HIGHMARK WHOLECARE
An Independent Licensee of the Blue Cross Blue Shield Association

Updated on 4/1/2025

Selected Formulary: 2025 Medicare Assured | CMS Formulary ID: 00025515 | CMS Version: 13

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
ABOBOTULINUMTOXINA (DYSPORT)	1 - All FDA-approved Indications.			Diagnosis.			12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0
ACITRETIN (SORIATANE)	1 - All FDA-approved Indications.			Diagnosis. Must have a trial of methotrexate or cyclosporine with inadequate response or significant side effect/toxicity or have a contraindication to these therapies.			12 months		0
ADALIMUMAB (HUMIRA)	3 - All Medically-accepted Indications.		Coverage is not provided for use of once weekly doses of Humira in combination with methotrexate.	Diagnosis. For rheumatoid arthritis (RA): history of trial and failure, contraindication, or intolerance to a 3 month trial with methotrexate or another DMARD. For juvenile idiopathic arthritis (JIA) with polyarthritis: history of trial and failure, contraindication, or intolerance to a 3 month trial with methotrexate, leflunomide, or sulfasalazine. For JIA with oligoarthritis, enthesitis and/or sacroiliitis: history of trial and failure, contraindication, or intolerance to at least a 4 week trial of 2 different NSAIDS. For ankylosing spondylitis (AS): history of trial and failure, contraindication, or intolerance to a 4 week trial each of at least 2 NSAIDs. For plaque psoriasis: 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	Member must be 2 years of age or older.	By or in consultation with a rheumatologist, gastroenterologist, ophthalmologist, or dermatologist.	12 months	For hidradenitis suppurativa (HS): moderate to severe disease with 3 active abscesses, inflammatory nodules, or lesions. For uveitis: trial of a corticosteroid or immunomodulator with inadequate response or side effects/toxicities unless contraindicated. For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
ALIROCUMAB (PRALUENT)	1 - All FDA-approved Indications.			Diagnosis. Must have confirmed diagnosis of heterozygous familial hypercholesterolemia (see Other Criteria), homozygous familial hypercholesterolemia (HoFH, see Other criteria), clinical atherosclerotic cardiovascular disease (ASCVD, see Other Criteria), or primary hyperlipidemia. Must have baseline LDL-cholesterol levels greater than or equal to 100 mg/dL (w/o ASCVD), 70mg/dL (w/ ASCVD), or 55mg/dl if has extreme risk designation (see Other Criteria). Must have failed to achieve goal LDL-C reduction after a trial of a high intensity statin (atorvastatin 40-80mg daily or rosuvastatin 20-40mg daily) OR 2 moderate-intensity statins (atorvastatin or rosuvastatin) at the member's maximally tolerated dose OR documentation the member is determined to be intolerant to statin therapy with provider attestation of intolerance to statin therapy consisting of statin related rhabdomyolysis or skeletal-muscle related symptoms while receiving at		By or in consultation with a cardiologist, endocrinologist, or lipid specialist	12 months	HoFH: must be confirmed by genetic testing with functional mutation(s) in both LDL receptor alleles or alleles known to affect LDL receptor functionality or have clinical diagnosis defined as one of the following: untreated LDL greater than 500mg/dL or a treated LDL-C greater than 300mg/dL AND either xanthoma before 10 years of age or evidence of HeFH in both parents. For ASCVD: must have chart documentation confirming history of at least one of the following: myocardial infarction or other acute coronary syndromes (including ST-elevation myocardial infarction, non-ST elevation myocardial infarction, and unstable angina), coronary or other revascularization procedure, ischemic stroke or transient ischemic attack, atherosclerotic peripheral arterial disease. For HeFH: must have chart documentation of one of the following: A score of greater than 8 using the Dutch Lipid Clinic Network criteria, Simon	0
ALOSETRON (LOTRONEX)	1 - All FDA-approved Indications.		Constipation. Concomitant use of fluvoxamine. Male gender. History of chronic or severe constipation or sequelae from constipation, intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation and/or adhesions, ischemic colitis, impaired intestinal circulation, thrombophlebitis, or hypercoagulable state, Crohn's disease, ulcerative colitis, diverticulitis, or severe hepatic impairment.	Diagnosis. Documentation of chronic IBS symptoms diarrhea lasting at least 6 months. Gastrointestinal tract abnormalities have been ruled out. Must have trial of loperamide and dicyclomine used in the treatment of IBS-D with inadequate response or significant side effects/toxicity unless contraindicated	Coverage is provided for members 18 years of age and older.	By or in consultation with a Gastroenterologist	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0
ALPELISIB (VIJOICE)	1 - All FDA-approved Indications.			Diagnosis of PIK3CA-Related Overgrowth Spectrum (PROS) confirmed by genetic testing. Disease must be severe or life-threatening and require systemic treatment.	Coverage is provided for members 2 years of age or older.	By or in consultation with an appropriate specialist depending on the symptoms and part of the body that are affected.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
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) of AAT. Member must have symptomatic emphysema confirmed with pulmonary function testing.	Coverage is provided for members 18 years of age and older.	By or in consultation with a pulmonologist	Initial: 6 months Reauthorization: 12 months	For reauth: documentation of 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
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 of alpha-1 antitrypsin (AAT) that are less than 11 micromoles per liter (80 milligrams per deciliter if measured by radial immunodiffusion or 57 milligrams per deciliter if measure by nephelometry) consistent with phenotypes PiZZ, PiZ (null) or Pi (null, null) of AAT. Member must have symptomatic emphysema confirmed with pulmonary function testing.	Coverage is provided for members 18 years of age and older.	By or in consultation with a pulmonologist	Initial: 6 months, Reauthorization: 12 months	For reauth: documentation of 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
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 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.		Prescribed by or in consultation with cardiologist or pulmonologist.	Initial authorization: 3 months Reauthorization: 12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
AMIKACIN INHALATION (ARIKAYCE)	1 - All FDA-approved Indications.			Diagnosis of Mycobacterium avium complex (MAC) lung disease. Must be used as part of a combination antibacterial drug regimen in patients who do not achieve negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy containing at least 2 of the following: a macrolide, a rifamycin (rifampin or rifabutin), and ethambutal.		By or in consultation with a pulmonologist or infectious disease specialist	12 months	For reauth: must have attestation confirming presence of a positive sputum culture or that there have been negative sputum cultures for an insufficient period of time (e.g. less than 12 months).	0
APREMILAST (OTEZLA)	1 - All FDA-approved Indications.			Diagnosis. For Psoriatic arthritis (PsA): for mild to moderate axial or enthesitis, must have a history of trial and failure, contraindication, or intolerance to a 4 week trial of 2 NSAIDs. For members 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 failure of ONE of the following: 1) topical therapy (e.g. corticosteroid, calcineurin inhibitor, vitamin D analog), 2) phototherapy, 3) systemic treatment (e.g. methotrexate, cyclosporine, oral retinoids). For Behcet's disease: must have 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 failure, intolerance, or	Coverage is provided for members 6 years of age or older.	By or in consultation with a dermatologist, rheumatologist	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
ARIMOCLOMOL (MIPLYFFA)	1 - All FDA-approved Indications.			Diagnosis. Documentation the diagnosis was confirmed by genetic testing demonstrating one of the following: 1. a mutation in both alleles of 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 combination with Aqneursa.	Member is 2 years of age and older		12 months	Reauthorization: Documentation the member is experiencing an improvement or stabilization in disease.	0
ARIPIPRAZOLE TABLET WITH SENSOR (ABILIFY MYCITE)	1 - All FDA-approved Indications.			Diagnosis. Documentation the member had at least a one-month trial of oral aripiprazole (Abilify) therapy.	Coverage is provided for members 18 years of age and older.		12 months		0
ARMODAFINIL (NUVIGIL)	1 - All FDA-approved Indications.			Diagnosis. Must have a history of trial and failure, contraindication, or intolerance to modafinil. For narcolepsy: Sleep Study (e.g. Polysomnogram, Multiple Sleep Latency Test) confirming diagnosis. For obstructive sleep apnea: Sleep study (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		By or in consultation with a sleep specialist, ENT (ear, nose, and throat specialist), neurologist, or pulmonologist	SWSD: 6 months. Narcolepsy, OSA: 12 months	For reauth: documentation of improvement or stabilization.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
ATOGEPANT (QULIPTA)	1 - All FDA-approved Indications.			Diagnosis. For episodic migraine: Provider attestation the member has 4 to 14 headache days per month. For chronic migraine: Provider attestation the member has at least 15 headache days per month for 3 or more months with at least 8 migraine days per month. For both: Must have a trial and failure of one beta-blocker and one anticonvulsant unless contraindicated or intolerant.	Coverage is provided for members 18 years of age and older.		Initial: 6 months Reauthorization: 12 months	For reauth: Provider attestation the member is having a reduced number of migraine/headache days per month or a decrease in migraine/headache severity. A migraine is defined as a headache that has at least two of the following characteristics: unilateral location, pulsating/throbbing quality, moderate or severe intensity (inhibits or prohibits daily activities), is aggravated by routine activity, nausea and/or vomiting, photophobia and phonophobia.	0
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, azathioprine, mycophenolate, rituximab).	Coverage is provided for members 18 years of age or 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
AVATROMBOPAG (DOPTELET)	1 - All FDA-approved Indications.			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	Chronic ITP: 6 months. Thrombocytopenia in patients with chronic liver disease: 1 month	For reauth of chronic ITP: documentation of improvement in platelet count from baseline.	0
B VS. D	3 - All Medically-accepted Indications.						NA		0
BECAPLERMIN (REGRANEX)	1 - All FDA-approved Indications.		Neoplasm at application site. Treatment of pressure ulcers and venous stasis ulcers. Use on exposed joints, tendons, ligaments, and bone.	Diagnosis. Must have a lower extremity diabetic neuropathic ulcer that extends into the subcutaneous tissue or beyond and have an adequate blood supply. Must be used as adjunctive therapy to good ulcer care practices (i.e. debridement, infection control, pressure relief).			3 months	For reauth: documentation of improvement or stabilization.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
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.	Member must be 5 years of age or older.	By or in consultation with a pulmonologist or infectious disease specialist	6 months		0
BELIMUMAB (BENLYSTA) (IV FORMULATION)	1 - All FDA-approved Indications.		Severe active central nervous system lupus. Combination therapy with other biologics or IV cyclophosphamide.	Diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE) or lupus nephritis. Must have ANA of at least 1:80 or anti-dsDNA of at least 30 IU/ml to support being autoantibody positive. Must be currently taking or has tried and failed or had an intolerance or contraindication to at least one standard therapy for systemic lupus erythematosus (e.g. corticosteroids, antimalarials, NSAIDS, or immunosuppressives) or lupus nephritis (e.g. corticosteroids, mycophenolate, cyclophosphamide, azathioprine). Diagnosis of active lupus nephritis. Documentation of a biopsy-proved lupus nephritis Class III, IV or V.	Coverage is provided for members 5 years of age and older	By or in consultation with a rheumatologist or hematologist	12 months	For reauth: documentation from the prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
BELIMUMAB (BENLYSTA) (SQ)	1 - All FDA-approved Indications.		Severe active central nervous system lupus. Combination therapy with other biologics or IV cyclophosphamide.	Diagnosis of active, autoantibody-positive, systemic lupus erythematosus (SLE) or lupus nephritis. Must have ANA of at least 1:80 or anti-dsDNA of at least 30 IU/ml to support being autoantibody positive. Must be currently taking or has tried and failed or had an intolerance or contraindication to at least one standard therapy for systemic lupus erythematosus (e.g. corticosteroids, antimalarials, NSAIDS, or immunosuppressives) or lupus nephritis (e.g. corticosteroids, mycophenolate, cyclophosphamide, azathioprine). Diagnosis of active lupus nephritis. Documentation of a biopsy-proved lupus nephritis Class III, IV or V.	Coverage is provided for members 5 years of age and older.	By or in consultation with a rheumatologist, hematologist, or nephrologist	12 months	For reauth: documentation from the prescriber indicating stabilization or improvement in condition.	0
BELUMOSUDIL (REZUROCK)	3 - All Medically-accepted Indications.			Diagnosis. For a diagnosis of chronic Graft versus host disease (GVHD), after a trial and failure of at least two prior lines of systemic therapy.	GVHD: age 12 years or older	By or in consultation with an oncologist, hematologist, or transplant specialist	12 months	For reauth: documentation of improvement or stabilization.	0
BENRALIZUMAB (FASENRA)	1 - All FDA-approved Indications.			Diagnosis. For severe eosinophilic asthma: eosinophil blood count greater than or equal to 150cells/microliter. 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.	Coverage is provided for members 6 years of age or older.	By or in consultation with an allergist, immunologist, pulmonologist, or rheumatologist.	12 months	For reauth: documentation of improvement (e.g. reduced symptoms, reduced exacerbations, need for oral steroids).	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
BEREMAGENE GEPERPAVEC (VYJUVEK)	1 - All FDA-approved Indications.			Diagnosis of Dystrophic Epidemolysis Bullosa (DEB) with a mutation in the collagen type VII alpha 1 chain (COL7A1) gene confirmed by genetic testing. Must have a wound with no evidence or history of squamous-cell carcinoma or active infection.	Coverage is provided for members 6 months of age or older.	By or in consultation with a dermatologist	6 months	Reauthorization: must have documentation from prescriber indicating improvement in condition.	0
BIRCH TRITERPENES (FILSUVEZ)	1 - All FDA-approved Indications.			Diagnosis of Dystrophic Epidemolysis Bullosa (DEB) or junctional epidermolysis bullosa (JEB) with an open wound.	Coverage is provided for members 6 months of age or older.	By or in consultation with a dermatologist	6 months	Reauthorization: must have documentation from prescriber indicating improvement in condition.	0
BOSENTAN (TRACLEER)	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 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.		Prescribed by or in consultation with cardiologist or pulmonologist.	Initial authorization: 3 months Reauthorization: 12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0
BUDESONIDE (EOHILIA)	1 - All FDA-approved Indications.		0	Diagnosis. For eosinophilic esophagitis (EoE): must have at least 15 intraepithelial eosinophils per high-power field (eos/hpf) following a treatment course with a PPI.	Coverage is provided for members 11 years of age or older.	By or in consultation with an allergist or gastroenterologist.	3 months	Reauth: use beyond 3 months has not been studied.	0
BUDESONIDE EXTENDED RELEASE TABLETS (UCERIS)	1 - All FDA-approved Indications.			Diagnosis. Must have a trial and failure, a contraindication, or an intolerance to two (2) of the following therapy options: topical mesalamine, oral aminosalicylate or corticosteroids with inadequate response or side effects/toxicity unless contraindicated.	Member must be 18 years of age or older.	By or in consultation with a rheumatologist or gastroenterologist.	8 weeks	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0

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

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
C1 ESTERASE INHIBITOR (HAEGARDA)	1 - All FDA-approved Indications.			Diagnosis of HAE is confirmed by laboratory values obtained on two separate instances (laboratory reports must contain reference ranges). For 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.	Coverage is provided for members 6 years of age or older.	Prescribed by or in consultation with an allergist/immunologist, hematologist, dermatologist	Initial: 6 months Reauthorization: 12 months	For reauth: must have documentation from prescriber indicating improvement in condition.	0
CANNABIDIOL (EPIDIOLEX)	1 - All FDA-approved Indications.			Diagnosis. Must have had an inadequate response or intolerance to one generic antiepileptic drug.	Member must be 1 year of age or older	By or in consultation with a neurologist	12 months		0
CARGLUMIC ACID (CARBAGLU)	1 - All FDA-approved Indications.			Diagnosis. This Prior Authorization requirement only applies to members when a non-FDA approved diagnosis is submitted at the point of sale. FDA-approved diagnosis codes submitted will pay without prior authorization requirement.			12 months		0
CEFTAROLINE (TEFLARO)	1 - All FDA-approved Indications.			Diagnosis. For acute bacterial skin and skin structure infection (ABSSSI), documentation of a history of treatment failure with or contraindication to vancomycin.			14 days		0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
CYSTEAMINE (CYSTAGON)	1 - All FDA-approved Indications.			Diagnosis. Must have documentation of CTNS gene mutation, elevated white blood cell cystine levels greater than 2nmol per half-cystine per mg of protein, or cystine corneal crystals by slit lamp examination.		By or in consultation with a nephrologist or physician who specializes in the treatment of inherited metabolic disorders	Initial: 3 months Reauthorization: 12 months	For reauth: must have documentation from prescriber indicating improvement in condition and a reduction in WBC cystine levels since starting treatment with oral cysteamine	0
DALFAMPRIDINE (AMPYRA)	1 - All FDA-approved Indications.		History of seizure disorder, moderate to severe renal impairment (CrCl less than or equal to 50 mL/min).	Diagnosis of multiple sclerosis. Chart documentation of baseline motor disability or dysfunction.	Coverage is provided for members 18 years of age or older.	Neurologist	Initial: 3 months Reauthorization: 12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
DARBEPOETIN ALFA (ARANESP)	1 - All FDA-approved Indications.		Uncontrolled hypertension	Diagnosis. Must have Hgb level less than 10 g/dL.			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
DEFERASIROX (EXJADE)	1 - All FDA-approved Indications.		Glomerular Filtration Rate less than 40mL/min/1.73 m2. Concomitant advanced malignancy or high risk myelodysplastic syndrome. Platelet count less than 50000000000/L	Diagnosis. For chronic iron overload due to blood transfusions: pretreatment serum ferritin level is greater than 1000 mcg/L. For chronic iron overload due to non-transfusion-dependent thalassemia (NTDT) syndromes: pretreatment serum ferritin level is greater than 300 mcg/L and a liver iron concentration of at least 5mg iron per gram dry weight.		Prescribed by or in consultation with a hematologist	12 months	For reauth: documentation from prescriber indicating stabilization or improvement in condition.	0
DEFERIPRONE (FERRIPROX)	1 - All FDA-approved Indications.			Diagnosis. Must have documentation of a trial and failure of Exjade (this requires a PA) unless contraindicated .		Prescribed by or in consultation with a hematologist	12 months	For reauth: documentation from prescriber indicating stabilization or improvement in condition.	0
DENOSUMAB (XGEVA)	3 - All Medically-accepted Indications.			Diagnosis.		Prescribed by or in consultation with a hematologist or oncologist	6 months		0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
DEUTETRABENAZINE (AUSTEDO)	1 - All FDA-approved Indications.		Uncontrolled depression, actively suicidal, hepatic 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 such as dose reduction or discontinuation were attempted but ineffective in	Coverage is provided for members 18 years of age or older.	By or in consultation with a neurologist or psychiatrist	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
DEUTIVACAFTOR/TEZACAFTOR /VANZACAFTOR (ALYFTREK)	pending CMS review			Diagnosis. Documentation of genetic test confirming the member has at least one F508del mutation or another responsive mutation in the CFTR gene.	Coverage is provided for members 6 years of age and older	By or in consultation with a cystic fibrosis specialist or pulmonologist	12 months	For reauthorization: documentation indicating stabilization or improvement in condition.	0

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

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
DRONABINOL	1 - All FDA-approved Indications.			Diagnosis. Nausea and vomiting associated with cancer chemotherapy: must have trial of two conventional antiemetic treatments (e.g., ondansetron, aprepitant, metoclopramide, dexamethasone, prochlorperazine) with inadequate response or significant side effects/toxicity unless contraindicated.			12 months		0
DROXIDOPA (NORTHERA)	1 - All FDA-approved Indications.			Diagnosis. Documentation of a clinical diagnosis of symptomatic neurogenic orthostatic hypotension caused by one of the following: Primary autonomic failure (Parkinson's disease, multiple system atrophy, or pure autonomic failure), dopamine beta-hydroxylase deficiency or non-diabetic autonomic neuropathy. Must have a trial of midodrine with inadequate response or significant side effects/toxicity unless contraindicated.	Coverage is provided for members 18 years of age and older.		2 weeks	For reauth: rationale from the provider for continuing therapy beyond 2 weeks	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
DUPILUMAB (DUPIXENT)	1 - All FDA-approved Indications.			Diagnosis. For asthma: must have either moderate to severe eosinophilic phenotype with an eosinophil count greater than or equal to 150 cells/microliter or oral corticosteroid dependent persistent asthma (chronic oral corticosteroid use). Documentation of recent use and failure to respond to inhaled steroid in combo with long acting beta agonist. Must 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 asthma exacerbations requiring oral systemic steroids, or inability to taper off daily corticosteroids). For atopic dermatitis: history of trial and failure, contraindication, or intolerance to a topical corticosteroid or topical calcineurin inhibitor. For nasal polyps: history of trial and failure of Xhance (fluticasone propionate). Must be used as add-on maintenance therapy	For atopic dermatitis: 6 months or older. For asthma: 6 years or older. For eosinophilic esophagitis: 1 year or older. For nasal polyps: 12 years and older. For all other indications: 18 years or older.	By or in consultation with an allergist, dermatologist, immunologist, pulmonologist, ear-nose/throat specialist, or gastroenterologist.	12 months	Reauth for asthma: documentation of improvement (e.g. reduced symptoms, reduced exacerbations, need for oral steroids). Reauth for all other indications: documentation from prescriber indicating stabilization or improvement in condition.	0
EDARAVONE (RADICAVA ORS)	1 - All FDA-approved Indications.			Diagnosis of Amyotrophic Lateral Sclerosis (ALS). Must have normal respiratory function (defined as a forced vital capacity (FVC) of at least 80%), must be able to perform activities of daily living (ADLs) such as eating and moving around independently, must provide a recent ALSFRS-R score.	Coverage is provided for members 18 years of age and older	By or in consultation with a neurologist	12 months	Reauth: must provide documentation of clinical benefit based on the prescriber's assessment and an ALSFRS-R score within the past 12 months	0
ELEXACAFTOR/TEZACAFTOR/IVACAFTOR (TRIKAFTA)	1 - All FDA-approved Indications.			Diagnosis. Documentation of genetic test confirming the member has at least one F508del mutation in the CFTR gene or a mutation in the CFTR gene that is responsive based on in vitro data.	Coverage is provided for members 2 years of age and older	By or in consultation with a cystic fibrosis specialist or pulmonologist	12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
ELTROMBOPAG (ALVAIZ)	1 - All FDA-approved Indications.			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 chronic 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.		By or in consultation with a hematologist, oncologist, gastroenterologist, or hepatologist	6 months	For reauth: for all dx documentation of improvement in platelet count from baseline. For hepatitis C: documentation the member is still on antiviral therapy.	0
EPOETIN ALFA-EPBX (RETACRIT)	3 - All Medically-accepted Indications.		Uncontrolled hypertension	Diagnosis. For Reduction of Allogeneic Red Blood Cell Transfusions in Members Undergoing Elective, Noncardiac, Nonvascular Surgery: must have hemoglobin (Hgb) greater than 10 and less than or equal to 13 g/dL, be at high risk for perioperative blood loss from surgery, and documentation that erythropoietin therapy 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.			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. For reauth for zidovudine treated members and 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

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
ERENUMAB-AOOE (AIMOVIG)	1 - All FDA-approved Indications.			Diagnosis. For episodic migraine: Provider attestation the member has 4 to 14 headache days per month. For chronic migraine: Provider attestation the member has at least 15 headache days per month for 3 or more months with at least 8 migraine days per month. For both: Must have a trial and failure of one beta-blocker and one anticonvulsant unless contraindicated or intolerant.	Coverage is provided for members 18 years of age and older		Initial: 6 months Reauthorization: 12 months	For reauth: Provider attestation the member is having a reduced number of migraine/headache days per month or a decrease in migraine/headache severity. A migraine is defined as a headache that has at least two of the following characteristics: unilateral location, pulsating/throbbing quality, moderate or severe intensity (inhibits or prohibits daily activities), is aggravated by routine activity, nausea and/or vomiting, photophobia and phonophobia.	0
ETANERCEPT (ENBREL)	3 - All Medically-accepted Indications.			Diagnosis. For rheumatoid arthritis (RA): history of trial and failure, contraindication, or intolerance to a three-month trial with methotrexate or another DMARD. For juvenile idiopathic arthritis (JIA) with polyarthritis: history of trial and failure, contraindication, or intolerance to a 3 month trial with methotrexate, leflunomide, or sulfasalazine. For JIA with oligoarthritis, enthesitis and/or sacroiilitis: 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 failure, contraindication, or intolerance to a 12 week trial with methotrexate or another	Member must be 2 years of age or older.	By or in consultation with a rheumatologist or dermatologist.	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
ETRASIMOD (VELSIPITY)	1 - All FDA-approved Indications.			Diagnosis. For ulcerative colitis (UC): history of trial and failure, contraindication, or intolerance to 2 of the following therapy options: aminosalicylates, corticosteroids or immunomodulators with inadequate response or side effects/toxicity unless contraindicated.	Coverage is provided for members 18 years of age and older	By or in consultation with a gastroenterologist	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0
FECAL MICROBIOTA SPORES, LIVE-BRPK (VOWST)	1 - All FDA-approved Indications.			Documentation of a recent diagnosis of recurrent Clostridioides difficile infection (CDI) -AND- Will be used for prophylaxis and not treatment of recurrent CDI -AND- Attestation that antibiotic treatment for the most recent recurrent CDI is complete or will be completed.			1 month	For reauthorization, attestation of recurrent CDI episodes after administration of the initial fecal microbiota product -AND- Will be used for prophylaxis and not treatment of recurrent CDI -AND- Attestation that antibiotic treatment for the most recent recurrent CDI is complete or will be completed.	0
FENFLURAMINE (FINTEPLA)	1 - All FDA-approved Indications.		Use of monoamine oxidase inhibitors within 14 days	Diagnosis. Must have had an inadequate response or intolerance to two generic antiepileptic drugs (e.g. valproate, lamotrigine, topiramate, clobazam).	Member must be 2 years of age or older	By or in consultation with a neurologist	12 months		0
FENTANYL CITRATE (TRANSMUCOSAL)	1 - All FDA-approved Indications.		Acute or postoperative pain including headache/migraines and dental pain.	Diagnosis. Documentation the member has active cancer and is experiencing breakthrough pain despite being on around the clock opioid therapy. Must be opioid tolerant. Must currently be using a long-acting opioid.		By or in consultation with an oncologist, pain specialist, or hospice/palliative care specialist	12 months	Opioid tolerant is defined as being on around-the-clock medicine consisting of at least 60 mg of oral morphine per day, at least 25 mcg of transdermal fentanyl per hour, at least 30 mg of oral oxycodone per day, at least 8 mg of oral hydromorphone per day, at least 25 mg oral oxymorphone per day, at least 60 mg oral hydrocodone per day, or an equianalgesic dose of another opioid daily for a week or longer. For reauthorization: Documentation the member still has active cancer and the member continues to have a medical need for the medication.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
FILGRASTIM-SNDZ (ZARXIO)	3 - All Medically-accepted Indications.			Diagnosis.			6 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
FLUTICASONE PROPIONATE (XHANCE)	1 - All FDA-approved Indications.			Diagnosis.	Coverage is provided for members 18 years of age or older.		12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
GALCANEZUMAB-GNLM (EMGALITY)	1 - All FDA-approved Indications.			Diagnosis. For episodic migraine: Provider attestation the member has 4 to 14 headache days per month. For chronic migraine: Provider attestation the member has at least 15 headache days per month for 3 or more months with at least 8 migraine days per month. For both: Must have tried and failed one beta-blocker for at least 2 months and one anticonvulsant for at least 2 months unless contraindicated or intolerant. For cluster headache: Provider attestation the member has at least one cluster attack every other day and no more than 8 attacks a day. Must have a trial and failure of either verapamil for at least 2 weeks or a one-time suboccipital steroid injection unless contraindicated or intolerant.	Coverage is provided for members 18 years of age and older		Initial: 6 months Reauthorization: 12 months	For reauth: Provider attestation the member is having a reduced number of migraine/headache days per month or a decrease in migraine/headache severity. A migraine is defined as a headache that has at least two of the following characteristics: unilateral location, pulsating/throbbing quality, moderate or severe intensity (inhibits or prohibits daily activities), is aggravated by routine activity, nausea and/or vomiting, photophobia and phonophobia. A cluster headache is defined as at least 5 severe to very severe unilateral headache attacks lasting 15 to 180 minutes untreated. Headaches occur once every other day to 8 times a day. The pain is associated with ipsilateral conjunctival injection, lacrimation, nasal congestion, rhinorrhea, forehead and facial sweating, miosis, ptosis and/or eyelid edema, and/or with restlessness or agitation.	0
GANAXOLONE (ZTALMY)	1 - All FDA-approved Indications.			Diagnosis.	Coverage is provided for members 2 years of age or older.	By or in consultation with a neurologist	12 months		0
GLECAPREVIR-PIBRENTASVIR (MAVYRET)	1 - All FDA-approved Indications.		Members with moderate or severe hepatic impairment (Child-Pugh C). Coadministration with atazanavir and rifampin.	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling	Coverage is provided for members who are age-appropriate according to AASLD/IDSA guidance and/or FDA-approved labeling.	By or in consultation with a gastroenterologist, hepatologist, infectious disease, HIV or transplant specialist.	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling		0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
GLP-1 RECEPTOR AGONISTS	1 - All FDA-approved Indications.			Diagnosis of Type 2 diabetes or documented prior therapy with a Type 2 diabetes medication. Claims will automatically pay on-line without a requirement to submit for prior authorization when one of the following criteria is met: 1. a Type 2 diabetes diagnosis code is submitted at the point of sale OR 2. a pharmacy claims history of a Type 2 diabetes medication within the past 130 days.			12 months		0
GLYCEROL PHENYLBUTYRATE (RAVICTI)	1 - All FDA-approved Indications.			Diagnosis. Documentation member has urea cycle disorders (UCDs). Must have a trial of sodium phenylbutyrate with inadequate response or significant side effects/toxicity unless contraindicated.		By or in consultation with a physician who specializes in the treatment of inherited metabolic disorders.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
GUSELKUMAB (TREMFYA)	1 - All FDA-approved Indications.			Diagnosis. 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).	Coverage is provided for members 18 years of age and older	By or in consultation with a rheumatologist, dermatologist, or gastroenterologist.	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
ICATIBANT ACETATE	1 - All FDA-approved Indications.			Diagnosis of HAE is confirmed by laboratory values obtained on two separate instances (laboratory reports must contain reference ranges). For Type I HAE: Low C4 level and 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.	Coverage is provided for members 18 years of age or older.	By or in consultation with an allergist, immunologist, hematologist, or dermatologist	12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0
ILOPERIDONE (FANAPT)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two of the following generic, oral atypical antipsychotics: olanzapine, quetiapine, paliperidone, risperidone, aripiprazole, or ziprasidone.	Coverage is provided for members 18 years of age or older.		12 months		0
INCOBOTULINUMTOXINA (XEOMIN)	1 - All FDA-approved Indications.			Diagnosis.			12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
INFLIXIMAB-ABDA (RENFLEXIS)	3 - All Medically-accepted Indications.		Doses greater than 5mg/kg in moderate to severe heart failure.	Diagnosis. For rheumatoid arthritis (RA): history of trial and failure, contraindication, or intolerance to a 3 month trial with methotrexate or another DMARD. For psoriatic arthritis (PsA) one of the following: 1.)members with axial or enthesitis must have a history of trial and failure, contraindication, or intolerance to a 4 week trial of 2 NSAIDs. 2.) the member has severe disease as defined by the prescriber. 3.) members with peripheral disease must have a history of a trial and failure, contraindication, or intolerance to a 12 week trial with methotrexate or another DMARD. For ankylosing spondylitis (AS): history of trial and failure, contraindication, or intolerance to a four-week trial each of at least 2 NSAIDs. For plaque psoriasis: 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)	For RA, PsA, AS, Plaque Psoriasis: coverage is provided for members 18 years of age or older. For CD, UC: coverage is provided for members 6 years of age or older.	By or in consultation with a rheumatologist, gastroenterologist, or dermatologist.	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
INFLIXIMAB-DYYB (INFLECTRA)	3 - All Medically-accepted Indications.		Doses greater than 5mg/kg in moderate to severe heart failure.	Diagnosis. For rheumatoid arthritis (RA): history of trial and failure, contraindication, or intolerance to a three-month trial with methotrexate or another DMARD. For psoriatic arthritis (PsA) one of the following: 1).members with axial or enthesitis must have a history of trial and failure, contraindication, or intolerance to a 4 week trial of 2 NSAIDs. 2.) the member has severe disease as defined by the prescriber. 3.) members with peripheral disease must have a history of a trial and failure, contraindication, or intolerance to a 12 week trial with methotrexate or another DMARD. For ankylosing spondylitis (AS): history of trial and failure, contraindication, or intolerance to a four-week trial each of at least 2 NSAIDs. For plaque psoriasis: 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)	For RA, PsA, AS, Plaque Psoriasis: Coverage is provided for members 18 years of age or older. For CD, UC: Coverage is provided for members 6 years of age or older.	By or in consultation with a rheumatologist, gastroenterologist, or dermatologist.	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0
INSULIN SUPPLIES	1 - All FDA-approved Indications.			Confirmation of insulin use within the past 12 months based on paid claims or provider documentation.			12 months		0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
IPTACOPAN (FABHALTA)	1 - All FDA-approved Indications.		Initiation in patients with unresolved serious infection caused by encapsulated bacteria.	Diagnosis. For paroxysmal nocturnal hemoglobinuria (PNH): confirmed diagnosis of PNH by flow cytometry 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.	Coverage is provided for members 18 years of age and older	By or in consultation with a hematologist, oncologist, immunologist, nephrologist, or genetic specialist	12 months	For reauth: documentation of improvement.	0
IVABRADINE (CORLANOR)	1 - All FDA-approved Indications.		Acute decompensated heart failure, blood pressure less than 90/50 mmHG, sick sinus syndrome, sinoatrial block, or 3rd degree AV block-unless a functioning demand pacemaker is present, resting heart rate less than 60 bpm prior to treatment, severe hepatic impairment, pacemaker dependence (heart rate maintained exclusively by the pacemaker), concomitant use of strong CYP3A4 inhibitors.	Diagnosis. For Adult Chronic Heart Failure (CHF): Must have left ventricular ejection fraction (LVEF) less than or equal to 35%, member is in sinus rhythm and has a resting heart rate of greater than or equal to 70 beats per minute, must currently be taking a beta-blocker (e.g., bisoprolol, carvedilol, metoprolol succinate) at the maximally tolerated dose or has a contraindication to beta-blocker use. For Pediatric 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).	CHF: coverage is provided for members 18 years of age or older. DCM: coverage is provided for members 6 months of age or older.	By or in consultation with a cardiologist	12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
IVACAFTOR (KALYDECO)	1 - All FDA-approved Indications.			Diagnosis. Documentation of genetic test confirming the member has at least one mutation in the CFTR gene that is responsive to ivacaftor based on clinical and/or in vitro assay data.	Coverage is provided for members 1 month of age or older.	By or in consultation with a pulmonologist or cystic fibrosis specialist	12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0
L-GLUTAMINE (ENDARI)	1 - All FDA-approved Indications.			Diagnosis. Must be used to reduce the acute complications of sickle cell disease (SCD) and the member must have 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.	Coverage is provided for members 5 years of age and older	By or in consultation with a physician who specializes in SCD (e.g.a hematologist)	12 months	For reauthorization: Documentation there has been a reduction in vaso-occlusive painful events or an improvement in condition.	0
LANREOTIDE (SOMATULINE DEPOT)	1 - All FDA-approved Indications.			Diagnosis. For acromegaly: must have inadequate response to surgery or radiotherapy or documentation that these therapies are inappropriate, must have the following baseline labs: elevated serum IGF-1 level for gender/age range (including lab reference range) and elevated growth hormone level defined as GH at least 1ng/mL during oral glucose tolerance test.	Coverage is provided for members 18 years of age and older.	By or in consultation with an endocrinologist or oncologist	For oncology indications: 6 months. All other indications: 12 months	For reauth: documentation of improvement or stabilization.	0
LEDISPASVIR-SOFOSBUVIR (HARVONI)	1 - All FDA-approved Indications.			Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling	Coverage is provided for members who are age-appropriate according to AASLD/IDSA guidance and/or FDA-approved labeling.	By or in consultation with a gastroenterologist, hepatologist, infectious disease, HIV or transplant specialist.	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA-approved labeling.		0
LENIOLISIB (JOENJA)	1 - All FDA-approved Indications.			Diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS). Must have genetic testing confirming the PI3K delta mutation with a documented variant in either PIK3CD or PIK3R1. Documentation of inadequate response to immunoglobulins.	Coverage is provided for members 12 years of age or older.	By or in consultation with a hematologist, immunologist, or geneticist.	12 months		0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
LETERMOVIR (PREVYMIS)	1 - All FDA-approved Indications.		Use with pimozide or ergot alkaloids. Use with pitavastatin and simvastatin when co-administered with cyclosporine.	Diagnosis. Must have received either an allogeneic hematopoietic stem cell transplant (HSCT) and have tested CMV-seropositive (Recipient positive, R+) or received a kidney transplant and be a high risk donor (CMV seropositive D+/recipient CMV seronegative R-). Must be used for prophylaxis of CMV infection.		By or in consultation with a hematologist, infectious disease or transplant specialist.	200 days post-transplant	For reauth: no reauthorization after initial coverage period.	0
LEUPROLIDE ACETATE	1 - All FDA-approved Indications.			Diagnosis. For endometriosis: Documentation the member has tried and failed or has a contraindication to 2 conventional treatments such as oral contraceptives, non steroidal anti-inflammatory agents, progestins, or danazol. For CPP: Documentation that the age of onset of secondary sexual characteristics occurred at less than 8 years of age in a female child or less than 9 years of age in a male child.			Prostate cancer and endometriosis: 6 months. CPP or Fibroids: 3 months	For reauth: documentation indicating stabilization or improvement in condition. For endometriosis, a single retreatment course of not more than six months may be administered after the initial course of treatment if symptoms recur	0
LEVACETYLLEUCINE (AQNEURSA)	1 - All FDA-approved Indications.			Diagnosis. Documentation the diagnosis was confirmed by genetic testing demonstrating one of the following: 1. a mutation in both alleles of 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.			12 months	Reauthorization: Documentation the member is experiencing an improvement or stabilization in disease.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
LEVETIRACETAM (SPRITAM)	1 - All FDA-approved Indications.			Diagnosis. Must have had an inadequate response or intolerance to generic levetiracetam and at least one of the following generic anticonvulsant drugs: phenytoin, carbamazepine, oxcarbazepine, gabapentin, lamotrigine, valproate, or topiramate.	Coverage is provided for members 4 years of age and older weighing more than 20kg.	By or in consultation with a neurologist.	12 months		0
LEVOMILNACIPRAN (FETZIMA)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two generic antidepressants alternatives such as an SSRI, SNRI, bupropion, trazodone or mirtazapine	Coverage is provided for members 18 years of age and older.		12 months		0
LIDOCAINE PATCH	3 - All Medically-accepted Indications.			Diagnosis. This Prior Authorization requirement only applies to members when a non-FDA approved diagnosis is submitted at the point of sale. FDA-approved diagnosis codes submitted will pay without prior authorization requirement.			12 months		0
LOTILANER (XDEMVY)	1 - All FDA-approved Indications.			Diagnosis of Demodex blepharitis confirmed by both of the following: 1. Member has at least mild erythema or itching of the upper eyelid margin. 2. Mite presence (e.g. collarettes) confirmed by slit lamp examination of the eyelashes.	Member must be 18 years of age and older	Prescribed by or in consultation with an optometrist or ophthalmologist	6 weeks		0
LUMACAFTOR/IVACAFTOR (ORKAMBI)	1 - All FDA-approved Indications.			Diagnosis. Documentation of a genetic test confirming that the member is homozygous for the F508del mutation in the CFTR gene (has two copies of the F508del mutation in the CFTR gene).		By or in consultation with a pulmonologist or cystic fibrosis specialist	12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
MACITENTAN (OPSUMIT)	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 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.		Prescribed by or in consultation with cardiologist or pulmonologist.	Initial: 3 months Reauth: 12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0
MANNITOL (BRONCHITOL)	1 - All FDA-approved Indications.			Diagnosis. Must have passed a bronchitol tolerance test. Must be used as add-on maintenance treatment with standard therapies (e.g. bronchodilators, antibiotics, anti-inflammatory therapy) to improve pulmonary function.			12 months	For reauth: documentation of improvement	0
MARALIXIBAT (LIVMARLI)	1 - All FDA-approved Indications.		PFIC type 2 patients with specific ABCB11 variants resulting in non-functional or complete absence of bile salt export pump (BSEP) protein.	Diagnosis of pruritis caused by progressive familial intrahepatic cholestatis (PFIC) or Allagile syndrome (ALGS) which has been confirmed by genetic testing. Documentation of trial and failure of ursodiol and another medication for cholestatic pruritis (e.g. cholestyramine, rifampin).	Coverage is provided for members 3 months of age and older.	By or in consultation with a hepatologist or gastroenterologist.	12 months	For reauth: documentation of improvement in pruritis.	0
MARIBAVIR (LIVTENCITY)	1 - All FDA-approved Indications.			Diagnosis of post-transplant (solid organ or hematopoietic stem cell) cytomegaloviris (CMV) infection/disease that is refractory to treatment with ganciclovir, valganciclovir, cidofovir, or foscarnet. Must weight at least 35 kg. Must not be used concomitantly with ganciclovir or valganciclovir.		By or in consultation with a hematologist, oncologist, infectious disease physician, or transplant specialist.	3 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
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 myelokathexis)	Members 12 years of age and older	By or in consultation with an immunologist, hematologist, or dermatologist	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
MECASERMIN (INCRELEX)	1 - All FDA-approved Indications.		Coverage is not provided for members with active or suspected neoplasia, closed epiphyses.	Diagnosis. Growth chart and documentation that epiphyses are open. For growth hormone deletion: must have growth hormone (GH) gene deletion in gene GH1 and developed neutralizing antibodies to GH therapy. For growth failure due to severe IGF-1 deficiency: must have dx of severe IGF-1 deficiency (defined as having all of the following: height below or equal to 3.0 standard deviation (SD) of the mean for age and sex, basal IGF-1 SD of less than or equal to 3.0 based on lab reference range, normal or elevated GH defined as stimulated serum GH level of greater than 10ng/mL or basal serum GH level greater than 5ng/mL).	Coverage is provided for members 2 years of age or older.	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

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
METHYLNALTREXONE (RELISTOR)	1 - All FDA-approved Indications.		Known or suspected gastrointestinal obstruction and members at an increased risk of recurrent obstruction.	Diagnosis. For opioid-induced constipation and advanced life-limiting illness: must have documentation of previous trial of lactulose. For opioid-induced constipation with chronic non-cancer pain: must have documentation of current and ongoing opioid therapy and must have trials with inadequate responses or significant side effects/toxicity or have a contraindication to naloxegol (Movantik) and lactulose.	Coverage is provided for members 18 years of age and older.		12 months	For reauth: documentation from the prescriber indicating an improvement in condition (both diagnoses) and must continue to be on opioid therapy (non-cancer pain).	0
MIFEPRISTONE (KORLYM)	1 - All FDA-approved Indications.			Diagnosis. Must have failed surgery or not be a candidate for surgery. Female members of reproductive potential: must have baseline (within previous month, must include date of test) negative pregnancy test prior to starting mifepristone and must be using nonhormonal medically acceptable method of contraception (unless surgically sterilized) during treatment and for 1 month after mifepristone therapy.	Coverage is provided for members 18 years of age and older.	By or in consultation with an endocrinologist	12 months		0
MIGLUSTAT (ZAVESCA)	1 - All FDA-approved Indications.		Miglustat is being used in combination with another therapy for Gaucher's disease	Diagnosis. Documentation the member has at least one of the following: 1) anemia not due to iron deficiency with a low hemoglobin for age and sex, 2) thrombocytopenia 3) 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).	Coverage is provided for members 18 years of age and older.	By or in consultation with an appropriate specialist (i.e. hematologist, geneticist, radiologist, orthopedist, endocrinologist, rheumatologist, hepatologist)	12 months	Reauthorization: Documentation from the prescriber indicating improvement or stabilization in member's condition.	0
MITAPIVAT (PYRUKYND)	1 - All FDA-approved Indications.			Diagnosis of hemolytic anemia with pyruvate kinase deficiency (PKD) confirmed by genetic testing.	Coverage is provided for members 18 years of age or older.	By or in consultation with a hematologist or a physician who specializes in the treatment of inherited metabolic disorders.	12 months	For reauthorization: documentation of improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
MODAFINIL (PROVIGIL)	1 - All FDA-approved Indications.			Diagnosis. For narcolepsy and obstructive sleep apnea: Sleep Study (e.g. Polysomnogram, Multiple Sleep Latency Test) 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 night shifts per month (defined as at least 4 hours of shift occurring between 10pm and 8am).		By or in consultation with a sleep specialist, ENT (ear, nose, and throat specialist), neurologist, or pulmonologist	SWSD: 6 months. Narcolepsy, OSA: 12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
MULTIPLE SCLEROSIS THERAPIES	1 - All FDA-approved Indications.			Diagnosis. For multiple sclerosis (MS), must have relapsing Multiple Sclerosis (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease) and functional status must be preserved and patient is either still able to walk at least 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 trial and failure, contraindication or intolerance to an immunomodulator (i.e., Azathioprine, 6-Mercaptopurine, Methotrexate).		By or in consultation with a neurologist or gastroenterologist	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
NETARSUDIL (RHOPRESSA)	1 - All FDA-approved Indications.			Diagnosis. Member must have a baseline intraocular pressure of less than 30 mmHg. Documentation of trial and failure, contraindication, or intolerance to timolol and latanoprost.	Coverage is provided for members 18 years of age and older.		12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
NINTEDANIB (OFEV)	1 - All FDA-approved Indications.			Diagnosis. For a diagnosis of Idiopathic Pulmonary Fibrosis (IPF): Must have diagnosis confirmed by either high-resolution computed tomography (HRCT) or surgical lung biopsy and must have all other diagnoses ruled out (e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity). 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). For a diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD): Must have onset of disease (first non-Raynaud symptom) within the past 7 years and at least 10% fibrosis on a chest high-resolution computed tomography (HRCT) scan within the past 12 months. 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 Interstitial	Coverage provided for members age 18 years and older.	By or in consultation with a pulmonologist	Initial: 6 months, Reauth: 12 months	For reauth: must have documentation from prescriber indicating that member still is a candidate for treatment.	0
NITISINONE (ORFADIN)	1 - All FDA-approved Indications.			Diagnosis of hereditary tyrosinemia type 1 (HT-1) confirmed by DNA testing or biochemical testing (ie. urine succinylacetone (SA) level).			12 months	For reauth: Documentation from the prescriber indicating improvement or stabilization in the member's condition	0
NITROGLYCERIN 0.4% OINTMENT (RECTIV)	1 - All FDA-approved Indications.		Severe anemia (defined as hemoglobin less than 8g/dL). Increased intracranial pressure. Concomitant use of a phosphodiesterase type 5 (PDE5) inhibitor such as sildenafil (Revatio, Viagra), tadalafil (Adcirca, Cialis), or vardenafil (Levitra, Staxyn).	Diagnosis. Must provide documentation that chronic anal fissure symptoms have persisted for at least 6 weeks.	Coverage is provided for members 18 years of age or older.		Initial: 2 months Reauthorization: 12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
ODEVIXIBAT (BYLVAY)	1 - All FDA-approved Indications.		PFIC type 2 patients with specific ABCB11 variants resulting in non-functional or complete absence of bile salt export pump (BSEP) protein.	Diagnosis of pruritis caused by progressive familial intrahepatic cholestatis (PFIC) or Allagile syndrome (ALGS) which has been confirmed by genetic testing. Documentation of trial and failure of ursodiol and another medication for cholestatic pruritis (e.g. cholestyramine, rifampin).	Coverage is provided for members 3 months of age and older.	By or in consultation with a hepatologist or gastroenterologist.	12 months	For reauth: documentation of improvement in pruritis.	0
OLANZAPINE/SAMIDORPHAN (LYBALVI)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two of the following generic, oral 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 member has tried and failed monotherapy, 3. Clinical rationale for use of 2 or more anticholinergic medications.	Coverage is provided for members 18 years of age or older.		12 months		0
OLEZARSEN (TRYNGOLZA)	1 - All FDA-approved Indications.			Diagnosis. Confirmation of the diagnosis by at least one of the following: 1. a genetic test 2. a North American Familial 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)	Coverage is provided for members 18 years of age and older	By on in consultation with a lipidologist, geneticist cardiologist, or endocrinologist	12 months	For reauthorization: documentation indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
OMALIZUMAB (XOLAIR)	1 - All FDA-approved Indications.			Diagnosis. For moderate to severe allergic asthma: recent total serum IgE level of greater than 30 IU/ml and the pre-treatment IgE levels do not exceed manufacturers dosing recommendations. Documentation of recent use and failure to respond to 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 H1 antihistamine (e.g.		By or in consultation with, for Urticaria: allergist, dermatologist, immunologist. Asthma: pulmonologist or allergist. Nasal Polyps: allergist, ear/nose/throat specialist, or immunologist. Allergy: allergist or immunologist.	12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0
OMAVELOXOLONE (SKYCLARYS)	1 - All FDA-approved Indications.			Diagnosis of Friedreich's ataxia that has been confirmed by genetic testing. Must have a modified Friedreich's Ataxia Rating Scale (mFARS) score between 20 and 80. Must have a left ventricular ejection fraction of at least 40%.	Coverage is provided for members 16 years of age or older.	By or in consultation with a neurologist.	12 months		0
OMNIPOD POD	1 - All FDA-approved Indications.			Must have documentation of previous insulin use.			12 months		0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
ONABOTULINUMTOXINA (BOTOX)	1 - All FDA-approved Indications.			Diagnosis. For migraine prophylaxis: must have adequate trial of two migraine prophylactic agents each from a separate class (e.g. anticonvulsants, beta-blockers, tricyclic antidepressants) with inadequate response. For urinary incontinence or OAB with urge urinary incontinence, urgency, frequency: must have adequate trial (at least 4 weeks) at recommended dose of 2 anticholinergic meds (e.g., oxybutynin ER, oxybutynin, Toviaz) with inadequate response or intolerance unless contraindicated.		By or in consultation with an appropriate specialist (ie. dermatologist, neurologist, urologist).	12 months	For reauth: documentation from prescriber indicating stabilization or improvement in condition.	0
ONCOLOGY MEDICATIONS	3 - All Medically-accepted Indications.			Diagnosis. For Bosulif, Iclusig, and Tasigna for CML: must have had an inadequate response or intolerance to imatinib or dasatinib.		By or in consultation with an oncologist, hematologist, neurologist, transplant specialist, allergist, or immunologist.	6 months		0
ORAL BENZODIAZEPINES	3 - All Medically-accepted Indications.			Prior authorization is only required for requests greater than a 14 day supply in a 30 day period and for members not in hospice care. Diagnosis. For seizure disorder: documentation the member has tried and failed or had an intolerance or contraindication to at least one non-benzodiazepine anticonvulsant. For sleep 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 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 to prevent harm to the member or others. For a musculoskeletal disorder: documentation the member			12 months	Reauth: For ongoing opioid and benzodiazepine therapy: Documentation to taper the benzodiazepine or opioid. If a taper is not appropriate at this time, documentation of when the taper will be reevaluated. For all other ongoing therapy: documentation the member has been treated with the requested agent within the past 90 days	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
PALIVIZUMAB (SYNAGIS)	1 - All FDA-approved Indications.		having received Beyfortus (nirsevimab-alip) for the current RSV season	DX. Must have documented reason not being able to use Beyfortus (nirsevimab-alip). If under age 12 mo at start of 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 control HF) OR have acyanotic heart disease (& be	Less than 12 months or less than 24 months of age at start of RSV season depending on criteria.		Minimum duration 1 month. Maximum of 5 doses per RSV season		0
PALOVAROTENE (SOHONOS)	1 - All FDA-approved Indications.			Diagnosis confirmed by precesence of ACVR1 mutation.	Members assigned female at birth must be 8 years and older. Members assigned male at birth must be 10 years and older.	Prescribed by or in consultation with an orthopedist or rheumatologist.	12 months		0
PAMIDRONATE (AREDIA)	1 - All FDA-approved Indications.			Diagnosis. For hypercalcemia of malignancy: must be used in conjunction with adequate hydration in members with moderate or severe 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 therapy .	Coverage is provided for members 18 years of age or older.		12 months	For reauth: documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
PASIREOTIDE (SIGNIFOR)	1 - All FDA-approved Indications.			Diagnosis of Cushing's disease for whom pituitary surgery is not an option or has not been curative. Documentation of trial and failure with ketoconazole to reduce cortisol secretion.	Coverage is provided for members 18 years of age or older.	By or in consultation with an Endocrinologist	12 months	For reauth: documentation of improvement or stabilization.	0
PEGFILGRASTIM-BMEZ (ZIEXTENZO)	3 - All Medically-accepted Indications.			Diagnosis.			6 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0
PEGVISOMANT (SOMAVERT)	1 - All FDA-approved Indications.			Diagnosis of acromegaly. Must have inadequate response to 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.	Coverage is provided for members 18 years of age or older.	By or in consultation with an Endocrinologist	12 months	For reauth: documentation of improvement or stabilization.	0
PERAMPANEL (FYCOMPA)	1 - All FDA-approved Indications.			Diagnosis. Must have had an inadequate response or intolerance to two of the following generic anticonvulsant drugs: levetiracetam, phenytoin, carbamazepine, oxcarbazepine, gabapentin, lamotrigine, valproate, or topiramate.	Coverage is provided for members 4 years of age or older.	By or in consultation with a neurologist.	12 months		0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
PIMAVANSERIN (NUPLAZID)	1 - All FDA-approved Indications.			Diagnosis. Must be using for the treatment of hallucinations and delusions 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 and documentation the member is able to self-report symptoms.	Coverage is provided for members 18 years of age or older.	By or in consultation with a neurologist or psychiatrist	12 months		0
PIRFENIDONE (ESBRIET)	1 - All FDA-approved Indications.			Diagnosis. Must have diagnosis of idiopathic pulmonary fibrosis (IPF) confirmed by either high-resolution computed tomography (HRCT) or surgical lung biopsy. Must have all other diagnoses ruled out (e.g., domestic and occupational environmental exposures, connective tissue disease, and drug toxicity). 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%	Coverage provided for members age 18 years and older.	Pulmonologist	Initial: 6 months, Reauth: 12 months	For reauth: must have documentation from prescriber indicating that member still is a candidate for treatment.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
POLYPHARMACY - MULTIPLE ACH MEDICATIONS	1 - All FDA-approved Indications.			This prior authorization requirement applies to members on 2 or more unique anticholinergic medications. Diagnosis. Provider must acknowledge that the benefit of the combination of the medications outweighs the potential risks. Documentation of both of the following: 1. the member has tried and failed monotherapy. 2. clinical rationale for use of 2 or more anticholinergic medications.	Prior authorization only applies to enrollees aged 65 or older not in hospice care.		12 months	Reauthorization: Documentation of one of the following: 1. attempt to taper of one of the medications OR 2. documentation of why tapering one of the medications is not appropriate at this time. Provider attestation the member continues to benefit from the combination of medications and this outweighs any potential risks.	0
POSACONAZOLE (NOXAFIL)	1 - All FDA-approved Indications.		Coadministration with sirolimus, ergot alkaloids (e.g., ergotamine, dihydroergotamine), HMG-CoA reductase inhibitors that are primarily metabolized through CYP3A4 (e.g., atorvastatin, lovastatin, simvastatin), or CYP3A4 substrates that prolong the QT interval (e.g., pimozide, quinidine), hypersensitivity to posaconazole, other azole antifungal agents, or any component of the formulation.	Diagnosis. For oropharyngeal candidiasis, must have at least a 2 week trial of fluconazole with an insufficient response, intolerable side effect, or have a contraindication.			12 months		0
PRAMLINTIDE (SYMLIN)	1 - All FDA-approved Indications.			Diagnosis of Type 1 or Type 2 Diabetes Mellitus. Documentation the member uses mealtime insulin and has failed to achieve desired glycemic control despite optimal insulin therapy. Initial A1C greater than or equal to 6.5.			12 months	For reauth: if the patient has been receiving Symlin for at least 3 months, patient demonstrated a reduction in HbA1c since starting therapy with Symlin.	0

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

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
RESMETIROM (REZDIFFRA)	1 - All FDA-approved Indications.		Members with decompensated cirrhosis	Diagnosis. Medication must be used in conjunction with diet and exercise for the treatment of adults with noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (stage F2 to F3 fibrosis) which has been 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.	Coverage is provided for members 18 years of age and older	By or in consultation with a hepatologist or gastroenterologist	12 months	For reauth: the member has received a clinical benefit demonstrated by either the resolution of steatohepatitis and no worsening of liver fibrosis or at least one stage improvement in liver fibrosis and no worsening of steatohepatitis.	0
RIFAXIMIN (XIFAXAN)	1 - All FDA-approved Indications.			Diagnosis. For hepatic encephalopathy: must have trial and failure of lactulose. For diarrhea-predominant irritable bowel syndrome (IBS-D): documentation of chronic IBS symptom diarrhea lasting at least 12 weeks and a trial and failure of two medications used in the treatment of IBS-D (i.e. loperamide, antispasmodics) with inadequate responses or significant side effect/toxicity unless contraindicated. For Traveler's diarrhea: must have a trial and failure, intolerance, or contraindication to one of the following: a fluoroquinolone (i.e. ciprofloxacin, levofloxacin) or azithromycin.	Hepatic encephalopathy and IBS-D: 18 years of age or older, Travelers diarrhea: 12 years of age or older	Hepatic encephalopathy: by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist, IBS-D: gastroenterologist	Hepatic encephalopathy: 12 months, IBS-D: 2 weeks, Travelers diarrhea: 3 days	For IBS-D: members who experience a recurrence of symptoms can be retreated up to two times with the same dosage regimen. Reauth for IBS-D: must have documentation from prescriber indicating recurrence of IBS-D symptoms after a successful treatment with rifaximin.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
RILONACEPT (ARCALYST)	1 - All FDA-approved Indications.			Diagnosis. For Cryopyrin-Associated Periodic Syndromes (CAPS) , must have documented genetic mutation in the Cold-Induced Auto-inflammatory Syndrome 1 (CIAS1) also known as NLRP3 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	CAPS and recurrent pericarditis: coverage provided for adults and children age 12 years and older. For DIRA: adults and pediatric members weighing 10kg or more.	By or in consultation with a hematologist, dermatologist, rheumatologist, neurologist, allergist, immunologist, cardiologist or a genetic specialist	12 months	For reauth: documentation from prescriber indicating stabilization or improvement in condition.	0
RIMEGEPANT (NURTEC ODT)	1 - All FDA-approved Indications.			Diagnosis. For episodic migraine: Provider attestation the member has 4 to 14 headache days per month. Must have a trial and failure of one beta-blocker and one anticonvulsant unless contraindicated or intolerant. For acute treatment of migraine: Must have a history of trial and failure, contraindication or intolerance to at least one triptan.	Coverage is provided for members 18 years of age and older.		For episodic migraine initial: 6 months. For acute migraine and reauthorization: 12 months	For reauth: Provider attestation the member is having a reduced number of migraine/headache days per month or a decrease in migraine/headache severity. A migraine is defined as a headache that has at least two of the following characteristics: unilateral location, pulsating/throbbing quality, moderate or severe intensity (inhibits or prohibits daily activities), is aggravated by routine activity, nausea and/or vomiting, photophobia and phonophobia.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
RIOCIGUAT (ADEMPAS)	1 - All FDA-approved Indications.		Coverage will not be provided for patients taking nitrates (nitrates in any form) or a PDE inhibitor (e.g. sildenafil).	Diagnosis. Pulmonary arterial hypertension (PAH) WHO Group I confirmed by chart documentation of right-heart catheterization (RHC) indicating a mean pulmonary 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 echocardiography.		Prescribed by or in consultation with cardiologist or pulmonologist.	Initial: 3 months, Reauth: 12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0
RISANKIZUMAB-RZAA (SKYRIZI)	1 - All FDA-approved Indications.			Diagnosis. 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) 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 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: aminosalicylates	Member must be 18 years of age or older.	By or in consultation with a rheumatologist, dermatologist or gastroenterologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
RISDIPLAM (EVRYSDI)	1 - All FDA-approved Indications.		Coverage will be not be provided to members who are concomitantly taking nusinersen.	Confirmed diagnosis fo 5q-autosomal recessive SMA. Baseline assessment motor milestone score from ONE of the following assessments: Hammersmith Functional Motor Scale Expanded (HFMSE), Hammersmith Infant Neurologic Exam (HINE), Upper limb module (ULM) score, Children?s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), or Six-minute walk test.		Prescribed by or in consultation with neurologist, or pediatric neurologist.	12 months	For reauth: documentation that the patient is responding to the medication as demonstrated by clinically significant improvement or maintenance of function from pretreatment baseline status using the same exam as performed at baseline assessment (progression, stabilization, or decreased decline in motor function).	0
ROFLUMILAST (DALIRESP)	1 - All FDA-approved Indications.		Moderate to sever liver impairment	Diagnosis of GOLD Stage III or IV COPD associated with chronic bronchitis. Documentation of COPD exacerbation within the past year. Must have a trial and failure of an inhaled long-acting beta-agonist or inhaled long-acting anticholinergic. Must be used as add on therapy with a long-acting beta agonist or long-acting anti-muscarinic. Must have trial and failure of inhaled glucocorticosteroid or a contraindication to these agents.			12 months	For reauthorization must have documentation from prescriber indicating improvement in condition.	0
RUFINAMIDE (BANZEL)	1 - All FDA-approved Indications.		Not covered for patients with Familial Short QT Syndrome	Diagnosis. Must have had an inadequate response or intolerance two generic anticonvulsant drugs (e.g. lamotrigine, valproate, topiramate, felbamate, clobazam). Must be using rufinamide as adjunctive therapy to other antiepileptic drugs (which can include medication from trial above).	Coverage is provided for members 1 year of age or older.	By or in consultation with a neurologist.	12 months		0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
RUXOLITINIB (JAKAFI)	1 - All FDA-approved Indications.			Diagnosis. Intermediate or high-risk myelofibrosis includes primary myelofibrosis, post-polycythemia vera myelofibrosis, and post-essential thrombocythemia myelofibrosis. For Polycythemia vera, must have trial and failure, intolerance, or contraindication of hydroxyurea. For acute Graft versus host disease (aGVHD), must have a trial and failure, intolerance, or contraindication to corticosteroids. For chronic Graft versus host disease (cGVHD), must have a trial and failure of at least two prior lines of systemic therapy.	GVHD: age 12 years or older All Others: age 18 years or older	By or in consultation with an oncologist, hematologist, or transplant specialist	6 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
SAPROTERIN DIHYDROCHLORIDE (KUVAN)	1 - All FDA-approved Indications.			Diagnosis. For treatment of Hyperphenylalaninemia. Clinically diagnosed with hyperphenylalaninemia due to tetrahydrobiopterin responsive phenylketonuria. Phe levels must be greater than 6 mg/dL (360 micromol/L).			Initial: 3 months, Reauth: 12 months	For reauthorization, must maintain Phe levels below member's baseline levels.	0
SATRALIZUMAB-MWGE (ENSPRYNG)	1 - All FDA-approved Indications.		Active hepatitis B infection, active or untreated latent tuberculosis	For Neuromyelitis Optica Spectrum Disorder (NMOSD): positive test for AQP4-IgG antibodies. At least 1 relapse 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.	Coverage is provided for members 18 years of age and older	By or in consultation with a neurologist or ophthalmologist	12 months	Part B before Part D Step Therapy. For reauth: documentation of stabilization or improvement in condition	1

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
SECUKINUMAB (COSENTYX)	1 - All FDA-approved Indications.			Diagnosis. For Psoriatic arthritis (PsA): for mild to moderate axial or enthesitis, must have a history of trial and failure, contraindication, or intolerance to a 4 week trial of 2 NSAIDs. For members 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 (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 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)	Must be 2 years of age or older.	By or in consultation with a rheumatologist, gastroenterologist, or dermatologist.	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0
SELEXIPAG (UPTRAVI)	1 - All FDA-approved Indications.			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 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.		Prescribed by or in consultation with cardiologist or pulmonologist.	Initial authorization: 3 months Reauthorization: 12 months	Reauthorization: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
SILDENAFIL CITRATE (REVATIO)	1 - All FDA-approved Indications.		Coverage will not be provided for patients taking nitrates (nitrates in any form) or a guanylate cyclase stimulator (e.g. Adempas).	Diagnosis. Pulmonary arterial hypertension (PAH) WHO Group I confirmed by chart documentation of right-heart catheterization (RHC) indicating a mean pulmonary 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 echocardiography.		Prescribed by or in consultation with a pulmonologist or cardiologist	Initial: 3 months, Reauth: 12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0
SODIUM OXYBATE (XYREM)	1 - All FDA-approved Indications.			Diagnosis. For excessive daytime sleepiness associated with narcolepsy: a sleep study (e.g. polysomnogram, multiple sleep latency Test) confirming diagnosis. For cataplexy associated with narcolepsy: a sleep study confirming the diagnosis.	Coverage is provided for members 7 years of age or older	By or in consultation with a neurologist or sleep specialist	Initial: 3 months, Reauthorization: 12 months	Reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
SODIUM PHENYLBUTYRATE	1 - All FDA-approved Indications.			Diagnosis.		By or in consultation with physician who specializes in the treatment of inherited metabolic disorders, a hematologist or a nephrologist.	12 months		0
SOFOSBUVIR-VELPATASVIR (EPCLUSA)	1 - All FDA-approved Indications.			Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling	Coverage is provided for members who are age-appropriate according to AASLD/IDSA guidance and/or FDA-approved labeling.	By or in consultation with a gastroenterologist, hepatologist, infectious disease, HIV or transplant specialist.	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling		0
SOFOSBUVIR-VELPATASVIR-VOXILAPREVIR (VOSEVI)	1 - All FDA-approved Indications.		Coadministration with rifampin	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling	Coverage is provided for members who are age-appropriate according to AASLD/IDSA guidance and/or FDA-approved labeling.	By or in consultation with a gastroenterologist, hepatologist, infectious disease, HIV or transplant specialist.	Criteria will be applied consistent with current AASLD/IDSA guidance and/or FDA approved labeling		0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
SOMATROPIN (GENOTROPIN)	3 - All Medically-accepted Indications.		Coverage will not be provided for members with active malignancy, active proliferative or severe non-proliferative diabetic retinopathy, pediatric member with closed epiphysis, members with Prader-Willi who are severely obese or have severe respiratory impairment.	Diagnosis. Growth chart required for all diagnoses except Adult Growth Hormone Deficiency (GHD). Documentation that epiphyses are open for all pediatric indications. For pediatric GHD: a height greater than or equal to 2 standard deviations below the mean for age and gender, documentation of growth velocity, skeletal maturation, 2 provocative stimulation tests which demonstrate GHD through peak growth hormone concentrations less than 10 ng/ml or IGF-1 or IGFBP-3 levels or only one stim test is needed in the presence of a pituitary abnormality. For Small for Gestational Age (SGA), a 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 growth not achieved by age 2. For adult GHD: documentation		By or in consultation with an endocrinologist or neonatologist.	6 months	For reauth for pediatric GHD, Turner and Noonan syndromes, SGA, Prader-Willi syndrome, and ISS: Documentation the patient has open epiphyses. For reauth for adult GHD: current IGF-1 level is normal for age and gender (does not apply to patients with structural abnormality of the hypothalamus/pituitary and 3 or more pituitary hormone deficiencies and childhood-onset growth hormone deficiency with congenital abnormality of the hypothalamus/pituitary). For reauth for Prader Willi: documentation growth hormone has resulted in an increase in lean body mass or decrease in fat mass.	0
SOTATERCEPT-CSRK (WINREVAIR)	1 - All FDA-approved Indications.			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 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)		Prescribed by or in consultation with cardiologist or pulmonologist	Initial: 3 months, Reauth: 12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
SPARSENTAN (FILSPARI)	1 - All FDA-approved Indications.			Diagnosis of primary immunoglobulin A nephropathy (IgAN) that has 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.	Coverage is provided for members 18 years of age or older.	By or in consultation with a nephrologist.	Initial: 6 months. Reauth: 12 months	For reauth: must have a decrease from baseline in total urine protein or UPCR.	0
SPESOLIMAB-SBZO (SPEVIGO)	1 - All FDA-approved Indications.			Diagnosis. For treatment of a generalized pustular psoriasis (GPP) flare, must have a moderate-to-severe flare 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).	Coverage is provided for members 12 years of age or older and weighing at least 40 kg.	By or in consultation with a dermatologist	For a flare: one treatment course (up to 2 infusions over 2 weeks). For maintenance: 12 months	For reauth: documentation of reduction in the frequency of flares while on treatment	0
STIRIPENTOL (DIACOMIT)	1 - All FDA-approved Indications.			Diagnosis. Must have had an inadequate response or intolerance to two generic antiepileptic drugs (e.g. valproate, topiramate, clobazam). Must be using in combination with clobazam.	Member must be 6 months of age or older	By or in consultation with a neurologist	12 months		0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
TADALAFIL (ADCIRCA)	1 - All FDA-approved Indications.		Coverage will not be provided for patients taking nitrates (nitrates in any form) or a guanylate cyclase stimulator (e.g. Adempas).	Diagnosis. Pulmonary arterial hypertension (PAH) WHO Group I confirmed by chart documentation of right-heart catheterization (RHC) indicating a mean pulmonary 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 echocardiography.		Prescribed by or in consultation with a pulmonologist or cardiologist	Initial: 3 months, Reauth: 12 months	For reauth: documentation from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment	0
TADALAFIL (CIALIS)	1 - All FDA-approved Indications.			Diagnosis of benign prostatic hyperplasia (BPH) and must have a trial and failure of at least two alternative medications in the following classes: alpha-1 adrenergic blockers or 5-alpha reductase inhibitors.			12 months		0
TASIMELTEON (HETLIOZ)	1 - All FDA-approved Indications.			Diagnosis. Must submit chart documentation describing how diagnosis was confirmed (e.g. sleep-wake logs, melatonin secretion abnormalities, or progress notes, etc.)	Coverage is provided for members 3 years of age or older.	By or in consultation with a neurologist or a physician who specializes in sleep medicine	12 months	For Reauth: documentation from prescriber indicating stabilization or improvement in condition.	0
TEDUGLUTIDE (GATTEX)	1 - All FDA-approved Indications.		Active intestinal obstruction or active gastrointestinal malignancy.	Diagnosis. For diagnosis of short bowel syndrome, member must be receiving parenteral support.		By or in consultation with a gastroenterologists	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
TELOTRISTAT (XERMELO)	1 - All FDA-approved Indications.			Diagnosis.	Coverage is provided for members 18 years of age and older.	By or in consultation with an oncologist	6 months	For reauth: documentation of improvement or stabilization.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
TETREBENAZINE (XENAZINE)	1 - All FDA-approved Indications.		Uncontrolled depression, actively suicidal. Currently using a monoamine oxidase inhibitor or reserpine. Hepatic impairment. Concurrent use of deutetrabenazine or valbenazine.	Diagnosis. 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 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).	Coverage is provided for members 18 years of age or older.	By or in consultation with a neurologist	12 months	Maximum dose approved is 100mg/day. For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
TOFACITINIB (XELJANZ)	1 - All FDA-approved Indications.			Diagnosis. Must have history of trial and failure, contraindication, or intolerance to a TNF blocker.	For Polyarticular course juvenile idiopathic arthritis: Coverage is provided for members 2 years of age and older. For all other diagnoses coverage is provided for members 18 years of age and older	By or in consultation with dermatologist, rheumatologist or gastroenterologist.	12 months	Reauth: Documentation from the prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
TOLVAPTAN (JYNARQUE)	1 - All FDA-approved Indications.		History of significant liver impairment or injury (not including uncomplicated polycystic liver disease), concomitant use of strong CYP3A inhibitors, uncorrected abnormal blood sodium concentrations, unable to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria	Diagnosis. Must meet one of the following criteria defining risk of rapidly progressing disease: (1) age 55 or younger and eGFR between 25 and 65 mL/min/1.73m^2, (2) age 56 to 65 and eGFR between 25 and 44 mL/min/1.73m^2 plus eGFR decline of greater than 2.0 mL/min/1.73m^2/year, (3) estimated CrCl greater than or equal to 60 mL/min, total kidney volume greater than or equal to 750 mL, and less than 51 years of age, (4) Mayo classification of 1C, 1D, or 1E disease.	Member must be 18 years of age or older	By or in consultation with a nephrologist	12 months	For reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0
TRIENTINE HCL (SYPRINE)	1 - All FDA-approved Indications.			Diagnosis. Must have a trial of penicillamine (Depen) with an inadequate response or significant side effects/toxicity or must have a contraindication to this therapy.		By or in consultation with a gastroenterologist, an ophthalmologist or a physician who specializes in the treatment of inherited metabolic disorders	12 months	For reauth: must have documentation from prescriber indicating improvement in condition.	0
TROFINETIDE (DAYBUE)	1 - All FDA-approved Indications.		0	Diagnosis. Documentation of a diagnosis of typical Rett syndrome according to the Rett Syndrome Diagnostic Criteria with a documented disease-causing mutation in the MECP2 gene.	Coverage is provided for members 2 years of age or older.	By or in consultation with a pediatric neurologist or neurologist	12 months	0	0
UBROGEPANT (UBRELVY)	1 - All FDA-approved Indications.			Diagnosis. Must have a history of trial and failure, contraindication, or intolerance to at least one triptan.	Coverage is provided for members 18 years of age and older.		12 months	For reauth: documentation of improvement or stabilization.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
UPADACITINIB (RINVOQ)	1 - All FDA-approved Indications.			Diagnosis. For rheumatoid arthritis (RA), psoriatic arthritis (PsA), ankylosing spondylitis (AS), non-radiographic axial spondyloarthritis (nr-axSpA), ulcerative colitis (UC), and Crohn's disease: history of trial and failure, contraindication, or intolerance to a TNF blocker. For atopic dermatitis (AD): history of trial and failure, contraindication, or intolerance to 2 systemic products (immunosuppressant or biologic).	For psoriatic arthritis and polyarticular juvenile idiopathic arthritis: 2 years or older, For atopic dermatitis: 12 years or older. All other indications: 18 years and older.	By or in consultation with a rheumatologist, dermatologist, or gastroenterologist.	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
USTEKINUMAB (STELARA) SQ	1 - All FDA-approved Indications.			Diagnosis. For Psoriatic arthritis (PsA): one of the following: 1) members with axial or enthesitis must have a history of trial and failure, contraindication, or intolerance to a 4 week trial of 2 NSAIDs, 2) the member has severe disease as defined by the prescriber, 3) members with peripheral disease must have a history of a trial and failure, contraindication, or intolerance to a 12 week trial with methotrexate or another DMARD. For 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:	Must be 6 years of age or older.	By or in consultation with a rheumatologist, gastroenterologist, or dermatologist.	12 months	For reauth: must have documentation from prescriber indicating stabilization or improvement in condition.	0
V-GO KIT	1 - All FDA-approved Indications.			Must have documentation of previous insulin use.			12 months		0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
VALBENAZINE (INGREZZA)	1 - All FDA-approved Indications.			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: 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 such as dose reduction or discontinuation were attempted but ineffective in	Coverage is provided for members 18 years of age or older	By or in consultation with a neurologist or psychiatrist	12 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0
VERICIGUAT (VERQUVO)	1 - All FDA-approved Indications.			Diagnosis. Must have a left ventricular ejection fraction (LVEF) less than or equal to 45%. Must have had a hospitalization for heart 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, angiotensin II receptor blocker or Entresto and a beta blocker.		Prescribed by or in consultation with cardiologist.	12 months	Reauthorization: documentation from prescriber indicating stabilization or improvement in condition.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
VIGABATRIN (SABRIL)	1 - All FDA-approved Indications.			Diagnosis. Must undergo vision testing prior to beginning treatment. For Refractory Complex Partial Seizures: must have inadequate response to at least two of the following anticonvulsant drugs: levetiracetam, phenytoin, carbamazepine, oxcarbazepine, gabapentin, lamotrigine, valproate, or topiramate. Must be using vigabatrin in combination with at least one other anticonvulsant medication (which can include medication from trial above).	Coverage is provided for members 1 month of age or older.	By or in consultation with a neurologist.	12 months		0
VILAZODONE (VIIBRYD)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two generic antidepressants alternatives such as an SSRI, SNRI, bupropion, trazodone or mirtazapine	Coverage is provided for members 18 years of age and older.		12 months		0
VORICONAZOLE INJECTION (VFEND)	1 - All FDA-approved Indications.			Diagnosis.	2 years of age or older	Prescribed by or in consultation with an infectious disease specialist	12 months		0
VORTIOXETINE (TRINTELLIX)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two generic antidepressants alternatives such as an SSRI, SNRI, bupropion, trazodone or mirtazapine	Coverage is provided for members 18 years of age and older.		12 months		0
VOSORITIDE (VOXZOGO)	1 - All FDA-approved Indications.			Diagnosis confirmed by documentation of one of the following: 1. genetic testing showing mutation in the FGFR3 gene or 2. radiographic assessment confirming achondroplasia (e.g. short, robust tubular bones, squared off iliac wings, flat horizontal acetabule, ect.). Documentation the member has open epiphyses.		Prescribed by or in consultation with an endocrinologist, geneticists, or other practitioner with expertise in the management of achondroplasia	12 Months	For reauth: documentation of both of the following: 1. improvement or stabilization. 2. The member's epiphyses remain open.	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite
XANOMELINE/TROSPIUM (COBENFY)	1 - All FDA-approved Indications.			Diagnosis. Documentation of trial and failure of at least two of the following generic atypical antipsychotics: olanzapine, quetiapine, paliperidone, risperidone, aripiprazole, or ziprasidone.	Members 18 years of age or older.		12 months		0
ZURANOLONE (ZURZUVAE)	1 - All FDA-approved Indications.			Diagnosis of postpartum depression (PPD) with onset during pregnancy or within 4 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).	Coverage is provided for members 18 years of age and older.	Prescribed by or in consultation with a psychiatrist or OB/GYN	14 days		0