Prior Authorization Detail
Updated on 10/23/26

Selected Formulary: 2027 Medicare Assured℠ | CMS Formulary ID: 00027427 | CMS Version: 11

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ACITRETIN (SORIATANE)	1 - All FDA-approved Indications.			Diagnosis. Must have a trial of methotrexate or cyclosporine with inadequate response or significant side effect/toxicity or have a contraindication to these therapies.			12 months		0	1
ADALIMUMAB PRODUCTS	Pending CMS Review		Coverage is not provided for use of once weekly doses in combination with methotrexate.	Diagnosis. For rheumatoid arthritis (RA): history of trial and failure, contraindication, or intolerance to a 3 month trial with methotrexate or another DMARD. For juvenile idiopathic arthritis (JIA) with polyarthritis: history of trial and failure, contraindication, or intolerance to a 3 month trial with methotrexate, leflunomide, or sulfasalazine. For JIA with oligoarthritis, enthesitis, or sacroiliitis: history of trial and failure, contraindication, or intolerance to at least a 4 week trial of 2 different NSAIDS. For ankylosing spondylitis (AS): history of trial and failure, contraindication, or intolerance to a 4 week trial each of at least 2 NSAIDs. For plaque psoriasis: a history of trial and failure of ONE of the following: 1) topical therapy (e.g. corticosteroid, calcineurin inhibitor, vitamin D analog), 2) phototherapy, 3) systemic treatment (e.g. methotrexate, cyclosporine, oral retinoids). For Crohns (CD): Member has moderate to severe CD. For Ulcerative		By or in consultation with a rheumatologist, gastroenterologist, ophthalmologist, or dermatologist.	12 months	For hidradenitis suppurativa (HS): moderate to severe disease. For uveitis: trial of a corticosteroid or immunomodulator with inadequate response or side effects/toxicities unless contraindicated. For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ALIROCUMAB (PRALUENT)	Pending CMS Review			Diagnosis. Provider confirms that the member has a cholesterol disorder for which treatment is indicated or that the member is an adult at increased risk for major adverse cardiovascular (CV) events and treatment is being prescribed to reduce the risk of cardiovascular death, heart attack, or stroke. Provider attests that the member failed to achieve the treatment goal after a trial of a high-intensity statin (atorvastatin 40-80 mg daily or rosuvastatin 20-40 mg daily) or two moderate-intensity statins (atorvastatin or rosuvastatin) at the member's maximally tolerated dose, or that the member is intolerant to statin therapy.			12 months	Extreme risk: Provider confirms that the member is at extreme risk for atherosclerotic cardiovascular disease (ASCVD) based on the member's diagnosis, clinical history, and cardiovascular risk factors, which may include, but are not limited to, diabetes, stage 3 or 4 chronic kidney disease, heterozygous familial hypercholesterolemia, or a history of premature ASCVD. For reauthorization: Provider attests that the member has experienced a positive clinical response to therapy, such as improvement in LDL-C from baseline.	0	1
ALPHA-1 PROTEINASE INHIBITOR	Pending CMS Review		Immunoglobulin A (IgA) deficient members with antibodies against IgA	Diagnosis. Member must have pre-treatment serum levels of alpha-1 antitrypsin (AAT) that are less than 11 micromoles per liter (80 milligrams per deciliter if measured by radial immunodiffusion or 57 milligrams per deciliter if measure by nephelometry) consistent with phenotypes PiZZ, PiZ (null) or Pi (null, null) of AAT. Member must have symptomatic emphysema confirmed with pulmonary function testing.	Coverage is provided for members 18 years of age and older.	By or in consultation with a pulmonologist	Initial: 6 months Reauthorization: 12 months	For reauth: documentation of slowed progression of emphysema as evidenced by annual spirometry testing or a decrease in frequency, duration or severity of pulmonary exacerbations	0	0
AMBRISENTAN (LETAIRIS)	Pending CMS Review		Pregnancy	Diagnosis. Pulmonary arterial hypertension (PAH), WHO Group I, confirmed by provider attestation. If an echocardiogram was performed instead of right-heart catheterization (RHC), the provider must confirm that the echocardiogram was performed and supports the diagnosis of PAH.		Prescribed by or in consultation with cardiologist or pulmonologist.	12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0	0
AMIKACIN INHALATION (ARIKAYCE)	1 - All FDA-approved Indications.			Diagnosis of Mycobacterium avium complex (MAC) lung disease. Must be used as part of a combination antibacterial drug regimen in patients who do not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy containing at least 2 of the following: a macrolide, a rifamycin (rifampin or rifabutin), and ethambutal.		By or in consultation with a pulmonologist or infectious disease specialist	12 months	For reauth: must have attestation confirming presence of a positive sputum culture or that there have been negative sputum cultures for an insufficient period of time (e.g. less than 12 months).	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
APREMILAST (OTEZLA)	Pending CMS Review			Diagnosis. For plaque psoriasis: a history of trial and failure of ONE of the following: 1) topical therapy (e.g. corticosteroid, calcineurin inhibitor, vitamin D analog), 2) phototherapy, 3) systemic treatment (e.g. methotrexate, cyclosporine, oral retinoids). For Behcet's disease: must have a trial and failure, intolerance, or contraindication to colchicine.		By or in consultation with a dermatologist, rheumatologist	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	1
ARMODAFINIL (NUVIGIL)	Pending CMS Review			Diagnosis. Must have a history of trial and failure, contraindication, or intolerance to modafinil. For narcolepsy: Sleep study (e.g. polysomnogram, Multiple Sleep Latency Test) confirming diagnosis. For obstructive sleep apnea: Sleep study confirming diagnosis. For shift work sleep disorder (SWSD): must meet International Classification of Sleep Disorders criteria for SWSD (either primary complaint of excessive sleepiness or insomnia temporarily associated with work period that occurs during habitual sleep phase OR polysomnography and (1) Multiple Sleep Latency Test demonstrate loss of normal sleep wake pattern, (2) no other medical or mental disorders account for symptoms, and (3) symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness such as time zone change syndrome)		By or in consultation with a sleep specialist, ENT (ear, nose, and throat specialist), neurologist, or pulmonologist	SWSD: 6 months. Narcolepsy, OSA: 12 months	For reauth: documentation of improvement or stabilization.	0	1
ASENAPINE (SECUADO)	1 - All FDA-approved Indications.		Dementia-related psychosis	Diagnosis. Documentation of trial and failure of at least two of the following generic atypical antipsychotics: olanzapine, quetiapine, paliperidone, risperidone, aripiprazole, ziprasidone, asenapine, or lurasidone.	Members 18 years of age or older.		12 months		0	1
ATOGEPANT (QULIPTA)	Pending CMS Review			Diagnosis. Provider attestation confirming the member has a diagnosis of migraine.	Coverage is provided for members 18 years of age and older.		Initial: 6 months Reauthorization: 12 months	For reauthorization: Provider attestation that the member has experienced clinically meaningful benefit from treatment, demonstrated by at least one of the following: (1) a reduction in migraine or headache frequency, severity, or duration, (2) improvement in migraine-related disability, functioning, or quality of life, or (3) reduced use of acute migraine medication.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
AVACOPAN (TAVNEOS)	Pending CMS Review			Diagnosis of ANCA-associated vasculitis (GPA or MPA). Must be on concurrent therapy with immunosuppressants (e.g. cyclophosphamide, azathioprine, mycophenolate, rituximab).	Coverage is provided for members 18 years of age or older.	By or in consultation with a rheumatologist, nephrologist, hematologist or oncologist.	12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0	0
AVATROMBOPAG (DOPTELET)	Pending CMS Review			For ITP: diagnosis. For thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure: platelet count less than 50,000/microliter.		By or in consultation with a hematologist, oncologist, hepatologist, or surgeon	Chronic or persistent ITP: 6 months. Thrombocytopenia with chronic liver disease: 1 month	For reauth of chronic ITP: documentation of improvement in platelet count from baseline.	0	0
B VS. D	3 - All Medically-accepted Indications.						NA		0	0
BECAPLERMIN (REGRANEX)	1 - All FDA-approved Indications.		Neoplasm at application site. Treatment of pressure ulcers and venous stasis ulcers. Use on exposed joints, tendons, ligaments, and bone.	Diagnosis. Must have a lower extremity diabetic neuropathic ulcer that extends into the subcutaneous tissue or beyond and have an adequate blood supply. Must be used as adjunctive therapy to good ulcer care practices (i.e. debridement, infection control, pressure relief).			3 months	For reauth: documentation of improvement or stabilization.	0	0
BEDAQUILINE (SIRTURO)	Pending CMS Review			Diagnosis. Must have either inadequate response to a first-line tuberculosis (TB) regimen containing isoniazid and rifampin OR provider attestation of resistance to isoniazid and rifampin. Must weigh at least 8 kg. Must be part of combination therapy.	Member must be 2 years of age and older	By or in consultation with a pulmonologist or infectious disease specialist	6 months		0	1
BELIMUMAB (BENLYSTA) (IV FORMULATION)	1 - All FDA-approved Indications.		Severe active central nervous system lupus. Combination therapy with other biologics or IV cyclophosphamide.	Diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE) or lupus nephritis. Must have ANA of at least 1:80 or anti-dsDNA of at least 30 IU/ml to support being autoantibody positive. Must be currently taking or has tried and failed or had an intolerance or contraindication to at least one standard therapy for systemic lupus erythematosus (e.g. corticosteroids, antimalarials, NSAIDS, or immunosuppressives) or lupus nephritis (e.g. corticosteroids, mycophenolate, cyclophosphamide, azathioprine). Diagnosis of active lupus nephritis. Documentation of a biopsy-proved lupus nephritis Class III, IV or V.	Coverage is provided for members 5 years of age and older	By or in consultation with a rheumatologist or hematologist	12 months	For reauth: documentation from the prescriber indicating stabilization or improvement in condition.	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
BELIMUMAB (BENLYSTA) (SQ)	Pending CMS Review		Previous anaphylaxis, Stevens-Johnson syndrome, or toxic epidermal necrolysis as a reaction to belimumab.	Diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE) or lupus nephritis. Must have ANA of at least 1:80 or anti-dsDNA of at least 30 IU/ml to support being autoantibody positive. Must be currently taking or has tried and failed or had an intolerance or contraindication to at least one standard therapy for systemic lupus erythematosus (e.g. corticosteroids, antimalarials, NSAIDS, or immunosuppressives) or lupus nephritis (e.g. corticosteroids, mycophenolate, cyclophosphamide, azathioprine). Diagnosis of active lupus nephritis. Documentation of a biopsy-proved lupus nephritis Class III, IV or V.		By or in consultation with a rheumatologist, hematologist, or nephrologist	12 months	For reauth: documentation from the prescriber indicating slowing of disease progression.	0	1
BELUMOSUDIL (REZUROCK)	Pending CMS Review			Diagnosis. For chronic Graft versus host disease (cGVHD), must have a trial and failure of at least two prior lines of systemic therapy.	GVHD: age 12 years or older	By or in consultation with an oncologist, hematologist, or transplant specialist	12 months		0	1
BENRALIZUMAB (FASENRA)	Pending CMS Review			Diagnosis. For severe eosinophilic asthma: Documentation of inadequate response, intolerance, or contraindication to a high-dose ICS in combination with a LABA. For eosinophilic gramunlomatosis with polyangiitis (EGPA): must have asthma, must have relapsing or refractory disease with maximally tolerated dose of corticosteroids unless contraindicated.		By or in consultation with an allergist, immunologist, pulmonologist, hematologist, or rheumatologist.	12 months	For reauth: documentation of improvement (e.g. reduced symptoms, reduced exacerbations, need for oral steroids).	0	1
BOSENTAN (TRACLEER)	Pending CMS Review		Pregnancy. Co-administration of cycloporine A or Glyburide	Diagnosis. Pulmonary arterial hypertension (PAH), WHO Group I, confirmed by provider attestation. If an echocardiogram was performed instead of right-heart catheterization (RHC), the provider must confirm that the echocardiogram was performed and supports the diagnosis of PAH.		Prescribed by or in consultation with cardiologist or pulmonologist.	12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0	0
BREXPIPRAZOLE (REXULTI)	1 - All FDA-approved Indications.			Diagnosis. For major depressive disorder and schizophrenia: documentation of trial and failure of at least two of the following generic atypical antipsychotics: olanzapine, quetiapine, paliperidone, risperidone, aripiprazole, ziprasidone, asenapine, or lurasidone.	Members 13 years of age or older.		12 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
BRIVARACETAM (BRIVIACT)	1 - All FDA-approved Indications.			Diagnosis. Must have had an inadequate response or intolerance to two generic antiepileptic drugs (e.g. valproate, lamotrigine, topiramate, clobazam).		By or in consultation with a neurologist	12 months		0	1
BUDESONIDE (EOHILIA)	Pending CMS Review			Diagnosis of eosinophilic esophagitis (EoE).	Coverage is provided for members 11 years of age or older.	By or in consultation with an allergist or gastroenterologist.	3 months	Reauth: use beyond 3 months has not been studied.	0	1
BUDESONIDE (TARPEYO)	Pending CMS Review			Diagnosis of primary immunoglobulin A nephropathy (IgAN) that has been confirmed by biopsy. Must be at risk of rapid disease progression (e.g. total urine protein greater than or equal to 0.5 g/day OR Urinary Protein-to-Creatinine Ration (UPCR) greater than or equal to 1.6 g/g).	Coverage is provided for members 18 years of age or older.	By or in consultation with a nephrologist.	9 months	For reauth: no reauthorization after initial coverage period. Safety and treatment with subsequent courses of Tarpeyo have not been established.	0	1
BUDESONIDE EXTENDED RELEASE TABLETS (UCERIS)	Pending CMS Review			Diagnosis. Must have a trial and failure, a contraindication, or an intolerance to two (2) of the following therapy options: topical mesalamine, oral aminosalicylate or corticosteroids with inadequate response or side effects/toxicity unless contraindicated.	Member must be 18 years of age or older.	By or in consultation with a rheumatologist or gastroenterologist.	8 weeks	For reauth: must have documentation from prescriber indicating slowing of disease progression.	0	1
BULEVIRTIDE-GMOD (HEPCLUDEX)	Pending CMS Review			Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling	Coverage is provided for members who are age-appropriate according to AASLD/IDSA guidance and/or FDA-approved labeling.	By or in consultation with a gastroenterologist, hepatologist, infectious disease, HIV or transplant specialist.	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling		0	0
C1 ESTERASE INHIBITOR (HAEGARDA)	Pending CMS Review			Diagnosis of HAE. Provider confirmation that diagnosis was confirmed based on C4 level, C1-INH antigenic level, C1-INH function level, genetic testing, or family history. Documentation of a history of at least one symptom of a moderate to severe HAE attack (i.e. moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema.	Coverage is provided for members 6 years of age or older.	Prescribed by or in consultation with an allergist/immunologist, hematologist, dermatologist	Initial: 6 months Reauthorization: 12 months	For reauth: must have documentation from prescriber indicating improvement in condition.	0	0
CANNABIDIOL (EPIDIOLEX)	1 - All FDA-approved Indications.			Diagnosis. Must have had an inadequate response or intolerance to two generic antiepileptic drugs (e.g. valproate, lamotrigine, topiramate, clobazam).		By or in consultation with a neurologist	12 months		0	1
CARGLUMIC ACID (CARBAGLU)	1 - All FDA-approved Indications.			Diagnosis. This Prior Authorization requirement only applies to members when a non-FDA approved diagnosis is submitted at the point of sale. FDA-approved diagnosis codes submitted will pay without prior authorization requirement.			12 months		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
CENOBAMATE (XCOPRI)	1 - All FDA-approved Indications.			Diagnosis. Must have had an inadequate response or intolerance to two generic antiepileptic drugs (e.g. valproate, lamotrigine, topiramate, clobazam).		By or in consultation with a neurologist	12 months		0	1
CEQUR	1 - All FDA-approved Indications.			Must have documentation of previous insulin use.			12 months		0	1
CYCLOBENZAPRINE	1 - All FDA-approved Indications.			Diagnosis. Documentation the member has had a three (3) month trial and failed or has a contraindication to tizanidine and baclofen.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.	0	12 months	Reauthorization: Documentation the member has had a three month trial to tizanidine and baclofen and has failed therapy or has a contraindication.	0	1
DALFAMPRIDINE (AMPYRA)	Pending CMS Review		History of seizure disorder, moderate to severe renal impairment (CrCl less than or equal to 50 mL/min).	Diagnosis of multiple sclerosis(MS). Must be ambulatory. Chart documentation of baseline motor disability or dysfunction evidenced by one of the following: documented timed 25-foot walk test (T25W) to establish baseline, documented Expanded Disability Status Scale (EDSS) score. Must be receiving, or is intolerant to, treatment with a disease-modifying agent for MS.	Coverage is provided for members 18 years of age or older.	Neurologist	12 months	For reauthorization: provider confirmation of improvement or stabilization since starting treatment. Improvement or stabilization from baseline of T25W improvement or EDSS since starting treatment.	0	0
DEFERASIROX (EXJADE)	1 - All FDA-approved Indications.		Glomerular Filtration Rate less than 40mL/min/1.73 m2. Concomitant advanced malignancy or high risk myelodysplastic syndrome. Platelet count less than 50000000000/L	Diagnosis. For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L. For chronic iron overload due to non-transfusion-dependent thalassemia (NTDT) syndromes: pretreatment serum ferritin level is greater than 300 mcg/L and a liver iron concentration of at least 5mg iron per gram dry weight.		Prescribed by or in consultation with a hematologist	12 months	For reauth: documentation from prescriber indicating stabilization or improvement in condition.	0	0
DENOSUMAB PRODUCTS	3 - All Medically-accepted Indications.			Diagnosis.		Prescribed by or in consultation with a hematologist or oncologist	6 months		0	0
DEUTETRABENAZINE (AUSTEDO)	Pending CMS Review		Hepatic impairment, concurrent use with MAOI's, reserpine, tetrabenazine, or valbenazine.	Diagnosis. Must have a left ventricular ejection fraction (LVEF) less than or equal to 45%. Must have had a hospitalization for heart failure or received outpatient IV diuretics. Documentation the member is currently taking or has had prior treatment with an angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker or Entresto and a beta blocker.	Coverage is provided for members 18 years of age or older.	By or in consultation with a neurologist or psychiatrist	12 months	For reauthorization: must have documentation from prescriber indicating condition stabilization, improvement, or slowing of disease progression.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
DEXTROMETHORPHAN-QUINIDINE (NUEDEXTA)	1 - All FDA-approved Indications.			Diagnosis. Pseudobulbar affect (PBA): documentation supporting the following: involuntary outbursts of laughing and/or crying that are incongruent or disproportionate to the member's emotional state AND other possible conditions that could result in emotional lability (e.g. depression, bipolar disorder, schizophrenia, epilepsy) have been ruled out. Must have underlying neurological disorder such as amyotrophic lateral sclerosis, multiple sclerosis, Alzheimer's and related diseases, Stroke, Traumatic Brain Injury, or Parkinsonian Syndrome.	Coverage is provided for members 18 years of age and older.	By or in consultation with neurologist	Initial: 3 months Reauthorization: 12 months	For reauthorization: Documentation indicating a decrease in the number of laughing and/or crying episodes since starting the medication.	0	0
DEXTROMETHORPHAN/BUPROPION (AUVELITY)	Pending CMS Review			Diagnosis. For major depressive disorder (MDD) documentation of trial and failure of at least two generic antidepressants alternatives such as an SSRI, SNRI, bupropion, trazodone or mirtazapine.	Coverage is provided for members 18 years of age or older.		12 months		0	1
DIAZEPAM (VALTOCO)	1 - All FDA-approved Indications.			Diagnosis. Must be using a maintenance antiepileptic drug.		By or in consultation with a neurologist	12 months		0	1
DIHYDROERGOTAMINE NASAL SPRAY (MIGRANAL)	1 - All FDA-approved Indications.		Members with hemiplegic or basilar migraine, ischemic heart disease (angina pectoris, history of MI, or documented silent ischemia) or who have clinical symptoms or findings consistent with coronary artery vasospasm (including Prinzmetal's variant angina or uncontrolled hypertension).	Diagnosis. Documentation of trial and failure of 1 medication from each of the following classes: a NSAID and a triptan unless contraindicated.	Coverage is provided for members 18 years of age and older.		12 months	For reauth: documentation from prescriber indicating stabilization or improvement in condition.	0	1
DIMETHYL FUMARATE	Pending CMS Review			Diagnosis: Patient has a relapsing form of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting multiple sclerosis, or active secondary progressive multiple sclerosis.		By or in consultation with a neurologist	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
DIROXIMEL FUMARATE VUMERITY)	Pending CMS Review			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).		By or in consultation with a neurologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
DORNASE ALFA (PULMOZYME)	Pending CMS Review			Diagnosis. B vs. D determination is made prior to clinical criteria being applied.		By or in consultation with a pulmonologist or cystic fibrosis specialist	12 months	For reauth: must have documentation of slowing of disease progression, stabilization, or improvement.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
DRONABINOL	1 - All FDA-approved Indications.			Diagnosis. Nausea and vomiting associated with cancer chemotherapy: must have trial of two conventional antiemetic treatments (e.g., ondansetron, aprepitant, metoclopramide, dexamethasone, prochlorperazine) with inadequate response or significant side effects/toxicity unless contraindicated.			12 months		0	1
DROXIDOPA (NORTHERA)	1 - All FDA-approved Indications.			Diagnosis. Documentation of a clinical diagnosis of symptomatic neurogenic orthostatic hypotension caused by one of the following: Primary autonomic failure (Parkinson's disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency or non-diabetic autonomic neuropathy. Must have a trial of midodrine with inadequate response or significant side effects/toxicity unless contraindicated.	Coverage is provided for members 18 years of age and older.		2 weeks	For reauth: rationale from the provider for continuing therapy beyond 2 weeks	0	1
DULAGLUTIDE (TRULICITY)	1 - All FDA-approved Indications.			Diagnosis of Type 2 diabetes or documented prior therapy with a Type 2 diabetes medication. Claims will automatically pay on-line without a requirement to submit for prior authorization when one of the following criteria is met: 1. a Type 2 diabetes diagnosis code is submitted at the point of sale OR 2. a pharmacy claims history of a Type 2 diabetes medication within the past 12 months.			12 months		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
DUPILUMAB (DUPIXENT)	Pending CMS Review			Diagnosis. For asthma: must have moderate to severe eosinophilic phenotype, must have recent t/f inhaled steroid in combo with long acting beta agonist (LABA). For atopic dermatitis: must have moderate to severe disease, must have a t/f with a topical calcineurin inhibitor for age 2 or older. For nasal polyps: must be used as add-on maintenance therapy, must have t/f intranasal corticosteroid treatment. For eosinophilic esophagitis: diagnosis. For prurigo nodularis: must have presence of firm, nodular lesions and pruritis for at least 6 wks. For COPD: must have an eosinophil count greater than or equal to 300 cells per microliter and must have uncontrolled symptoms despite triple therapy with inhaled corticosteroid, LABA, and long-acting muscarinic antagonist. Must be used as add on to triple therapy. For chronic spontaneous urticaria (CSU): history of urticaria w/ presence of hives, must have trial of a 2nd generation H1		By or in consultation with an allergist, dermatologist, immunologist, pulmonologist, ear-nose/throat specialist, or gastroenterologist.	12 months	For reauth: must have documentation of slowing of disease progression, stabilization, or improvement.	0	1
EDARAVONE (RADICAVA ORS)	Pending CMS Review			Diagnosis of Amyotrophic Lateral Sclerosis (ALS).		By or in consultation with a neurologist	12 months	For reauth: must have documentation of slowing of disease progression, stabilization, or improvement.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
EFGARTIGIMOD ALFA/HYALURONIDASE-QVFC (VYVGART HYTRULO)	Pending CMS Review			Diagnosis. Provider confirmation the member has documented generalized myasthenia gravis (gMG) or chronic inflammatory demyelinating polyneuropathy (CIDP). The requested agent must not be used in combination with another myasthenia gravis medication. The member has experienced therapeutic failure, contraindication or intolerance to generic pyridostigmine. A Myasthenia Gravis Foundation of America (MGFA) clinical classification and a MG activities of daily living score. For CIDP, the member has experienced progressive symptoms for at least two (2) months. The member has progressive or relapsing motor sensory dysfunction of more than one limb or a peripheral nerve nature, developing over at least 2 months. The member has hypo-or areflexia (usually involves all four limbs). The member has electrodiagnostic testing (e.g., electromyography (EMG), nerve conduction studies	Member must be 18 years of age or older.	By or in consultation with a neurologist.	12 months	For reauthorization: Documentation from the provider that the member has experienced improvement in signs and symptoms of generalized myasthenia gravis (for example, speech, swallowing, mobility, or respiratory function). The member has also experienced a decrease in the number of exacerbations of generalized myasthenia gravis. For CIDP, the member has experienced a slowing of disease progression in their functional ability or strength from baseline.	0	1
ELAMIPRETIDE (FORZINITY)	1 - All FDA-approved Indications.			Diagnosis. Confirmation of the diagnosis by at least one of the following: 1. a genetic test showing mutations in the TAZ gene. 2. an elevated (greater than 0.3) MLCL:CL ratio (monolysocardiolipin to tetralinoleoyl). Member must weigh at least 30kg.		By on in consultation with a cardiologist, endocrinologist, hematologist, geneticist, or neurologist	12 months	For reauthorization: documentation indicating slowing of disease progression.	0	0
ELAPEGADEMASE-LVLR (REVCOVI)	1 - All FDA-approved Indications.			Diagnosis. Must have a diagnosis of adenosine deaminase severe combined immunodeficiency disease (ADA-SCID) confirmed by either 1) genetic testing or 2) absent or very low adenosine deaminase activity in red blood cells (less than 1 percent of normal) and presence of either deoxyadenosine triphosphate (dATP) or deoxyadenine nucleotides (dAXP) in red blood cells. Must have severely impaired immune function (e.g. lymphopenia, extensive dermatitis, persistent diarrhea, recurrent pneumonia, life threatening illness caused by opportunistic infections.		By or in consultation with an immunologist or geneticist	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ELEXACAFTOR/TEZACAFTOR/IVACAFTOR (TRIKAFTA)	Pending CMS Review			Diagnosis. Documentation of genetic test confirming the member has at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive based on clinical data or results in production of CFTR protein.	Coverage is provided for members 2 years of age and older.	By or in consultation with a cystic fibrosis specialist or pulmonologist	12 months	For reauth: must have documentation of slowing of disease progression, stabilization, or improvement.	0	0
ELTROMBOPAG (ALVAIZ)	Pending CMS Review			Diagnosis. For ITP: diagnosis. For chronic hepatitis C: documentation that thrombocytopenia prevents the initiation of interferon-based therapy or limits the ability to maintain interferon-based therapy. For severe aplastic anemia: the member has had an insufficient response to immunosuppressive therapy or the members will be using the medication in combination with immunosuppressive therapy.		By or in consultation with a hematologist, oncologist, gastroenterologist, hepatologist, or infectious disease specialist	6 months	For reauth: for all dx documentation of improvement in platelet count from baseline. For hepatitis C: documentation the member is still on antiviral therapy.	0	1
ERENUMAB-AOOE (AIMOVIG)	Pending CMS Review			Diagnosis. Provider attestation confirming the member has a diagnosis of migraine.	Coverage is provided for members 18 years of age and older.		Initial: 6 months Reauthorization: 12 months	For reauthorization: Provider attestation that the member has experienced clinically meaningful benefit from treatment, demonstrated by at least one of the following: (1) a reduction in migraine or headache frequency, severity, or duration, (2) improvement in migraine-related disability, functioning, or quality of life, or (3) reduced use of acute migraine medication.	0	0
ESLICARBAZEPINE (APTIOM)	1 - All FDA-approved Indications.			Diagnosis. Must have had an inadequate response or intolerance to two generic antiepileptic drugs (e.g. valproate, lamotrigine, topiramate, clobazam).		By or in consultation with a neurologist	12 months		0	1
ETANERCEPT (ENBREL)	Pending CMS Review			Diagnosis. For rheumatoid arthritis (RA): history of trial and failure, contraindication, or intolerance to a three-month trial with methotrexate or another DMARD. For juvenile idiopathic arthritis (JIA) with polyarthritis: history of trial and failure, contraindication, or intolerance to a 3 month trial with methotrexate, leflunomide, or sulfasalazine. For JIA: diagnosis. For ankylosing spondylitis (AS): history of trial and failure, contraindication, or intolerance to a four-week trial each of at least 2 NSAIDs. For plaque psoriasis: a history of trial and failure of phototherapy or systemic treatment (e.g. methotrexate, cyclosporine, oral retinoids).	Member must be 2 years of age or older.	By or in consultation with a rheumatologist or dermatologist.	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
EVOLOCUMAB (REPATHA)	Pending CMS Review			Diagnosis. Provider confirms that the member has a cholesterol disorder for which treatment is indicated or that the member is an adult at increased risk for major adverse cardiovascular events, including members without a history of cardiovascular events, and treatment is being prescribed to reduce this risk. Provider attests that the member failed to achieve the treatment goal after a trial of a high-intensity statin (atorvastatin 40-80 mg daily or rosuvastatin 20-40 mg daily) or two moderate-intensity statins (atorvastatin or rosuvastatin) at the member's maximally tolerated dose, or that the member is intolerant to statin therapy.			12 months	Extreme risk: Provider confirms that the member is at extreme risk for atherosclerotic cardiovascular disease (ASCVD) based on the member's diagnosis, clinical history, and cardiovascular risk factors, which may include, but are not limited to, diabetes, stage 3 or 4 chronic kidney disease, heterozygous familial hypercholesterolemia, or a history of premature ASCVD. For reauthorization: Provider attests that the member has experienced a positive clinical response to therapy, such as improvement in LDL-C from baseline.	0	0
FECAL MICROBIOTA SPORES, LIVE-BRPK (VOWST)	1 - All FDA-approved Indications.			Documentation of a recent diagnosis of recurrent Clostridioides difficile infection (CDI) -AND- Will be used for prophylaxis and not treatment of recurrent CDI -AND- Attestation that antibiotic treatment for the most recent recurrent CDI is complete or will be completed.			1 month	For reauthorization, attestation of recurrent CDI episodes after administration of the initial fecal microbiota product -AND- Will be used for prophylaxis and not treatment of recurrent CDI -AND- Attestation that antibiotic treatment for the most recent recurrent CDI is complete or will be completed.	0	0
FENFLURAMINE (FINTEPLA)	1 - All FDA-approved Indications.		Use of monoamine oxidase inhibitors within 14 days	Diagnosis. Must have had an inadequate response or intolerance to two generic antiepileptic drugs (e.g. valproate, lamotrigine, topiramate, clobazam).		By or in consultation with a neurologist	12 months		0	1
FILGRASTIM-SNDZ (ZARXIO)	3 - All Medically-accepted Indications.			Diagnosis.			6 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
FINGOLIMOD HCL	Pending CMS Review			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).		By or in consultation with a neurologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
GALCANEZUMAB-GNLM (EMGALITY)	Pending CMS Review			Diagnosis: Provider attestation confirming the member has a diagnosis of migraine or episodic cluster headache. For episodic cluster headache: The member must have a trial and failure of verapamil for at least 2 weeks or a one-time suboccipital steroid injection, unless contraindicated or not tolerated.	Coverage is provided for members 18 years of age and older.		Initial: 6 months Reauthorization: 12 months	For reauthorization: Provider attestation that the member has experienced clinically meaningful benefit from treatment, demonstrated by at least one of the following: (1) reduction in migraine or cluster headache frequency, severity, or duration, (2) improvement in headache-related disability, functioning, or quality of life, or (3) reduced use of acute headache medication.	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
GANAXOLONE (ZTALMY)	Pending CMS Review			Diagnosis. Must have chart documentation of a diagnosis of CDKL5 deficiency disorder, including documentation of a CDKL5 gene mutation. Must submit provider confirmation of seizures.	Coverage is provided for members 2 years of age or older.	By or in consultation with a neurologist.	12 months		0	0
GEPIRONE (EXXUA)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two generic antidepressants alternatives such as an SSRI, SNRI, bupropion, trazodone or mirtazapine	Coverage is provided for members 18 years of age and older.		12 months		0	1
GLATIRAMER	Pending CMS Review			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).		By or in consultation with a neurologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
GLECAPREVIR-PIBRENTASVIR (MAVYRET)	1 - All FDA-approved Indications.		Members with moderate or severe hepatic impairment (Child-Pugh C). Coadministration with atazanavir and rifampin.	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling	Coverage is provided for members who are age-appropriate according to AASLD/IDSA guidance and/or FDA-approved labeling.	By or in consultation with a gastroenterologist, hepatologist, infectious disease, HIV or transplant specialist.	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling		0	0
GUSELKUMAB (TREMFYA)	1 - All FDA-approved Indications.			Diagnosis. For plaque psoriasis (PsO): a history of trial and failure of ONE of the following: 1) topical therapy (e.g. corticosteroid, calcineurin inhibitor, vitamin D analog), 2) phototherapy, 3) systemic treatment (e.g. methotrexate, cyclosporine, oral retinoids). For Crohn's (CD): Member has moderate to severe CD. For Ulcerative colitis(UC): Member has moderately to severely active ulcerative colitis.	For plaque psoriasis and active psoriatic arthritis: 6 years of age and older. All others uses: 18 years of age and older	By or in consultation with a rheumatologist, dermatologist, or gastroenterologist.	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0	1
ICATIBANT ACETATE	Pending CMS Review			Diagnosis of HAE. Provider confirmation that diagnosis was confirmed based on C4 level, C1-INH antigenic level, C1-INH function level, genetic testing, or family history. Documentation of a history of at least one symptom of a moderate to severe HAE attack (i.e. moderate to severe abdominal pain, facial swelling, airway swelling) in the absence of hives or a medication known to cause angioedema.	Coverage is provided for members 18 years of age or older.	By or in consultation with an allergist, immunologist, hematologist, or dermatologist.	12 months	For reauthorization: documentation from the prescriber indicating there is disease state improvement with one of the following: decrease in the number of HAE attacks, decrease in the severity of the HAE attacks or duration of HAE attacks since starting the medication.	0	0
ILOPERIDONE (FANAPT)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two of the following generic atypical antipsychotics: olanzapine, quetiapine, paliperidone, risperidone, aripiprazole, ziprasidone, asenapine, or lurasidone.	Coverage is provided for members 18 years of age or older.		12 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
INCRETIN MIMETIC DUPLICATE THERAPY-SITAGLIPTAN	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on a DPP-4 inhibitor and a GLP-1 receptor agonist. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of clinical rationale for concurrent use of a DPP-4 inhibitor and GLP-1 receptor agonist.			12 months	Reauthorization: Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	0
INCRETIN MIMETIC DUPLICATE THERAPY-SITAGLIPTAN-METFORMIN	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on a DPP-4 inhibitor and a GLP-1 receptor agonist. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of clinical rationale for concurrent use of a DPP-4 inhibitor and GLP-1 receptor agonist.			12 months	Reauthorization: Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	0
INCRETIN MIMETIC DUPLICATE THERAPY-EMPAGLIFLOZIN-LINAGLIPTIN	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on a DPP-4 inhibitor and a GLP-1 receptor agonist. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of clinical rationale for concurrent use of a DPP-4 inhibitor and GLP-1 receptor agonist.			12 months	Reauthorization: Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	0
INCRETIN MIMETIC DUPLICATE THERAPY-EMPAGLIFLOZIN-LINAGLIPTIN-METFORMIN	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on a DPP-4 inhibitor and a GLP-1 receptor agonist. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of clinical rationale for concurrent use of a DPP-4 inhibitor and GLP-1 receptor agonist.			12 months	Reauthorization: Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	0
INCRETIN MIMETIC DUPLICATE THERAPY-LINAGLIPTIN	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on a DPP-4 inhibitor and a GLP-1 receptor agonist. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of clinical rationale for concurrent use of a DPP-4 inhibitor and GLP-1 receptor agonist.			12 months	Reauthorization: Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
INCRETIN MIMETIC DUPLICATE THERAPY-LINAGLIPTIN-METFORMIN	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on a DPP-4 inhibitor and a GLP-1 receptor agonist. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of clinical rationale for concurrent use of a DPP-4 inhibitor and GLP-1 receptor agonist.			12 months	Reauthorization: Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	0
INFLIXIMAB PRODUCTS	3 - All Medically-accepted Indications.		Doses greater than 5mg/kg in moderate to severe heart failure.	Diagnosis. For rheumatoid arthritis (RA): history of trial and failure, contraindication, or intolerance to a 3 month trial with methotrexate or another DMARD. For psoriatic arthritis (PsA) one of the following: 1.)members with axial or enthesitis must have a history of trial and failure, contraindication, or intolerance to a 4 week trial of 2 NSAIDs. 2.) the member has severe disease as defined by the prescriber. 3.) members with peripheral disease must have a history of a trial and failure, contraindication, or intolerance to a 12 week trial with methotrexate or another DMARD. For ankylosing spondylitis (AS): history of trial and failure, contraindication, or intolerance to a four-week trial each of at least 2 NSAIDs. For plaque psoriasis: a history of trial and failure of ONE of the following: 1) topical therapy (e.g. corticosteroid, calcineurin inhibitor, vitamin D analog), 2) phototherapy, 3) systemic treatment (e.g. methotrexate, cyclosporine, oral retinoids). For Crohn's		By or in consultation with a rheumatologist, gastroenterologist, or dermatologist.	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0	1
INFLIXIMAB-DYYB (ZYMFENTRA)	Pending CMS Review			Diagnosis. Must have completed an intravenous induction regimen with an infliximab product before starting Infliximab-DYYB subcutaneous. For Crohns (CD): Member has moderate to severe CD. For Ulcerative colitis(UC): Member has moderately to severely active ulcerative colitis.	18 years of age or older	By or in consultation with a gastroenterologist	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	1	1
INSULIN SUPPLIES	1 - All FDA-approved Indications.			Confirmation of insulin use within the past 12 months based on paid claims or provider documentation.			12 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
INTERFERON BETA-1A (AVONEX)	Pending CMS Review			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).		By or in consultation with a neurologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
INTERFERON BETA-1B (BETASERON)	Pending CMS Review			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).		By or in consultation with a neurologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
IVABRADINE (CORLANOR)	Pending CMS Review		Acute decompensated heart failure, sick sinus syndrome, sinoatrial block, or 3rd degree AV block-unless a functioning demand pacemaker is present, resting heart rate less than 60 bpm prior to treatment, severe hepatic impairment, pacemaker dependence (heart rate maintained exclusively by the pacemaker), concomitant use of strong CYP3A4 inhibitors.	Diagnosis. For Adult Chronic Heart Failure (CHF): Must have left ventricular ejection fraction (LVEF) less than or equal to 35%, member is in sinus rhythm and has a resting heart rate of greater than or equal to 70 beats per minute, must currently be taking a beta-blocker (e.g., bisoprolol, carvedilol, metoprolol succinate) at the maximally tolerated dose or has a contraindication to beta-blocker use.	chf: coverage is provided for members 18 years of age or older. dcm: coverage is provided for members 6 months of age or older.	By or in consultation with a cardiologist	12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0	1
IVACAFTOR (KALYDECO)	Pending CMS Review			Diagnosis of cystic fibrosis that has been confirmed by genetic testing.		By or in consultation with a pulmonologist or cystic fibrosis specialist	12 months	For reauth: must have documentation of slowing of disease progression, stabilization, or improvement.	0	0
L-GLUTAMINE (ENDARI)	Pending CMS Review			Diagnosis. Must be used to reduce the acute complications of sickle cell disease (SCD). Member has had an adequate trial of at least 90 days of oral hydroxyurea unless the member has tried and failed or has a contraindication to hydroxyurea. Must not be used in combination with Adakveo (crizanlizumab-tmca).	Coverage is provided for members 5 years of age and older.	By or in consultation with a physician who specializes in SCD (e.g. a hematologist)	12 months	For reauthorization: Documentation there has been a reduction in vaso-occlusive painful events or an improvement in condition.	0	1
LANREOTIDE (SOMATULINE DEPOT)	1 - All FDA-approved Indications.			Diagnosis. For acromegaly: must have inadequate response to surgery or radiotherapy or documentation that these therapies are inappropriate, must have the following baseline labs: elevated serum IGF-1 level for gender/age range (including lab reference range) and elevated growth hormone level defined as GH at least 1ng/mL during oral glucose tolerance test.	Coverage is provided for members 18 years of age and older.	By or in consultation with an endocrinologist or oncologist	For oncology indications: 6 months. All other indications: 12 months	For reauth: documentation of improvement or stabilization.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
LETERMOVIR (PREVYMIS)	Pending CMS Review		Use with pimozide or ergot alkaloids. Use with pitavastatin and simvastatin when co-administered with cyclosporine.	Diagnosis. Must have received either an allogeneic hematopoietic stem cell transplant (HSCT) and have tested CMV-seropositive (Recipient positive, R+) or received a kidney transplant and be at high risk (donor CMV seropositive D+/recipient CMV seronegative R-). Must be used for prophylaxis of CMV infection.		By or in consultation with a hematologist, infectious disease, oncologist, or transplant specialist.	200 days post-transplant	For reauth: no reauthorization after initial coverage period.	0	0
LEUPROLIDE ACETATE	Pending CMS Review			Diagnosis. For endometriosis: Documentation the member has tried and failed or has a contraindication to 2 conventional treatments such as oral contraceptives, non steroidal anti-inflammatory agents, progestins, or danazol. For CPP: Documentation that the age of onset of secondary sexual characteristics occurred at less than 8 years of age in a female child or less than 9 years of age in a male child.	cpp: up to age 11 years in females and age 12 years in males. may be continued per individualized decision making in conjunction with the provider.		Prostate cancer and endometriosis: 6 months. Fibroids: 3 months. CPP: 12 months		0	1
LEVETIRACETAM (SPRITAM)	1 - All FDA-approved Indications.			Diagnosis. Must have had an inadequate response or intolerance to one of the following generic anticonvulsant drugs: phenytoin, carbamazepine, oxcarbazepine, gabapentin, lamotrigine, valproate, or topiramate.	Coverage is provided for members 4 years of age and older weighing more than 20kg.	By or in consultation with a neurologist.	12 months		0	1
LEVOMILNACIPRAN (FETZIMA)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two generic antidepressants alternatives such as an SSRI, SNRI, bupropion, trazodone or mirtazapine	Coverage is provided for members 18 years of age and older.		12 months		0	1
LIDOCAINE PATCH	3 - All Medically-accepted Indications.			Diagnosis. This Prior Authorization requirement only applies to members when a non-FDA approved diagnosis is submitted at the point of sale. FDA-approved diagnosis codes submitted will pay without prior authorization requirement.			12 months		0	0
LOTILANER (XDEMVY)	Pending CMS Review			Diagnosis of Demodex blepharitis confirmed by mite presence (e.g. collarettes) confirmed by slit lamp examination of the eyelashes.	Member must be 18 years of age and older.	Prescribed by or in consultation with an optometrist or ophthalmologist	6 weeks		0	0
LUMACAFTOR/IVACAFTOR (ORKAMBI)	Pending CMS Review			Diagnosis of cystic fibrosis that has been confirmed by genetic testing.		By or in consultation with a pulmonologist or cystic fibrosis specialist	12 months	For reauth: must have documentation of slowing of disease progression, stabilization, or improvement.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
LUMATEPERONE (CAPLYTA)	Pending CMS Review			Diagnosis. For major depressive disorder and schizophrenia: documentation of trial and failure of at least two of the following generic atypical antipsychotics: olanzapine, quetiapine, paliperidone, risperidone, aripiprazole, ziprasidone, asenapine, or lurasidone. For bipolar I depression a trial and failure of both lurasidone and quetiapine. For bipolar II depression a trial and failure of quetiapine.	Members 18 years of age or older.		12 months		0	1
MACITENTAN (OPSUMIT)	Pending CMS Review		Pregnancy	Diagnosis. Pulmonary arterial hypertension (PAH), WHO Group I, confirmed by provider attestation. If an echocardiogram was performed instead of right-heart catheterization (RHC), the provider must confirm that the echocardiogram was performed and supports the diagnosis of PAH.		Prescribed by or in consultation with cardiologist or pulmonologist.	12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0	0
MARIBAVIR (LIVTENCITY)	1 - All FDA-approved Indications.			Diagnosis of post-transplant (solid organ or hematopoietic stem cell) cytomegaloviris (CMV) infection/disease that is refractory to treatment with ganciclovir, valganciclovir, cidofovir, or foscarnet. Must weight at least 35 kg. Must not be used concomitantly with ganciclovir or valganciclovir.		By or in consultation with a hematologist, oncologist, infectious disease physician, or transplant specialist.	3 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0	1
MECASERMIN (INCRELEX)	1 - All FDA-approved Indications.		Active or suspected neoplasia, closed epiphyses.	Diagnosis. Growth chart and documentation that epiphyses are open. For growth hormone deletion: must have growth hormone (GH) gene deletion in gene GH1 and developed neutralizing antibodies to GH therapy. For growth failure due to severe IGF-1 deficiency: must have dx of severe IGF-1 deficiency (defined as having all of the following: height below or equal to 3.0 standard deviation (SD) of the mean for age and sex, basal IGF-1 SD of less than or equal to 3.0 based on lab reference range, normal or elevated GH defined as stimulated serum GH level of greater than 10ng/mL or basal serum GH level greater than 5ng/mL).		By or in consultation with an Endocrinologist	12 months	For reauth, must include a recent progress note from prescriber indicating growth and maturation as a result of treatment and that epiphyses have not closed.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
MEPOLIZUMAB (NUCALA)	Pending CMS Review			Diagnosis. For severe eosinophilic asthma: Documentation of inadequate response, intolerance, or contraindication to a high-dose ICS in combination with a LABA. For nasal polyps: Must be used as add-on maintenance therapy. Must have t/f intranasal corticosteroid treatment. For COPD: must have uncontrolled symptoms despite triple therapy with inhaled corticosteroid, LABA, and long-acting muscarinic antagonist. Must be used as add on to triple therapy. For eosinophilic granulomatosis with polyangiitis (EGPA): must have t/f corticosteroids unless contraindicated. For hypereosinophilic syndrome (HES): must have eosinophil blood count greater than or equal to 1,000 cells/microliter, must have FIP1L1-PDGFR-alpha negative disease, must have uncontrolled disease despite being on other HES therapy (e.g. corticosteroids, immunosuppressives, cytotoxic therapy), non-hematologic secondary causes		By or in consultation with an allergist, immunologist, pulmonologist, ear-nose/throat specialist, rheumatologist, or hematologist.	12 months	For reauth: must have documentation of slowing of disease progression, stabilization, or improvement.	0	1
METHYLNALTREXONE (RELISTOR)	1 - All FDA-approved Indications.		Known or suspected gastrointestinal obstruction and members at an increased risk of recurrent obstruction.	Diagnosis. For opioid-induced constipation and advanced life-limiting illness: must have documentation of previous trial of lactulose. For opioid-induced constipation with chronic non-cancer pain: must have documentation of current and ongoing opioid therapy and must have trials with inadequate responses or significant side effects/toxicity or have a contraindication to naloxegol (Movantik) and lactulose.	Coverage is provided for members 18 years of age and older.		12 months	For reauth: documentation from the prescriber indicating an improvement in condition (both diagnoses) and must continue to be on opioid therapy (non-cancer pain).	0	1
MIFEPRISTONE (KORLYM)	1 - All FDA-approved Indications.			Diagnosis. Must have failed surgery or not be a candidate for surgery. Female members of reproductive potential: must have baseline (within previous month, must include date of test) negative pregnancy test prior to starting mifepristone and must be using nonhormonal medically acceptable method of contraception (unless surgically sterilized) during treatment and for 1 month after mifepristone therapy.	Coverage is provided for members 18 years of age and older.	By or in consultation with an endocrinologist	12 months		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
MILSAPERIDONE (BYSANTI)	1 - All FDA-approved Indications.		Elderly patients with dementia-related psychosis.	Diagnosis. Documentation of trial and failure of at least two of the following generic atypical antipsychotics: olanzapine, quetiapine, paliperidone, risperidone, aripiprazole, ziprasidone, asenapine, or lurasidone.	Coverage is provided for members 18 years of age or older.		12 months		0	1
MODAFINIL (PROVIGIL)	Pending CMS Review			Diagnosis. Must have a history of trial and failure, contraindication, or intolerance to modafinil. For narcolepsy: Sleep study (e.g. polysomnogram, Multiple Sleep Latency Test) confirming diagnosis. For obstructive sleep apnea: Sleep study confirming diagnosis. For shift work sleep disorder (SWSD): must meet International Classification of Sleep Disorders criteria for SWSD (either primary complaint of excessive sleepiness or insomnia temporarily associated with work period that occurs during habitual sleep phase OR polysomnography and (1) Multiple Sleep Latency Test demonstrate loss of normal sleep wake pattern, (2) no other medical or mental disorders account for symptoms, and (3) symptoms do not meet criteria for any other sleep disorder producing insomnia or excessive sleepiness such as time zone change syndrome)		By or in consultation with a sleep specialist, ENT (ear, nose, and throat specialist), neurologist, or pulmonologist	SWSD: 6 months. Narcolepsy, OSA: 12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
MONOMETHYL FUMARATE (BAFIERTAM)	Pending CMS Review			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).		By or in consultation with a neurologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
NINTEDANIB (OFEV)	Pending CMS Review			Diagnosis. For a diagnosis of Idiopathic Pulmonary Fibrosis (IPF): Must have diagnosis confirmed by either high-resolution computed tomography (HRCT) or surgical lung biopsy and must have all other diagnoses ruled out (e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity). For a diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD): Must have onset of disease (first non-Raynaud symptom) within the past 7 years and at least 10% fibrosis on a chest high-resolution computed tomography (HRCT) scan within the past 12 months. For a diagnosis of Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a Progressive Phenotype: Must have diagnosis confirmed by HRCT. Must have a progressive phenotype.	Coverage provided for members age 18 years and older.	By or in consultation with a pulmonologist or rheumatologist	Initial: 6 months, Reauth: 12 months	For reauth: must have documentation from prescriber indicating that member still is a candidate for treatment.	0	0
NITISINONE (ORFADIN)	Pending CMS Review			Diagnosis of hereditary tyrosinemia type 1 (HT-1) confirmed by newborn screening for HT-1 with positive succinylacetone test, genetic DNA testing showing fumarylacetoacetate hydrolase (FAH) gene mutation or elevated blood or urine succinylacetone or succinylacetoacetate (SA) level. Test results with reference range if applicable is required.		By or in consultation with a gastroenterologist, a hematologist, a nephrologist, or a physician who specializes in the treatment of inherited metabolic disorders.	12 months	For reauth: Documentation from the prescriber indicating slowing of disease progression in the member's condition.	0	0
OFATUMUMAB (KESIMPTA)	Pending CMS Review			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).		By or in consultation with a neurologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
OLANZAPINE/SAMIDORPHAN (LYBALVI)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two of the following generic atypical antipsychotics: olanzapine, quetiapine, paliperidone, risperidone, aripiprazole, ziprasidone, asenapine, or lurasidone. If the member is 65 and older and not in hospice care and taking this medication at the same time as another anticholinergic medication, must provide documentation of the following: 1. Provider must acknowledge that the benefit or the combination of medication outweighs the potential risks, 2. The member has tried and failed monotherapy, 3. Clinical rationale for use of 2 or more anticholinergic medications.	Coverage is provided for members 18 years of age or older.		12 months		0	1
OMALIZUMAB (XOLAIR)	Pending CMS Review			Diagnosis. For moderate to severe allergic asthma: Documentation of recent use and failure to respond to inhaled steroid in combo with long acting beta agonist. Must follow recommended dosing guidelines based upon weight and IgE level. For chronic spontaneous urticaria (CSU): must have chart documentation showing history of urticaria w/ presence of hives, must have trial of a 2nd generation H1 antihistamine (e.g. levocetirizine) with inadequate responses or significant side effects/toxicity unless contraindicated. For nasal polyps: must be used as add-on maintenance therapy, must have t/f intranasal corticosteroid treatment, must follow recommended dosing guidelines based upon weight and IgE level. For IgE-mediated food allergy: must be confirmed by skin prick test or serum IgE level.		By or in consultation with, for Urticaria: allergist, dermatologist, immunologist. Asthma: pulmonologist or allergist. Nasal Polyps: allergist, ear/nose/throat specialist, or immunologist. Allergy: allergist or immunologist.	12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0	1
OMNIPOD PUMP KIT	1 - All FDA-approved Indications.			Must have documentation of previous insulin use.			12 months		0	1
OMNIPOD PUMP RESERVOIR	1 - All FDA-approved Indications.			Must have documentation of previous insulin use.			12 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ONABOTULINUMTOXINA (BOTOX)	1 - All FDA-approved Indications.			Diagnosis. For migraine prophylaxis: must have adequate trial of two migraine prophylactic agents each from a separate class (e.g. anticonvulsants, beta-blockers, tricyclic antidepressants) with inadequate response. For urinary incontinence or OAB with urge urinary incontinence, urgency, frequency: must have adequate trial (at least 4 weeks) at recommended dose of 2 anticholinergic meds (e.g., oxybutynin ER, oxybutynin, Toviaz) with inadequate response or intolerance unless contraindicated.		By or in consultation with an appropriate specialist (i.e.. dermatologist, neurologist, urologist).	12 months	For reauth: documentation from prescriber indicating stabilization or improvement in condition.	0	1
ONCOLOGY MEDICATIONS - ABEMACICLIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ABIRATERONE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ABIRATERONE/NIRAPARIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ACALABRUTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ADAGRASIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - AFATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ALECTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ALITRETINOIN	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ALPELISIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - APALUTAMIDE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ASCIMINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ASPARAGINASE	3 - All Medically-accepted Indications.			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months	Reauth: documentation that disease progression has not occurred.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ONCOLOGY MEDICATIONS - AVAPRITINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - AVUTOMETINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - AXITINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - AZACITIDINE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months		0	0
ONCOLOGY MEDICATIONS - BELZUTIFAN	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - BEXAROTENE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - BINIMETINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - BOSUTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - BRIGATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - CABOZANTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - CAPIVASERTIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - CAPMATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - CERITINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - COBIMETINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months	Reauth: documentation that disease progression has not occurred.	0	0
ONCOLOGY MEDICATIONS - CRIZOTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - DABRAFENIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - DACOMITINIB	3 - All Medically-accepted Indications.			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months	Reauth: documentation that disease progression has not occurred.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ONCOLOGY MEDICATIONS - DARATUMUMAB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months	Reauth: documentation that disease progression has not occurred.	0	0
ONCOLOGY MEDICATIONS - DARAXONRASIB	3 - All Medically-accepted Indications.			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months	Reauth: documentation that disease progression has not occurred.	0	0
ONCOLOGY MEDICATIONS - DAROLUTAMIDE	3 - All Medically-accepted Indications.			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - DASATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - DECITABINE-CEDAZURIDINE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - DEGARELIX	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - DORDAVIPRONE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - DUVELISIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - EFLORNITHINE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ELACESTRANT	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months		0	0
ONCOLOGY MEDICATIONS - ENASIDENIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ENCORAFENIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ENSARTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ENTRECTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ENZALUTAMIDE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - EPCORITAMAB	3 - All Medically-accepted Indications.			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months	Reauth: documentation that disease progression has not occurred.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ONCOLOGY MEDICATIONS - ERDAFITINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ERLOTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - EVEROLIMUS	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - FEDRATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - FLUTAMIDE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - FRUQUINTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - FUTIBATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - GEFITINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - GILTERITINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - GLASDEGIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - IBRUTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - IDELALISIB	3 - All Medically-accepted Indications.			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months	Reauth: documentation that disease progression has not occurred.	0	0
ONCOLOGY MEDICATIONS - IMATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - IMLUNESTRANT	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months		0	0
ONCOLOGY MEDICATIONS - INAVOLISIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - IVOSIDENIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - IXAZOMIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ONCOLOGY MEDICATIONS - LAPATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - LAROTRECTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - LAZERTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - LENALIDOMIDE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months		0	0
ONCOLOGY MEDICATIONS - LENVATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - LEUPROLIDE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - LOMUSTINE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months		0	0
ONCOLOGY MEDICATIONS - LORLATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - MECHLORETHAMINE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months		0	0
ONCOLOGY MEDICATIONS - MIDOSTAURIN	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - MIRDAMETINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - MOMELOTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - NERATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - NILOTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - NIRAPARIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - NIROGACESTAT	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ONCOLOGY MEDICATIONS - OLAPARIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - OLUTASIDENIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - OSIMERTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - PACRITINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - PALBOCICLIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - PAZOPANIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - PEMIGATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - PERTUZUMAB-TRASTUZUMAB	3 - All Medically-accepted Indications.			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months	Reauth: documentation that disease progression has not occurred.	0	0
ONCOLOGY MEDICATIONS - PEXIDARTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - PIRTOBRUTINIB	Pending CMS Review			Diagnosis. Must have a trial and failure or contraindication to Brukinsa, Calquence, or Imbruvica when the indication is shared.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - POMALIDOMIDE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - PONATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - PRALSETINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - QUIZARTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - REGORAFENIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - RELACORILANT	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ONCOLOGY MEDICATIONS - RELUGOLIX	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - REPOTRECTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - REVUMENIB	Pending CMS Review			Diagnosis. For adults with AML with NPM1 mutations, must have either 1) a trial and failure or contraindication to Komzifti or 2) Revuforj is being used in combination with a strong CYP3A4 inhibitor (e.g. posaconazole).		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	1
ONCOLOGY MEDICATIONS - RIBOCICLIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - RIPRETINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ROPEGINTERFERON	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - RUCAPARIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - SELINEXOR	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - SELPERCATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - SELUMETINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - SEVABERTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - SONIDEGIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - SORAFENIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - SOTORASIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - SUNITINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - TALAZOPARIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ONCOLOGY MEDICATIONS - TALETRECTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - TECLISTAMAB	3 - All Medically-accepted Indications.			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months	Reauth: documentation that disease progression has not occurred.	0	0
ONCOLOGY MEDICATIONS - TEPOTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - THALIDOMIDE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - THIOGUANINE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months		0	0
ONCOLOGY MEDICATIONS - TIVOZANIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - TOVORAFENIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - TRAMETINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - TRIFLURIDINE-TIPIRACIL	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - TUCATINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - VEMURAFENIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - VENDETANIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - VENETOCLAX	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - VEPDEGESTRANT	3 - All Medically-accepted Indications.			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months	Reauth: documentation that disease progression has not occurred.	0	0
ONCOLOGY MEDICATIONS - VIMSELTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - VISMODEGIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ONCOLOGY MEDICATIONS - VORASIDENIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - VORINOSTAT	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ZANUBRUTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ZIDESAMTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months	Reauth: documentation that disease progression has not occurred.	0	0
ONCOLOGY MEDICATIONS - ZIFTOMENIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS - ZONGERTINIB	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, or appropriate specialist depending on the indication.	6 months		0	0
ONCOLOGY MEDICATIONS-IBERDOMIDE	Pending CMS Review			Diagnosis.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months	Reauth: documentation that disease progression has not occurred.	0	0
ORAL BENZODIAZEPINES (ALPRAZOLAM)	Pending CMS Review			Prior authorization is required only for requests exceeding a 14-day supply within a 30-day period for members who are not receiving hospice care. For treatment of a psychiatric disorder (e.g., generalized anxiety disorder, panic disorder, or post-traumatic stress disorder), one of the following criteria must be met: (1) the member has tried and failed, experienced an intolerance to, or has a contraindication to at least two antidepressants, or (2) the request is related to a hospitalization within the past three months or the requested therapy is medically necessary to prevent harm to the member or others. For requests in which a benzodiazepine will be filled concurrently with an opioid, defined as an overlapping days' supply of at least 30 cumulative days, the provider must confirm all of the following: (1) there is a clinical rationale for concomitant use of the opioid and benzodiazepine, (2) an ongoing treatment plan is in			12 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ORAL BENZODIAZEPINES (CLONAZEPAM)	Pending CMS Review			Prior authorization is required only for requests exceeding a 14-day supply within a 30-day period for members who are not receiving hospice care. The member must meet one of the following diagnosis-specific criteria. Seizure disorder: The member has tried and failed, had an intolerance to, or has a contraindication to at least one non-benzodiazepine anticonvulsant. Panic disorder: (1) The member has tried and failed, had an intolerance to, or has a contraindication to at least two antidepressants, (2) the request is related to a hospitalization within the past three months, or (3) the requested therapy is medically necessary to prevent harm to the member or others. For requests involving concurrent use of a benzodiazepine and an opioid, defined as overlapping days' supply totaling at least 30 cumulative days, the prescriber must confirm: (1) the clinical rationale for concomitant therapy, (2) that			12 months		0	1
ORAL BENZODIAZEPINES (CLORAZEPATE)	Pending CMS Review			Prior authorization is required only for requests exceeding a 14-day supply in a 30-day period for members who are not receiving hospice care. The member must meet one of the following diagnosis-specific requirements. Seizure disorder: The member has tried and failed, had an intolerance to, or has a contraindication to at least one non-benzodiazepine anticonvulsant. Anxiety disorder: The member meets one of the following: (1) has tried and failed, had an intolerance to, or has a contraindication to at least two antidepressants, (2) the request is related to a hospitalization within the past 3 months, or (3) the requested therapy is medically necessary to prevent harm to the member or others. For requests involving concurrent use of a benzodiazepine and an opioid, defined as overlapping days' supply totaling at least 30 cumulative days, the prescriber must confirm (1) the clinical rationale for			12 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ORAL BENZODIAZEPINES (DIAZEPAM)	Pending CMS Review			Prior authorization is required only for requests exceeding a 14-day supply within a 30-day period for members who are not receiving hospice care. The member must meet one of the following diagnosis-specific requirements. Seizure disorder: Provider confirmation that the member has tried and failed, had an intolerance to, or has a contraindication to at least one non-benzodiazepine anticonvulsant. Anxiety disorder: Provider confirmation of one of the following: (1) the member has tried and failed, had an intolerance to, or has a contraindication to at least two antidepressants, (2) the request is related to a hospitalization within the past 3 months, or (3) the requested therapy is medically necessary to prevent harm to the member or others. Musculoskeletal disorder: Provider confirmation that the member has tried and failed, had an intolerance to, or has a contraindication to at least			12 months		0	1
ORAL BENZODIAZEPINES (LORAZEPAM)	Pending CMS Review			Prior authorization is required only for requests exceeding a 14-day supply within a 30-day period and for members who are not receiving hospice care. The member must meet one of the following diagnosis-specific requirements. Seizure disorder: Provider confirmation that the member has tried and failed, had an intolerance to, or has a contraindication to at least one non-benzodiazepine anticonvulsant. Sleep disorder: Provider confirmation that the member has tried and failed, has an intolerance to, or has a contraindication to at least two non-benzodiazepine sleep medications. Anxiety disorder: Provider confirmation of one of the following: (1) the member has tried and failed, has an intolerance to, or has a contraindication to at least two antidepressants, (2) the request is related to a hospitalization within the past three months, or (3) the requested therapy is medically necessary to prevent harm to the member			12 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
ORAL BENZODIAZEPINES (TEMAZEPAM)	Pending CMS Review			Prior authorization is required only for requests exceeding a 14-day supply within a 30-day period for members who are not receiving hospice care. For requests in which a benzodiazepine will be filled concurrently with an opioid, defined as an overlapping days' supply of at least 30 cumulative days, the provider must confirm all of the following: (1) there is a clinical rationale for concomitant use of the opioid and benzodiazepine, (2) an ongoing treatment plan is in place for continued concomitant use, and (3) a plan is in place to taper the benzodiazepine or opioid. If a taper is not appropriate at this time, the provider must confirm when tapering will be reevaluated.			12 months		0	1
OZANIMOD (ZEPOSIA)	Pending CMS Review			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).		By or in consultation with a neurologist or gastroenterologist	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
PASIREOTIDE (SIGNIFOR)	1 - All FDA-approved Indications.			Diagnosis of Cushing's disease for whom pituitary surgery is not an option or has not been curative. Documentation of trial and failure with ketoconazole to reduce cortisol secretion.	Coverage is provided for members 18 years of age or older.	By or in consultation with an Endocrinologist	12 months	For reauth: documentation of improvement or stabilization.	0	1
PEGFILGRASTIM-BMEZ (ZIEXTENZO)	3 - All Medically-accepted Indications.			Diagnosis.			6 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0	0
PEGINTERFERON BETA-1A (PLEGRIDY)	Pending CMS Review			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).		By or in consultation with a neurologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
PEGVISOMANT (SOMAVERT)	Pending CMS Review			Diagnosis of acromegaly. Must have elevated serum IGF-1 level for gender/age range and elevated growth hormone level defined as GH at least 1ng/mL during oral glucose tolerance test.	Coverage is provided for members 18 years of age or older.		12 months	For reauth: documentation of improvement or stabilization.	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
PERAMPANEL (FYCOMPA)	1 - All FDA-approved Indications.			Diagnosis. Must have had an inadequate response or intolerance to two of the following generic anticonvulsant drugs: levetiracetam, phenytoin, carbamazepine, oxcarbazepine, gabapentin, lamotrigine, valproate, or topiramate.		By or in consultation with a neurologist.	12 months		0	1
PIMAVANSERIN (NUPLAZID)	Pending CMS Review			Diagnosis. The prescriber must confirm that the member has hallucinations and/or delusions associated with Parkinson s disease psychosis. The prescriber must also confirm that medications that may cause or contribute to hallucinations or delusions have been reduced or discontinued when clinically appropriate, or that dose reduction or discontinuation is not clinically appropriate.	Coverage is provided for members 18 years of age or older.	By or in consultation with a neurologist or psychiatrist	12 months		0	0
PIRFENIDONE (ESBRIET)	Pending CMS Review			Diagnosis. Must have diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by either high-resolution computed tomography (HRCT) or surgical lung biopsy. Must have all other diagnoses ruled out (e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity).	Coverage provided for members age 18 years and older.	Pulmonologist	Initial: 6 months, Reauth: 12 months	For reauth: must have documentation from prescriber indicating that member still is a candidate for treatment.	0	0
PLOZASIRAN (REDEMPLO)	Pending CMS Review			Diagnosis: The prescriber confirms that the member has a diagnosis of familial chylomicronemia syndrome (FCS).	Coverage is provided for members 18 years of age and older	By on in consultation with a lipidologist, geneticist cardiologist, or endocrinologist	12 months	For reauthorization: documentation indicating stabilization or improvement in condition.	0	0
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (CHLORPROMAZINE)	Pending CMS Review			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (CHLORZOXAZONE)	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months	Reauthorization: Documentation of one of the following: 1. attempt to taper of one of the medications OR 2. documentation of why tapering one of the medications is not appropriate at this time. Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (CLOMIPRAMINE)	Pending CMS Review			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months		0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (CLOZAPINE)	Pending CMS Review			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months		0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (CYPROHEPTADINE)	Pending CMS Review			This prior authorization requirement applies to members receiving 2 or more unique anticholinergic medications. Provider confirmation of both of the following: (1) the member has tried and failed monotherapy, and (2) there is a clinical rationale for the use of 2 or more anticholinergic medications. The provider must attest that the benefit of the medication combination outweighs the potential risks.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months	Reauthorization: Provider confirmation of one of the following: (1) an attempt has been made to taper one of the medications, OR (2) tapering one of the medications is not appropriate at this time. Provider attestation that the member continues to benefit from the combination of medications and that the benefit outweighs any potential risks.	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (DICYCLOMINE)	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months	Reauthorization: Documentation of one of the following: 1. attempt to taper of one of the medications OR 2. documentation of why tapering one of the medications is not appropriate at this time. Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (DIPHENOXYLATE-ATROPINE)	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months	Reauthorization: Documentation of one of the following: 1. attempt to taper of one of the medications OR 2. documentation of why tapering one of the medications is not appropriate at this time. Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (GUANFACINE)	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months	Reauthorization: Documentation of one of the following: 1. attempt to taper of one of the medications OR 2. documentation of why tapering one of the medications is not appropriate at this time. Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (HYDROXYZINE)	Pending CMS Review			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (LOXAPINE)	Pending CMS Review			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months		0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (MEGESTROL)	Pending CMS Review			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months		0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (METHOCARBAMOL)	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months	Reauthorization: Documentation of one of the following: 1. attempt to taper of one of the medications OR 2. documentation of why tapering one of the medications is not appropriate at this time. Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (OLANZAPINE)	Pending CMS Review			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (PAROXETINE)	Pending CMS Review			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months		0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (PERPHENAZINE)	Pending CMS Review			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months		0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (PROMETHAZINE)	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months	Reauthorization: Documentation of one of the following: 1. attempt to taper of one of the medications OR 2. documentation of why tapering one of the medications is not appropriate at this time. Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0	1
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (THIORIDAZINE)	Pending CMS Review			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
POLYPHARMACY - MULTIPLE ACH MEDICATIONS (TRIFLUOPERAZINE)	Pending CMS Review			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months		0	1
POSACONAZOLE (NOXAFIL)	1 - All FDA-approved Indications.		Coadministration with sirolimus, ergot alkaloids (e.g., ergotamine, dihydroergotamine), HMG-CoA reductase inhibitors that are primarily metabolized through CYP3A4 (e.g., atorvastatin, lovastatin, simvastatin), or CYP3A4 substrates that prolong the QT interval (e.g., pimozide, quinidine), hypersensitivity to posaconazole, other azole antifungal agents, or any component of the formulation.	Diagnosis. For oropharyngeal candidiasis, must have at least a 2 week trial of fluconazole with an insufficient response, intolerable side effect, or have a contraindication.			12 months		0	1
PREGABALIN (LYRICA)	Pending CMS Review			Diagnosis. For fibromyalgia: must have trial and failure to duloxetine or muscle relaxant unless contraindicated. For PHN: must have trial and failure, intolerance, or contraindication to gabapentin. For DPN: must have documented pharmacy claim history or prior therapy with a diabetic medication OR a medical/lab claim or physician chart note of diabetes diagnosis and must have trial and failure, intolerance, or contraindication to gabapentin.	For partial onset seizures, coverage is provided for members 1 month of age and older. For fibromyalgia, phn, dpn, and neuropathic pain associated with spinal cord injury, coverage is provided for members 18 years of age or older.		12 months		0	1
PRETOMANID	Pending CMS Review			Diagnosis. Must have either inadequate response to a first-line tuberculosis (TB) regimen containing isoniazid and rifampin OR provider attestation of resistance to isoniazid and rifampin. Must be part of combination therapy with linezolid and bedaquiline.	Member must be 18 years of age or older	By or in consultation with a pulmonologist or infectious disease specialist	6 months		0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
PURIFIED CORTROPHIN GEL (CORTICOTROPIN) INJECTION	1 - All FDA-approved Indications.		Members with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, hypertension, or sensitivity to proteins derived from porcine sources, primary adrenocortical insufficiency or adrenocortical hyperfunction are excluded.	Diagnosis. For acute exacerbation of multiple sclerosis, member must have tried and failed or have a contraindication to 2 corticosteroids (e.g. IV methylprednisolone, IV dexamethasone, or high dose oral steroids). Must have documentation or claims verifying the member is on a medication for the treatment of multiple sclerosis. For RA (incl. Juvenile RA), psoriatic arthritis, ankylosing spondylitis, acute gouty arthritis: must be using as adjunctive therapy for short-term administration (to tide over an acute episode or exacerbation) and have a trial of 2 IV steroids w/ inadeq response or signif side effects/toxicity. The member is concurrently receiving maintenance therapy with at least one of the following: an NSAID, DMARD (e.g. methotrexate, leflunomide, sulfasalazine) or biologic (e.g. adalimumab, etanercept, infliximab, tofacitinib). For collagen disease, member must have tried and failed or		Must be prescribed by or in consultation with a neurologist or physician that specializes in the treatment of multiple sclerosis, a rheumatologist, allergist, dermatologist, immunologist, ophthalmologist, pulmonologist, nephrologist	1 month	For allergic states such as serum sickness or transfusion reaction due to serum protein reaction, member must have tried and failed 2 corticosteroids (e.g. IV methylprednisolone, IV dexamethasone, or high dose oral steroids) or has a contraindication to corticosteroid therapy. If the member has a diagnosis of atopic dermatitis, the member is concurrently receiving maintenance therapy with one (1) of the following, or is contraindicated to all: topical corticosteroid, topical calcineurin inhibitor (e.g., tacrolimus, pimecrolimus), topical PDE-4 inhibitor or Dupixent (dupilumab). For a diagnosis of serum sickness, must provide laboratory documentation demonstrating neutropenia, development of reactive plasmacytoid lymphocytes, and elevated erythrocyte sedimentation rate or C-reactive protein. For ophthalmic diseases such as severe acute and chronic	1	1
RESMETIROM (REZDIFFRA)	Pending CMS Review		Members with decompensated cirrhosis	Diagnosis. Medication will be used for the treatment of an adult with noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH), with moderate to advanced liver fibrosis consistent with stage F2 to F3 fibrosis, as confirmed by the prescriber. Member must not have cirrhosis or hepatic decompensation. Prescriber must attest that the member has MASH/NASH with moderate to advanced liver fibrosis consistent with stage F2 to F3 fibrosis without cirrhosis and that Rezdiffra will be used in conjunction with diet and exercise. Member must have at least a 3-month trial and failure, contraindication, or intolerance to Wegovy. Must have attestation from prescriber that the member does not have significant alcohol use, hepatic decompensation or hepatocellular carcinoma (HCC).	Coverage is provided for members 18 years of age and older.	By or in consultation with a hepatologist or gastroenterologist	12 months	For reauth: coverage may be renewed when the member has (1) demonstrated clinical benefit from Rezdiffra (e.g., improvement or stabilization of liver fibrosis, liver stiffness, etc), (2) has not developed decompensated cirrhosis, (3) continues diet and exercise as clinically appropriate, and (4) has no clinically significant drug-related toxicity warranting discontinuation.	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
RIFAXIMIN (XIFAXAN)	Pending CMS Review			Diagnosis. For hepatic encephalopathy: must have trial and failure of lactulose. For diarrhea-predominant irritable bowel syndrome (IBS-D): diagnosis. For Traveler's diarrhea: must have a trial and failure, intolerance, or contraindication to one of the following: a fluoroquinolone (i.e. ciprofloxacin, levofloxacin) or azithromycin.	Hepatic encephalopathy and IBS-D: 18 years of age or older, travelers diarrhea: 12 years of age or older	Hepatic encephalopathy: by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist, IBS-D: gastroenterologist	Hepatic encephalopathy: 12 months, IBS-D: 2 weeks, Travelers diarrhea: 3 days		0	1
RILONACEPT (ARCALYST)	Pending CMS Review			Diagnosis. For Cryopyrin-Associated Periodic Syndromes (CAPS) , must have documented genetic mutation in the Cold-Induced Auto-inflammatory Syndrome 1 (CIAS1) also known as NLRP3 including prescriber confirmation of Familial Cold Autoinflammatory Syndrome (FCAS) or Muckle Wells Syndrome (MWS) diagnoses. For Deficiency of Interleukin-1 Receptor Antagonist (DIRA), must have a confirmed diagnosis of DIRA as evidenced by a mutation in the IL1RN gene. For recurrent pericarditis, must have a history of trial and failure of at least 1 month, contraindication, or intolerance to colchicine in combination with an NSAID or aspirin.	CAPS and recurrent pericarditis: coverage provided for adults and children age 12 years and older. For DIRA: adults and pediatric members weighing 10kg or more.	By or in consultation with a hematologist, dermatologist, rheumatologist, neurologist, allergist, immunologist, cardiologist, a genetic specialist, primary care provider (PCP) and pediatrician.	12 months	For reauth: documentation from prescriber indicating stabilization or improvement in condition.	0	1
RIMEGEPANT (NURTEC ODT)	Pending CMS Review			Diagnosis: Provider confirmation of a diagnosis of migraine. For acute treatment of migraine: The member must have a history of trial and failure, contraindication, or intolerance to at least one triptan.	Coverage is provided for members 18 years of age and older.		For episodic migraine initial: 6 months. For acute migraine and reauthorization: 12 months	For reauthorization: Provider attestation that the member has experienced clinically meaningful benefit from treatment, demonstrated by at least one of the following: (1) a reduction in migraine or headache frequency, severity, or duration, (2) improvement in migraine-related disability, functioning, or quality of life, or (3) reduced use of acute migraine medication.	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
RIOCIGUAT (ADEMPAS)	Pending CMS Review		Coverage will not be provided for patients taking nitrates (nitrates in any form) or a PDE inhibitor (e.g. sildenafil).	Diagnosis. Pulmonary arterial hypertension (PAH), WHO Group I, or persistent/recurrent chronic thromboembolic pulmonary hypertension (CTEPH), WHO Group IV, following surgical treatment or when inoperable, confirmed by provider attestation. The provider must confirm that appropriate diagnostic testing was performed and supports the diagnosis. If an echocardiogram was performed instead of right-heart catheterization (RHC), the provider must confirm that the echocardiogram was performed and supports the diagnosis.		Prescribed by or in consultation with cardiologist or pulmonologist.	12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0	0
RISANKIZUMAB-RZAA (SKYRIZI)	1 - All FDA-approved Indications.			Diagnosis. For plaque psoriasis: a history of trial and failure of ONE of the following: 1) topical therapy (e.g. corticosteroid, calcineurin inhibitor, vitamin D analog), 2) phototherapy, 3) systemic treatment (e.g. methotrexate, cyclosporine, oral retinoids). For Crohn's (CD): Member has moderate to severe CD. For Ulcerative colitis(UC): Member has moderately to severely active ulcerative colitis.		By or in consultation with a rheumatologist, dermatologist or gastroenterologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	1
ROZANOLIXIZUMAB-NOLI (RYSTIGGO)	1 - All FDA-approved Indications.			Diagnosis. Member must have generalized myasthenia gravis (gMG) who are anti-acetylcholine receptor (AChR) or antimuscle-specific tyrosine kinase (MuSK) antibody positive. The requested agent must not be used in combination with another myasthenia gravis medication. Documentation of a Myasthenia Gravis Foundation of America Clinical Classification class II to IVa. Must have a Myasthenia Gravis-Specific Activities of Daily Living (MG-ADL) total score greater than or equal to 3 with at least 3 points from non-ocular symptoms. Member must have laboratory testing demonstrating IgG levels of at least 5.5 g per Liter. Documentation of a baseline Quantitative Myasthenia Gravis (QMG) scale score. Must have documentation of one of the following: failed treatment over 1 year or more with 2 or more immunosuppressive therapies either in combination or as monotherapy (e.g.	Member must be 18 years of age or older.	By or in consultation with a neurologist.	12 months	For reauthorization: Documentation from the provider that the member had a positive clinical response and tolerates therapy supported by at least one of the following: a 2 point improvement in the member's total MG-ADL score OR a 3 or more point improvement in QMG total score.	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
RUFINAMIDE (BANZEL)	1 - All FDA-approved Indications.		Not covered for patients with Familial Short QT Syndrome	Diagnosis. Must have had an inadequate response or intolerance two generic anticonvulsant drugs (e.g. lamotrigine, valproate, topiramate, felbamate, clobazam). Must be using rufinamide as adjunctive therapy to other antiepileptic drugs (which can include medication from trial above).		By or in consultation with a neurologist.	12 months		0	1
RUXOLITINIB (JAKAFI)	Pending CMS Review			Diagnosis. Intermediate or high-risk myelofibrosis includes primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis. For Polycythemia vera, must have trial and failure, intolerance, or contraindication of hydroxyurea. For acute Graft versus host disease (aGVHD), must have a trial and failure, intolerance, or contraindication to corticosteroids. For chronic Graft versus host disease (cGVHD), must have a trial and failure of at least two prior lines of systemic therapy.	GVHD: age 12 years or older All Others: age 18 years or older	By or in consultation with an oncologist, hematologist, or transplant specialist	6 months		0	1
SAPROPTERIN DIHYDROCHLORIDE	1 - All FDA-approved Indications.			Diagnosis. For treatment of Hyperphenylalaninemia. Clinically diagnosed with hyperphenylalaninemia due to tetrahydrobiopterin responsive phenylketonuria. Phe levels must be greater than 6 mg/dL (360 micromol/L).			Initial: 3 months, Reauth: 12 months	For reauthorization, must maintain Phe levels below member's baseline levels.	0	0
SARGRAMOSTIM (LEUKINE)	3 - All Medically-accepted Indications.			Diagnosis.			6 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
SECUKINUMAB (COSENTYX)	Pending CMS Review			Diagnosis. Must have a history of trial and failure to one of the following that shares the same FDA-approved indication: Enbrel, Hadlima, Humira, Otezla, Rinvoq, Skyrizi, Spevigo, Stelara, Tremfya, Xeljanz. For ankylosing spondylitis (AS), non-radiographic axial spondyloarthritis (nr-axSpA), and enthesitis-related arthritis (ERA): history of trial and failure, contraindication, or intolerance to a four-week trial with an NSAID. For plaque psoriasis (PsO): a history of trial and failure of ONE of the following: 1) topical therapy (e.g. corticosteroid, calcineurin inhibitor, vitamin D analog), 2) phototherapy, 3) systemic treatment (e.g. methotrexate, cyclosporine, oral retinoids). For hidradenitis supperativa (HS): moderate to severe disease.		By or in consultation with a rheumatologist, gastroenterologist, or dermatologist.	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0	1
SELEXIPAG (UPTRAVI)	Pending CMS Review			Diagnosis. Pulmonary arterial hypertension (PAH), WHO Group I, confirmed by provider attestation. If an echocardiogram was performed instead of right-heart catheterization (RHC), the provider must confirm that the echocardiogram was performed and supports the diagnosis of PAH.		Prescribed by or in consultation with cardiologist or pulmonologist.	12 months	Reauthorization: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0	0
SEMAGLUTIDE (OZEMPIC)	1 - All FDA-approved Indications.			Diagnosis of Type 2 diabetes or documented prior therapy with a Type 2 diabetes medication. Claims will automatically pay on-line without a requirement to submit for prior authorization when one of the following criteria is met: 1. a Type 2 diabetes diagnosis code is submitted at the point of sale OR 2. a pharmacy claims history of a Type 2 diabetes medication within the past 12 months.			12 months		0	0
SEMAGLUTIDE (RYBELSUS)	1 - All FDA-approved Indications.			Diagnosis of Type 2 diabetes or documented prior therapy with a Type 2 diabetes medication. Claims will automatically pay on-line without a requirement to submit for prior authorization when one of the following criteria is met: 1. a Type 2 diabetes diagnosis code is submitted at the point of sale OR 2. a pharmacy claims history of a Type 2 diabetes medication within the past 12 months.			12 months		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
SEMAGLUTIDE (WEGOVY)	Pending CMS Review		Concurrent therapy with another Glp-1 receptor agonist including other strengths of same Glp-1 receptor agonist OR has personal or family history of medullary thyroid carcinoma (MTC) or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN-2)	Diagnosis. For MASH: Medication will be used for the treatment of an adult with noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH), formerly known as nonalcoholic steatohepatitis (NASH), with moderate to advanced liver fibrosis consistent with stage F2 to F3 fibrosis, as confirmed by the prescriber. Must have attestation from prescriber that the member does not have significant alcohol use, hepatic decompensation or hepatocellular carcinoma. Diet and exercise requirements will be met via provider attestation. For MACE: To reduce risk of major adverse cardiovascular events (CV death, non-fatal myocardial infarction (MI) or non-fatal stroke) in members with established CV disease defined as post-MI, post stroke or history of peripheral artery disease (PAD) confirmed by the prescriber, with either obesity/overweight (BMI of at least 27 Kg/m2). Member is		MASH: By or in consultation with a specialist (including a gastroenterologist, hepatologist). For MACE: By or in consultation with a cardiologist. Primary care provider (PCP).	6 months	For reauthorization: For MASH: coverage may be renewed when the member has demonstrated (1) clinical benefit (e.g., resolution of steatohepatitis and no worsening of liver fibrosis or at least one stage improvement in liver fibrosis and no worsening of steatohepatitis), (2) has not developed cirrhosis, (3) continues diet and exercise as clinically appropriate, and (4) has no clinically significant drug-related toxicity warranting discontinuation. Must have attestation from prescriber that the member does not have significant alcohol use. For MACE: Prescriber attests the member requires continued therapy to reduce major adverse cardiovascular event. Member is receiving guideline-directed secondary CVD prevention therapy when clinically appropriate for established CV disease unless contraindicated, not tolerated or not indicated (e.g. antiplatelet therapy, lipid lowering agents, ACEI, ARBs,	0	0
SILDENAFIL CITRATE (REVATIO)	Pending CMS Review		Coverage will not be provided for patients taking nitrates (nitrates in any form) or a guanylate cyclase stimulator (e.g. Adempas).	Diagnosis. Pulmonary arterial hypertension (PAH), WHO Group I, confirmed by provider attestation. The provider must confirm that right-heart catheterization (RHC) was completed or, if RHC was not recommended, that echocardiography was completed and supports the diagnosis of PAH.		Prescribed by or in consultation with a pulmonologist or cardiologist	12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0	0
SIPONIMOD FUMARATE (MAYZENT)	Pending CMS Review			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).		By or in consultation with a neurologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
SODIUM OXYBATE (XYREM)	Pending CMS Review			Diagnosis. For excessive daytime sleepiness associated with narcolepsy: a sleep study (e.g. polysomnogram, multiple sleep latency Test) confirming diagnosis. For cataplexy associated with narcolepsy: a sleep study confirming the diagnosis.	Coverage is provided for members 7 years of age or older	By or in consultation with a neurologist or sleep specialist	Initial: 6 months, Reauthorization: 12 months	Reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
SODIUM PHENYLBUTYRATE	1 - All FDA-approved Indications.		Treatment of acute hyperammonemia in urea cycle disorders	Diagnosis.		By or in consultation with physician who specializes in the treatment of inherited metabolic disorders, a hematologist or a nephrologist.	12 months		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
SOFOSBUVIR, VELPATASVIR, AND VOXILAPREVIR (VOSEVI)	1 - All FDA-approved Indications.		Members with moderate or severe hepatic impairment (Child-Pugh C). Coadministration with atazanavir and rifampin.	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling	Coverage is provided for members who are age-appropriate according to AASLD/IDSA guidance and/or FDA-approved labeling.	By or in consultation with a gastroenterologist, hepatologist, infectious disease, HIV or transplant specialist.	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling		0	0
SOFOSBUVIR-VELPATASVIR (EPCLUSA)	1 - All FDA-approved Indications.			Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling	Coverage is provided for members who are age-appropriate according to AASLD/IDSA guidance and/or FDA-approved labeling.	By or in consultation with a gastroenterologist, hepatologist, infectious disease, HIV or transplant specialist.	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling		0	0
SOMATROPIN (GENOTROPIN)	Pending CMS Review		Coverage will not be provided for members with active malignancy, active proliferative or severe non-proliferative diabetic retinopathy, pediatric member with closed epiphysis, members with Prader-Willi who are severely obese or have severe respiratory impairment.	Diagnosis. For pediatric indications (e.g. Growth Hormone Deficiency (GHD), Small for Gestational Age (SGA), Idiopathic Short Stature (ISS), Turner's Syndrome, Noonan Syndrome): must have open epiphyses. For adult GHD: the deficiency must be a result of pituitary or hypothalamic disease, surgery, radiation therapy, trauma, or childhood onset GHD and showing clinical benefit.		By or in consultation with an endocrinologist or neonatologist.	12 months	For reauth for pediatric use: documentation the patient has open epiphyses. For reauth for adult GHD: current IGF-1 level is normal for age and gender (does not apply to patients with structural abnormality of the hypothalamus/pituitary and 3 or more pituitary hormone deficiencies and childhood-onset growth hormone deficiency with congenital abnormality of the hypothalamus/pituitary). For reauth for Prader Willi: documentation growth hormone has resulted in an increase in lean body mass or decrease in fat mass.	0	0
SOTATERCEPT-CSRK (WINREVAIR)	Pending CMS Review			Diagnosis. Pulmonary arterial hypertension (PAH), WHO Group I, confirmed by provider attestation. If an echocardiogram was performed instead of right-heart catheterization (RHC), the provider must confirm that the echocardiogram was performed and supports the diagnosis of PAH. Must be used in combination with standard-of-care therapy (e.g., an endothelin receptor antagonist [ERA] or phosphodiesterase-5 [PDE-5] inhibitor).		Prescribed by or in consultation with cardiologist or pulmonologist	12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0	0
SPARSENTAN (FILSPARI)	Pending CMS Review			Diagnosis. For primary immunoglobulin A nephropathy (IgAN): must have been confirmed by biopsy, must have a total urine protein of at least 0.5 g/day, must be at risk of rapid disease progression, must have tried and failed a stable and maximum tolerated dose of an ACE inhibitor or ARB. For focal segmental glomerulosclerosis (FSGS) without nephrotic syndrome: diagnosis has been confirmed by biopsy or genetic testing, must have tried and failed a stable and maximum tolerated dose of an ACE inhibitor or ARB.	Coverage is provided for members 8 years of age or older.	By or in consultation with a nephrologist.	Initial: 6 months. Reauth: 12 months	For reauth: must have documentation of slowing of disease progression, stabilization, or improvement.	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
STIRIPENTOL (DIACOMIT)	1 - All FDA-approved Indications.			Diagnosis. Must have had an inadequate response or intolerance to two generic antiepileptic drugs (e.g. valproate, topiramate, clobazam). Must be using in combination with clobazam.		By or in consultation with a neurologist	12 months		0	1
SUZETRIGINE (JOURNAVX)	1 - All FDA-approved Indications.			Must have a diagnosis of moderate-to-severe acute pain. The prescriber attests that the episode of acute pain is anticipated to last less than one month and the member has tried and failed within the previous 30 days or has a contraindication to either TWO alternative pain medications for moderate pain (e.g. acetaminophen, NSAIDs) or ONE alternative pain medication for severe pain (e.g. NSAID, opioid).	Coverage is provided for members 18 years of age and older		14 Days	For reauthorization: Documentation that the member is experiencing a new episode of moderate-to-severe acute pain, separate and distinct from the previous episode. The prescriber attests that the episode of acute pain is anticipated to last less than one month and the member has tried and failed within the previous 30 days or has a contraindication to either TWO alternative pain medications for moderate pain (e.g. acetaminophen, NSAIDs) or ONE alternative pain medication for severe pain (e.g. NSAID, opioid).	0	1
TADALAFIL (ADCIRCA)	Pending CMS Review		Coverage will not be provided for patients taking nitrates (nitrates in any form) or a guanylate cyclase stimulator (e.g. Adempas).	Diagnosis. Pulmonary arterial hypertension (PAH), WHO Group I, confirmed by provider attestation. The provider must confirm that right-heart catheterization (RHC) was completed or, if RHC was not recommended, that echocardiography was completed and supports the diagnosis of PAH.		Prescribed by or in consultation with a pulmonologist or cardiologist	12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0	0
TADALAFIL (CIALIS)	1 - All FDA-approved Indications.			Diagnosis of benign prostatic hyperplasia (BPH) and must have a trial and failure of at least two alternative medications in the following classes: alpha-1 adrenergic blockers or 5-alpha reductase inhibitors.			12 months		0	1
TASIMELTEON	Pending CMS Review			Diagnosis. Provider confirmation that appropriate testing or laboratory evaluation was completed to confirm the diagnosis.	Coverage is provided for members 3 years of age or older.	By or in consultation with a neurologist or a physician who specializes in sleep medicine	12 months	For Reauth: documentation from prescriber indicating stabilization or improvement in condition.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
TEDUGLUTIDE (GATTEX)	Pending CMS Review		Active intestinal obstruction or active gastrointestinal malignancy.	Diagnosis. For diagnosis of short bowel syndrome, member must be receiving parenteral support (documentation of baseline PN/IV frequency and volume), members 18 and older must have documentation of a colonscopy and an upper gastrointestinal(GI) endoscopy was performed and polyps have been removed, Members under 18 years old must have a fecal occult blood test performed and if unexplained blood in the stool a colonscopy/sigmoidoscopy has been performed and an upper GI endoscopy.		By or in consultation with a gastroenterologists	Initial: 6 months Reauthorization: 12 months	For reauthorization: Documentation member is experiencing clinical benefit from therapy as evidenced by improvement in intestinal absorption and/or a decreased need for parenteral support (e.g., reduction in parenteral nutrition volume, reduction in intravenous fluid requirements, reduction in frequency of parenteral support administration, increased enteral intake, or achievement of enteral autonomy).	0	0
TELOTRISTAT (XERMELO)	1 - All FDA-approved Indications.			Diagnosis.	Coverage is provided for members 18 years of age and older.	By or in consultation with an oncologist	6 months	For reauth: documentation of improvement or stabilization.	0	0
TERIFLUNOMIDE	Pending CMS Review			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease).		By or in consultation with a neurologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0
TETRABENAZINE (XENAZINE)	Pending CMS Review		Uncontrolled depression, actively suicidal. Currently using a monoamine oxidase inhibitor or reserpine. Hepatic impairment. Concurrent use of deutetrabenazine or valbenazine.	Diagnosis.	Coverage is provided for members 18 years of age or older.	By or in consultation with a neurologist	12 months	Maximum dose approved is 100mg/day. For reauthorization: must have documentation from prescriber indicating slowing of disease progression.	0	0
TIRZEPATIDE (MOUNJARO)	1 - All FDA-approved Indications.			Diagnosis of Type 2 diabetes or documented prior therapy with a Type 2 diabetes medication. Claims will automatically pay on-line without a requirement to submit for prior authorization when one of the following criteria is met: 1. a Type 2 diabetes diagnosis code is submitted at the point of sale OR 2. a pharmacy claims history of a Type 2 diabetes medication within the past 12 months.			12 months		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
TOCILIZUMAB	Pending CMS Review		Part A covered for Covid-19 in hospitalized patients	Diagnosis. Must have a history of trial and failure to one of the following that shares the same FDA-approved indication: adalimumab biosimilar, Enbrel, Hadlima, Otezla, Rinvoq, Skyrizi, Spevigo, Tremfya, ustekinumab biosimilar, Xeljanz. For rheumatoid arthritis (RA): history of trial and failure, contraindication, or intolerance to a 3 month trial with methotrexate or another DMARD (e.g., leflunomide). For juvenile idiopathic arthritis (JIA) with polyarthritis: history of trial and failure, contraindication, or intolerance to a 3 month trial with methotrexate, leflunomide, or sulfasalazine. For JIA with oligoarthritis, enthesitis, or sacroiliitis: diagnosis. For cytokine release syndrome (CRS): must have severe or life-threatening disease induced by CAR-T therapy. For giant cell arteritis (GCA): diagnosis.	Must be 2 years of age or older.	By or in consultation with a rheumatologist, oncologist, hematologist, or pulmonologist.	CRS: 1 month, all other indications: 12 months	For CRS reauth: must meet initial criteria and provide clinical rationale for additional treatment. For all other reauths: must have documentation of stabilization or improvement in condition.	0	1
TOFACITINIB (XELJANZ)	1 - All FDA-approved Indications.			Diagnosis. Must have history of trial and failure, contraindication, or intolerance to a TNF blocker.	For Polyarticular course juvenile idiopathic arthritis and active psoriatic arthritis: must be 2 years of age and older. For all other indications: must be 18 years of age and older	By or in consultation with dermatologist, rheumatologist or gastroenterologist.	12 months	Reauth: Documentation from the prescriber indicating stabilization or improvement in condition.	0	1
TOLVAPTAN (JYNARQUE)	Pending CMS Review		History of significant liver impairment or injury (not including uncomplicated polycystic liver disease), concomitant use of strong CYP3A inhibitors, uncorrected abnormal blood sodium concentrations, unable to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria	Diagnosis. Must have an estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73m^2 and at least one of the following: 1. Mayo classification 1C, 1D, or 1E 2. a historical rate of eGFR decline based on serial measurements (greater than or equal to 3 ml/min /1.73 m^2 per year)	Member must be 18 years of age or older	By or in consultation with a nephrologist	12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition or slowing of disease progression.	0	0
TOLVAPTAN (SAMSCA)	Pending CMS Review		Member has any of the following: autosomal dominant polycystic kidney disease (ADPKD) outside of FDA-approved REMS, unable to respond appropriately to thirst, hypovolemic hyponatremia, concomitant use of strong CYP3A inhibitors, anuria, or liver disease, including cirrhosis.	Diagnosis. Member must have clinically significant hypervolemic and euvolemic hyponatremia (serum sodium less than 125 mEq/L or less marked hyponatremia that is symptomatic and has resisted correction with fluid restriction), including members with heart failure and Syndrome of Inappropriate Antidiuretic Hormone (SIADH). Prescriber attests treatment will not exceed 30 days. Prescriber attests medication was initiated or re-initiated in the hospital.		By or in consultation with a nephrologist, cardiologist or endocrinologist	30 days		0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
TRIENTINE HCL (SYPRINE)	1 - All FDA-approved Indications.			Diagnosis. Must have a trial of penicillamine (Depen) with an inadequate response or significant side effects/toxicity or must have a contraindication to this therapy.		By or in consultation with a gastroenterologist, an ophthalmologist or a physician who specializes in the treatment of inherited metabolic disorders.	12 months	For reauth: must have documentation from prescriber indicating improvement in condition.	0	1
UBROGEPANT (UBRELVY)	1 - All FDA-approved Indications.			Diagnosis. Must have a history of trial and failure, contraindication, or intolerance to at least one triptan.	Coverage is provided for members 18 years of age and older.		12 months	For reauth: documentation of improvement or stabilization.	0	1
UPADACITINIB (RINVOQ)	Pending CMS Review			Diagnosis. For rheumatoid arthritis (RA), psoriatic arthritis (PsA), ankylosing spondylitis (AS), non-radiographic axial spondyloarthritis (nr-axSpA), ulcerative colitis (UC), and Crohn's disease: history of trial and failure, contraindication, or intolerance to a TNF blocker. For atopic dermatitis (AD): history of trial and failure, contraindication, or intolerance to 2 systemic products (immunosuppressant or biologic). For giant cell arteritis (GCA): diagnosis.	For PsA and and polyarticular juvenile idiopathic arthritis: 2 years or older, For atopic dermatitis: 12 years or older. All other indications: 18 years and older.	By or in consultation with a rheumatologist, dermatologist, or gastroenterologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	1
USTEKINUMAB PRODUCTS	1 - All FDA-approved Indications.			Diagnosis. For plaque psoriasis (PsO): a history of trial and failure of ONE of the following: 1) topical therapy (e.g. corticosteroid, calcineurin inhibitor, vitamin D analog), 2) phototherapy, 3) systemic treatment (e.g. methotrexate, cyclosporine, oral retinoids). For Crohn's (CD): Member has moderate to severe CD. For Ulcerative colitis(UC): Member has moderately to severely active ulcerative colitis.		By or in consultation with a rheumatologist, gastroenterologist, or dermatologist.	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0	1
VALBENAZINE (INGREZZA)	Pending CMS Review			Diagnosis. For chorea: Must have documentation of contraindication, intolerance, or inadequate response to at least 12 weeks of tetrabenazine treatment. For tardive dyskinesia (TD): Adjustments to possible offending medication such as dose reduction or discontinuation were attempted but ineffective in resolving TD symptoms or member is not a candidate for dose reduction or discontinuation of the offending medication.	Coverage is provided for members 18 years of age or older	By or in consultation with a neurologist or psychiatrist	12 months	For reauthorization: must have documentation from prescriber indicating condition stabilization, improvement, or slowing of disease progression.	0	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
VEDOLIZUMAB (ENTYVIO)	Pending CMS Review			Diagnosis. Must have completed an intravenous induction regimen before starting the subcutaneous product. For Crohns (CD): Member has moderate to severe CD. For Ulcerative colitis(UC): Member has moderately to severely active ulcerative colitis.	18 years of age or older	By or in consultation with a gastroenterologist	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	1	1
VERICIGUAT (VERQUVO)	Pending CMS Review			Diagnosis. Must have a left ventricular ejection fraction (LVEF) less than or equal to 45%. Must have had a hospitalization for heart failure or received outpatient IV diuretics. Documentation the member is currently taking or has had prior treatment with an angiotensin-converting enzyme inhibitor, angiotensin II receptor blocker or Entresto and a beta blocker.		Prescribed by or in consultation with cardiologist.	12 months	Reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0	1
VIGABATRIN	1 - All FDA-approved Indications.			Diagnosis. Must undergo vision testing prior to beginning treatment. For Refractory Complex Partial Seizures: must have inadequate response to at least two of the following anticonvulsant drugs: levetiracetam, phenytoin, carbamazepine, oxcarbazepine, gabapentin, lamotrigine, valproate, or topiramate. Must be using vigabatrin in combination with at least one other anticonvulsant medication (which can include medication from trial above).		By or in consultation with a neurologist.	12 months		0	1
VORICONAZOLE INJECTION (VFEND)	1 - All FDA-approved Indications.			Diagnosis.	2 years of age or older	Prescribed by or in consultation with an infectious disease specialist	12 months		0	0
VORTIOXETINE (TRINTELLIX)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two generic antidepressants alternatives such as an SSRI, SNRI, bupropion, trazodone or mirtazapine	Coverage is provided for members 18 years of age and older.		12 months		0	1
XANOMELINE/TROSPIUM (COBENFY)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two of the following generic atypical antipsychotics: olanzapine, quetiapine, paliperidone, risperidone, aripiprazole, ziprasidone, asenapine, or lurasidone.	Members 18 years of age or older.		12 months		0	1
ZURANOLONE (ZURZUVAE)	Pending CMS Review			Diagnosis of postpartum depression (PPD) with onset during pregnancy or within 4 weeks postpartum. Documentation of current depressive symptoms consistent with a diagnosis of depressive disorder with peripartum onset.	Coverage is provided for members 18 years of age and older.		14 days		0	0