM/400ML, 5 GM/100ML, 5 GM/50ML
- Gammagard
- Gammagard S/D Less IgA
- Gammaked Injection Solution 1 GM/10ML, 10 GM/100ML, 20 GM/200ML, 5 GM/50ML
- Gammaplex Intravenous Solution 10 GM/100ML, 10 GM/200ML, 20 GM/200ML, 20 GM/400ML, 5 GM/100ML, 5 GM/50ML
- Gamunex-C
- Octagam
- Panzyga
- Privigen

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For CLL: 1) serum IgG less than 500 mg/dL OR 2) a history of recurrent bacterial infections. For BMT/HSCT: 1) IVIG is requested within the first 100 days post-transplant OR 2) serum IgG less than 400 mg/dL. For pediatric 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 (corticosteroids or immunosuppressants) 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 PRCA: PRCA is secondary to parvovirus B19 infection. For management of immune checkpoint inhibitor-related nervous system adverse events: 1) Patient has experienced a moderate or severe adverse event to a PD-1 or PD-L1 inhibitor, 2) IVIG is requested to manage one or more of the following nervous system adverse event types: pneumonitis, myasthenia gravis, peripheral neuropathy, encephalitis or transverse myelitis, and 3) the offending medication is temporarily being held or has been discontinued.
Age Restrictions	For pediatric HIV infection: age 12 years or younger.
Prescriber Restrictions	
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.

PA Criteria	Criteria Details
Off Label Uses	

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For polycythemia vera: patients with inadequate response or intolerance to interferon therapy or hydroxyurea.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Low-risk, accelerated phase, or blast phase myelofibrosis

JUXTAPID

Products Affected

- Juxtapid Oral Capsule 10 MG, 20 MG, 30 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	UNDER CMS REVIEW
Required Medical Information	UNDER CMS REVIEW
Age Restrictions	UNDER CMS REVIEW
Prescriber Restrictions	UNDER CMS REVIEW
Coverage Duration	UNDER CMS REVIEW
Other Criteria	UNDER CMS REVIEW
Indications	UNDER CMS REVIEW
Off Label Uses	UNDER CMS REVIEW

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For cystic fibrosis: The patient has one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation.
Age Restrictions	4 months of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	The requested drug will not be used in combination with lumacaftor/ivacaftor or tezacaftor/ivacaftor.
Indications	All FDA-approved Indications.
Off Label Uses	

KANJINTI

Products Affected

- Kanjinti

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: 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	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.

KETOCONAZOLE

Products Affected

- Ketoconazole Oral

PA Criteria	Criteria Details
Exclusion Criteria	Acute or chronic liver disease. Current use with dofetilide, quinidine, pimozide, cisapride, methadone, disopyramide, dronedarone, ranolazine, ergot alkaloids, alprazolam or simvastatin.
Required Medical Information	1) Patient has one of the following diagnoses: blastomycosis, coccidioidomycosis, histoplasmosis, chromomycosis, or paracoccidioidomycosis, OR 2) The requested drug is being prescribed for a patient with Cushing's syndrome who cannot tolerate surgery or surgery has not been curative.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Cushing's syndrome.

KEYTRUDA

Products Affected

- Keytruda Intravenous Solution

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Epithelial ovarian cancer/fallopian tube cancer/primary peritoneal cancer, uveal melanoma, esophageal and esophagogastric junction cancers, Ewing's sarcoma, osteosarcoma, testicular cancer, endometrial carcinoma, anal carcinoma, adrenal gland tumors, penile cancer, central nervous system (CNS) brain metastases in patients with melanoma or non-small cell lung cancer (NSCLC), Non-Hodgkin's lymphoma, pancreatic adenocarcinoma, hepatobiliary cancers (extrahepatic cholangiocarcinoma, intrahepatic cholangiocarcinoma, gallbladder cancer).

KISQALI

Products Affected

- Kisqali (200 MG Dose)
- Kisqali (400 MG Dose)
- Kisqali (600 MG Dose)
- Kisqali Femara (400 MG Dose)
- Kisqali Femara (600 MG Dose)
- Kisqali Femara(200 MG Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For breast cancer: The requested drug is used in combination with an aromatase inhibitor, fulvestrant, or tamoxifen.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

KUVAN

Products Affected

- Kuvan
- Sapropterin Dihydrochloride

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For phenylketonuria: 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 a reduction in blood phenylalanine level of greater than or equal to 30 percent from baseline OR the patient has demonstrated an improvement in neuropsychiatric symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 2 months. All others: Plan Year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LENVIMA

Products Affected

- Lenvima (10 MG Daily Dose)
- Lenvima (12 MG Daily Dose)
- Lenvima (14 MG Daily Dose)
- Lenvima (18 MG Daily Dose)
- Lenvima (20 MG Daily Dose)
- Lenvima (24 MG Daily Dose)
- Lenvima (4 MG Daily Dose)
- Lenvima (8 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Medullary thyroid carcinoma

LETAIRIS

Products Affected

- Ambrisentan

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LIDOCAINE PATCHES

Products Affected

- Lidocaine External Patch 5 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Pain associated with diabetic neuropathy, pain associated with cancer-related neuropathy (including treatment-related neuropathy [e.g., neuropathy associated with radiation treatment or chemotherapy]).

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For colorectal cancer: The disease is unresectable advanced or metastatic. Patient has progressed on treatment with EITHER a) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR b) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LUMIZYME

Products Affected

- Lumizyme

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Pompe disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of acid alpha-glucosidase (GAA) enzyme activity or by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LUPRON

Products Affected

- Leuprolide Acetate Injection
- Lupron Depot (1-Month) Intramuscular Kit 3.75 MG
- Lupron Depot (3-Month) Intramuscular Kit 11.25 MG
- Lupron Depot-Ped (1-Month)
- Lupron Depot-Ped (3-Month)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For central precocious puberty (CPP), patients not currently receiving therapy must meet all of the following criteria: 1) Diagnosis of CPP confirmed by: a) a pubertal response to a gonadotropin releasing hormone (GnRH) agonist test OR a pubertal level of a third generation luteinizing hormone (LH) assay AND b) Assessment of bone age versus chronological age, and 2) The onset of secondary sexual characteristics occurred prior to 8 years of age for female patients OR prior to 9 years of age for male patients. For uterine fibroids, patient must meet one of the following: 1) Diagnosis of anemia (eg, 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.
Age Restrictions	CPP: Patient must be less than 12 years old if female and less than 13 years old if male.
Prescriber Restrictions	
Coverage Duration	Fibroids: 3 months (mo), max 6 mo total. Endometriosis: 6 mo, max 12 mo total. Others: Plan Year
Other Criteria	
Indications	All Medically-accepted Indications.
Off Label Uses	

LYNPARZA

Products Affected

- Lynparza Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For HER2-negative, recurrent or metastatic breast cancer, patient must have a deleterious or suspected deleterious germline BRCA mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LYRICA CR

Products Affected

- Lyrica CR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MAVYRET

Products Affected

- Mavyret

PA Criteria	Criteria Details
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C).
Required Medical Information	For chronic 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, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MEGESTROL

Products Affected

- Megestrol Acetate Oral Suspension 625 MG/5ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MEKINIST

Products Affected

- Mekinist

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For brain metastasis from melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with dabrafenib. For adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with dabrafenib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with dabrafenib. For non-small cell lung cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used in combination with dabrafenib. For anaplastic thyroid cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used in combination with dabrafenib. For uveal melanoma, the requested drug will be used as a single agent.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Brain metastases from melanoma, uveal melanoma.

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MEMANTINE

Products Affected

- Memantine HCl ER
- Memantine HCl Oral Solution 2 MG/ML
- Memantine HCl Oral Tablet 10 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	This edit only applies to patients less than 30 years of age.
Indications	All FDA-approved Indications.
Off Label Uses	

MIGLUSTAT

Products Affected

- Miglustat

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For Gaucher disease, the diagnosis was confirmed by an enzyme assay demonstrating a deficiency of beta-glucocerebrosidase enzyme activity or by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MODAFINIL

Products Affected

- Modafinil

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Diagnosis is narcolepsy confirmed by sleep lab evaluation OR 2) Diagnosis is shift work disorder (SWD) OR 3) Diagnosis is obstructive sleep apnea (OSA) confirmed by polysomnography.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MVASI

Products Affected

- Mvasi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
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	Breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity.

NAGLAZYME

Products Affected

- Naglazyme

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Diagnosis of mucopolysaccharidosis VI disease was confirmed by an enzyme assay demonstrating a deficiency of N-acetylgalactosamine 4-sulfatase (arylsulfatase B) enzyme activity or by genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Exclusion Criteria	Acute postsurgical hypoparathyroidism (within 6 months of surgery) and expected recovery from the hypoparathyroidism.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Brain metastases.

NEXAVAR

Products Affected

- NexAVAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For thyroid carcinoma: histology is follicular, papillary, Hurthle cell or medullary. For acute myeloid leukemia: 1) the disease is relapsed or refractory, and 2) the patient has FLT3-ITD mutation-positive disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Acute myeloid leukemia, soft tissue sarcoma (angiosarcoma, desmoid tumors/aggressive fibromatosis, gastrointestinal stromal tumor, solitary fibrous tumor, and hemangiopericytoma subtypes), medullary thyroid carcinoma, osteosarcoma, chordoma.

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For multiple myeloma: The requested drug will be used in combination with lenalidomide and dexamethasone OR pomalidomide and dexamethasone OR dexamethasone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NITYR

Products Affected

- Nityr

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 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 Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NORTHERA

Products Affected

- Northera

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Prior to initial therapy for neurogenic orthostatic hypotension (NOH), 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. For continuation of therapy for NOH, patient must experience a sustained decrease in dizziness. 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 Restrictions	
Prescriber Restrictions	
Coverage Duration	3 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For initial therapy for severe asthma: 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 at optimized doses: a) inhaled corticosteroid and b) additional controller (long acting beta2-agonist, leukotriene modifier, or sustained-release theophylline). For continuation therapy for severe asthma: Asthma control has improved on treatment with the requested drug, demonstrated by a reduction in the frequency and/or severity of symptoms and exacerbations or a reduction in the daily maintenance oral corticosteroid dose. For initial therapy for eosinophilic granulomatosis with polyangiitis (EGPA): Patient has a history or the presence of an eosinophil count of more than 1000 cells per microliter or a blood eosinophil level greater than 10 percent. For continuation of therapy for EGPA: Patient has a beneficial response to treatment with the requested drug, demonstrated by any of the following: 1) a reduction in the frequency of relapses, 2) a reduction in the daily oral corticosteroid dose, or 3) no active vasculitis.
Age Restrictions	Asthma: 6 years of age or older, EGPA: 18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NUPLAZID

Products Affected

- Nuplazid Oral Capsule
- Nuplazid Oral Tablet 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The diagnosis of Parkinson's disease must be made prior to the onset of psychotic symptoms.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OCTREOTIDE

Products Affected

- Octreotide Acetate Injection Solution 100 MCG/ML, 1000 MCG/ML, 200 MCG/ML, 50 MCG/ML, 500 MCG/ML

PA Criteria	Criteria Details
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 meningiomas: patient has unresectable disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly (continuation of therapy): patient's IGF-1 level has decreased or normalized since initiation of therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Meningiomas, thymomas and thymic carcinomas, and neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, and pancreas.

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OFEV

Products Affected

- Ofev

PA Criteria	Criteria Details
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 Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OGIVRI

Products Affected

- Ogivri

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: 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	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.

ONTRUZANT

Products Affected

- Ontruzant

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: 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	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.

ONUREG

Products Affected

- Onureg

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OPSUMIT

Products Affected

- Opsumit

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Pulmonary arterial hypertension (WHO Group 1) was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ORAL-INTRANASAL FENTANYL

Products Affected

- FentaNYL Citrate Buccal Lozenge On A Handle

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The requested drug is indicated for the treatment of breakthrough CANCER-related pain only. The requested drug is being prescribed for the management of breakthrough pain in a CANCER patient who is currently receiving around-the-clock opioid therapy for underlying CANCER pain. [Note: Ensure that the patient is opioid tolerant. Patients considered opioid tolerant are those who are taking around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg per hour of transdermal fentanyl, at least 30 mg of oral oxycodone per day, at least 60 mg oral hydrocodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg oral oxymorphone per day, or an equianalgesic dose of another opioid medication daily for a week or longer.]AND 2) The International Classification of Diseases (ICD) diagnosis code provided supports the CANCER-RELATED diagnosis. [Note: For drug coverage approval, ICD diagnosis code provided MUST support the CANCER-RELATED diagnosis.]
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ORFADIN

Products Affected

- Nitisinone
- Orfadin

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For hereditary tyrosinemia type 1: Diagnosis of hereditary tyrosinemia type 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 Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ORKAMBI

Products Affected

- Orkambi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For cystic fibrosis: the patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	The requested drug will not be used in combination with ivacaftor or tezacaftor/ivacaftor.
Indications	All FDA-approved Indications.
Off Label Uses	

OSPHENA

Products Affected

- Osphena

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OXANDROLONE

Products Affected

- Oxandrolone Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	Coverage will be denied if request is for an indication excluded from Part D.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Cachexia associated with AIDS (HIV-wasting) or to enhance growth in patients with Turner's Syndrome.

PEGASYS

Products Affected

- Pegasys ProClick Subcutaneous Solution 180 MCG/0.5ML
- Pegasys Subcutaneous Solution

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For chronic hepatitis C (CHC): CHC infection confirmed by presence of HCV RNA in 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, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD-IDSA treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	HCV=Criteria will be applied consistent with current AASLD-IDSA guidance. HBV=48 wks. Other=Plan Yr
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Myeloproliferative neoplasm (essential thrombocythemia, polycythemia vera, primary myelofibrosis and post-polycythemia vera or post-essential thrombocythemia myelofibrosis)

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PHENYLBUTYRATE

Products Affected

- Sodium Phenylbutyrate Oral Powder 3 GM/TSP
- Sodium Phenylbutyrate Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For urea cycle disorder: Diagnosis of urea cycle disorder (UCD) was confirmed by enzymatic, biochemical or genetic testing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PHESGO

Products Affected

- Phesgo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PIQRAY

Products Affected

- Piqray (200 MG Daily Dose)
- Piqray (250 MG Daily Dose)
- Piqray (300 MG Daily Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Systemic light chain amyloidosis, acquired immunodeficiency syndrome (AIDS)-related Kaposi sarcoma

PRALUENT

Products Affected

- Praluent Subcutaneous Solution Auto-Injector

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For chronic or persistent 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 30,000-50,000/mcL with symptomatic bleeding or risk factor(s) for bleeding. 2) For continuation of therapy, platelet (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 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: patient is receiving interferon-based therapy. For severe aplastic anemia (AA): For continuation of therapy following the initial 6 month approval for severe aplastic anemia: The patient must meet one of the following: 1) Current plt count is 50,000-200,000/mcL OR 2) Current plt count is less than 50,000/mcL and patient has not received appropriately titrated therapy for at least 16 weeks, OR 3) Current plt count is less than 50,000/mcL and patient is transfusion-independent, OR 4) Current plt count is greater than 200,000/mcL and dosing will be adjusted to achieve and maintain an appropriate target plt count.
Age Restrictions	
Prescriber Restrictions	
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.

PA Criteria	Criteria Details
Off Label Uses	

PULMOZYME

Products Affected

- Pulmozyme

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For cystic fibrosis: Diagnosis of cystic fibrosis was confirmed by appropriate diagnostic or genetic testing.
Age Restrictions	
Prescriber Restrictions	
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	

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

QUETIAPINE XR

Products Affected

- QUEtiapine Fumarate ER

PA Criteria	Criteria Details
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 has had an inadequate treatment response, intolerance or contraindication to one of the following: aripiprazole, lurasidone, olanzapine, paliperidone, quetiapine immediate-release, risperidone, or ziprasidone
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Maintenance monotherapy treatment in bipolar I disorder, monotherapy treatment of generalized anxiety disorder, monotherapy treatment of major depressive disorder

QUININE SULFATE

Products Affected

- QuiNINE Sulfate Oral

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	1 month
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Babesiosis, uncomplicated Plasmodium vivax malaria.

REGRANEX

Products Affected

- Regranex

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For the treatment of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond and have an adequate blood supply
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	20 weeks
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RELISTOR INJ

Products Affected

- Relistor Subcutaneous Solution

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for opioid-induced constipation in an adult patient with advanced illness or pain caused by active cancer who requires opioid dosage escalation for palliative care OR 2) The requested drug is being prescribed for opioid-induced constipation in an adult 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 AND 3) The patient is unable to tolerate oral medications OR 4) An oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain has been tried. (Note: Examples are Amitiza or Movantik) AND 5) The patient experienced an inadequate treatment response or intolerance to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain. (Note: Examples are Amitiza or Movantik) OR 6) The patient has a contraindication to an oral drug indicated for opioid-induced constipation in an adult patient with chronic non-cancer pain (Note: Examples are Amitiza or Movantik).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 months
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

REMICADE

Products Affected

- Remicade

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor. For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a self-injectable TNF inhibitor. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Axial spondyloarthritis, Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.

RENFLEXIS

Products Affected

- Renflexis

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For moderately to severely active Crohn's disease (new starts only): 1) Patient has fistulizing disease OR 2) Inadequate response or intolerance to a self-injectable tumor necrosis factor (TNF) inhibitor. For moderately to severely active ulcerative colitis (new starts only): 1) Inadequate response to at least one conventional therapy (e.g., corticosteroids, aminosalicylates) OR 2) Intolerance or contraindication to conventional therapy. For moderately to severely active rheumatoid arthritis (new starts only): 1) Will be used in combination with methotrexate (MTX) or leflunomide OR patient has intolerance or contraindication to MTX or leflunomide AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). For active ankylosing spondylitis and axial spondyloarthritis (new starts only): Inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR intolerance or contraindication to NSAIDs. For moderate to severe chronic plaque psoriasis (new starts only): 1) At least 5% of body surface area (BSA) is affected OR crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected at time of diagnosis, AND 2) Inadequate response or intolerance to a self-injectable TNF inhibitor. For juvenile idiopathic arthritis (new starts only): Inadequate response or intolerance to a self-injectable TNF inhibitor. For hidradenitis suppurativa (new starts only): patient has severe, refractory disease. For uveitis (new starts only): Patient has experienced an inadequate response or intolerance or has a contraindication to a trial of immunosuppressive therapy for uveitis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Axial spondyloarthritis, Behcet's syndrome, granulomatosis with polyangiitis (Wegener's granulomatosis), hidradenitis suppurativa, juvenile idiopathic arthritis, pyoderma gangrenosum, sarcoidosis, Takayasu's arteritis, uveitis.

RETEVMO

Products Affected

- Retevmo

PA Criteria	Criteria Details
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 Restrictions	Non-small cell lung cancer: 18 years of age or older. Medullary thyroid cancer and thyroid cancer: 12 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Recurrent or advanced rearranged during transfection (RET)-rearrangement positive non-small cell lung cancer

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For myelodysplastic syndrome (MDS): Low- to intermediate-1 risk MDS with symptomatic anemia
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Systemic light chain amyloidosis, classical Hodgkin lymphoma, myelodysplastic syndrome without the 5q deletion cytogenetic abnormality, myelofibrosis-associated anemia, POEMS syndrome, non-Hodgkin's lymphoma with the following subtypes: AIDS-related diffuse large B-cell lymphoma, primary central nervous system (CNS) lymphoma, monomorphic post-transplant lymphoproliferative disorder, chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), diffuse large B-cell lymphoma, nongastric/gastric mucosa associated lymphoid tissue (MALT) lymphoma, primary cutaneous B-cell lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma, mycosis fungoides (MF)/Sezary syndrome (SS), angioimmunoblastic T-cell lymphoma (AITL), peripheral T-cell lymphoma not otherwise specified (PTCL NOS), enteropathy-associated T-cell lymphoma, monomorphic epitheliotropic intestinal T-cell lymphoma, nodal peripheral T-cell lymphoma, follicular T-cell lymphoma, primary cutaneous anaplastic large cell lymphoma (ALCL).

RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
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 (e.g. tofacitinib).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RITUXAN

Products Affected

- Rituxan Intravenous Solution

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): A) the requested medication is used in combination with methotrexate (MTX) unless MTX is contraindicated or not tolerated, AND B) patient has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). Hematologic malignancies must be CD20-positive. For multiple sclerosis: A) patient has a diagnosis of relapsing remitting multiple sclerosis and B) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric MALT, nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, Castleman's disease, AIDS-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary CNS lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, and idiopathic refractory inflammatory myopathy

RITUXAN HYCELA

Products Affected

- Rituxan Hycela

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Malignancies must be CD20 positive. Patient must receive at least one full dose of a rituximab product by intravenous infusion without experiencing severe adverse reactions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Acquired immune deficiency syndrome (AIDS)-related B-cell lymphoma, Burkitt lymphoma, Castleman's disease (CD), small lymphocytic lymphoma (SLL), gastric MALT lymphoma, mantle cell lymphoma, nodal marginal zone lymphoma, nongastric MALT lymphoma, primary cutaneous B-cell lymphoma (e.g., cutaneous marginal zone lymphoma or cutaneous follicle center lymphomas), post-transplant lymphoproliferative disorder (PTLD), splenic marginal zone lymphoma

ROZLYTREK

Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RUXIENCE

Products Affected

- Ruxience

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): A) the requested medication is used in combination with methotrexate (MTX) unless MTX is contraindicated or not tolerated, AND B) patient has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). Hematologic malignancies must be CD20-positive. For multiple sclerosis: A) patient has a diagnosis of relapsing remitting multiple sclerosis and B) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric MALT, nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, Castleman's disease, AIDS-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary CNS lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, and idiopathic refractory inflammatory myopathy

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For acute myeloid leukemia (AML), AML must be FLT3 mutation-positive.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Relapsed or refractory acute myeloid leukemia

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SILDENAFIL

Products Affected

- Sildenafil Citrate Oral Tablet 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, and 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	The requested drug is not being prescribed for the treatment of latent infection due to Mycobacterium tuberculosis, drug-sensitive tuberculosis, extra-pulmonary tuberculosis, or infection caused by the non-tuberculous mycobacteria
Indications	All FDA-approved Indications.
Off Label Uses	

SKYRIZI

Products Affected

- Skyrizi (150 MG Dose)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 5% 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 disease-modifying antirheumatic drug (DMARD) as first-line therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SOMATULINE DEPOT

Products Affected

- Somatuline Depot Subcutaneous Solution 120 MG/0.5ML, 60 MG/0.2ML, 90 MG/0.3ML

PA Criteria	Criteria Details
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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Neuroendocrine tumors (NETs) of the gastrointestinal (GI) tract, thymus, lung, and pancreas

SOMAVERT

Products Affected

- Somavert

PA Criteria	Criteria Details
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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For acromegaly continuation of therapy: patient's IGF-1 level has decreased or normalized since initiation of therapy.
Indications	All FDA-approved Indications.
Off Label Uses	

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, patient has one of the following a) patient is 21 years of age or younger, or b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib, or regorafenib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Gastrointestinal stromal tumor (GIST)

STELARA

Products Affected

- Stelara Subcutaneous Solution 45 MG/0.5ML
- Stelara Subcutaneous Solution Prefilled Syringe

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For moderate to severe plaque psoriasis (new starts only): 1) at least 5% 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 had an inadequate response, intolerance, or contraindication to Humira. For active psoriatic arthritis (PsA) (new starts only): the patient had an inadequate response, intolerance, or contraindication to Humira or Xeljanz/Xeljanz XR. For moderately to severely active Crohn's disease (new starts only): patient had an inadequate response, intolerance, or contraindication to Humira. For moderately to severely active ulcerative colitis (new starts only): patient had an inadequate response, intolerance, or contraindication to Humira or Xeljanz.
Age Restrictions	Plaque psoriasis: 6 years of age or older. All other indications: 18 years of age or older.
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For colorectal cancer: The disease is unresectable, advanced, or metastatic. The patient has progressed on treatment with EITHER 1) FOLFOXIRI (fluorouracil, leucovorin, oxaliplatin, and irinotecan) regimen OR 2) irinotecan- AND oxaliplatin-based regimens.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Progressive gastrointestinal stromal tumors (GIST)

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma: Either 1) The disease is relapsed, metastatic, or unresectable, OR 2) The patient is at high risk of disease recurrence following nephrectomy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), soft tissue sarcoma (angiosarcoma, solitary fibrous tumor, and hemangiopericytoma subtypes), chordoma, thymic carcinoma

SYLATRON

Products Affected

- Sylatron Subcutaneous Kit 200 MCG, 300 MCG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Myelofibrosis, polycythemia vera, essential thrombocythemia, systemic mastocytosis.

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For cystic fibrosis (CF): The patient is positive for the F508del mutation on both alleles of the cystic fibrosis transmembrane conductance regulator (CFTR) gene OR the patient has a mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor potentiation based on clinical and/or in vitro assay data. If the patient's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation
Age Restrictions	6 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	Symdeko will not be used in combination with Orkambi or Kalydeco.
Indications	All FDA-approved Indications.
Off Label Uses	

SYMPAZAN

Products Affected

- Sympazan

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	2 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SYNRIBO

Products Affected

- Synribo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Follow-up therapy for CML patients after hematopoietic stem cell transplant (HSCT), treatment of chronic CML patients with a T315I mutation.

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For recurrent, advanced, or metastatic NSCLC: Tumor is positive for mesenchymal-epithelial transition (MET) exon 14 skipping mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Treatment of recurrent or advanced non-small cell lung cancer (NSCLC).

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For brain metastases from melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with trametinib. For adjuvant treatment of melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used in combination with trametinib. For unresectable or metastatic melanoma, the tumor is positive for a BRAF V600 activating mutation and the requested drug will be used as a single agent or in combination with trametinib. For non-small cell lung cancer, the tumor is positive for a BRAF V600E mutation and the requested drug will be used as a single agent or in combination with trametinib. For thyroid carcinoma, the tumor is positive for BRAF activating mutation with papillary, follicular, or Hurthle histology.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Brain metastases from melanoma, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma)

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For metastatic or recurrent non-small cell lung cancer (NSCLC), patient must have sensitizing EGFR mutation-positive NSCLC (including brain metastases from non-small cell lung cancer).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Sensitizing epidermal growth factor receptor (EGFR) mutation-positive recurrent or metastatic non-small cell lung cancer, brain metastases from non-small cell lung cancer.

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TARCEVA

Products Affected

- Erlotinib HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC (including brain metastases from NSCLC), patient has a known sensitizing EGFR mutation. For pancreatic cancer, the disease is locally advanced, unresectable, or metastatic.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Chordoma, renal cell carcinoma (RCC), brain metastases from non-small cell lung cancer (NSCLC).

TASIGNA

Products Affected

- Tasigna

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For chronic myelogenous leukemia (CML) or acute lymphoblastic leukemia (ALL), diagnosis was confirmed by detection of the Philadelphia chromosome or BCR-ABL gene. For CML, 1) patient has received a hematopoietic stem cell transplant, OR 2) patient has accelerated or blast phase CML, OR 3) For chronic phase CML, the patient has one of the following: a) patient is 18 years of age or younger, b) high or intermediate risk for disease progression, or c) low risk for disease progression and has experienced resistance, intolerance or toxicity to imatinib or an alternative tyrosine kinase inhibitor. If patient experienced resistance to imatinib or an alternative tyrosine kinase inhibitor for CML, patient is negative for T315I mutation. For GIST, patient must have progressed on imatinib, sunitinib or regorafenib.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Philadelphia chromosome positive acute lymphoblastic leukemia (Ph+ ALL), gastrointestinal stromal tumor (GIST).

TAZAROTENE

Products Affected

- Tazarotene External
- Tazorac External Cream 0.05 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For plaque psoriasis, the requested drug is being prescribed to treat less than 20 percent of the patient's body surface area.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TAZVERIK

Products Affected

- Tazverik

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	Epithelioid sarcoma: 16 years of age or older, Follicular lymphoma: 18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TECENTRIQ

Products Affected

- Tecentriq

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For non-small cell lung cancer (NSCLC): Patient meets one of the following: 1) The requested medication will be used as first line treatment for NSCLC with high programmed death-ligand 1 (PD-L1) expression (PD-L1 stained greater than or equal to 50 percent of tumor cells) with no epidermal growth factor receptor (EGFR) or anaplastic lymphoma kinase (ALK) genomic aberrations, OR 2) The disease has progressed during or following cytotoxic chemotherapy, OR 3) Patient has positive EGFR mutation, positive ALK, or positive c-ros oncogene 1 (ROS1) gene rearrangement and has had disease progression on targeted FDA-approved therapy (e.g., erlotinib, afatinib, gefitinib, crizotinib, ceritinib) prior to receiving the requested drug, OR 4) Patient has non-squamous histology and has negative EGFR, negative ALK, negative ROS1 non-small cell lung cancer.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TECFIDERA

Products Affected

- Tecfidera

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TETRABENAZINE

Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For treatment of chorea associated with Huntington's disease and tardive dyskinesia: The patient must have a prior inadequate response or intolerable adverse event with deutetrabenazine therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Chronic tics, tardive dyskinesia, hemiballismus, chorea not associated with Huntington's disease.

THALOMID

Products Affected

- Thalomid

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For cachexia: Cachexia must be due to cancer or human immunodeficiency virus (HIV) infection. For Kaposi's sarcoma: The patient has human immunodeficiency virus (HIV) infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Myelofibrosis-related anemia, recurrent aphthous stomatitis, recurrent HIV-associated aphthous ulcers, cachexia, human immunodeficiency virus (HIV)-associated diarrhea, Kaposi's sarcoma, Behcet's syndrome, chronic graft-versus-host disease, Crohn's disease, multicentric Castleman's disease.

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TOBRAMYCIN

Products Affected

- Tobramycin Inhalation Nebulization Solution 300 MG/5ML

PA Criteria	Criteria Details
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 Restrictions	
Prescriber Restrictions	
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	Non-cystic fibrosis bronchiectasis

TOPICAL LIDOCAINE

Products Affected

- Glydo External Gel
- Lidocaine External Ointment
- Lidocaine HCl External Solution
- Lidocaine HCl Urethral/Mucosal External Gel
- Lidocaine-Prilocaine External Cream

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The requested drug is being used for topical anesthesia, 2) If the requested drug will be used as part of a compounded product, then all the active ingredients in the compounded product are FDA-approved for topical use
Age Restrictions	
Prescriber Restrictions	
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	

TOPICAL TESTOSTERONES

Products Affected

- Androderm Transdermal Patch 24 Hour
- Testosterone Transdermal Gel 12.5 MG/ACT (1%), 25 MG/2.5GM (1%), 50 MG/5GM (1%)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) Request is for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who had a confirmed low testosterone level according to current practice guidelines or your standard male lab reference values before starting testosterone therapy OR 2) Request is not for continuation of testosterone therapy and requested drug is being prescribed for hypogonadism in a male patient or a patient that self-identifies as male who has at least two confirmed low testosterone levels according to current practice guidelines or your standard male lab reference values OR 3) Requested drug is being prescribed for gender dysphoria in a transgender male patient who is able to make an informed, mature decision to engage in therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Gender Dysphoria in transgender male patients.

TOPICAL TRETINOIN

Products Affected

- Avita
- Tretinoin External Cream
- Tretinoin External Gel 0.01 %, 0.025 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TRAZIMERA

Products Affected

- Trazimera

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Neoadjuvant therapy for breast cancer: 6 months. Other: 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	Neoadjuvant treatment for human epidermal growth factor receptor 2 (HER2)-positive breast cancer, recurrent HER2-positive breast cancer, leptomeningeal metastases from breast cancer, HER2-positive esophageal and esophagogastric junction cancer, HER2-positive advanced and recurrent uterine serous carcinoma.

TRELSTAR

Products Affected

- Trelstar Mixject Intramuscular Suspension Reconstituted 11.25 MG, 3.75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TREPROSTINIL INJ

Products Affected

- Treprostinil

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
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	

TRIENTINE

Products Affected

- Clovique
- Trientine HCl

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TRIKAFTA

Products Affected

- Trikafta

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For cystic fibrosis (CF): The patient has at least one F508del mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene.
Age Restrictions	12 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	The requested medication will not be used in combination with other medications containing ivacaftor.
Indications	All FDA-approved Indications.
Off Label Uses	

TRUXIMA

Products Affected

- Truxima

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): A) the requested medication is used in combination with methotrexate (MTX) unless MTX is contraindicated or not tolerated, AND B) patient has an inadequate response, intolerance or contraindication to a self-injectable tumor necrosis factor (TNF) inhibitor or a targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., tofacitinib). Hematologic malignancies must be CD20-positive. For multiple sclerosis: A) patient has a diagnosis of relapsing remitting multiple sclerosis and B) patient has had an inadequate response to two or more disease-modifying drugs indicated for multiple sclerosis despite adequate duration of treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Immune checkpoint inhibitor-related toxicities: 3 months, All other: Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.

PA Criteria	Criteria Details
Off Label Uses	Non-Hodgkin's lymphoma subtypes [small lymphocytic lymphoma (SLL), mantle cell lymphoma, marginal zone lymphomas (nodal, splenic, gastric MALT, nongastric MALT), Burkitt lymphoma, primary cutaneous B-cell lymphoma, Castleman's disease, AIDS-related B-cell lymphoma, hairy cell leukemia, post-transplant lymphoproliferative disorder (PTLD)], refractory immune or idiopathic thrombocytopenic purpura (ITP), autoimmune hemolytic anemia, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, chronic graft-versus-host disease (GVHD), Sjogren syndrome, thrombotic thrombocytopenic purpura, refractory myasthenia gravis, Hodgkin's lymphoma (nodular lymphocyte-predominant), primary CNS lymphoma, leptomeningeal metastases from lymphomas, acute lymphoblastic leukemia, prevention of Epstein-Barr virus (EBV)-related PTLD, multiple sclerosis, immune checkpoint inhibitor-related toxicities, and idiopathic refractory inflammatory myopathy

TUKYSA

Products Affected

- Tukysa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Recurrent human epidermal growth factor receptor 2 (HER2)-positive breast cancer, including patients with brain metastasis, who have received one or more lines of prior HER2-targeted therapy in the metastatic setting.

TURALIO

Products Affected

- Turalio

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TYKERB

Products Affected

- Lapatinib Ditosylate
- Tykerb

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For HER2-positive breast cancer, the requested drug will be used in combination with any of the following: 1) aromatase inhibitor, 2) capecitabine, OR 3) trastuzumab.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Metastatic CNS lesions from HER2-positive breast cancer, recurrent EGFR-positive chordoma.

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For postmenopausal osteoporosis: patient has ONE of the following: 1) a history of fragility fractures, OR 2) a pre-treatment T-score of less than or equal to -2.5 or osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than or equal to -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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	24 months lifetime total for parathyroid hormone analogs (e.g., abaloparatide or teriparatide)
Other Criteria	Patient has high Fracture Risk Assessment Tool (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 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	

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	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.

VELCADE

Products Affected

- Bortezomib
- Velcade Injection

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
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	Systemic light chain amyloidosis, Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma, multicentric Castleman's disease, adult T-cell leukemia/lymphoma.

VELTASSA

Products Affected

- Veltassa

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The patient has experienced an inadequate treatment response or intolerance to Lokelma OR 2) The patient has a contraindication that would prohibit a trial of Lokelma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For AML, patient meets any of the following: 1) the patient is 60 years of age or older, OR 2) the requested drug will be used as a component of repeating the initial successful induction regimen if late relapse, OR 3) the patient has comorbidities that preclude use of intensive induction chemotherapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Mantle cell lymphoma

VENTAVIS

Products Affected

- Ventavis

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For pulmonary arterial hypertension (WHO Group 1), the diagnosis was confirmed by right heart catheterization. For new starts only, the patient must meet all of the following: 1) pretreatment mean pulmonary arterial pressure is greater than or equal to 25 mmHg, 2) pretreatment pulmonary capillary wedge pressure is less than or equal to 15 mmHg, AND 3) pretreatment pulmonary vascular resistance is greater than 3 Wood units.
Age Restrictions	
Prescriber Restrictions	
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	

VERSACLOZ

Products Affected

- Versacloz

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

V-GO

Products Affected

- V-Go 20
- V-Go 30
- V-Go 40

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The patient has diabetes requiring insulin management with multiple daily injections AND 2) The patient is self-testing glucose levels 4 or more times per day AND 3) The patient has experienced any of the following with the current diabetes regimen: inadequate glycemic control, recurrent hypoglycemia, wide fluctuations in blood glucose, dawn phenomenon with persistent severe early morning hyperglycemia, severe glycemic excursions.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	For continuation of therapy with an insulin pump, the patient has stable or improved glycemic control.
Indications	All FDA-approved Indications.
Off Label Uses	

VIGABATRIN

Products Affected

- Vigabatrin
- Vigadrone

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For complex partial seizures (CPS): patient had an inadequate response to at least 2 alternative therapies for CPS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VORICONAZOLE

Products Affected

- Voriconazole Intravenous
- Voriconazole Oral Suspension Reconstituted

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	The patient will be using the requested drug orally or intravenously.
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Prophylaxis of invasive aspergillosis in a high-risk patient, empiric antifungal therapy for febrile neutropenia in a high-risk patient, pulmonary aspergillosis, oropharyngeal candidiasis, mycosis due to Scedosporium prolificans

VOSEVI

Products Affected

- Vosevi

PA Criteria	Criteria Details
Exclusion Criteria	Decompensated cirrhosis/moderate or severe hepatic impairment (Child Turcotte Pugh class B or C)
Required Medical Information	For chronic 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, liver and kidney transplantation status if applicable. Coverage conditions and specific durations of approval will be based on current AASLD treatment guidelines.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Criteria will be applied consistent with current AASLD-IDSA guidance.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For renal cell carcinoma: The disease is relapsed, metastatic, or unresectable. For soft tissue sarcoma (STS): 1) The patient does not have an adipocytic soft tissue sarcoma, AND 2) The patient has one of the following subtypes of STS: a) gastrointestinal stromal tumor (GIST), b) angiosarcoma, c) pleomorphic rhabdomyosarcoma, d) retroperitoneal/intra-abdominal sarcoma, or e) extremity/superficial trunk, head/neck sarcoma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Thyroid carcinoma (follicular, papillary, Hurthle cell, or medullary), uterine sarcoma, ovarian cancer (epithelial ovarian, fallopian tube, or primary peritoneal).

VRAYLAR

Products Affected

- Vraylar

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	The patient experienced an inadequate treatment response, intolerance, or contraindication to one of the following: lurasidone, aripiprazole, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VUMERITY

Products Affected

- Vumerity
- Vumerity (Starter)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XALKORI

Products Affected

- Xalkori

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Recurrent anaplastic lymphoma kinase (ALK)-positive or ROS1-positive non-small cell lung cancer (NSCLC), NSCLC with high-level MET amplification or MET exon 14 skipping mutation, ALK- or ROS1-postive brain metastases from NSCLC, ALK-positive inflammatory myofibroblastic tumors (IMT), ALK-positive anaplastic large cell lymphoma (ALCL).

XELJANZ

Products Affected

- Xeljanz
- Xeljanz XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For moderately to severely active rheumatoid arthritis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to methotrexate (MTX), OR 2) Inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD). For active psoriatic arthritis (new starts only): Patient meets BOTH of the following criteria: 1) Inadequate response to MTX or other nonbiologic DMARDs OR a prior biologic DMARD, AND 2) The requested drug is used in combination with a nonbiologic DMARD. For moderately to severely active ulcerative colitis (new starts only): Patient meets at least one of the following criteria: 1) Inadequate response, intolerance or contraindication to at least one conventional therapy option (e.g., aminosalicylates), or 2) Inadequate response or intolerance to a prior biologic DMARD.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
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 Restrictions	
Prescriber Restrictions	
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	Systemic mastocytosis related osteopenia or osteoporosis

XIFAXAN

Products Affected

- Xifaxan Oral Tablet 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed to reduce the risk of overt hepatic encephalopathy (HE) recurrence OR 2) The patient has the diagnosis of irritable bowel syndrome with diarrhea (IBS-D) AND 3) If the patient has previously received treatment with the requested drug, the patient has experienced a recurrence of symptoms AND 4) 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 OR 5) The patient has not previously received treatment with the requested drug
Age Restrictions	
Prescriber Restrictions	
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	

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
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 at optimized doses: a) Inhaled corticosteroid, and b) Additional controller (long acting beta2-agonist, 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.
Age Restrictions	For CIU: 12 years of age or older. For allergic asthma: 6 years of age or older.
Prescriber Restrictions	
Coverage Duration	Allergic asthma: Plan Year. CIU initial: 6 months. CIU continuation: Plan Year.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XPOVIO

Products Affected

- Xpovio (100 MG Once Weekly)
- Xpovio (40 MG Once Weekly)
- Xpovio (40 MG Twice Weekly)
- Xpovio (60 MG Once Weekly)
- Xpovio (60 MG Twice Weekly)
- Xpovio (80 MG Once Weekly)
- Xpovio (80 MG Twice Weekly)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	1) The requested drug is being prescribed for the treatment of excessive daytime sleepiness in a patient 7 years of age or older with narcolepsy and 2) If the patient is 18 years of age or older, the patient experienced an inadequate treatment response, intolerance, or contraindication to at least one central nervous system (CNS) wakefulness promoting drug and at least one central nervous system (CNS) stimulant drug OR 3) If the patient is less than 18 years of age, the patient experienced an inadequate treatment response, intolerance, or contraindication to at least one central nervous system (CNS) stimulant drug (NOTE: Examples of a central nervous system (CNS) stimulant drug are amphetamine, dextroamphetamine, or methylphenidate. Example of a central nervous system (CNS) wakefulness promoting drug is armodafinil. Coverage of armodafinil or amphetamines may require prior authorization). OR 4) The requested drug is being prescribed for the treatment of cataplexy in a patient 7 years of age or older with narcolepsy
Age Restrictions	7 years of age or older
Prescriber Restrictions	
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	

ZARXIO

Products Affected

- Zarxio

PA Criteria	Criteria Details
Exclusion Criteria	Use of the requested product within 24 hours prior to or following chemotherapy or radiotherapy.
Required Medical Information	For prophylaxis or treatment of myelosuppressive chemotherapy-induced FN patients must meet all of the following: 1) Patient has a non-myeloid cancer, 2) Patient has received, is currently receiving, or will be receiving treatment with myelosuppressive anti-cancer therapy
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Treatment of chemotherapy-induced febrile neutropenia (FN), following chemotherapy for acute lymphocytic leukemia (ALL), stem cell transplantation related indications, myelodysplastic syndromes (MDS), agranulocytosis, aplastic anemia, HIV-related neutropenia, neutropenia related to renal transplant.

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For brain metastases with melanoma, all of the following criteria must be met: 1) The tumor is positive for BRAF V600 activating mutation (e.g., BRAF V600E or V600K mutation), and 2) The requested drug will be used in combination with cobimetinib. For non-small cell lung cancer, tumor is positive for the BRAF V600E mutation. For thyroid carcinoma, tumor is positive for BRAF mutation. For rectal cancer, tumor is positive for the BRAF V600E mutation. For colon cancer, tumor is positive for the BRAF V600E mutation.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Brain metastases with melanoma, non-small cell lung cancer, hairy cell leukemia, thyroid carcinoma (papillary carcinoma, follicular carcinoma, and Hurthle cell carcinoma), rectal cancer, and colon cancer.

ZIRABEV

Products Affected

- Zirabev

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
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	Breast cancer, central nervous system (CNS) tumor types: adult intracranial and spinal ependymoma and anaplastic gliomas, malignant pleural mesothelioma, ovarian malignant sex cord-stromal tumors, soft tissue sarcoma types: AIDS-related Kaposi sarcoma, angiosarcoma and solitary fibrous tumor/hemangiopericytoma, uterine cancer, endometrial cancer, diabetic macular edema, neovascular (wet) age-related macular degeneration including polypoidal choroidopathy and retinal angiomatous proliferation subtypes, macular edema following retinal vein occlusion, proliferative diabetic retinopathy, choroidal neovascularization, neovascular glaucoma, and retinopathy of prematurity.

ZOLINZA

Products Affected

- Zolinza

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Mycosis fungoides, Sezary syndrome.

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Relapsed or refractory chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL), refractory or progressive follicular lymphoma, and marginal zone lymphomas [nodal marginal zone lymphoma, gastric mucosa associated lymphoid tissue (MALT) lymphoma, non-gastric MALT lymphoma, and splenic marginal zone lymphoma].

ZYKADIA

Products Affected

- Zykadia Oral Tablet

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	For NSCLC, patient has recurrent or metastatic ALK-positive or ROS1-positive disease. For inflammatory myofibroblastic tumor, the tumor is ALK-positive. For brain metastases, patient has ALK-positive NSCLC.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications, Some Medically-accepted Indications.
Off Label Uses	Anaplastic lymphoma kinase (ALK)-positive inflammatory myofibroblastic tumor, recurrent ALK-positive non-small cell lung cancer (NSCLC), metastatic or recurrent ROS1-positive NSCLC, brain metastases from NSCLC.

ZYPREXA RELPREVV

Products Affected

- ZyPREXA Relprevv

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	Tolerability with oral olanzapine has been established.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Plan Year
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	