

## **Prior Authorization Detail**

Updated on 11/1/2025

Selected Formulary: 2025 Health Options Duals | CMS Formulary ID: 00025515 | CMS Version: 20

			•	In	1					In the
				Required Medical	l					Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ABOBOTULINUMTOXINA	1 - All FDA-approved			Diagnosis.			12 months	For reauthorization:	0	0
(DYSPORT)	Indications.							documentation from		
								prescriber indicating		
								stabilization or improvement		
								in condition.		
ACITRETIN (SORIATANE)	1 - All FDA-approved			Diagnosis. Must have a trial of	•		12 months		0	0
	Indications.			methotrexate or cyclosporine						
				with inadequate response or						
				significant side effect/toxicity						
				or have a contraindication to						
				these therapies.						
ADALIMUMAB (HUMIRA)	Pending CMS Review		Coverage is not provided for	Diagnosis. For rheumatoid	Member must be 2 years of	By or in consultation with a	12 months	For hidradenitis suppurativa	0	0
			use of once weekly doses of	arthritis (RA): history of trial	age or older.	rheumatologist,		(HS): moderate to severe		
			Humira in combination with	and failure, contraindication,		gastroenterologist,		disease with 3 active		
			methotrexate.	or intolerance to a 3 month		ophthalmologist, or		abscesses, inflammatory		
				trial with methotrexate or		dermatologist.		nodules, or lesions. For		
				another DMARD. For juvenile				uveitis: trial of a corticosteroi	d	
				idiopathic arthritis (JIA) with				or immunomodulator with		
				polyarthritis: history of trial				inadequate response or side		
				and failure, contraindication,				effects/toxicities unless		
				or intolerance to a 3 month				contraindicated. For reauth:		
				trial with methotrexate,				must have documentation		
				leflunomide, or sulfasalazine.				from prescriber indicating		
				For JIA with oligoarthritis,				stabilization or improvement		
				enthesitis and/or sacroiliitis:				in condition.		
				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 tria	ıl					
				and failure, contraindication,						
				or intolerance to a 4 week						
				trial each of at least 2 NSAIDs.						
				For plaque psoriasis: minimun						
				BSA involvement of at least						
				3% (not required if on palms,						
				soles, head/neck, genitalia), 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	<b>'</b>					
				treatment (e.g. methotrexate						
				treatment (e.g. methotrexate	, [					

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ALIROCUMAB (PRALUENT)	1 - All FDA-approved			Diagnosis. Must have		By or in consultation with a	12 months	HoFH: must be confirmed by	0	0
	Indications.			confirmed diagnosis of		cardiologist, endocrinologist,		genetic testing with functiona	ı	
				heterozygous familial		or lipid specialist		mutation(s) in both LDL		
				hypercholesterolemia (see				receptor alleles or alleles		
				Other Criteria), homozygous				known to affect LDL receptor		
				familial hypercholesterolemia				functionality or have clinical		
				(HoFH, see Other criteria),				diagnosis defined as one of		
				clinical atherosclerotic				the following: untreated LDL		
				cardiovascular disease				greater than 500mg/dL or a		
				(ASCVD, see Other Criteria), or	-			treated LDL-C greater than		
				primary hyperlipidemia. Must				300mg/dL AND either		
				have baseline LDL-cholesterol				xanthoma before 10 years of		
				levels greater than or equal to	,			age or evidence of HeFH in		
				100 mg/dL (w/o ASCVD),				both parents. For ASCVD:		
				70mg/dL (w/ ASCVD), or				must have chart		
				55mg/dl if has extreme risk				documentation confirming		
				designation (see Other				history of at least one of the		
				Criteria). Must have failed to				following: myocardial		
				achieve goal LDL-C reduction				infarction or other acute		
				after a trial of a high intensity				coronary syndromes		
				statin (atorvastatin 40-80mg				(including ST-elevation		
				daily or rosuvastatin 20-40mg				myocardial infarction, non-ST		
				daily) OR 2 moderate-intensity	/			elevation myocardial		
				statins (atorvastatin or				infarction, and unstable		
				rosuvastatin) at the member's				angina), coronary or other		
				maximally tolerated dose OR				revascularization procedure,		
				documentation the member is	5			ischemic stroke or transient		
				determined to be intolerant				ischemic attack,		
				to statin therapy with				atherosclerotic peripheral		
				provider attestation of				arterial disease. For HeFH:		
				intolerance to statin therapy				must have chart		
				consisting of statin related				documentation of one of the		
				rhabdomyolysis or skeletal-				following: A score of greater		
				muscle related symptoms				than 8 using the Dutch Lipid		
ALOSETRON (LOTRONEX)	1 - All FDA-approved		Constipation. Concomitant	Diagnosis. Documentation of	Coverage is provided for	By or in consultation with a	12 months	For reauth: must have	0	0
	Indications.		use of fluvoxamine. Male	chronic IBS symptoms	members 18 years of age and	Gastroenterologist		documentation from		
			gender. History of chronic or	diarrhea lasting at least 6	older.			prescriber indicating		
			severe constipation or	months. Gastrointestinal tract				stabilization or improvement		
			sequelae from constipation,	abnormalities have been ruled	i			in condition.		
			intestinal obstruction,	out. Must have trial of						
			stricture, toxic megacolon,	loperamide and dicyclomine						
			gastrointestinal perforation	used in the treatment of IBS-D						
			and/or adhesions, ischemic	with inadequate response or						
			•	significant side effects/toxicity	<u>/</u>					
			circulation, thrombophlebitis,	unless contraindicated						
			or hypercoagulable state,							
			Crohn's disease, ulcerative							
			colitis, diverticulitis, or severe							
			hepatic impairment.							
ALPELISIB (VIJOICE)	1 - All FDA-approved			_	Coverage is provided for	By or in consultation with an	12 months	For reauthorization: must	0	0
	Indications.			Overgrowth Spectrum (PROS)		appropriate specialist		have documentation from		
				confirmed by genetic testing.		depending on the symptoms		prescriber indicating		
				Disease must be severe or life	-	and part of the body that are		stabilization or improvement		
				threatening and require		affected.		in condition.		
				systemic treatment.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ALPHA-1 PROTEINASE INHIBITOR (PROLASTIN)	1 - All FDA-approved Indications.		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)	f members 18 years of age and older.	By or in consultation with a pulmonologist	Initial: 6 months Reauthorization: 12 months	For reauth: documentation of improvement or stabilization of the signs and symptoms of emphysema associated with alpha-1 antitrypsin deficiency including slowed progression of emphysema as evidenced by annual spirometry testing or a decrease in frequency, duration or severity of pulmonary exacerbations		0
				of AAT. Member must have symptomatic emphysema confirmed with pulmonary function testing.						
ALPHA-1 PROTEINASE INHIBITOR (ZEMAIRA)	1 - All FDA-approved Indications.		Immunoglobulin A (IgA) deficient members with antibodies against IgA	Diagnosis. Member must have pre-treatment serum levels or 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.	f members 18 years of age and older.	By or in consultation with a pulmonologist	Initial: 6 months, Reauthorization: 12 months	For reauth: documentation of improvement or stabilization of the signs and symptoms of emphysema associated with alpha-1 antitrypsin deficiency including slowed progression of emphysema as evidenced by annual spirometry testing or a decrease in frequency, duration or severity of pulmonary exacerbations		
AMBRISENTAN (LETAIRIS)	1 - All FDA-approved Indications.		Pregnancy	Diagnosis. Pulmonary arterial hypertension (PAH) WHO Group I confirmed by chart documentation of right-heart catheterization (RHC) indicating a mean pulmonary arterial pressure greater than 20 mmHg, pulmonary vascula resistance greater than 2 wood units, and mean pulmonary capillary wedge pressure less than or equal to 15 mmHg. If provider indicates RHC is not recommended, must have documentation of an echocardiography.	r	or pulmonologist.	Initial authorization: 3 months Reauthorization: 12 months	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 antibacteria 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.	1	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	0

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
APREMILAST (OTEZLA)	1 - All FDA-approved			Diagnosis. For Psoriatic	Coverage is provided for	By or in consultation with a	12 months	For reauthorization: must	0	0
	Indications.			arthritis (PsA): for mild to	members 6 years of age or	dermatologist, rheumatologist	:	have documentation from		
				moderate axial or enthesitis,	older.			prescriber indicating		
				must have a history of trial				stabilization or improvement		
				and failure, contraindication,				in condition.		
				or intolerance to a 4 week						
				trial of 2 NSAIDs. For member	s					
				with mild to moderate						
				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 plaque psoriasis:						
				minimum BSA involvement of						
				at least 2% (not required if on						
				palms, soles, head/neck,						
				genitalia), a history of trial and	d l					
				failure of ONE of the						
				following: 1) topical therapy						
				(e.g. corticosteroid,						
				calcineurin inhibitor, vitamin						
				D analog), 2) phototherapy, 3)	1					
				systemic treatment (e.g.						
				methotrexate, cyclosporine,						
				oral retinoids). For Behcet's						
				disease: must have recurrent						
				oral ulceration (at least 3						
				times within the past year)						
				plus 2 of the following						
				symptoms: recurrent genital						
				ulceration, eye lesions, skin						
				lesions, positive pathergy						
				reaction, must have a trial and	1					
ARIMOCLOMOL (MIPLYFFA)	1 - All FDA-approved			Diagnosis. Documentation the	Member is 2 years of age and		12 months	Reauthorization:	0	0
	Indications.			diagnosis was confirmed by	older			Documentation the member		
				genetic testing demonstrating				is experiencing an		
				one of the following: 1. a				improvement or stabilization		
				mutation in both alleles of				in disease.		
				NPC1 or NPC2 OR 2. mutation						
				in one allele and either a						
				positive filipin-staining or						
				elevated cholestance						
				triol/oxysterols ( greater than						
				2x ULN). Documentation the						
				member has at least one						
				neurological symptom of NPC						
				(e.g. decrease in motor skills,						
				ataxia, seizures, etc.). Must be						
				using in combination with						
				miglustat. Must not be used in	n					
				combination with Aqneursa.						
ARIPIPRAZOLE TABLET WITH	1 - All FDA-approved			Diagnosis. Documentation the	Coverage is provided for		12 months		0	0
SENSOR (ABILIFY MYCITE)	Indications.				members 18 years of age and					
				month trial of oral aripiprazole						
				(Abilify) therapy.						
-	•	•	•		•	•	•	•	•	•

				Required Medical						Prerequisite Therapy
•	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information		Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ARMODAFINIL (NUVIGIL)	1 - All FDA-approved			Diagnosis. Must have a history		By or in consultation with a		For reauth: documentation of	0	0
	Indications.			of trial and failure,		sleep specialist, ENT (ear,	OSA: 12 months	improvement or stabilization.		
				contraindication, or		nose, and throat specialist),				
				intolerance to modafinil. For		neurologist, or pulmonologist				
				narcolepsy: Sleep Study (e.g.						
				Polysomnogram, Multiple						
				Sleep Latency Test) confirming	g					
				diagnosis. For obstructive						
				sleep apnea: Sleep study (e.g.						
				polysomnogram) 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						
				Multiple Sleep Latency Test						
				demonstrate loss of normal						
				sleep wake pattern, no other medical or mental disorders						
				account for symptoms, and						
				symptoms do not meet						
				criteria for any other sleep						
				disorder producing insomnia						
				or excessive sleepiness such						
				as time zone change						
				syndrome) and must provide						
				documentation of shift work						
				schedule showing 5 or more						
ATOGEPANT (QULIPTA)	1 - All FDA-approved			Diagnosis. For episodic	Coverage is provided for		Initial: 6 months	For reauth: Provider	n	0
ATOGET ANY (QUELL TA)	Indications.				members 18 years of age and			attestation the member is		
	maleucions.			the member has 4 to 14	older.			having a reduced number of		
				headache days per month. Fo	•			migraine/headache days per		
				chronic migraine: Provider				month or a decrease in		
				attestation the member has a	t			migraine/headache severity. A		
				least 15 headache days per				migraine is defined as a		
				month for 3 or more months				headache that has at least		
				with at least 8 migraine days				two of the following		
				per month. For both: Must				characteristics: unilateral		
				have a trial and failure of one				location, pulsating/throbbing		
				beta-blocker and one				quality, moderate or severe		
				anticonvulsant unless				intensity (inhibits or prohibits		
				contraindicated or intolerant.				daily activities), is aggravated		
								by routine activity, nausea		
								and/or vomiting, photophobia		
								and phonophobia.		
ATRASENTAN (VANRAFIA)	1 - All FDA-approved			Diagnosis of primary		By or in consultation with a		For reauth: must have a	0	0
	Indications.			immunoglobulin A		nephrologist.		decrease from baseline in		
				nephropathy (IgAN) that has	older.			total urine protein or UPCR.		
				been confirmed by biopsy.						
				Must have a total urine						
				protein of at least 1.0 g/day.						
				Must be at risk of rapid						
				disease progression defined a	>					
				having a urine protein-to-						
				creatinine ratio (UPCR) of at						
				least 1.5 g/g. Must have tried						
				and failed a stable and						
				maximum tolerated dose of						
				both 1) an ACE inhibitor or						
				ARB and 2) an SGLT-2 inhibito	r					
	i	Ī	I	(e.g. Farxiga).	İ	i	İ	İ	Ī	Î.

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
AVACOPAN (TAVNEOS)	1 - All FDA-approved Indications.			Diagnosis of ANCA-associated vasculitis (GPA or MPA). Must be on concurrent therapy with glucocorticoids and immunosuppressants (e.g. cyclophosphamide,	members 18 years of age or n older.	By or in consultation with a rheumatologist, hematologist or oncologist.	12 Months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0	0
				azathioprine, mycophenolate,						
AVATROMBOPAG (DOPTELET)	1 - All FDA-approved Indications.			rituximab).  Diagnosis. For ITP, documentation of inadequate response to corticosteroids or immunoglobulins and documentation of a platelet count less than or equal to 30,000/microliter. For thrombocytopenia in adult patients with chronic liver disease who are scheduled to undergo a procedure, documentation of a platelet count less than 50,000/microliter.		By or in consultation with a hematologist, oncologist, hepatologist, or surgeon	Thrombocytopenia in patients with chronic liver disease: 1	For reauth of chronic ITP: documentation of improvement in platelet count from baseline.	0	0
B VS. D	3 - All Medically-accepted						NA		0	0
	Indications.									
BECAPLERMIN (REGRANEX)	1 - All FDA-approved Indications.		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)	1 - All FDA-approved Indications.			Diagnosis. Must have either inadequate response to a first line tuberculosis (TB) regimen containing isoniazid and rifampin OR chart documentation of resistance to isoniazid and rifampin per susceptibility testing. Must weigh at least 15 kg. Must be used in combination with at least 3 other drugs indicated for the treatment of TB.	- age or older.	By or in consultation with a pulmonologist or infectious disease specialist	6 months			0

				Required Medical						Prerequisite T	herapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria		Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required	
BELIMUMAB (BENLYSTA) (IV	1 - All FDA-approved		Severe active central nervous	Diagnosis of active,	Coverage is provided for	By or in consultation with a	12 months	For reauth: documentation	0	0	
FORMULATION)	Indications.		system lupus. Combination	autoantibody-positive,	members 5 years of age and	rheumatologist or		from the prescriber indicating			
			therapy with other biologics	systemic lupus erythematosus	older	hematologist		stabilization or improvement			
			or IV cyclophosphamide.	(SLE) or lupus nephritis. Must				in condition.			
				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.							
DELINALINAAD (DENILVICTA) (CO)	4. All FDA		C	Diamondo of cotion	Commence to many toleral form	D to	42	Farmer the decree of the			
BELIMUMAB (BENLYSTA) (SQ)	Indications.		Severe active central nervous system lupus. Combination	_	Coverage is provided for members 5 years of age and	By or in consultation with a rheumatologist,	12 months	For reauth: documentation from the prescriber indicating		ľ	
	illuications.		therapy with other biologics	systemic lupus erythematosus		or nephrologist		stabilization or improvement			
			or IV cyclophosphamide.	(SLE) or lupus nephritis. Must	older.	of Hephrologist		in condition.			
			or iv cyclophosphamide.	have ANA of at least 1:80 or				in condition.			
				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.							
				, iv or v.							
BELUMOSUDIL (REZUROCK)	3 - All Medically-accepted			Diagnosis. For a diagnosis of	GVHD: age 12 years or older	By or in consultation with an	12 months	For reauth: documentation of	0	0	
	Indications.			chronic Graft versus host		oncologist, hematologist, or		improvement or stabilization.			
				disease (GVHD), after a trial		transplant specialist					
				and failure of at least two							
				prior lines of systemic							
				therapy.							
	•	•		1	•		•	1	•		

				Required Medical						Prerequisite Therapy
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BENRALIZUMAB (FASENRA)	1 - All FDA-approved Indications.			Diagnosis. For severe eosinophilic asthma:	Coverage is provided for members 6 years of age or	By or in consultation with an allergist, immunologist,	12 months	For reauth: documentation of improvement (e.g. reduced	0	0
	indications.			eosinophil blood count	older.	pulmonologist, or		symptoms, reduced		
				greater than or equal to		rheumatologist.		exacerbations, need for oral		
				150cells/microliter.				steroids).		
				Documentation of inadequate	!					
				response, intolerance, or						
				contraindication to a high-						
				dose ICS in combination with a LABA. Meets one of the						
				following within the past year						
				one or more acute asthma-						
				related ED visit(s), one or						
				more acute inpatient visits						
				where asthma was the						
				principal diagnosis, or two or						
				more acute asthma						
				exacerbations requiring oral systemic steroids.						
				systemic steroids.						
BEREMAGENE GEPERPAVEC	1 - All FDA-approved			Diagnosis of Dystrophic	Coverage is provided for	By or in consultation with a	6 months	Reauthorization: must have	0	0
(VYJUVEK)	Indications.			Epidemolysis Bullosa (DEB)	_	dermatologist		documentation from		
				with a mutation in the	older.			prescriber indicating		
				collagen type VII alpha 1 chair				improvement in condition.		
				(COL7A1) gene confirmed by genetic testing. Must have a						
				wound with no evidence or						
				history of squamous-cell						
				carcinoma or active infection.						
BIRCH TRITERPENES	1 - All FDA-approved			Diagnosis of Dystrophic	Coverage is provided for	By or in consultation with a		Reauthorization: must have	0	0
(FILSUVEZ)	Indications.			Epidemolysis Bullosa (DEB) or junctional epidermolysis	members 6 months of age or older.	dermatologist	I .	documentation from prescriber indicating		
				bullosa (JEB) with an open	oluer.			improvement in condition.		
				wound.				improvement in condition.		
BOSENTAN (TRACLEER)	1 - All FDA-approved		Pregnancy	Diagnosis. Pulmonary arterial		Prescribed by or in	Initial authorization: 3 months		0	0
	Indications.			hypertension (PAH) WHO		consultation with cardiologist		from prescriber that		
				Group I confirmed by chart		or pulmonologist.		demonstrates member is		
				documentation of right-heart catheterization (RHC)				tolerating and receiving clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than				treatment.		
				20 mmHg, pulmonary vascula						
				resistance greater than 2						
				wood units, and mean						
				pulmonary capillary wedge						
				pressure less than or equal to						
				15 mmHg. If provider indicates RHC is not						
				recommended, must have						
				documentation of an						
				echocardiography.						
BUDESONIDE (EOHILIA)	1 - All FDA-approved		0	Diagnosis. For eosinophilic	Coverage is provided for	1 '	3 months	Reauth: use beyond 3 months	0	0
	Indications.			esophagitis (EoE): must have at least 15 intraepithelial	members 11 years of age or older.	allergist or gastroenterologist.		has not been studied.		
				eosinophils per high-power	oldel.					
				field (eos/hpf) following a						
				treatment course with a PPI.						
BUDESONIDE EXTENDED	1 - All FDA-approved			Diagnosis. Must have a trial		By or in consultation with a	8 weeks	For reauth: must have	0	0
RELEASE TABLETS (UCERIS)	Indications.			and failure, a	age or older.	rheumatologist or		documentation from		
				contraindication, or an		gastroenterologist.		prescriber indicating		
				intolerance to two (2) of the				stabilization or improvement in condition.		
				following therapy options: topical mesalamine, oral				in Condition.		
				aminosalicylate or						
				corticosteroids with						
				inadequate response or side						
				effects/toxicity unless						
Ī			1	contraindicated.					1	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
BUROSUMAB-TWZA	1 - All FDA-approved		Use with oral phosphate or	Diagnosis. For X-linked		By or in consultation with a	12 months	Reauthorization:	0	0
(CRYSVITA)	Indications.		active vitamin D analogs	hypophosphatemia:		physician who is experienced		Documentation current		
,				confirmation of the diagnosis		in the management of		(within the past 12 months)		
				by at least one of the		patients with metabolic bone		serum phosphorus level is not		
				following: A genetic test		disease.		above the upper limit of the		
				showing a PHEX gene				laboratory normal reference		
				mutation (phosphate				range and documentation the		
				regulating gene with				member has had a positive		
				homology to endopeptidase				clinical response or		
				on the X chromosome) or				stabilization in their disease.		
				Serum fibroblast growth				stabilization in their disease.		
				factor 23 (FGF23) level greate	r					
				than 30 pg/mL.	`					
				Documentation of a baseline						
				fasting serum phosphorus						
				concentration that is below						
				the reference range for the						
				members age (reference						
				range must be provided). For						
				FGF23-related						
				hypophosphatemia in tumor-						
				induced osteomalacia (TIO):						
				documentation the member						
				has a phosphaturic						
				mesenchymal tumor that						
				cannot be resected or						
				localized. Documentation of a	'					
				baseline fasting serum						
				phosphorus concentration						
				that is below the reference						
				range for the members age						
				(reference range must be						
				provided).						
BUT/APAP/CAF TAB	3 - All Medically-accepted			Diagnosis. This Prior	Coverage is provided for		12 months		0	0
	Indications.			Authorization requirement	members 12 years of age or					
				only applies to members	older.					
				when a non-FDA approved						
				diagnosis is submitted. FDA-						
				approved diagnosis codes						
				submitted will pay without						
				prior authorization						
				requirement.						
BUTAL/APAP TAB 50-325N				Diagnosis. This Prior	Coverage is provided for		12 months		0	0
	Indications.			Authorization requirement	members 12 years of age or					
				only applies to members	older.					
1				when a non-FDA approved						
				diagnosis is submitted. FDA-						
1				approved diagnosis codes						
				submitted will pay without						
				prior authorization						
				requirement.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	1 · · · · ·	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
C1 ESTERASE INHIBITOR	1 - All FDA-approved			Diagnosis of HAE is confirmed		Prescribed by or in	Initial: 6 months	For reauth: must have	0	0
(HAEGARDA)	Indications.			by laboratory values obtained	- · · · · · · · · · · · · · · · · · · ·	consultation with an	Reauthorization: 12 months	documentation from		
,					older.	allergist/immunologist,		prescriber indicating		
				(laboratory reports must		hematologist, dermatologist		improvement in condition.		
				contain reference ranges). For		The materiagnet, actimateriagnet				
				Type I: Low C4 level and low						
				C1-INH antigenic level. For						
				Type II: Low C4 level and						
				normal or elevated C1-INH						
				antigenic level and low C1-INH						
				functional level. Must have						
				documentation of a previous						
				HAE attack in the absence of						
				hives or a medication known						
				to cause angioedema to						
				demonstrate member is						
				candidate for prophylactic						
				therapy. Member must not be						
				taking any medications that						
				may exacerbate HAE,						
				including angiotensin-						
				converting enzyme (ACE)						
				inhibitors, Tamoxifen, and						
				estrogen-containing						
				medications. Must be using as						
				prophylactic therapy for the						
				prevention of HAE attacks.						
CANNABIDIOL (EPIDIOLEX)	1 - All FDA-approved			Diagnosis. Must have had an	Member must be 1 year of	By or in consultation with a	12 months		0	0
,	Indications.			_	age or older	neurologist				
				intolerance to one generic						
				antiepileptic drug.						
CARGLUMIC ACID	1 - All FDA-approved			Diagnosis. This Prior			12 months		0	0
(CARBAGLU)	Indications.			Authorization requirement						
(6,11,5,1,62,6)	maleations.			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.						
CEFTAROLINE (TEFLARO)	1 - All FDA-approved			Diagnosis. For acute bacterial			14 days		U	U
	Indications.			skin and skin structure						
				infection (ABSSSI),						
				documentation of a history of						
				treatment failure with or						
				contraindication to						
				vancomycin.						
CYSTEAMINE (CYSTAGON)	1 - All FDA-approved			Diagnosis. Must have		By or in consultation with a	Initial: 3 months	For reauth: must have	0	0
	Indications.			documentation of CTNS gene		nephrologist or physician who	Reauthorization: 12 months	documentation from		
				mutation, elevated white		specializes in the treatment of		prescriber indicating		
				blood cell cystine levels		inherited metabolic disorders		improvement in condition and		
				greater than 2nmol per half-				a reduction in WBC cystine		
				cystine per mg of protein, or				levels since starting treatment		
				cystine corneal crystals by slit				with oral cysteamine		
				lamp examination.						
DALFAMPRIDINE (AMPYRA)	1 - All FDA-approved	+	History of seizure disorder,	Diagnosis of multiple sclerosis.	Coverage is provided for	Neurologist	Initial: 3 months	For reauthorization: must	0	0
Z. Z. Z. Z. Z. Z. Z. Z. Z. Z. Z. Z. Z. Z	Indications.		moderate to severe renal		members 18 years of age or		Reauthorization: 12 months	have documentation from	Ĭ	ľ
	ווועונמנוטווז.						Meauthorization, 12 Months			
			impairment (CrCl less than or	-	older.			prescriber indicating		
			equal to 50 mL/min).	dysfunction.				stabilization or improvement in condition.		
	i	i	•	i .	I		I	Lin condition	Ī .	•

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
DARBEPOETIN ALFA (ARANESP)	1 - All FDA-approved Indications.	Off-Label Uses	Uncontrolled hypertension	Diagnosis. Must have Hgb level less than 10 g/dL.	Age Restriction		6 months	For reauth for CKD on dialysis: must have a Hgb less than or equal to 11g/dl. For reauth for CKD not on dialysis: must have Hgb less than or equal to 10 g/dl. Reauth for pediatric members with CKD: must have a Hgb less than or equal to 12 g/dl. Reauth for all other dx must meet initial criteria.	0	0 Required
DEFERASIROX (EXJADE)	1 - All FDA-approved Indications.		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 nontransfusion-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.	U	
DEFERIPRONE (FERRIPROX)	1 - All FDA-approved			Diagnosis. Must have		Prescribed by or in	12 months	For reauth: documentation	0	0
	Indications.			documentation of a trial and failure of Exjade (this requires a PA) unless contraindicated .		consultation with a hematologist		from prescriber indicating stabilization or improvement in condition.		
DENOSUMAB (XGEVA)	3 - All Medically-accepted Indications.			Diagnosis.		Prescribed by or in consultation with a hematologist or oncologist	6 months		0	0
DEUTETRABENAZINE (AUSTEDO)	1 - All FDA-approved Indications.		impairment, concurrent use with MAOI's, reserpine, tetrabenazine, or valbenazine.	Diagnosis. For chorea: must have confirmed Huntington's disease either by Huntington Disease Mutation analysis (with laboratory result indicating expanded CAG repeat of greater than or equal to 36 in the Huntington gene) or a positive family history of Huntington's Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart documentation of chorea. For tardive dyskinesia (TD): must have chart documentation of involuntary athetoid or choreiform movements and has a history of treatment with neuroleptic agent (i.e. antipsychotic). Adjustments to possible offending medication or discontinuation were	older.	By or in consultation with a neurologist or psychiatrist	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.		

				Required Medical						Prerequisite Therapy
·	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
DEUTIVACAFTOR/TEZACAFTO				Diagnosis. Documentation of	Coverage is provided for	By or in consultation with a	12 months	For reauthorization:	0	0
R/VANZACAFTOR (ALYFTREK)	Indications.			genetic test confirming the		cystic fibrosis specialist or		documentation indicating		
				member has at least one	older	pulmonologist		stabilization or improvement		
				F508del mutation or another				in condition.		
				responsive mutation in the						
				CFTR gene.						
DEXTROMETHORPHAN-	1 - All FDA-approved			Diagnosis. Pseudobulbar	_	By or in consultation with	Initial: 3 months	For reauthorization:	0	0
QUINIDINE (NUEDEXTA)	Indications.			affect (PBA): documentation	members 18 years of age and	neurologist	Reauthorization: 12 months	Documentation indicating a		
				supporting the following:	older.			decrease in the number of		
				involuntary outbursts of laughing and/or crying that				laughing and/or crying		
				are incongruent or				episodes since starting the medication.		
				disproportionate to the				medication.		
				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.						
DEXTROMETHORPHAN/BUPR	1 - All FDA-approved			Diagnosis. Documentation of	Coverage is provided for		12 months		0	0
OPION (AUVELITY)	Indications.			trial and failure of at least two	members 18 years of age or					
				generic antidepressants	older.					
				alternatives such as an SSRI,						
				SNRI, bupropion, trazodone or						
				mirtazapine.						
DIAZOXIDE CHOLINE (VYKAT	1 - All FDA-approved			Diagnosis. Must have a	1	By or in consultation with an	Initial: 6 months	For reauth: must have	0	0
XR)	Indications.			diagnosis of Prader-Willi	age or older.	endocrinologist or geneticist	Reauthorization: 12 months	documentation from		
				syndrome (PWS) confirmed by				prescriber indicating		
				genetic testing and have				stabilization or improvement		
				symptoms associated with				in hyperphagia symptoms.		
				hyperphagia (i.e. persistent						
				sensation of hunger, food						
				preoccupations, an extreme drive to consume food, food-						
				related behavior problems,						
				lack of normal satiety). Must						
				have baseline fasting plasma						
				glucose or hemoglobin A1c.						
DIHYDROERGOTAMINE NASAL	1 - All FDA-approved	1	Members with hemiplegic or	Diagnosis. Documentation of	Coverage is provided for	<u>†</u>	12 months	For reauth: documentation	0	0
	Indications.			trial and failure of 1	members 18 years of age and			from prescriber indicating		
' ' '			heart disease (angina pectoris,		older.			stabilization or improvement		
				following classes: a NSAID and				in condition.		
			•	a triptan unless						
				contraindicated.						
			consistent with coronary							
			artery vasospasm (including							
			Prinzmetal's variant angina or							
			uncontrolled hypertension).							
DORNASE ALFA	1 - All FDA-approved			Diagnosis.		By or in consultation with a	12 months	For reauth: must have	0	0
(PULMOZYME)	Indications.					pulmonologist or cystic		documentation from		
						fibrosis specialist		prescriber indicating		
								stabilization or improvement		
			1					in condition.		

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
DRONABINOL	1 - All FDA-approved			Diagnosis. Nausea and			12 months		0	0
	Indications.			vomiting associated with						
				cancer chemotherapy: must	.1					
				have trial of two conventiona	11					
				antiemetic treatments (e.g.,						
				ondansetron, aprepitant,						
				metoclopramide,						
				dexamethasone, prochlorperazine) with						
				inadequate response or						
				significant side effects/toxicit	V					
				unless contraindicated.	'					
DROXIDOPA (NORTHERA)	1 - All FDA-approved			Diagnosis. Documentation of	a Coverage is provided for		2 weeks	For reauth: rationale from the	0	0
	Indications.			clinical diagnosis of	members 18 years of age and			provider for continuing		
				symptomatic neurogenic	older.			therapy beyond 2 weeks		
				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	` <b> </b>					
				significant side effects/toxicit	v					
				unless contraindicated.	<u>'</u>					
DUPILUMAB (DUPIXENT)	1 - All FDA-approved			Diagnosis. For asthma: must	For atopic dermatitis: 6	By or in consultation with an	12 months	Reauth for asthma:	0	0
	Indications.			have either moderate to	months or older. For asthma:	allergist, dermatologist,		documentation of		
				severe eosinophilic phenotyp		immunologist, pulmonologist		improvement (e.g. reduced		
					eosinophilic esophagitis: 1	ear-nose/throat specialist, or		symptoms, reduced		
				greater than or equal to 150	■   E'	gastroenterologist.		exacerbations, need for oral		
				cells/microliter or oral corticosteroid dependent	polyps: 12 years and older. Fo			steroids). Reauth for all other indications: documentation		
				persistent asthma (chronic	all other indications: 18 years or older.			from prescriber indicating		
				oral corticosteroid use).	or older.			stabilization or improvement		
				Documentation of recent use				in condition.		
				and failure to respond to				in condition.		
				inhaled steroid in combo with	n					
				long acting beta agonist. Mus						
				have asthma symptoms that						
				are inadequately controlled						
				while on treatment						
				(uncontrolled defined as						
				having an asthma						
				exacerbation requiring						
				hospitalization in the past						
				year, having 2 or more asthm	a					
				exacerbations requiring oral						
				systemic steroids, or inability to taper off daily						
				corticosteroids). For atopic						
				dermatitis: history of trial and	4					
				failure, contraindication, or						
				intolerance to a topical						
				corticosteroid or topical						
				calcineurin inhibitor. For nasa	<sub>11</sub>					
				polyps: history of trial and	"					
				failure of Xhance (fluticasone						
				propionate). Must be used as						
				add-on maintenance therapy						
L	-				-	1		ı		

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
EDARAVONE (RADICAVA ORS)	1 - All FDA-approved			Diagnosis of Amyotrophic	Coverage is provided for	By or in consultation with a	12 months	Reauth: must provide	0	0
	Indications.			Lateral Sclerosis (ALS). Must	members 18 years of age and	neurologist		documentation of clinical		
				have normal respiratory	older			benefit based on the		
				function (defined as a forced				prescriber's assessment and		
				vital capacity (FVC) of at least				an ALSFRS-R score within the		
				80%), must be able to perform				past 12 months		
				activities of daily living (ADLs)						
				such as eating and moving						
				around independently, must						
				provide a recent ALSFRS-R						
				score.						
EFGARTIGIMOD	1 - All FDA-approved				Member must be 18 years of	By or in consultation with a	12 months	For reauthorization:	0	0
ALFA/HYALURONIDASE-QVFC				_	-	neurologist.		Documentation from the		
(VYVGART HYTRULO)				gravis (gMG) who are anti-	Ĭ			provider that the member has		
, ,				acetylcholine receptor (AChR)				experienced improvement in		
				antibody positive or chronic				signs and symptoms of		
				inflammatory demyelinating				generalized myasthenia gravis		
				polyneuropathy (CIDP). The				(for example, speech,		
				requested agent must not be				swallowing, mobility, or		
				used in combination with				respiratory function). The		
				another myasthenia gravis				member has also experienced		
				medication. The member has				a decrease in the number of		
				experienced therapeutic				exacerbations of generalized		
				failure, contradindication or				myasthenia gravis. For CIDP,		
				intolerance to generic				the member has experineced		
				pyridostigmine. For CIDP, the				improvement in their		
				member has experienced				functional ability or strength		
				progressive symptoms for at				from baseline.		
				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 nerve conduction						
				studies strongly supportive of						
				demyelination and meets one						
				of the following: motor distal						
			I .	latency prolongation in at						
			I .	least 2 nerves, reduction of						
1			I .	motor conduction velocity in						
				at least 2 nerves, prolongation						
ELEXACAFTOR/TEZACAFTOR/I	1 - All FDA-annroved			Diagnosis. Documentation of		By or in consultation with a	12 months	For reauthorization:	0	0
	Indications.			genetic test confirming the		cystic fibrosis specialist or		documentation from		
MONITOR (TRIKAPIA)	maications.			member has at least one		pulmonologist		prescriber indicating		
				F508del mutation in the CFTR		paintonologist		stabilization or improvement		
				gene or a mutation in the				in condition.		
				CFTR gene that is responsive				in condition.		
		l .	<u> </u>	based on in vitro data.	1	l	<u> </u>			

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ELTROMBOPAG (ALVAIZ)	1 - All FDA-approved			Diagnosis. For ITP,		By or in consultation with a	6 months	For reauth: for all dx	0	0
	Indications.			documentation of inadequate		hematologist, oncologist,		documentation of		
				response to corticosteroids or		gastroenterologist, or		improvement in platelet		
				immunoglobulins and		hepatologist		count from baseline. For		
				documentation of a platelet				hepatitis C: documentation		
				count less than or equal to				the member is still on antiviral		
				30,000/microliter. For chronic				therapy.		
				hepatitis C, documentation						
				that thrombocytopenia						
				prevents the initiation of						
				interferon-based therapy or						
				limits the ability to maintain						
				interferon-based therapy, and						
				documentation of a platelet						
				count less than						
				75,000/microliter. For severe						
				aplastic anemia,						
				documentation of a platelet						
				count less than						
				30,000/microliter and one of						
				the following: the member						
				has had an insufficient						
				response to						
				immunosuppressive therapy						
				or the members will be using						
				the medication in						
				combination with						
				immunosuppressive therapy.						
				minutesappressive therapy.						
EPOETIN ALFA-EPBX	3 - All Medically-accepted		Uncontrolled hypertension	Diagnosis. For Reduction of			6 months	For reauth for CKD on dialysis:	0	0
(RETACRIT)	Indications.		oncontrolled hypertension	Allogeneic Red Blood Cell			o months	must have a Hgb less than or	ľ	o a constant of the constant o
(RETACKIT)	illuications.			_						
				Transfusions in Members				equal to 11g/dl. For reauth for		
				Undergoing Elective,				CKD not on dialysis: must have		
				Noncardiac, Nonvascular				Hgb less than or equal to 10		
				Surgery: must have				g/dl. For reauth for zidovudine		
				hemoglobin (Hgb) greater				treated members and		
				than 10 and less than or equal				pediatric members with CKD:		
				to 13 g/dL, be at high risk for				must have a Hgb less than or		
				perioperative blood loss from				equal to 12 g/dl. Reauth for all		
				surgery, and documentation				other dx must meet initial		
				that erythropoietin therapy				criteria.		
				will be used to decrease the						
				need for transfusions						
				associated with surgery in						
				members unwilling or unable						
				to undergo autologous blood						
				donation prior to surgery. All						
				other dx must have Hgb level						
				less than 10 g/dL.						
				0, 42.						
ERENUMAB-AOOE (AIMOVIG)	1 - All FDA-approved			Diagnosis. For episodic	Coverage is provided for		Initial: 6 months	For reauth: Provider	0	0
<u></u>	Indications.				members 18 years of age and		Reauthorization: 12 months	attestation the member is		
				the member has 4 to 14	older			having a reduced number of		
				headache days per month. For				migraine/headache days per		
				chronic migraine: Provider				month or a decrease in		
				attestation the member has a	+			migraine/headache severity. A		
					1			migraine/neadache severity. A		
				least 15 headache days per				_		
				month for 3 or more months				headache that has at least		
				with at least 8 migraine days				two of the following		
				per month. For both: Must				characteristics: unilateral		
				have a trial and failure of one				location, pulsating/throbbing		
				beta-blocker and one				quality, moderate or severe		
				anticonvulsant unless				intensity (inhibits or prohibits		
				contraindicated or intolerant.				daily activities), is aggravated		
								by routine activity, nausea		
								and/or vomiting, photophobia		
								and phonophobia.		
								l ' '		
	1	1	1	ı	1	1	1	1	I .	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	-	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ETANERCEPT (ENBREL)	3 - All Medically-accepted			Diagnosis. For rheumatoid	Member must be 2 years of	By or in consultation with a	12 months	For reauth: must have	0	0
	Indications.			arthritis (RA): history of trial	age or older.	rheumatologist or		documentation from		
				and failure, contraindication,		dermatologist.		prescriber indicating		
				or intolerance to a three-				stabilization or improvement		
				month trial with methotrexate				in condition.		
				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 and/or sacroilitis:						
				history of trial and failure,						
				contraindication, or						
				intolerance to at least a 4						
				week trial of 2 different						
				NSAIDS. 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						
				7						
				failure, contraindication, or						
				intolerance to a 12 week trial						
ETRACINAGE (VELCIPITA)	4 411504			with methotrexate or another		D : 11 :: 11	42			1
ETRASIMOD (VELSIPITY)	1 - All FDA-approved				Coverage is provided for	1 '	12 months	For reauth: must have	0	0
	Indications.				members 18 years of age and	gastroenterologist		documentation from		
					older			prescriber indicating		
				intolerance to 2 of the				stabilization or improvement		
				following therapy options:				in condition.		
				aminosalicylates,						
				corticosteroids or						
				immunomodulators with						
				inadequate response or side						
				effects/toxicity unless						
FECAL MUCROPIOTA CROSS	4. All EDA			contraindicated.			1	Fanna and barden de a	0	
	1 - All FDA-approved			Documentation of a recent			1 month	For reauthorization,	U	U
LIVE-BRPK (VOWST)	Indications.			diagnosis of recurrent				attestation of recurrent CDI		
				Clostridioides difficile				episodes after administration		
				infection (CDI) -AND- Will be				of the initial fecal microbiota		
				used for prophylaxis and not				product -AND- Will be used		
				treatment of recurrent CDI -				for prophylaxis and not		
				AND- Attestation that				treatment of recurrent CDI -		
				antibiotic treatment for the				AND- Attestation that		
				most recent recurrent CDI is				antibiotic treatment for the		
				complete or will be				most recent recurrent CDI is		
				completed.				complete or will be		
								completed.		
FENFLURAMINE (FINTEPLA)	1 - All FDA-approved		Use of monoamine oxidase	_	Member must be 2 years of	The state of the s	12 months		0	0
	Indications.		inhibitors within 14 days		age or older	neurologist				
				intolerance to two generic						
				antiepileptic drugs (e.g.						
				valproate, lamotrigine,						
	-		I	topiramate, clobazam).	Ī		i .	Ī		i

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
FENTANYL CITRATE	1 - All FDA-approved		Acute or postoperative pain	Diagnosis. Documentation the		By or in consultation with an	12 months	Opioid tolerant is defined as	0	0
(TRANSMUCOSAL)	Indications.		including headache/migraines	member has active cancer and	1	oncologist, pain specialist, or		being on around-the-clock	1	
			and dental pain.	is experiencing breakthrough		hospice/palliative care		medicine consisting of at least	1	
				pain despite being on around		specialist		60 mg of oral morphine per	1	
				the clock opioid therapy. Must				day, at least 25 mcg of	1	
				be opioid tolerant. Must	'			transdermal fentanyl per	1	
				currently be using a long-	'			hour, at least 30 mg of oral	1	
					'				1	
				acting opioid.	'			oxycodone per day, at least 8	1	
					'			mg of oral hydromorphone	1	
					· ·			per day, at least 25 mg oral	1	
					'			oxymorphone per day, at least	1	
					'			60 mg oral hydrocodone per	1	
					· ·			day, or an equianalgesic dose	1	
					· ·			of another opioid daily for a	1	
					· ·			week or longer. For	1	
					'			reauthorization:	1	
					· ·			Documentation the member	1	
					· ·				1	
					· ·			still has active cancer and the	1	
		1						member continues to have a	1	
								medical need for the	1	
								medication.	1	
FILGRASTIM-SNDZ (ZARXIO)	3 - All Medically-accepted			Diagnosis.			6 months	For reauthorization: must	0	0
	Indications.				· ·			have documentation from	1	
					· ·			prescriber indicating	1	
					'			stabilization or improvement	1	
					'			in condition.	1	
FLUTICASONE PROPIONATE	1 - All FDA-approved			Diagnosis.	Coverage is provided for		12 months	For reauthorization: must	0	0
(XHANCE)	Indications.			Jiagnesis.	members 18 years of age or		12 months	have documentation from	ľ	
(XIIAIVCE)	malcations.				older.			prescriber indicating	1	
					older.			1 · · · · · · · · · · · · · · · · · · ·	1	
					'			stabilization or improvement	1	
					1			in condition.	t	
GALCANEZUMAB-GNLM	1 - All FDA-approved			Diagnosis. For episodic	Coverage is provided for		Initial: 6 months	For reauth: Provider	0	0
(EMGALITY)	Indications.				members 18 years of age and		Reauthorization: 12 months	attestation the member is	1	
				the member has 4 to 14	older			having a reduced number of	1	
				headache days per month. For	'			migraine/headache days per	1	
				chronic migraine: Provider	· ·			month or a decrease in	1	
				attestation the member has at	ξ			migraine/headache severity. A	1	
				least 15 headache days per	· ·			migraine is defined as a	1	
				month for 3 or more months	· ·			headache that has at least	1	
				with at least 8 migraine days	'			two of the following	1	
				per month. For both: Must	'			_	1	
					'			characteristics: unilateral	1	
				have tried and failed one beta	1			location, pulsating/throbbing	1	
				blocker for at least 2 months	'			quality, moderate or severe	1	
				and one anticonvulsant for at	I '			intensity (inhibits or prohibits	1	
				least 2 months unless	I '			daily activities), is aggravated	1	
		1		contraindicated or intolerant.				by routine activity, nausea	1	
		1		For cluster headache: Provider	1			and/or vomiting, photophobia	1	
		1		attestation the member has at	ٔ '			and phonophobia. A cluster	1	
		1		least one cluster attack every				headache is defined as at least	1	
				other day and no more than 8				5 severe to very severe	1	
				attacks a day. Must have a				unilateral headache attacks	1	
				trial and failure of either					1	
					I '			lasting 15 to 180 minutes	1	
				verapamil for at least 2 weeks	I '			untreated. Headaches occur	1	
				or a one-time subocciptal	I '			once every other day to 8	1	
				steroid injection unless	I '			times a day. The pain is	1	
				contraindicated or intolerant.	I '			associated with ipsilateral	1	
								conjunctival injection,	1	
								lacrimation, nasal congestion,	1	
								rhinorrhea, forehead and	1	
					I '			facial sweating, miosis, ptosis	1	
								and/or eyelid edema, and/or	1	
					I '			with restlessness or agitation.	1	
								with restlessiless of agitation.	1	
									1	
									ł	
	Į	<b>+</b>	+	Diama air	Coverage is provided for	By or in consultation with a	12 months		0	0
GANAXOLONE (7TALNAV)	1 - All FDA-approved									
GANAXOLONE (ZTALMY)	1 - All FDA-approved			Diagnosis.		l '	12 months		Į v	U
	1 - All FDA-approved Indications.			Diagnosis.		neurologist	12 1110111115			

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
GLECAPREVIR-PIBRENTASVIR	1 - All FDA-approved		Members with moderate or	Criteria will be applied	Coverage is provided for	By or in consultation with a	Criteria will be applied		0	0
(MAVYRET)	Indications.		severe hepatic impairment	consistent with current	members who are age-	gastroenterologist,	consistent with current			
			(Child-Pugh C).	AASLD/IDSA guidance and/or	appropriate according to	hepatologist, infectious	AASLD/IDSA guidance and/or			
			Coadministration with	FDA approved labeling		disease, HIV or transplant	FDA approved labeling			
			atazanavir and rifampin.		FDA-approved labeling.	specialist.	1			
GLP-1 RECEPTOR AGONISTS	1 - All FDA-approved			Diagnosis of Type 2 diabetes			12 months		0	0
	Indications.			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						
				130 days.						
GLYCEROL PHENYLBUTYRATE	1 - All FDA-approved			Diagnosis. Documentation		By or in consultation with a	12 months	For reauthorization: must	0	0
(RAVICTI)	Indications.			member has urea cycle		physician who specializes in		have documentation from		
				disorders (UCDs). Must have a		the treatment of inherited		prescriber indicating		
				trial of sodium phenylbutyrate		metabolic disorders.		stabilization or improvement		
				with inadequate response or				in condition.		
				significant side effects/toxicity	,					
				unless contraindicated.						
GUSELKUMAB (TREMFYA)	1 - All FDA-approved			Diagnosis. For plaque psoriasis	Coverage is provided for	By or in consultation with a	12 months	For reauth: must have	0	0
, , , , ,	Indications.			(PsO): minimum BSA	members 18 years of age and	1 .		documentation from		
				involvement of at least 3%	older	dermatologist, or		prescriber indicating		
				(not required if on palms,		gastroenterologist.		stabilization or improvement		
				soles, head/neck, genitalia), a				in condition.		
				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).						
				cyclospornie, oral recinolos).						
	I									

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria		Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ICATIBANT ACETATE	1 - All FDA-approved			Diagnosis of HAE is confirmed		By or in consultation with an	12 months	For reauthorization:	0	0
i e, tri e, tit e, te e, tre	Indications.			by laboratory values obtained		allergist, immunologist,		documentation from		
					older.	hematologist, or		prescriber indicating		
				(laboratory reports must	older.	dermatologist		stabilization or improvement		
				contain reference ranges). For		dermatologist		in condition.		
				Type I HAE: Low C4 level and				in condition.		
				low C1-INH antigenic level. For						
				Type II HAE: Low C4 level and						
				Normal or elevated C1-INH						
				antigenic level and low C1-INH						
				functional level. There is a						
				documented 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. Member must						
				not be taking any medications						
				that may exacerbate HAE,						
				including angiotensin-						
				converting enzyme (ACE)						
				inhibitors, tamoxifen, or						
				estrogen-containing						
				medications.						
				inedications.						
ILOPERIDONE (FANAPT)	1 - All FDA-approved			Diagnosis. Documentation of	Coverage is provided for		12 months		0	0
1201 21112 0112 (171117 11 17	Indications.			trial and failure of at least two						
	maleacions.			of the following generic, oral						
				atypical antipsychotics:	older:					
				olanzapine, quetiapine,						
				paliperidone, risperidone,						
				aripiprazole, or ziprasidone.						
INCOBOTULINUMTOXINA	1 - All FDA-approved	<del> </del>		Diagnosis.			12 months	For reauthorization:	0	0
(XEOMIN)	Indications.							documentation from	Ĭ	Ĩ
(··=• ·······)								prescriber indicating		
								stabilization or improvement		
								in condition.		
								in condition.		

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses		Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
INFLIXIMAB-ABDA	3 - All Medically-accepted			Diagnosis. For rheumatoid	For RA, PsA, AS, Plaque	By or in consultation with a	12 months	For reauth: must have	0	0
(RENFLEXIS)	Indications.			arthritis (RA): history of trial	Psoriasis: coverage is provided			documentation from		
				and failure, contraindication,		gastroenterologist, or		prescriber indicating		
				or intolerance to a 3 month	or older. For CD, UC: coverage	dermatologist.		stabilization or improvement		
			•	trial with methotrexate or	is provided for members 6			in condition.		
				another DMARD. For psoriatic	years of age or older.					
				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 o	f					
				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 tria	1					
				and failure, contraindication,						
				or intolerance to a four-week						
				trial each of at least 2 NSAIDs.						
				For plaque psoriasis: minimum	n					
				BSA involvement of at least						
				3% (not required if on palms, soles, head/neck, genitalia), a						
				history of trial and failure of						
				ONE of the following: 1)						
				topical therapy (e.g.						
				corticosteroid, calcineurin						
				inhibitor, vitamin D analog), 2	)					
INFLIXIMAB-DYYB (INFLECTRA)	) 3 - All Medically-accepted		Doses greater than 5mg/kg in	Diagnosis. For rheumatoid	For RA, PsA, AS, Plaque	By or in consultation with a	12 months	For reauth: must have	0	0
	Indications.				Psoriasis: Coverage is	rheumatologist,		documentation from		
						gastroenterologist, or		prescriber indicating		
				or intolerance to a three-		dermatologist.		stabilization or improvement		
					UC: Coverage is provided for			in condition.		
				or another DMARD. For	members 6 years of age or					
				psoriatic arthritis (PsA) one of the following: 1).members	older.					
				with axial or enthesitis must						
			•	have a history of trial and						
				failure, contraindication, or						
				intolerance to a 4 week trial o	f					
				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 tria	<u>. </u>					
				and failure, contraindication,						
				or intolerance to a four-week						
				trial each of at least 2 NSAIDs.						
				For plaque psoriasis: minimum						
				BSA involvement of at least						
				3% (not required if on palms,						
				soles, head/neck, genitalia), a						
				history of trial and failure of						
				ONE of the following: 1)						
	1		1	topical therapy (e.g.			1			
Ī										
				corticosteroid, calcineurin inhibitor, vitamin D analog), 2	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
INSULIN SUPPLIES	1 - All FDA-approved	On Edder Oses	Exclusion criteria	Confirmation of insulin use	Age Reserverion	Trescriber restriction	12 months	other enteria	0	0
INTO EINT SOLT EILS	Indications.			within the past 12 months						
				based on paid claims or						
				provider documentation.						
IPTACOPAN (FABHALTA)	1 - All FDA-approved		Initiation in patients with		Coverage is provided for	By or in consultation with a	12 months	For reauth: documentation of	0	0
	Indications.		unresolved serious infection		members 18 years of age and			improvement.		
			caused by encapsulated	(PNH): confirmed diagnosis of		immunologist, nephrologist,				
			bacteria.	PNH by flow cytometry		or genetic specialist				
				testing. Flow Cytometry pathology report must be						
				supplied and demonstrate at						
				least 2 different GPI protein						
				deficiencies within 2 different						
				cell lines from granulocytes,						
				monocytes, or erythrocytes.						
				Member is transfusion						
				dependent as defined by						
				having a transfusion within						
				the last 12 months and one of						
				the following: a hemoglobin is						
				less than or equal to 7 g per						
				dL or has symptoms of anemia and the hemoglobin is less						
				than or equal to 10 g per dL.						
				Must have a Lactate						
				dehydrogenase (LDH) level at						
				least 1.5 times the upper limit						
				of the normal range.						
IVABRADINE (CORLANOR)	1 - All FDA-approved			_	• .	1 '	12 months	For reauthorization:	0	0
	Indications.		failure, blood pressure less		members 18 years of age or	cardiologist		documentation from		
			than 90/50 mmHG, sick sinus syndrome, sinoatrial block, or		older. DCM: coverage is provided for members 6			prescriber indicating stabilization or improvement		
			3rd degree AV block-unless a		months of age or older.			in condition.		
			functioning demand	sinus rhythm and has a resting	_			in condition.		
			pacemaker is present, resting	-						
			heart rate less than 60 bpm	equal to 70 beats per minute,						
			prior to treatment, severe	must currently be taking a						
			hepatic impairment,	beta-blocker (e.g., bisoprolol,						
			pacemaker dependence	carvedilol, metoprolol						
			(heart rate maintained	succinate) at the maximally						
			exclusively by the	tolerated dose or has a						
			pacemaker), concomitant use of strong CYP3A4 inhibitors.	blocker use. For Pediatric						
			of strong CYP3A4 inhibitors.	Dilated Cardiomyopathy						
				(DCM): Must have stable						
				symptomatic heart failure						
				with left ventricular ejection						
				fraction less than or equal to						
				45%, must be in sinus rhythm,						
				must have an elevated heart						
				rate (greater than or equal to						
				105 beats per minute (BPM)						
				for 6-12 months of age,						
				greater than or equal to 95 for						
				1-3 years of age, greater than or equal to 75 for 3-5 years of						
				age, greater than or equal to						
				70 for 5-18 years of age).						
				,						
IVACAFTOR (KALYDECO)	1 - All FDA-approved			Diagnosis. Documentation of			12 months	For reauthorization:	0	0
	Indications.				members 1 month of age or	pulmonologist or cystic		documentation from		
					older.	fibrosis specialist		prescriber indicating		
				mutation in the CFTR gene that is responsive to ivacaftor				stabilization or improvement in condition.		
				based on clinical and/or in				in condition.		
				vitro assay data.						
•	•			,			•	1	•	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
L-GLUTAMINE (ENDARI)	1 - All FDA-approved			Diagnosis. Must be used to	Coverage is provided for	By or in consultation with a	12 months	For reauthorization:	0	0
	Indications.			reduce the acute	members 5 years of age and	physician who specializes in		Documentation there has		
				complications of sickle cell	older	SCD (e.g.a hematologist)		been a reduction in vaso-		
				disease (SCD) and the				occlusive painful events or an	16	
				member must have				improvement in condition.		
				experienced at least 2 painful						
				episodes of sickle cell crises						
				(SCC) in the previous 12						
				months.Member has had an						
				adequate trial (3 months) of						
				hydroxyurea unless the						
				member has tried and failed						
				or has a contraindication to						
				hydroxyurea.		5 1 10 11				
LANREOTIDE (SOMATULINE	1 - All FDA-approved			Diagnosis. For acromegaly:	Coverage is provided for	By or in consultation with an	For oncology indications: 6	For reauth: documentation of		0
DEPOT)	Indications.			must have inadequate	members 18 years of age and	endocrinologist or oncologist	months. All other indications:	improvement or stabilization.		
				response to surgery or	older.		12 months			
				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.						
				glucose tolerance test.						
LEDISPASVIR-SOFOSBUVIR	1 - All FDA-approved			Criteria will be applied	Coverage is provided for	By or in consultation with a	Criteria will be applied		0	0
(HARVONI)	Indications.			consistent with current	members who are age-	gastroenterologist,	consistent with current			
				AASLD/IDSA guidance and/or	_	hepatologist, infectious	AASLD/IDSA guidance and/or			
				FDA approved labeling		disease, HIV or transplant	FDA-approved labeling.			
					FDA-approved labeling.	specialist.				
LENIOLISIB (JOENJA)	1 - All FDA-approved			Diagnosis of activated	Coverage is provided for	By or in consultation with a	12 months		0	0
	Indications.			phosphoinositide 3-kinase	members 12 years of age or	hematologist, immunologist,				
				delta syndrome (APDS). Must	older.	or geneticist.				
				have genetic testing						
				confirming the PI3K delta						
				mutation with a documented						
				variant in either PIK3CD or						
				PIK3R1. Documentation of						
				inadequate response to						
LETERA 401 112 (22 21 21 21 21 21 21 21 21 21 21 21 21 2	A All ED:		11 21 1	immunoglobulins.		B 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	200 1	F 11 11 11 11 11 11	<u> </u>	
LETERMOVIR (PREVYMIS)	1 - All FDA-approved		Use with pimozide or ergot	Diagnosis. Must have received	1	By or in consultation with a	200 days post-transplant	For reauth: no reauthorization	n U	U
	Indications.		alkaloids. Use with	either an allogeneic		hematologist, infectious		after initial coverage period.		
			pitavastatin and simvastatin	hematopoietic stem cell		disease or transplant				
			when co-administered with	transplant (HSCT) and have		specialist.				
			cyclosporine.	tested CMV-seropositive						
				(Recipient positive, R+) or						
				received a kidney transplant	,					
				and be a high risk donor (CMV						
				1						
				CIVIV INTECTION.						
				seropositive D+/recipient CMV seronegative R-). Must be used for prophylaxis of CMV infection.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
LEUPROLIDE ACETATE	1 - All FDA-approved			Diagnosis. For endometriosis:				For reauth: documentation	0	0
	Indications.			Documentation the member			endometriosis: 6 months. CPP	indicating stabilization or		
				has tried and failed or has a			or Fibroids: 3 months	improvement in condition. For	•	
				contraindication to 2				endometriosis, a single		
				conventional treatments such				retreatment course of not		
				as oral contraceptives, non				more than six months may be		
				steroidal anti-inflammatory				administered after the initial		
				agents, progestins, or danazol				course of treatment if		
				For CPP: Documentation that				symptoms recur		
				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.						
LEVACETYLLEUCINE	1 - All FDA-approved			Diagnosis. Documentation the	1		12 months	Reauthorization:	U	ال
(AQNEURSA)	Indications.		1	diagnosis was confirmed by			1	Documentation the member		
				genetic testing demonstrating				is experiencing an		
				one of the following: 1. a				improvement or stabilization		
				mutation in both alleles of				in disease.		
				NPC1 or NPC2 OR 2. mutation						
				in one allele and either a						
				positive filipin-staining or						
				elevated cholestance						
				triol/oxysterols (greater than						
				2x ULN). Documentation the						
				member has at least one						
				neurological symptom of NPC						
				(e.g. decrease in motor skills,						
				ataxia, seizures, etc.). Must						
				not be used in combination						
				with Miplyffa.						
LEVETIRACETAM (SPRITAM)	1 - All FDA-approved			Diagnosis. Must have had an	Coverage is provided for	By or in consultation with a	12 months		0	0
ELVETHOREET/HVI (3F HTT/HVI)	Indications.			inadequate response or		neurologist.	12 months			ŭ
				intolerance to generic	older weighing more than	inear ereBisti				
				levetiracetam and at least one						
				of the following generic	2018.					
				anticonvulsant drugs:						
				phenytoin, carbamazepine,						
				oxcarbazepine, gabapentin,						
				lamotrigine, valproate, or						
				topiramate.						
LEVOMILNACIPRAN (FETZIMA)	1 - All FDA-approved	†		Diagnosis. Documentation of	Coverage is provided for		12 months		0	0
1 (1 = 1 = 1/11 )	Indications.			•	members 18 years of age and					
				generic antidepressants	older.					
				alternatives such as an SSRI,						
				SNRI, bupropion, trazodone or	.[					
				mirtazapine						
LIDOCAINE PATCH	3 - All Medically-accepted	1		Diagnosis. This Prior	1	1	12 months		0	0
	Indications.			Authorization requirement					-	
				only applies to members						
				when a non-FDA approved						
				diagnosis is submitted at the						
				point of sale. FDA-approved						
				diagnosis codes submitted wil	ı					
				pay without prior	Ϊ					
				authorization requirement.						
LOTILANER (XDEMVY)	1 - All FDA-approved	†		Diagnosis of Demodex	Member must be 18 years of	Prescribed by or in	6 weeks		0	0
	Indications.			blepharitis confirmed by both		consultation with an			-	
				of the following: 1. Member		optometrist or				
				has at least mild erythema or		ophthalmologist				
				itching of the upper eyelid		opinina inioiogist				
				margin. 2. Mite presence (e.g.						
				collarettes) confirmed by slit						
				lamp examination of the						
				<u> </u>						
	1	1	<u> </u>	eyelashes.		<u> </u>	l		1	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
LUMACAFTOR/IVACAFTOR	1 - All FDA-approved			Diagnosis. Documentation of a	9	By or in consultation with a	12 months	For reauthorization:	0	0
(ORKAMBI)	Indications.			genetic test confirming that		pulmonologist or cystic		documentation from		
				the member is homozygous		fibrosis specialist		prescriber indicating		
				for the F508del mutation in				stabilization or improvement		
				the CFTR gene (has two copies	5			in condition.		
				of the F508del mutation in the	2					
				CFTR gene).						
MACITENTAN (OPSUMIT)	1 - All FDA-approved		Pregnancy	Diagnosis. Pulmonary arterial		Prescribed by or in	Initial: 3 months Reauth: 12	For reauth: documentation	0	0
	Indications.			hypertension (PAH) WHO		consultation with cardiologist	months	from prescriber that		
				Group I confirmed by chart		or pulmonologist.		demonstrates member is		
				documentation of right-heart				tolerating and receiving		
				catheterization (RHC)				clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than						
				20 mmHg, pulmonary vascular	r					
				resistance greater than 2						
				wood units, and mean						
				pulmonary capillary wedge						
				pressure less than or equal to						
				15 mmHg. If provider						
				indicates RHC is not						
				recommended, must have						
				documentation of						
				echocardiography.						
MANNITOL (BRONCHITOL)	1 - All FDA-approved			Diagnosis. Must have passed a			12 months	For reauth: documentation of	0	0
	Indications.			bronchitol tolerance test.				improvement		
				Must be used as add-on						
				maintenance treatment with						
				standard therapies (e.g.						
				bronchodilators, antibiotics,						
				anti-inflammatory therapy) to						
				improve pulmonary function.						
MARALIXIBAT (LIVMARLI)	1 - All FDA-approved		PFIC type 2 patients with	Diagnosis of pruritis caused by	Coverage is provided for	By or in consultation with a	12 months	For reauth: documentation of	0	0
	Indications.		specific ABCB11 variants	progressive familial	members 3 months of age and	hepatologist or		improvement in pruritis.		
			resulting in non-functional or	intrahepatic cholestatis (PFIC)	older.	gastroenterologist.				
			complete absence of bile salt	or Allagile syndrome (ALGS)						
			export pump (BSEP) protein.	which has been confirmed by						
				genetic testing.						
				Documentation of trial and						
				failure of ursodiol and another	r					
				medication for cholestatic						
				pruritis (e.g. cholestyramine,						
				rifampin).						
MARIBAVIR (LIVTENCITY)	1 - All FDA-approved			Diagnosis of post-transplant		By or in consultation with a	3 months	For reauthorization:	0	0
	Indications.			(solid organ or hematopoietic		hematologist, oncologist,		documentation from		
				stem cell) cytomegaloviris		infectious disease physician,		prescriber indicating		
				(CMV) infection/disease that		or transplant specialist.		stabilization or improvement		
				is refractory to treatment with				in condition.		
				ganciclovir, valganciclovir,						
				cidofovir, or foscarnet. Must						
				weight at least 35 kg. Must						
				not be used concomitantly						
				with ganciclovir or						
				valganciclovir.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
MAVORIXAFOR (XOLREMDI)	1 - All FDA-approved Indications.			Diagnosis. Confirmation of the diagnosis with a genetic test confirming pathogenic or likely pathogenic variants in the CXCR4 gene.  Documentation of a baseline absolute neutrophil count (ANC) less than or equal to 400 cells/?L or absolute lymphocyte count (ALC) less than or equal to 650 cells/?L. Documentation of symptoms and complications associated with WHIM syndrome (e.g. warts, hypogammaglobulinemia, recurrent infections, and	Members 12 years of age and older		12 months	For reauthorization: Documentation of one of the following: 1. an improvement in ANC or ALC from baseline 2. A decrease in frequency or severity of infections since initiating therapy.	0	0
MECASERMIN (INCRELEX)	1 - All FDA-approved Indications.			myelokathexis) Diagnosis. Growth chart and documentation that epiphyse 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 do for 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).	older. x	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
METHYLNALTREXONE (RELISTOR)	1 - All FDA-approved Indications.		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.	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	0

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	<u> </u>	Other Criteria	Part B Prerequisite	Required
MIFEPRISTONE (KORLYM)	1 - All FDA-approved			Diagnosis. Must have failed	Coverage is provided for	By or in consultation with an	12 months		0	0
	Indications.			surgery or not be a candidate		endocrinologist				
				for surgery. Female members of reproductive potential:	older.					
				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						
MIGLUSTAT (ZAVESCA)	1 - All FDA-approved	+		after mifepristone therapy. Diagnosis. Documentation the	Coverage is provided for	By or in consultation with an	12 months	Reauthorization:	0	0
WIIGLUSTAT (ZAVESCA)	Indications.			member has at least one of	members 18 years of age and	1 '		Documentation from the	U	U
	indications.		•	the following: 1) anemia not	older.	hematologist, geneticist,		prescriber indicating		
				due to iron deficiency with a	older.	radiologist, orthopedist,		improvement or stabilization		
			•	low hemoglobin for age and		endocrinologist,		in member's condition.		
				sex, 2) thrombocytopenia 3)		rheumatologist, hepatologist)				
				evidence of bone disease, 4)						
				presence of hepatomegaly or						
				splenomegaly. Enzyme						
				replacement therapy must						
				not be a therapeutic option						
			•	for the member (i.e. due to						
				allergy, hypersensitivity, or						
				poor venous access).						
MITAPIVAT (PYRUKYND)	1 - All FDA-approved			Diagnosis of hemolytic anemia	Coverage is provided for	By or in consultation with a	12 months	For reauthorization:	0	0
William Will (Friedrich)	Indications.			with pyruvate kinase		hematologist or a physician	12 months	documentation of		·
				deficiency (PKD) confirmed by		who specializes in the		improvement in condition.		
			•	genetic testing.		treatment of inherited		<b>,</b>		
						metabolic disorders.				
MODAFINIL (PROVIGIL)	1 - All FDA-approved			Diagnosis. For narcolepsy and		By or in consultation with a	SWSD: 6 months. Narcolepsy,		0	0
	Indications.			obstructive sleep apnea: Sleep	P	sleep specialist, ENT (ear,	OSA: 12 months	have documentation from		
				Study (e.g. Polysomnogram,		nose, and throat specialist),		prescriber indicating		
				Multiple Sleep Latency Test)		neurologist, or pulmonologist		stabilization or improvement		
			•	confirming diagnosis. For shift				in condition.		
				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						
				Multiple Sleep Latency Test						
				demonstrate loss of normal						
				sleep wake pattern, no other medical or mental disorders						
			•	account for symptoms, and						
				symptoms do not meet						
				criteria for any other sleep						
				disorder producing insomnia						
			•	or excessive sleepiness such						
				as time zone change						
				syndrome) and must provide						
				documentation of shift work						
				schedule showing 5 or more						
			•	night shifts per month						
				(defined as at least 4 hours of						
				shift occurring between 10pm						
				and 8am).						
		1	1		<u> </u>	l	<u> </u>		1	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
MULTIPLE SCLEROSIS	1 - All FDA-approved			Diagnosis. For multiple		By or in consultation with a		For reauthorization: must	0	0
THERAPIES	Indications.			sclerosis (MS), must have		neurologist or		have documentation from		
			I .	relapsing Multiple Sclerosis		gastroenterologist		prescriber indicating		
				(including clinically isolated				stabilization or improvement		
				syndrome, relapsing-remitting				in condition.		
				disease, and active secondary						
				progressive disease) and						
				functional status must be						
				preserved and patient is						
				either still able to walk at least	t					
				a few steps or alternatively						
				must have some functional						
				arm/hand use consistent with						
				performing activities of daily						
				living. For ulcerative colitis						
				(UC): must have history of tria	1					
				and failure, contraindication						
				or intolerance to an						
				immunomodulator (i.e.,						
				Azathioprine, 6-						
			I .	Mercaptopurine,						
				Methotrexate).						
NETARSUDIL (RHOPRESSA)	1 - All FDA-approved			Diagnosis. Member must have	Coverage is provided for		12 months	For reauthorization: must	0	0
THE IT MISSIBLE (MITOF NESSA)	Indications.			a baseline intraocular	members 18 years of age and			have documentation from		
	malcations.			pressure of less than 30	older.			prescriber indicating		
				mmHg. Documentation of tria				stabilization or improvement		
				and failure, contraindication,	1			in condition.		
			I .	or intolerance to timolol and				in condition.		
				latanoprost.						
				latanoprost.						
NINTEDANIB (OFEV)	1 - All FDA-approved			Diagnosis. For a diagnosis of	Coverage provided for	By or in consultation with a	Initial: 6 months, Reauth: 12	For reauth: must have	0	0
	Indications.					pulmonologist	· ·	documentation from		
				(IPF): Must have diagnosis	older.			prescriber indicating that		
				confirmed by either high-				member still is a candidate for		
				resolution computed				treatment.		
			I .	tomography (HRCT) or surgical	1					
				lung biopsy and must have all						
				other diagnoses ruled out						
			I .	(e.g., domestic and						
				occupational environmental						
				exposures, connective tissue						
				disease, and drug toxicity).						
				Must have a forced vital						
				capacity (FVC) greater than or						
				equal to 50% of predicted and						
				a carbon monoxide diffusing						
				capacity (DLCO) of at least						
				30% of predicted. Must have a						
				trial of pirfenidone (Esbriet).						
			I .	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						
			I .	on a chest high-resolution						
				computed tomography (HRCT)	)					
			I .	scan within the past 12						
				months. Must have a FVC						
				greater than or equal to 40%						
				of predicted and a DLCO of at						
				least 30% of predicted. For a						
				diagnosis of Chronic Fibrosing						
NITISINONE (ORFADIN)	1 - All FDA-approved			Diagnosis of hereditary			12 months	For reauth: Documentation	0	0
	Indications.		I .	tyrosinemia type 1 (HT-1)				from the prescriber indicating		
				confirmed by DNA testing or				improvement or stabilization		
			I .	biochemical testing (ie. urine				in the member's condition		
				succinylacetone (SA) level).				s		
<b>↓</b>					-	-	•	-		

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
NITROGLYCERIN 0.4% OINTMENT (RECTIV)	1 - All FDA-approved Indications.		Severe anemia (defined as hemoglobin less than 8g/dL).	Diagnosis. Must provide documentation that chronic	Coverage is provided for members 18 years of age or		Initial: 2 months Reauthorization: 12 months	For reauthorization: documentation from	0	0
			Increased intracranial	anal fissure symptoms have	older.			prescriber indicating		
				persisted for at least 6 weeks.				stabilization or improvement		
			a phosphodiesterase type 5					in condition.		
			(PDE5) inhibitor such as							
			sildenafil (Revatio, Viagra),							
			tadalafil (Adcirca, Cialis), or							
ODENINIDAT (DVIDAN)	4. All EDA		vardenafil (Levitra, Staxyn).	Diameter of a section of the		D in	42	Farman the damentation of		
ODEVIXIBAT (BYLVAY)	1 - All FDA-approved		PFIC type 2 patients with specific ABCB11 variants	Diagnosis of pruritis caused by		By or in consultation with a	12 months	For reauth: documentation of	0	0
	Indications.			progressive familial intrahepatic cholestatis (PFIC)	members 3 months of age and	gastroenterologist.		improvement in pruritis.		
			•	or Allagile syndrome (ALGS)	older.	gastroenterologist.				
				which has been confirmed by						
			export pamp (BBE) y protein.	genetic testing.						
				Documentation of trial and						
				failure of ursodiol and anothe	r					
				medication for cholestatic						
				pruritis (e.g. cholestyramine,						
				rifampin).						
OLANZAPINE/SAMIDORPHAN	1 - All FDA-approved			Diagnosis. Documentation of			12 months		0	0
(LYBALVI)	Indications.			trial and failure of at least two						
				of the following generic, oral	older.					
				atypical antipsychotics:						
				olanzapine, quetiapine, paliperidone, risperidone,						
				aripiprazole, or ziprasidone. 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 membe	r					
				has tried and failed monotherapy, 3. Clinical						
				rationale for use of 2 or more						
				anticholinergic medications.						
OLEZARSEN (TRYNGOLZA)	1 - All FDA-approved			Diagnosis. Confirmation of the	Coverage is provided for	By on in consultation with a	12 months	For reauthorization:	0	0
	Indications.			diagnosis by at least one of	members 18 years of age and	lipidologist, geneticist		documentation indicating		
				the following: 1. a genetic tes	t older	cardiologist, or		stabilization or improvement		
				2. a North American Familial		endocrinologist		in condition.		
				Chylomicronemia Syndrome						
				(NAFCS) score of greater than						
				or equal to 60. 3. fasting						
				triglycerides greater than 10						
				mmol/l or 880mg/dl and						
				symptoms of the disease (e.g.						
				acute pancreatitis, hepatosplenomegaly,						
				abdominal pain, lipemia						
				retinalis)						
				i Carrans)						
	L		L	L	1	L	1	L		

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
OMALIZUMAB (XOLAIR)	1 - All FDA-approved			Diagnosis. For moderate to		By or in consultation with, for	12 months	For reauthorization:	0	0
	Indications.			severe allergic asthma: recent	:	Urticaria: allergist,		documentation from		
				total serum IgE level of		dermatologist, immunologist.		prescriber indicating		
				greater than 30 IU/ml and the		Asthma: pulmonologist or		stabilization or improvement		
				pre-treatment IgE levels do		allergist. Nasal Polyps:		in condition.		
				not exceed manufacturers		allergist, ear/nose/throat				
				dosing recommendations.		specialist, or immunologist.				
				Documentation of recent use		Allergy: allergist or				
				and failure to respond to		immunologist.				
				inhaled steroid in combo with						
				long acting beta agonist.						
				Documentation of a positive						
				skin or in vitro reactivity to						
				perennial aeroallergen. Must						
				have asthma symptoms that						
				are inadequately controlled						
				while on treatment						
				(uncontrolled defined as						
				having an asthma						
				exacerbation requiring						
				hospitalization in the past						
				year or having 2 or more						
				asthma exacerbations						
				requiring oral systemic						
				steroids). Must follow						
				recommended dosing						
				guidelines based upon weight						
				and IgE level. For chronic						
				spontaneou urticaria (CSU):						
				must have chart						
				documentation showing						
				history of urticaria w/						
				presence of hives, must have						
				trial of one 2nd generation H2						
OMAVELOXOLONE	1 - All FDA-approved			Diagnosis of Friedreich's	Coverage is provided for	By or in consultation with a	12 months		0	0
(SKYCLARYS)	Indications.			ataxia that has been		neurologist.				
				confirmed by genetic testing.  Must have a modified	older.					
				Friedreich's Ataxia Rating						
				_						
				Scale (mFARS) score between 20 and 80. Must have a left						
				•	£					
				ventricular ejection fraction o at least 40%.	T.					
OMNIPOD POD	1 - All FDA-approved	+		Must have documentation of	1		12 months	+	0	0
OIVINIPOD POD	Indications.			previous insulin use.			12 months		U	0
ONABOTULINUMTOXINA	1 - All FDA-approved			Diagnosis. For migraine	<del> </del>	By or in consultation with an	12 months	For reauth: documentation	0	0
(BOTOX)	Indications.			prophylaxis: must have		appropriate specialist (ie.	בב וווטוונווט	from prescriber indicating	ľ	ľ
(5010)	maications.			adequate trial of two migrain		dermatologist, neurologist,		stabilization or improvement		
				prophylactic agents each fron		urologist).		in condition.		
				a separate class (e.g.	'	urologist).		in condition.		
				anticonvulsants, beta-						
				blockers, tricyclic						
				antidepressants) with						
		1		inadequate response. For						
		1		urinary incontinence or OAB						
		1		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						
I		1	l	contraindicated.		1	1	l	1	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ONCOLOGY MEDICATIONS	Pending CMS Review			Diagnosis. For Bosulif, Iclusig,		By or in consultation with an	6 months		0	0
				and Tasigna for CML: must		oncologist, hematologist,				
				have had an inadequate		neurologist, transplant				
				response or intolerance to		specialist, allergist, or				
				imatinib or dasatinib.		immunologist.				
ORAL BENZODIAZEPINES	3 - All Medically-accepted			Prior authorization is only			12 months	Reauth: For ongoing opioid	0	0
	Indications.			required for requests greater				and benzodiazepine therapy:		
				than a 14 day supply in a 30				Documentation to taper the		
				day period and for members				benzodiazepine or opioid. If a		
				not in hospice care. Diagnosis.				taper is not appropriate at this	S	
				For seizure disorder:				time, documentation of when		
				documentation the member				the taper will be reevaluated.		
				has tried and failed or had an				For all other ongoing therapy:		
				intolerance or				documentation the member		
				contraindication to at least				has been treated with the		
				one non-benzodiazepine				requested agent within the		
				anticonvulsant. For sleep				past 90 days		
				disorder: documentation the						
				member has tried and failed						
				or had an intolerance to at						
				least 2 non-benzodiazepine						
				sleep medications. For a						
				psychiatric disorder (e.g.						
				generalized anxiety disorder,						
				panic disorder, post-traumatic						
				stress disorder, etc.):						
				documentation of one of the						
				following: 1. the member tried	d l					
				and failed or had an						
				intolerance or						
				contraindication to at least 2						
				antidepressants. 2. The						
				request is related to a recent						
				hospitalization within the past	:					
				3 months. 3. The requested						
				therapy is medically necessary	<b>,</b>					
				to prevent harm to the						
				member or others. For a						
				musculoskeletal disorder:						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
PALIVIZUMAB (SYNAGIS)	1 - All FDA-approved		having received Beyfortus	DX. Must have documented	Less than 12 months or less		Minimum duration 1 month.		0	0
	Indications.		(nirsevimab-alip) for the	_	than 24 months of age at start		Maximum of 5 doses per RSV			
			current RSV season		of RSV season depending on		season			
					criteria.					
				RSV season w/ no other						
				medical dx: must have						
				gestational age (GA) less than						
				29 wks. If under age 24 mo at start of RSV season during 1st						
				yr of life w/ Chronic Lung						
				Disease (CLD) of prematurity:						
				must have GA less than 32						
				wks 0 days & required greater						
				than 21% oxygen (O2) for at						
				least 1st 28 days of life. If						
				under age 24 mo at start of						
				RSV season during 2nd yr of						
				life w/ CLD of prematurity:						
				must have GA less than 32						
				wks 0 days & required greater						
				than 21% O2 for at least 1st						
				28 days of life & have						
				continued to require medical						
				support (chronic corticosteroid therapy,						
				diuretic therapy,						
				supplemental O2) during 6 mo						
				before start of 2nd RSV						
				season. If under age 12 mo. at						
				start of RSV season w/ heart						
				disease: must have						
				hemodynamically significant						
				Congenital Heart Disease						
				(CHD) (& be on drugs to						
PALOVAROTENE (SOHONOS)	1 - All FDA-approved			_	Members assigned female at	Prescribed by or in	12 months		0	0
	Indications.				birth must be 8 years and	consultation with an				
					older. Members assigned	orthopedist or				
					male at birth must be 10 years	rheumatologist.				
DANAIDDONATE (ADEDIA)	1 All EDA anamanad	_			and older.		12	Fau was with a de access and a time.	0	0
PAMIDRONATE (AREDIA)	1 - All FDA-approved Indications.			Diagnosis. For hypercalcemia of malignancy: must be used	members 18 years of age or		12 months	For reauth: documentation from prescriber indicating	U	0
	illuications.			in conjunction with adequate				stabilization or improvement		
				hydration in members with	older.			in condition.		
				moderate or severe				in condition.		
				hypercalcemia associated						
				with malignancy, with or						
				without bone metastases. For						
				Paget's disease: must have						
				moderate to severe Paget's						
				disease of bone. For osteolytic						
				bone metastases of breast						
				cancer and osteolytic lesions						
				of multiple myeloma: must be						
				used in conjunction with						
				standard antineoplastic						
PASIREOTIDE (SIGNIFOR)	1 - All FDA-approved		+	therapy .  Diagnosis of Cushing's disease	Coverage is provided for	By or in consultation with an	12 months	For reauth: documentation of	0	0
L ASINEOTIDE (SIGNIFOR)	Indications.			for whom pituitary surgery is		Endocrinologist	בב וווטוועווז	improvement or stabilization.	ľ	
	maications.			not an option or has not been		Endocimologist		improvement of stabilization.		
				curative. Documentation of						
				trial and failure with						
				ketoconazole to reduce						
				cortisol secretion.						
	3 - All Medically-accepted			Diagnosis.			6 months	For reauth: documentation	0	0
ii.		i	1	I	I	I		from prescriber that		1
(ZIEXTENZO)	Indications.							•		
(ZIEXTENZO)	Indications.							demonstrates member is		
(ZIEXTENZO)	Indications.							demonstrates member is tolerating and receiving		
(ZIEXTENZO)	Indications.							demonstrates member is		

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
PEGVISOMANT (SOMAVERT)	1 - All FDA-approved			Diagnosis of acromegaly. Mus	t Coverage is provided for	By or in consultation with an	12 months	For reauth: documentation of	0	0
	Indications.			have inadequate response to		Endocrinologist		improvement or stabilization.		
				surgery or radiation therapy						
				or documentation that these						
				therapies are inappropriate.						
				Must have a trial and failure						
				or inadequate response to						
				one medical therapy (e.g.						
				octreotide, octreotide LAR,						
				lanreotide) 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.						
				tolerance test.						
PERAMPANEL (FYCOMPA)	1 - All FDA-approved			Diagnosis. Must have had an	Coverage is provided for	By or in consultation with a	12 months		0	0
	Indications.			inadequate response or	members 4 years of age or	neurologist.				
				intolerance to two of the	older.					
				following generic						
				anticonvulsant drugs:						
				levetiracetam, phenytoin,						
				carbamazepine,						
				oxcarbazepine, gabapentin,						
				lamotrigine, valproate, or						
				topiramate.						
PIMAVANSERIN (NUPLAZID)	1 - All FDA-approved			Diagnosis. Must be using for	Coverage is provided for	By or in consultation with a	12 months		0	0
	Indications.			the treatment of	members 18 years of age or	neurologist or psychiatrist				
				hallucinations and delusions	older.					
				associated with Parkinson's						
				disease psychosis. Must						
				provide clinical rationale for						
				diagnosis and exclusion of						
				other diagnoses (e.g.,						
				dementia with Lewy bodies,						
				visual processing deficits/loss						
				of visual acuity, infectious						
				causes). Must have tried to						
				discontinue or reduce dose of any medication(s) that may						
				cause or contribute to						
				hallucinations and delusions						
				(e.g., dopamine agonist,						
				amantadine, monoamine						
				oxidase B inhibitors,						
				anticholinergics) or provide						
				clinical rationale indicating						
				why dose reduction or						
				discontinuation of applicable						
				medications would not be						
				appropriate.Submission of a						
				Mini-Mental State						
				Examination (MMSE) score						
				greater than or equal to 21						
	Ī.	i	I		1	i	I	i	1	
				and documentation the						
				and documentation the member is able to self-report						

				Required Medical						Prerequisite T	herapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria		Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required	
PIRFENIDONE (ESBRIET)	1 - All FDA-approved			Diagnosis. Must have	Coverage provided for	Pulmonologist	Initial: 6 months, Reauth: 12	For reauth: must have	0	0	
, , ,	Indications.				members age 18 years and		months	documentation from			
					older.			prescriber indicating that			
				confirmed by either high-				member still is a candidate for	r		
				resolution computed				treatment.			
				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).							
				Must have forced vital							
				capacity (FVC) greater than or							
				equal to 50% and a percent							
				predicted diffusing capacity of							
				the lungs for carbon							
				monoxide (DLCO) greater than							
				or equal to 30%							
POLYPHARMACY - MULTIPLE	1 - All FDA-approved				Prior authorization only		12 months	Reauthorization:	0	0	
ACH MEDICATIONS	Indications.				applies to enrollees aged 65			Documentation of one of the			
				members on 2 or more unique	or older not in hospice care.			following: 1. attempt to taper			
				anticholinergic medications.				of one of the medications OR			
				Diagnosis. Provider must				2. documentation of why			
				acknowledge that the benefit				tapering one of the			
				of the combination of the				medications is not			
				medications outweighs the				appropriate at this time.			
				potential risks.				Provider attestation the			
				Documentation of both of the				member continues to benefit			
				following: 1. the member has				from the combination of			
				tried and failed monotherapy.				medications and this			
				2. clinical rationale for use of 2	-			outweighs any potential risks.			
				or more anticholinergic							
				medications.							
POSACONAZOLE (NOXAFIL)	1 - All FDA-approved		Coadministration with	Diagnosis. For oropharyngeal			12 months		0		
POSACONAZOLE (NOXAFIL)	Indications.			candidiasis, must have at least			12 months		U	U	
	indications.		ergotamine,	a 2 week trial of fluconazole							
			dihydroergotamine), HMG-	with an insufficient response,							
			CoA reductase inhibitors that	intolerable side effect, or have							
			are primarily metabolized	a contraindication.							
			through CYP3A4 (e.g.,	a contramalcation.							
			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.								
PRAMLINTIDE (SYMLIN)	1 - All FDA-approved			Diagnosis of Type 1 or Type 2			12 months	For reauth: if the patient has	0	0	
	Indications.			Diabetes Mellitus.				been receiving Symlin for at			
				Documentation the member				least 3 months, patient			
				uses mealtime insulin and has				demonstrated a reduction in			
				failed to achieve desired				HbA1c since starting therapy			
				glycemic control despite				with Symlin.			
				optimal insulin therapy. Initial							
				A1C greater than or equal to							
				6.5.							
	•		<del>-</del>	•	•	•	•	•	•	<del></del>	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
PREGABALIN (LYRICA)	1 - All FDA-approved			Diagnosis. For fibromyalgia:	For partial onset seizures,		12 months		0	0
	Indications.			must have trial and failure or	coverage is provided for					
				contraindication to	members 1 month of age and					
				gabapentin at a dose of at	older. For fibromyalgia, PHN,					
				least 1200mg/day or	DPN, and neuropathic pain					
				maximally tolerated dose in	associated with spinal cord					
				intolerant patients AND either						
					for members 18 years of age					
				unless contraindicated. For	or older.					
				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 OF						
				a medical/lab claim or	`\					
				physician chart note of						
				diabetes diagnosis and must						
				have trial and failure,						
				intolerance, or						
				contraindication to						
				gabapentin.						
				gabapentini.						
PURIFIED CORTROPHIN GEL	1 - All FDA-approved		Members with scleroderma,	Diagnosis. For acute		Must be prescribed by or in	1 month	For allergic states such as	1	0
(CORTICOTROPIN) INJECTION	Indications.		osteoporosis, systemic fungal	exacerbation of multiple		consultation with a		serum sickness or transfusior	ı	
			infections, ocular herpes	sclerosis, member must have		neurologist or physician that		reaction due to serum protei	n	
			simplex, recent surgery,	tried and failed or have a		specializes in the treatment of	f	reaction, member must have	•	
			history of or the presence of a	contraindication to 2		multiple sclerosis, a		tried and failed 2		
			peptic ulcer, congestive heart	corticosteroids (e.g. IV		rheumatologist, allergist,		corticosteroids (e.g. IV		
			failure, hypertension, or	methylprednisolone, IV		dermatologist, immunologist,		methylprednisolone, IV		
				dexamethasone, or high dose		ophthalmologist,		dexamethasone, or high dose	e	
			from porcine sources, primary	·		pulmonologist, nephrologist		oral steroids) or has a		
			adrenocortical insufficiency or					contraindication to		
			adrenocortical hyperfunction	verifying the member is on a				corticosteroid therapy. If the		
			are excluded.	medication for the treatment				member has a diagnosis of		
				of multiple sclerosis. For RA				atopic dermatitis, the		
				(incl. Juvenile RA), psoriatic				member is concurrently		
				arthritis, ankylosing				receiving maintenance		
				spondylitis, acute gouty				therapy with one (1) of the		
				arthritis: must be using as				following, or is		
				adjunctive therapy for short-				contraindicated to all: topica	1	
				term administration (to tide				corticosteroid, topical		
				over an acute episode or				calcineurin inhibitor (e.g.,		
				exacerbation) and have a trial				tacrolimus, pimecrolimus),		
				of 2 IV steroids w/ inadeq				topical PDE-4 inhibitor or		
				response or signif side				Dupixent (dupilumab). For a		
				effects/toxicity. The member				diagnosis of serum sickness,		
				is concurrently receiving				must provide laboratory		
				maintenance therapy with at				documentation		
				least one of the following: an				demonstrating neutropenia,		
1				NSAID, DMARD (e.g.				development of reactive		
				methotrexate, leflunomide,				plasmacytoid lymphocytes,		
				sulfasalazine) or biologic (e.g.				and elevated erythrocyte		
				adalimumab, etanercept,				sedimentation rate or C-		
				infliximab, tofacitinib). For				reactive protein. For		
				collagen disease, member				ophthalmic diseases such as		
1				must have tried and failed or				severe acute and chronic		

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
RESMETIROM (REZDIFFRA)	1 - All FDA-approved		Members with	Diagnosis. Medication must	Coverage is provided for	By or in consultation with a	12 months	For reauth: the member has	0	0
	Indications.		decompensated cirrhosis	be used in conjunction with	members 18 years of age and	hepatologist or		received a clinical benefit		
				diet and exercise for the	older	gastroenterologist		demonstrated by either the		
				treatment of adults with				resolution of steatohepatitis		
				noncirrhotic nonalcoholic				and no worsening of liver		
				steatohepatitis (NASH) with				fibrosis or at least one stage		
				moderate to advanced liver				improvement in liver fibrosis		
				fibrosis (stage F2 to F3				and no worsening of		
				fibrosis) which has been				steatohepatitis.		
				confirmed by one of the						
				following (1, 2, or 3): 1) a liver						
				biopsy within the past 6						
				months with a NAFLD Activity						
				Score (NAS) of at least 4 and a						
				score of at least 1 in each NAS						
				component (steatosis,						
				ballooning degeneration, and						
				lobular inflammation) OR 2)						
				vibration-controlled transient						
				elastography (VCTE, e.g.						
				FibroScan) within the past 3						
				months with kPa greater than						
				or equal to 8.5 and controlled						
				attenuation parameter (CAP)						
				greater than or equal to 280						
			•	dB.m-1, OR 3) MRI with an						
			•	MRI-PDFF greater than or						
				equal to 8% liver fat.						
DIE AVIDAINI (VIE AVANI)	4. All EDA			Diamenta Faultenatia	Hanak'a an andrala anklassada	Hanak'a ananahalanakhan ka	11	Facility Demonstrates	0	
RIFAXIMIN (XIFAXAN)	1 - All FDA-approved			Diagnosis. For hepatic		Hepatic encephalopathy: by	Hepatic encephalopathy: 12	For IBS-D: members who	0	0
	Indications.			encephalopathy: must have	•	or in consultation with a	months, IBS-D: 2 weeks,	experience a recurrence of		
				trial and failure of lactulose.		gastroenterologist,	Travelers diarrhea: 3 days	symptoms can be retreated		
				For diarrhea-predominant	years of age or older	hepatologist, or infectious		up to two times with the same		
				irritable bowel syndrome (IBS-		disease specialist, IBS-D:		dosage regimen. Reauth for		
				D): documentation of chronic		gastroenterologist		IBS-D: must have		
				IBS symptom diarrhea lasting				documentation from		
				at least 12 weeks and a trial				prescriber indicating		
				and failure of two medications				recurrence of IBS-D symptoms	5 <b> </b>	
				used in the treatment of IBS-D				after a successful treatment		
				(i.e. loperamide,				with rifaximin.		
				antispasmodics) with						
				inadequate responses or						
			1	significant side effect/toxicity						
			1	unless contraindicated. For						
			1	Traveler's diarrhea: must have						
			1	a trial and failure, intolerance,						
			1	or contraindication to one of						
			1	the following: a						
			1	fluoroquinolone (i.e.						
			1	ciprofloxacin, levofloxacin) or						
			1	azithromycin.						
				azidilolliyelli.						
			1							
	1			<u> </u>	<u> </u>	ļ		ļ	<u>L</u>	<u> </u>

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	-	Other Criteria	Part B Prerequisite	Required
RILONACEPT (ARCALYST)	1 - All FDA-approved			Diagnosis. For Cryopyrin-	CAPS and recurrent	By or in consultation with a	12 months	For reauth: documentation	0	0
	Indications.			Associated Periodic	pericarditis: coverage	hematologist, dermatologist,		from prescriber indicating		
				Syndromes (CAPS), must have documented genetic mutation		rheumatologist, neurologist, allergist, immunologist,		stabilization or improvement in condition.		
				in the Cold-Induced Auto-	older. For DIRA: adults and	cardiologist or a genetic		in condition.		
				inflammatory Syndrome 1		specialist				
				and a documented diagnosis						
				of Familial Cold						
				Autoinflammatory Syndrome						
				(FCAS) or Muckle Wells						
				Syndrome (MWS). Member						
				must have two or more of any						
				of the CAPS-typical symptoms						
				urticaria-like rash, cold- triggered episodes,						
				sensorineural hearing loss,						
				musculoskeletal symptoms,						
				chronic aseptic meningitis and						
				skeletal abnormalities.						
				Member must have						
			•	documented baseline						
				inflammatory markers						
				including serum C-reactive						
				protein and serum amyloid A.						
				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,						
RIMEGEPANT (NURTEC ODT)	1 - All FDA-approved			Diagnosis. For episodic	Coverage is provided for		For episodic migraine initial: 6	For reauth: Provider	0	0
	Indications.			migraine: Provider attestation	members 18 years of age and			attestation the member is		
			•	the member has 4 to 14	older.			having a reduced number of		
				headache days per month.			months	migraine/headache days per		
				Must have a trial and failure				month or a decrease in		
				of one beta-blocker and one				migraine/headache severity.	\	
				anticonvulsant unless contraindicated or intolerant.				migraine is defined as a headache that has at least		
				For acute treatment of				two of the following		
				migraine: Must have a history				characteristics: unilateral		
				of trial and failure,				location, pulsating/throbbing		
				contraindication or				quality, moderate or severe		
				intolerance to at least one				intensity (inhibits or prohibits		
				triptan.				daily activities), is aggravated		
								by routine activity, nausea		
								and/or vomiting, photophobia		
								and phonophobia.		
RIOCIGUAT (ADEMPAS)	1 - All FDA-approved	1	Coverage will not be assuided	Diagnosis. Pulmonary arterial		Prescribed by or in	Initial: 3 months, Reauth: 12	For reauth: documentation	10	0
MOCIGUAT (ADEIVIPAS)	Indications.		-	hypertension (PAH) WHO		consultation with cardiologist		from prescriber that		ľ
	aisacions.		(nitrates in any form) or a PDE			or pulmonologist.		demonstrates member is		
				documentation of right-heart		- Pannonologisti		tolerating and receiving		
				catheterization (RHC)				clinical benefit from		
				indicating a mean pulmonary			I .	treatment		
				arterial pressure greater than						
				20 mmHg, pulmonary vascular						
				resistance greater than 2						
			•	wood units, and mean						
				pulmonary capillary wedge						
				pressure less than or equal to						
				15 mmHg. If provider						
				indicates RHC is not						
				recommended, must have documentation of						
1	1			echocardiography.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
RISANKIZUMAB-RZAA	1 - All FDA-approved			Diagnosis. For plaque	•	By or in consultation with a	12 months	For reauthorization: must	0	0
(SKYRIZI)	Indications.			psoriasis: minimum BSA	age or older.	rheumatologist, dermatologist	t	have documentation from		
				involvement of at least 3%		or gastroenterologist.		prescriber indicating		
				(not required if on palms,				stabilization or improvement		
				soles, head/neck, genitalia), a				in condition.		
				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 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	ıf					
				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 Crohn's (CD):						
				history of trial and failure,						
				contraindication, or						
				intolerance to 2 of the						
				following therapy options:						
	4			aminosalicylates,						
RISDIPLAM (EVRYSDI)	1 - All FDA-approved		Coverage will be not be	Confirmed diagnosis fo 5q-		Prescribed by or in	12 months	For reauth: documentation	0	0
	Indications.		provided to members who are	•		consultation with neurologist,		that the patient is responding		
			concomitantly taking	Baseline assessment motor		or pediatric neurologist.		to the medication as		
			nusinersen.	milestone score from ONE of				demonstrated by clinically		
				the following assessments:				significant improvement or		
				Hammersmith Functional				maintenance of function from		
				Motor Scale Expanded				pretreatment baseline status		
				(HFMSE), Hammersmith Infan	t			using the same exam as		
				Neurologic Exam (HINE),				performed at baseline		
				Upper limb module (ULM)				assessment (progression,		
				score, Children?s Hospital of				stabilization, or decreased		
				Philadelphia Infant Test of				decline in motor function).		
				Neuromuscular Disorders						
				(CHOP INTEND), or Six-minute						
				walk test.						
ROFLUMILAST (DALIRESP)	1 - All FDA-approved		Moderate to sever liver	Diagnosis of GOLD Stage III or			12 months	For reauthorization must have	0	0
, , ,	Indications.		impairment	IV COPD associated with				documentation from		
		1		chronic bronchitis.				prescriber indicating		
				Documentation of COPD				improvement in condition.		
				exacerbation within the past				i '		
				year. Must have a trial and						
		1		failure of an inhaled long-						
				acting beta-agonist or inhaled	1					
		1		long-acting anticholinergic.						
				Must be used as add on						
				therapy with a long-acting						
		1								
				beta agonist or long-acting						
		1		anti-muscarinic. Must have						
		1		trial and failure of inhaled						
				glucocorticosteroid or a						
Ī	Ī	1	ì	contraindication to these	1	i e	i	i .	i .	i
				agents.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ROZANOLIXIZUMAB-NOLI	1 - All FDA-approved			Diagnosis. Memember must	Member must be 18 years of	By or in consultation with a	12 months	For reauthorization:	0	0
(RYSTIGGO)	Indications.			have generalized myasthenia	age or older.	neurologist.		Documentation from the		
				gravis (gMG) who are anti-				provider that the member had	ı	
				acetylcholine receptor (AChR)				a positive clinical response		
				or antimuscle-specific tyrosine	2			and tolerates therapy		
				kinase (MuSK) antibody				supported by at least one of		
				positive. The requested agent				the following: a 2 point		
				must not be used in				improvement in the member's	5	
				combination with another				total MG-ADL score OR a 3 or		
				myasthenia gravis				more point improvement in		
				medication.Documentation of	F			QMG total score.		
				a Myasthenia Gravis						
				Foundation of America Clinica	ı <b>l</b>					
				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	` <b> </b>					
DUENA AIDE (DANZEI)	4. 411.504		Not a second for a set of a second	monotherapy (e.g.	Commence in a service of feet	Donation and the state of the	42	<u> </u>		
RUFINAMIDE (BANZEL)	1 - All FDA-approved		•			By or in consultation with a	12 months		0	0
	Indications.		Familial Short QT Syndrome	inadequate response or	members 1 year of age or	neurologist.				
				intolerance two generic	older.					
				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).						
RUXOLITINIB (JAKAFI)	1 - All FDA-approved			Diagnosis. Intermediate or		1 .	6 months	For reauthorization: must	0	0
	Indications.			high-risk myelofibrosis	All Others: age 18 years or	oncologist, hematologist, or		have documentation from		
				includes primary	older	transplant specialist		prescriber indicating		
				myelofibrosis, post-				stabilization or improvement		
				polycythemia vera				in condition.		
				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.						
				шетару.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
SAPROTERIN	1 - All FDA-approved			Diagnosis. For treatment of			Initial: 3 months, Reauth: 12	For reauthorization, must	0	0
DIHYDROCHLORIDE (KUVAN)	Indications.			Hyperphenylalaninemia.			months	maintain Phe levels below		
				Clinically diagnosed with				member's baseline levels.		
				hyperphenylalaninemia due to						
				tetrahydrobiopterin						
				responsive phenylketonuria.						
				Phe levels must be greater						
				than 6 mg/dL (360						
				micromol/L).			1.0			
SATRALIZUMAB-MWGE	1 - All FDA-approved		Active hepatitis B infection,	For Neuromyelitis Optica	Coverage is provided for	By or in consultation with a	12 months	Part B before Part D Step		0
(ENSPRYNG)	Indications.		active or untreated latent	Spectrum Disorder (NMOSD):	members 18 years of age and			Therapy. For reauth:		
			tuberculosis	positive test for AQP4-IgG	older	ophthalmologist		documentation of stabilization	n	
				antibodies. At least 1 relapse				or improvement in condition		
				in the last 12 months or 2						
				relapses in the last 24 months						
				that required rescue therapy.						
				Expanded Disability Status						
				Scale (EDSS) score less than or						
				equal to 6.5. Must have						
				documentation of inadequate						
				response, contraindication or						
				intolerance to an						
				immunosuppressant (e.g.						
				mycophenolate mofetil,						
				azathioprine) or rituximab.						
SECUKINUMAB (COSENTYX)	1 - All FDA-approved			Diagnosis. For Psoriatic	Must be 2 years of age or	By or in consultation with a	12 months	For reauth: must have	0	0
SECONITO IVIND (COSENTIN)	Indications.			arthritis (PsA): for mild to	older.	rheumatologist,		documentation from		o de la companya de l
	maications.			moderate axial or enthesitis,	older.	gastroenterologist, or		prescriber indicating		
				must have a history of trial		dermatologist.		stabilization or improvement		
				and failure, contraindication,		dermatologist.		in condition.		
				or intolerance to a 4 week				in condition.		
				trial of 2 NSAIDs. For members	5					
				with mild to moderate						
				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), non-						
				radiographic axial						
				spondyloarthritis (nr-axSpA),						
				and enthesitis-related arthritis	5					
				(ERA): history of trial and						
				failure, contraindication, or						
				intolerance to a four-week						
				trial each of at least 2 NSAIDs.						
				For plaque psoriasis (PsO):						
				minimum BSA involvement of						
				at least 3% (not required if on						
				palms, soles, head/neck,						
				genitalia), a history of trial and	<u>,                                    </u>					
				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,						
	I .	1		methodickate, cyclosponile,		1		1	1	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
SELEXIPAG (UPTRAVI)	1 - All FDA-approved			Diagnosis. Pulmonary arterial		Prescribed by or in	Initial authorization: 3 months	Reauthorization:	0	0
	Indications.			hypertension (PAH) WHO		consultation with cardiologist	Reauthorization: 12 months	documentation from		
				Group I confirmed by chart		or pulmonologist.		prescriber that demonstrates		
				documentation of right-heart				member is tolerating and		
				catheterization (RHC)				receiving clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than						
				20 mmHg, pulmonary vascular						
				resistance greater than 2						
				wood units, and mean						
				·						
				pulmonary capillary wedge						
				pressure less than or equal to						
				15 mmHg. If provider						
				indicates RHC is not						
				recommended, must have						
				documentation of an						
				echocardiography.						
SILDENAFIL CITRATE	1 - All FDA-approved		Coverage will not be provided			Prescribed by or in	Initial: 3 months, Reauth: 12	For reauth: documentation	0	0
(REVATIO)	Indications.		for patients taking nitrates	hypertension (PAH) WHO		consultation with a	months	from prescriber that		
			(nitrates in any form) or a	Group I confirmed by chart		pulmonologist or cardiologist		demonstrates member is		
			guanylate cyclase stimulator	documentation of right-heart				tolerating and receiving		
			(e.g. Adempas).	catheterization (RHC)				clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than						
				20 mmHg, pulmonary vascular	r					
				resistance greater than 2						
				wood units, and mean						
				pulmonary capillary wedge						
				pressure less than or equal to						
				15 mmHg. If provider						
				indicates RHC is not						
				recommended, must have						
				1						
				documentation of						
CODULA OVACATE (VACATA)	4. All EDA			echocardiography.	C	December 1	latical 2 manuals	D th	0	
SODIUM OXYBATE (XYREM)	1 - All FDA-approved			Diagnosis. For excessive	Coverage is provided for	By or in consultation with a	Initial: 3 months,	Reauthorization: must have	0	0
	Indications.			daytime sleepiness associated		neurologist or sleep specialist	Reauthorization: 12 months	documentation from		
				with narcolepsy: a sleep study				prescriber indicating		
				(e.g. polysomnogram, multiple				stabilization or improvement		
				sleep latency Test) confirming				in condition.		
				diagnosis. For cataplexy						
				associated with narcolepsy: a						
				sleep study confirming the						
				diagnosis.						
SODIUM PHENYLBUTYRATE	1 - All FDA-approved			Diagnosis.		By or in consultation with	12 months		0	0
	Indications.					physician who specializes in				
						the treatment of inherited				
						metabolic disorders, a				
						hematologist or a				
						nephrologist.				
SOFOSBUVIR-VELPATASVIR	1 - All FDA-approved			Criteria will be applied	Coverage is provided for	By or in consultation with a	Criteria will be applied		0	0
(EPCLUSA)	Indications.			consistent with current	members who are age-	gastroenterologist,	consistent with current			
					appropriate according to	hepatologist, infectious	AASLD/IDSA guidance and/or			
				FDA approved labeling	AASLD/IDSA guidance and/or	disease, HIV or transplant	FDA approved labeling			
				I DY abbiosed langillig	FDA-approved labeling.	specialist.	I DY abbiosed langillig			
SOFOSBUVIR-VELPATASVIR-	1 - All FDA-approved		Coadministration with	Criteria will be applied	Coverage is provided for	By or in consultation with a	Criteria will be applied		0	0
			rifampin	* *			* *		٦	ľ
VOXILAPREVIR (VOSEVI)	Indications.		mampin	consistent with current	members who are age-	gastroenterologist,	consistent with current			
				AASLD/IDSA guidance and/or		hepatologist, infectious	AASLD/IDSA guidance and/or			
				FDA approved labeling	AASLD/IDSA guidance and/or	disease, HIV or transplant	FDA approved labeling			
				l	FDA-approved labeling.	specialist.	<u> </u>			

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
SOMATROPIN (GENOTROPIN)	3 - All Medically-accepted		Coverage will not be provided	Diagnosis. Growth chart		By or in consultation with an	6 months	For reauth for pediatric GHD,	0	0
	Indications.			required for all diagnoses		endocrinologist or		Turner and Noonan		
				except Adult Growth		neonatologist.		syndromes, SGA, Prader-Willi		
			proliferative or severe non-	Hormone Deficiency (GHD).				syndrome, and ISS:		
			l'	Documentation that				Documentation the patient		
				epiphyses are open for all				has open epiphyses. For		
				pediatric indications. For				reauth for adult GHD: current		
				pediatric GHD: a height				IGF-1 level is normal for age		
				greater than or equal to 2				and gender (does not apply to		
			obese or have severe	standard deviations below the				patients with structural		
			respiratory impairment.	mean for age and gender,				abnormality of the		
				documentation of growth				hypothalamus/pituitary and 3		
				velocity, skeletal maturation,				or more pituitary hormone		
				2 provocative stimulation				deficiencies and childhood-		
				tests which demonstrate GHD				onset growth hormone		
				through peak growth				deficiency with congenital		
				hormone concentrations less				abnormality of the		
				than 10 ng/ml or IGF-1 or				hypothalamus/pituitary). For		
				IGFBP-3 levels or only one				reauth for Prader Willi:		
				stim test is needed in the				documentation growth		
				presence of a pituitary				hormone has resulted in an		
				abnormality. For Small for				increase in lean body mass or		
				Gestational Age (SGA), a				decrease in fat mass.		
				height greater than or equal to 2 standard deviations						
				below the mean for age and						
				gender, and EITHER a birth						
				weight less than 2500 g at a						
				gestational age greater than						
				37 weeks, OR weight or length						
				at birth greater than 2						
				standard deviations below the						
				mean for gestational age and						
				documentation that catch up						
SOTATERCEPT-CSRK	1 - All FDA-approved			Diagnosis. Pulmonary arterial		Prescribed by or in	Initial: 3 months, Reauth: 12	For reauth: documentation	0	0
	Indications.			hypertension (PAH) WHO		consultation with cardiologist		from prescriber that	ľ	O .
(WINKEVAIK)	indications.			Group I confirmed by chart		or pulmonologist		demonstrates member is		
				documentation of right-heart		or pullionologist		tolerating and receiving		
				catheterization (RHC)				clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than				treatment		
				20 mmHg, pulmonary vascular						
				resistance greater than 2						
				wood units, and mean						
				pulmonary capillary wedge						
				pressure less than or equal to						
				15 mmHg. If provider						
				indicates RHC is not						
				recommended, must have						
				documentation of						
				echocardiography. Must be						
				used in combination with						
				standard of care therapy (e.g.						
				ERA or PDE-5 inhibitor)						
SPARSENTAN (FILSPARI)	1 - All FDA-approved			Diagnosis of primary	Coverage is provided for	By or in consultation with a	Initial: 6 months. Reauth: 12	For reauth: must have a	0	0
	Indications.			immunoglobulin A		nephrologist.		decrease from baseline in		
				nephropathy (IgAN) that has				total urine protein or UPCR.		
				been confirmed by biopsy.				·		
				Must have an eGFR rate of at						
				least 30 ml/min/1.73m^2.						
				Must have a total urine						
				protein of at least 1.0 g/day.						
				Must be at risk of rapid						
				disease progression defined as	;					
				having a urine protein-to-						
				creatinine ratio (UPCR) of at						
				least 1.5 g/g. Must have tried						
				and failed a stable and						
				maximum tolerated dose of						
				an ACE inhibitor or ARB.						
		•			•				1	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
SPESOLIMAB-SBZO (SPEVIGO)	Pending CMS Review			Diagnosis. For treatment of a	Coverage is provided for	By or in consultation with a		For reauth: documentation of	0	0
				generalized pustular psoriasis		dermatologist	course (up to 2 infusions over			
				(GPP) flare, must have a	older and weighing at least 40		2 weeks). For maintenance: 12	flares while on treatment		
				moderate-to-severe flare	kg.		months			
				defined by ALL of the						
				following: 1) GPPGA total						
				score greater than or equal to						
				3 (moderate or severe), 2)						
				presence of fresh pustules, 3)						
				GPPGA postulation subscore of at least 2 (mild, moderate,						
				or severe), and 4) at least 5%						
				BSA covered with erythema						
				and presence of pustules. For						
				treatment of GPP when not						
				experiencing a flare, must						
				have a history of at least 2						
				moderate or severe GPP flares						
				in the past and must have a						
				history of flaring while on						
				systemic treatment or upon						
				reduction or discontinuation						
				of systemic therapy for GPP						
				(e.g. retinoids, methotrexate,						
				cyclosporine).						
STIRIPENTOL (DIACOMIT)	1 - All FDA-approved		+	Diagnosis. Must have had an	Member must be 6 months of	By or in consultation with a	12 months		0	0
	Indications.			inadequate response or		neurologist	12 111011(113			
	malcations.			intolerance to two generic	age of older	incurologist				
				antiepileptic drugs (e.g.						
				valproate, topiramate,						
				clobazam). Must be using in						
				combination with clobazam.						
SUZETRIGINE (JOURNAVX)	1 - All FDA-approved			Must have a diagnosis of	Coverage is provided for		14 Days	For reauthorization:	0	0
	Indications.			moderate-to-severe acute	members 18 years of age and			Documentation that the		
				1:	older			member is experiencing a new		
				that the episode of acute pain				episode of moderate-to-		
				is anticipated to last less than				severe acute pain, separate		
				one month and the member				and distinct from the previous		
				has tried and failed within the				episode. The prescriber		
				previous 30 days or has a				attests that the episode of		
				contraindication to either TWO alternative pain				acute pain is anticipated to last less than one month and		
				medications for moderate				the member has tried and		
				pain (e.g. acetaminophen,				failed within the previous 30		
				NSAIDs) or ONE alternative				days or has a contraindication		
				pain medication for severe				to either TWO alternative pain		
				pain (e.g. NSAID, opioid).				medications for moderate		
								pain (e.g. acetaminophen,		
								NSAIDs) or ONE alternative		
								pain medication for severe		
								pain (e.g. NSAID, opioid).		
TADALAFIL (ADCIRCA)	1 - All FDA-approved		Coverage will not be assuided	Diagnosis. Pulmonary arterial		Prescribed by or in	Initial: 3 months, Reauth: 12	For reauth: documentation	0	0
	Indications.			hypertension (PAH) WHO		consultation with a		from prescriber that	U	U
	maicaciolis.			Group I confirmed by chart		pulmonologist or cardiologist		demonstrates member is		
				documentation of right-heart		Farmonologist of cardiologist		tolerating and receiving		
				catheterization (RHC)				clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than						
				20 mmHg, pulmonary vascular						
				resistance greater than 2						
				wood units, and mean						
				pulmonary capillary wedge						
				pressure less than or equal to						
				15 mmHg. If provider						
				indicates RHC is not						
				recommended, must have						
		1		documentation of	1		1			
				echocardiography.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	-	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
TADALAFIL (CIALIS)	1 - All FDA-approved			Diagnosis of benign prostatic			12 months		0	0
	Indications.			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.						
TASIMELTEON (HETLIOZ)	1 - All FDA-approved			Diagnosis. Must submit chart	Coverage is provided for	By or in consultation with a	12 months	For Reauth: documentation	0	0
	Indications.			_	members 3 years of age or	neurologist or a physician who		from prescriber indicating		
				how diagnosis was confirmed	older.	specializes in sleep medicine		stabilization or improvement		
				(e.g. sleep-wake logs,				in condition.		
				melatonin secretion						
				abnormalities, or progress						
				notes, etc.)						
TEDUGLUTIDE (GATTEX)	1 - All FDA-approved		Active intestinal obstruction	Diagnosis. For diagnosis of		By or in consultation with a	12 months	For reauthorization: must	0	0
	Indications.		or active gastrointestinal	short bowel syndrome,		gastroenterologists		have documentation from		
			malignancy.	member must be receiving				prescriber indicating		
				parenteral support.				stabilization or improvement		
								in condition.		
TELOTRISTAT (XERMELO)	1 - All FDA-approved			Diagnosis.	Coverage is provided for	By or in consultation with an	6 months	For reauth: documentation of	0	0
	Indications.				members 18 years of age and	oncologist		improvement or stabilization.		
TETDEDENIA ZINIE (VIZINIE)	4 All ED:		Harrier W. J. J.		older.	Proposition on the second	42	Nandania I		
TETREBENAZINE (XENAZINE)	1 - All FDA-approved		Uncontrolled depression,	_	Coverage is provided for	By or in consultation with a	12 months	Maximum dose approved is	0	0
	Indications.		actively suicidal. Currently	_	members 18 years of age or	neurologist		100mg/day. For		
			using a monoamine oxidase	disease either by Huntington	older.			reauthorization: must have		
			inhibitor or reserpine. Hepatic					documentation from		
			impairment. Concurrent use	(with laboratory result				prescriber indicating		
			of deutetrabenazine or	indicating expanded CAG				stabilization or improvement		
			valbenazine.	repeat of greater than or				in condition.		
				equal to 36 in the Huntington						
				gene) or a positive family						
				history of Huntington's						
				Disease with autosomal						
				dominant inheritance pattern.	•					
				Must have clinical signs of						
				Huntington's Disease to						
				include chart documentation						
				of a clinical work-up showing						
				one or more of the following						
				signs: motor (e.g. finger						
				tapping, rigidity), oculomotor,						
				bulbar (e.g. dysarthria,						
				dysphagia), affective (e.g.						
				depression), cognitive. Must						
				have chart documentation of						
				chorea. For doses greater						
				than 50mg/day: must have						
				chart documentation of a trial						
				of 50mg/day dose with						
				inadequate response OR must						
				be CYP2D6 intermediate or						
				extensive metabolizer (as						
				documented through CYP2D6						
				genotyping results).						
TOFACITINIB (XELJANZ)	1 - All FDA-approved		+	Diagnosis. Must have history	For Polyarticular course	By or in consultation with	12 months	Reauth: Documentation from	0	0
TOT ACTITIVED (ALLJANZ)	Indications.			of trial and failure,	juvenile idiopathic arthritis:	dermatologist, rheumatologist		the prescriber indicating		<b> </b>
	mulcations.					or gastroenterologist.		stabilization or improvement		
					Coverage is provided for members 2 years of age and	or gastroenterologist.		in condition.		
								in condition.		
					older. For all other diagnoses					
					coverage is provided for					
					members 18 years of age and					
				<u> </u>	older	<u> </u>	<u> </u>		<u> </u>	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
TOLVAPTAN (JYNARQUE)	1 - All FDA-approved		History of significant liver	Diagnosis. Must have an	Member must be 18 years of	By or in consultation with a	12 months	For reauthorization:	0	0
	Indications.		impairment or injury (not	estimated glomerular	age or older	nephrologist		documentation from		
			including uncomplicated	filtration rate (eGFR) greater				prescriber indicating		
			polycystic liver disease),	than or equal to 25				stabilization or improvement		
			concomitant use of strong	mL/min/1.73m^2 and at least				in condition.		
			CYP3A inhibitors, uncorrected	one of the following: 1. Mayo						
			abnormal blood sodium	classification 1C, 1D, or 1E 2. a						
			concentrations, unable to	historical rate of eGFR decline						
			sense or respond to thirst,	(greater than or equal to 3						
			hypovolemia, uncorrected	ml/min /1.73 m^2 per year)						
			urinary outflow obstruction,							
			anuria							
TRIENTINE HCL (SYPRINE)	1 - All FDA-approved			Diagnosis. Must have a trial of	F	By or in consultation with a	12 months	For reauth: must have	0	0
,	Indications.			penicillamine (Depen) with an	•	gastroenterologist, an		documentation from		
				inadequate response or		ophthalmologist or a		prescriber indicating		
				significant side effects/toxicity	,	physician who specializes in		improvement in condition.		
				or must have a		the treatment of inherited				
				contraindication to this		metabolic disorders				
				therapy.		metabone disorders				
TROFINETIDE (DAYBUE)	1 - All FDA-approved		0	· ' '	a Coverage is provided for	By or in consultation with a	12 months	<u> </u>	0	0
morniembe (B/mboe)	Indications.		ŭ	diagnosis of typical Rett	members 2 years of age or	pediatric neurologist or	12 months		Ŭ	Ŭ
	indications.			syndrome according to the	older.	neurologist				
				Rett Syndrome Diagnostic	older.	Tieurologist				
				Criteria with a documented						
				disease-causing mutation in						
				the MECP2 gene.						
UBROGEPANT (UBRELVY)	1 - All FDA-approved			Diagnosis. Must have a history	/ Coverage is provided for		12 months	For reauth: documentation of	F 0	0
OBROGET AIVT (OBREEVT)	Indications.			of trial and failure,	members 18 years of age and		12 1110111113	improvement or stabilization.		Ŭ
	indications.			contraindication, or	older.			improvement or stabilization.		
				intolerance to at least one	older.					
				triptan.						
UPADACITINIB (RINVOQ)	1 - All FDA-approved			Diagnosis. For rheumatoid	For psoriatic arthritis and	By or in consultation with a	12 months	For reauthorization: must	0	0
OF ADACTINIB (MINVOQ)	Indications.			arthritis (RA), psoriatic	polyarticular juvenile	rheumatologist,	12 111011(113	have documentation from	O Company	Ü
	ilidications.			arthritis (PsA), ankylosing	idiopathic arthritis: 2 years or			prescriber indicating		
					older, For atopic dermatitis:			stabilization or improvement		
				spondylitis (AS), non-	12 years or older. All other	gastroenterologist.		in condition.		
				radiographic axial spondyloarthritis (nr-axSpA),	indications: 18 years and			in condition.		
					older.					
				ulcerative colitis (UC), and	older.					
				Crohn's disease: history of						
				trial and failure,						
				contraindication, or						
				intolerance to a TNF blocker.						
				For atopic dermatitis (AD):						
		1		history of trial and failure,						
				contraindication, or						
				intolerance to 2 systemic						
				products (immunosuppressan	t					
				or biologic).						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria		Required
USTEKINUMAB (STELARA) SQ						By or in consultation with a		For reauth: must have	0	0
	Indications.			arthritis (PsA): one of the		rheumatologist,		documentation from		
				following: 1) members with		gastroenterologist, or		prescriber indicating		
				axial or enthesitis must have a history of trial and failure,		dermatologist.		stabilization or improvement in condition.		
				contraindication, or				in condition.		
				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 plaque psoriasis						
				(PsO): minimum BSA						
				involvement of at least 3%						
				(not required if on palms,						
				soles, head/neck, genitalia), 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 disease (CD):						
				history of trial and failure,						
				contraindication, or						
				intolerance to 2 of the						
				following therapy options:						
				aminosalicylates,						
V-GO KIT	1 - All FDA-approved			Must have documentation of			12 months		0	0
VALBENAZINE (INGREZZA)	Indications. 1 - All FDA-approved			previous insulin use. Diagnosis. For chorea: must	Coverage is provided for	By or in consultation with a	12 months	For reauthorization: must	0	0
	Indications.			have confirmed Huntington's		neurologist or psychiatrist		have documentation from	U	U
	indications.			disease either by Huntington	-	incurologist or psychiatrist		prescriber indicating		
				Disease Mutation analysis	0.00			stabilization or improvement		
				(with laboratory result				in condition.		
				indicating expanded CAG						
				repeat of greater than or						
				equal to 36 in the Huntington						
				gene) or a positive family						
				history of Huntington's						
				,						
				Disease with autosomal						
				Disease with autosomal dominant inheritance pattern,						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of						
				Disease with autosomal dominant inheritance pattern,						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity),						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g.						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia),						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression),						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart documentation of chorea. For						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart documentation of chorea. For Tardive Dyskinesia: must have						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart documentation of chorea. For Tardive Dyskinesia: must have chart documentation of involuntary athetoid or choreiform movements and						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart documentation of chorea. For Tardive Dyskinesia: must have chart documentation of involuntary athetoid or choreiform movements and has a history of treatment						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart documentation of chorea. For Tardive Dyskinesia: must have chart documentation of involuntary athetoid or choreiform movements and has a history of treatment with neuroleptic agent (i.e.						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart documentation of chorea. For Tardive Dyskinesia: must have chart documentation of involuntary athetoid or choreiform movements and has a history of treatment with neuroleptic agent (i.e. antipsychotic). Adjustments to						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart documentation of chorea. For Tardive Dyskinesia: must have chart documentation of involuntary athetoid or choreiform movements and has a history of treatment with neuroleptic agent (i.e. antipsychotic). Adjustments to possible offending medication						
				Disease with autosomal dominant inheritance pattern, must have clinical signs of Huntington's Disease including chart documentation of a clinical work-up showing one or more of the following signs: motor (e.g. finger tapping, rigidity), oculomotor, bulbar (e.g. dysarthria, dysphagia), affective (e.g. depression), cognitive. Must have chart documentation of chorea. For Tardive Dyskinesia: must have chart documentation of involuntary athetoid or choreiform movements and has a history of treatment with neuroleptic agent (i.e. antipsychotic). Adjustments to						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
VERICIGUAT (VERQUVO)	1 - All FDA-approved			Diagnosis. Must have a left		Prescribed by or in	12 months	Reauthorization:	0	0
	Indications.			ventricular ejection fraction		consultation with cardiologist		documentation from		
				(LVEF) less than or equal to				prescriber indicating		
				45%. Must have had a				stabilization or improvement		
				hospitalization for heart				in condition.		
				failure within the past 6						
				months or received						
				outpatient IV diuretics within						
				the past 3 months.						
				Documentation the member						
				is currently taking or has had						
				prior treatment with an						
				angiotensin-converting						
				enzyme inhibitor, angiotensir						
				II receptor blocker or Entresto	P					
				and a beta blocker.	1					
VIGABATRIN (SABRIL)	1 - All FDA-approved			Diagnosis. Must undergo	Coverage is provided for	By or in consultation with a	12 months		0	0
	Indications.			vision testing prior to	members 1 month of age or	neurologist.				
				beginning treatment. For	older.					
				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 wit	h					
				at least one other						
				anticonvulsant medication						
				(which can include medicatio	n					
				from trial above).	1					
VILAZODONE (VIIBRYD)	1 - All FDA-approved			Diagnosis. Documentation of			12 months		0	0
	Indications.				members 18 years of age and					
				generic antidepressants	older.					
				alternatives such as an SSRI,						
				SNRI, bupropion, trazodone o	er					
	4 411 55 4			mirtazapine		- " " .	10 11			
VORICONAZOLE INJECTION	1 - All FDA-approved			Diagnosis.	2 years of age or older	Prescribed by or in	12 months		0	0
(VFEND)	Indications.					consultation with an				
VODELOVETINE (TRINITELLIV)	4. All EDA			Diamaria Danumantatian af	Carrage in a second and face	infectious disease specialist	42			
VORTIOXETINE (TRINTELLIX)	1 - All FDA-approved			Diagnosis. Documentation of			12 months		U	0
	Indications.				members 18 years of age and					
				generic antidepressants	older.					
				alternatives such as an SSRI,						
				SNRI, bupropion, trazodone o				1		
VOCODITIDE (VOVZOCO)	1 All EDA agranced			mirtazapine		Drocerihad by anim	12 Months	For required described (	: 10	0
VOSORITIDE (VOXZOGO)	1 - All FDA-approved			Diagnosis confirmed by		Prescribed by or in	12 Months	For reauth: documentation of	U	U
	Indications.			documentation of one of the		consultation with an		both of the following: 1.		
				following: 1. genetic testing		endocrinologist, geneticists,		improvement or stabilization.		
				showing mutation in the		or other practitioner with		2. The member's epiphyses		
				FGFR3 gene or 2. radiographic		expertise in the management		remain open.		
				assessment confirming		of achondroplasia				
				achondroplasia (e.g. short,	4					
				robust tubular bones, squared	4			1		
				off iliac wings, flat horizontal						
				acetabule, ect.).						
				Documentation the member				1		
				has open epiphyses.						
VANONATIANT/TROCERIA	1 All EDA amana card			Diagnosis Desumerates 5	Mambara 10		12 month -		10	
XANOMELINE/TROSPIUM	1 - All FDA-approved				Members 18 years of age or		12 months	1	U	U
(COBENFY)	Indications.			trial and failure of at least two	older.					
				of the following generic						
				atypical antipsychotics:				1		
				olanzapine, quetiapine,				1		
				paliperidone, risperidone,						
I			1	aripiprazole, or ziprasidone.	1	1				

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ZURANOLONE (ZURZUVAE)	1 - All FDA-approved			Diagnosis of postpartum	Coverage is provided for	Prescribed by or in	14 days		0	0
	Indications.			depression (PPD) with onset	members 18 years of age and	consultation with a				
				during pregnancy or within 4	older.	psychiatrist or OB/GYN				
				weeks postpartum.						
				Documentation of current						
				depressive symptoms						
				consistent with a diagnosis of						
				major depressive disorder						
				with peripartum onset.						
				Baseline assessment using a						
				validated depression rating						
				scale indicates at least						
				moderate severity depression						
				(e.g. PHQ-9 score of 10 or						
				higher, EPDS score of 14 or						
				higher).						