

Prior Authorization Detail

Updated on 9/30/2025

Selected Formulary: 2026 Highmark Health Options Duals | CMS Formulary ID: 00026454 | CMS Version: 6

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

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ALIROCUMAB (PRALUENT)	1 - All FDA-approved			Diagnosis. Provider attests			12 months	Extreme risk: must have one	0	1
1	Indications.			member's baseline LDL-				of the following: progressive		
1				cholesterol levels are greater				atherosclerotic cardiovascular	•	
1				than or equal to 100 mg/dL				disease (ASCVD), including		
1				(w/o ASCVD), 70mg/dL (w/				unstable angina, that persists		
1				ASCVD), or 55mg/dl if has				after achieving an LDL-C less		
1				extreme risk designation (see				than 70 mg/dL, or established		
1				Other Criteria). Provider				clinical cardiovascular disease		
1				attests member failed to				in individuals with diabetes,		
1				achieve goal LDL-C reduction				stage 3 or 4 chronic kidney		
1				after a trial of a high intensity				disease (CKD), or		
1				statin (atorvastatin 40-80mg				heterozygous familial		
1				daily or rosuvastatin 20-40mg				hypercholesterolemia (HeFH),	,	
1				daily) OR 2 moderate-intensit	y			or a history of premature		
1				statins (atorvastatin or				ASCVD (less than 55 years of		
1				rosuvastatin) at the member's	5			age for males, less than 65 for		
1				maximally tolerated dose OR				females) . For reauthorization:		
1				attests the member is				Provider attests member had		
1				determined to be intolerant				improvement in LDL from		
1				to statin therapy .				baseline.		
ALOSETRON (LOTRONEX)	1 - All FDA-approved		Constipation. Concomitant	Diagnosis. Documentation of	Coverage is provided for	By or in consultation with a	12 months	For reauth: must have	0	1
I	Indications.		use of fluvoxamine. Male	chronic IBS symptoms	members 18 years of age and	1 .	12 months	documentation from	o de la companya de l	
1	indications.		gender. History of chronic or	diarrhea lasting at least 6	older.	dastrochterologist		prescriber indicating		
1			severe constipation or	months. Gastrointestinal tract				stabilization or improvement		
1				abnormalities have been ruled				in condition.		
1				out. Must have trial of	1			in condicion.		
1				loperamide and dicyclomine						
1			gastrointestinal perforation	used in the treatment of IBS-D						
1			and/or adhesions, ischemic	with inadequate response or						
1				significant side effects/toxicity	4					
1			circulation, thrombophlebitis,		'					
1			or hypercoagulable state,	amess contramareated						
1			Crohn's disease, ulcerative							
1			colitis, diverticulitis, or severe							
			hepatic impairment.							
ALPELISIB (VIJOICE)	1 - All FDA-approved			Diagnosis of PIK3CA-Related	Coverage is provided for	By or in consultation with an	12 months	For reauthorization: must	0	0
1	Indications.			Overgrowth Spectrum (PROS)	members 2 years of age or	appropriate specialist		have documentation from		
1				confirmed by genetic testing.	older.	depending on the symptoms		prescriber indicating		
1				Disease must be severe or life	-	and part of the body that are		stabilization or improvement		
1				threatening and require		affected.		in condition.		
				systemic treatment.						
ALPHA-1 PROTEINASE	1 - All FDA-approved			Diagnosis. Member must have		By or in consultation with a	Initial: 6 months	For reauth: documentation of	0	0
INHIBITOR (PROLASTIN)	Indications.				members 18 years of age and	pulmonologist	Reauthorization: 12 months	improvement or stabilization		
1				alpha-1 antitrypsin (AAT) that	older.			of the signs and symptoms of		
1				are less than 11 micromoles				emphysema associated with		
1				per liter (80 milligrams per				alpha-1 antitrypsin deficiency		
1				deciliter if measured by radial				including slowed progression		
1				immunodiffusion or 57				of emphysema as evidenced		
1				milligrams per deciliter if				by annual spirometry testing		
1				measure by nephelometry)				or a decrease in frequency,		
1				consistent with phenotypes				duration or severity of		
1				PiZZ, PiZ (null) or Pi (null, null)				pulmonary exacerbations		
1				of AAT. Member must have						
1				symptomatic emphysema						
1				confirmed with pulmonary						
1				function testing.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ALPHA-1 PROTEINASE	1 - All FDA-approved		Immunoglobulin A (IgA)	Diagnosis. Member must have	Coverage is provided for	By or in consultation with a	Initial: 6 months,	For reauth: documentation of	0	0
INHIBITOR (ZEMAIRA)	Indications.		deficient members with	pre-treatment serum levels of	members 18 years of age and	pulmonologist	Reauthorization: 12 months	improvement or stabilization		
			antibodies against IgA	alpha-1 antitrypsin (AAT) that	older.			of the signs and symptoms of		
				are less than 11 micromoles				emphysema associated with		
				per liter (80 milligrams per				alpha-1 antitrypsin deficiency		
				deciliter if measured by radial				including slowed progression		
				immunodiffusion or 57				of emphysema as evidenced		
				milligrams per deciliter if				by annual spirometry testing		
				measure by nephelometry)				or a decrease in frequency,		
				consistent with phenotypes				duration or severity of		
				PiZZ, PiZ (null) or Pi (null, null)				pulmonary exacerbations		
				of AAT. Member must have				pullionary exacerbations		
				symptomatic emphysema						
				confirmed with pulmonary						
				function testing.						
AMBRISENTAN (LETAIRIS)	Pending CMS review		Prognancy	Diagnosis. Pulmonary arterial		Prescribed by or in	Initial authorization: 3 months	For resulth, decumentation	0	0
AMBRISLIVIAN (LETAINIS)	rending civis review		Pregnancy	hypertension (PAH) WHO		consultation with cardiologist		from prescriber that	o o	o o
				Group I confirmed by chart		or pulmonologist.	Reauthorization. 12 months	demonstrates member is		
						or pulmonologist.				
				documentation of right-heart				tolerating and receiving		
				catheterization (RHC)				clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than						
				20 mmHg, pulmonary vascula	r					
				resistance greater than 2						
				wood units, and mean						
				pulmonary capillary wedge						
				pressure less than or equal to						
				15 mmHg. If provider						
				indicates RHC is not						
				recommended, must have						
				documentation of an						
				echocardiography.						
AMIKACIN INHALATION	1 - All FDA-approved			Diagnosis of Mycobacterium		By or in consultation with a	12 months	For reauth: must have	0	1
(ARIKAYCE)	Indications.			avium complex (MAC) lung		pulmonologist or infectious		attestation confirming		
				disease. Must be used as part		disease specialist		presence of a positive sputum		
				of a combination antibacteria		· ·		culture or that there have		
				drug regimen in patients who				been negative sputum		
				do not achieve negative				cultures for an insufficient		1
				sputum cultures after a				period of time (e.g. less than		
				minimum of 6 consecutive				12 months).		
				months of a multidrug						1
				background regimen therapy						
				containing at least 2 of the						
				_						
				following: a macrolide, a						
				rifamycin (rifampin or						
				rifabutin), and ethambutal.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction		Coverage Duration	Other Criteria	Part B Prerequisite	Required
APREMILAST (OTEZLA)	1 - All FDA-approved			Diagnosis. For plaque	Coverage is provided for	By or in consultation with a	12 months	For reauthorization: must	0	1
	Indications.			psoriasis: minimum BSA	members 6 years of age or	dermatologist, rheumatologist		have documentation from		
				involvement of at least 2%	older.			prescriber indicating stabilization or improvement		
				(not required if on palms, soles, head/neck, genitalia), a				in condition.		
				history of trial and failure of	' 			in condition.		
				ONE of the following: 1)						
				topical therapy (e.g.						
				corticosteroid, calcineurin						
				inhibitor, vitamin D analog), 2						
				phototherapy, 3) systemic	<u> </u>					
				treatment (e.g. methotrexate	,					
				cyclosporine, oral retinoids).						
				For Behcet's disease: must						
				have recurrent oral ulceratior	ı					
				(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						
				contraindication to colchicine	·					
ARIMOCLOMOL (MIPLYFFA)	1 - All FDA-approved			Diagnosis Documentation the	Member is 2 years of age and		12 months	Reauthorization:	0	0
AKINOCEOMOE (WIII ETTTA)	Indications.			diagnosis was confirmed by	older		12 months	Documentation the member	l ^o	
	maleucions.			genetic testing demonstrating				is experiencing an		
				one of the following: 1. a				improvement or stabilization		
				mutation in both alleles of				in disease.		
				NPC1 or NPC2 OR 2. mutation	1					
				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	e					
				using in combination with						
				miglustat. Must not be used i	n					
				combination with Aqneursa.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ARMODAFINIL (NUVIGIL)	Pending CMS review			Diagnosis. Must have a history	,	By or in consultation with a	SWSD: 6 months. Narcolepsy,	For reauth: documentation of		1
, ,	· ·			of trial and failure,		sleep specialist, ENT (ear,	OSA: 12 months	improvement or stabilization.		
				contraindication, or		nose, and throat specialist),				
				intolerance to modafinil. For		neurologist, or pulmonologist				
				narcolepsy: Sleep Study (e.g.						
				Polysomnogram, Multiple						
				Sleep Latency Test) confirming	3					
				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						
ASENAPINE (SECUADO)	1 - All FDA-approved			Diagnosis. Documentation of	Members 18 years of age or		12 months		0	1
	Indications.			trial and failure of at least two	older.					
				of the following generic						
				atypical antipsychotics:						
				olanzapine, quetiapine,						
				paliperidone, risperidone,						
				aripiprazole, ziprasidone,						
				asenapine, or lurasidone.						
ATOGEPANT (QULIPTA)	Pending CMS review			Diagnosis. For episodic	Coverage is provided for			For reauth: Provider	0	1
				the member has 4 to 14	members 18 years of age and			attestation the member is		
				headache days per month. For	older.			having a reduced number of migraine/headache days per		
				chronic migraine: Provider				month or a decrease in		
				attestation the member has a				migraine/headache severity. A		
				least 15 headache days per	1			migraine is defined as a]	
				month for 3 or more months				headache that has at least		
				with at least 8 migraine days				two of the following		
				per month. For both: Must				characteristics: unilateral		
				have a trial and failure of one				location, pulsating/throbbing		
				beta-blocker and one				quality, moderate or severe		
				anticonvulsant unless				intensity (inhibits or prohibits		
				contraindicated or intolerant.				daily activities), is aggravated		
								by routine activity, nausea		
								and/or vomiting, photophobia		
								and phonophobia.		

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ATRASENTAN (VANRAFIA)	Pending CMS review			Diagnosis of primary	Coverage is provided for	By or in consultation with a	Initial: 6 months. Reauth: 12	For reauth: must have a	0	0
				immunoglobulin A	members 18 years of age or	nephrologist.		decrease from baseline in		
				nephropathy (IgAN) that has	older.			total urine protein or UPCR.		
				been confirmed by biopsy.						
				Must have an eGFR rate of at						
				least 30 ml/min/1.73m^2.						
				Must have a total urine						
				protein of at least 1.0 g/day.						
				Must be at risk of rapid						
				disease progression defined as	5					
				having a urine protein-to-						
				creatinine ratio (UPCR) of at least 1.5 g/g. Must have tried						
				and failed a stable and						
				maximum tolerated dose of						
				both 1) an ACE inhibitor or						
				ARB and 2) an SGLT-2 inhibitor	_					
				(e.g. Farxiga).						
AVACOPAN (TAVNEOS)	1 - All FDA-approved			Diagnosis of ANCA-associated	Coverage is provided for	By or in consultation with a	12 Months	For reauthorization:	0	0
	Indications.			vasculitis (GPA or MPA). Must		rheumatologist, hematologist	I	documentation from		
				be on concurrent therapy with	, ,	or oncologist.		prescriber indicating		
				glucocorticoids and				stabilization or improvement		
				immunosuppressants (e.g.				in condition.		
				cyclophosphamide,						
				azathioprine, mycophenolate,						
				rituximab).						
AVATROMBOPAG (DOPTELET)	1 - All FDA-approved			Diagnosis. For ITP,		By or in consultation with a	Chronic ITP: 6 months.	For reauth of chronic ITP:	0	0
	Indications.			documentation of inadequate		hematologist, oncologist,	Thrombocytopenia in patients	documentation of		
				response to corticosteroids or		hepatologist, or surgeon	with chronic liver disease: 1	improvement in platelet		
				immunoglobulins and			month	count from baseline.		
				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.						
BECAPLERMIN (REGRANEX)	1 - All FDA-approved			Diagnosis. Must have a lower			3 months	For reauth: documentation of		0
	Indications.		-	extremity diabetic				improvement or stabilization.		
				neuropathic ulcer that						
				extends into the subcutaneous tissue or						
			-	beyond and have an adequate	I					
				blood supply. Must be used as adjunctive therapy to good	1					
				ulcer care practices (i.e.						
				debridement, infection						
				control, pressure relief).						
				control, pressure relief.						
BEDAQUILINE (SIRTURO)	Pending CMS review			Diagnosis. Must have either	Member must be 5 years of	By or in consultation with a	6 months		0	1
	. sao sino review			inadequate response to a first	•	pulmonologist or infectious			Ī	_
				line tuberculosis (TB) regimen		disease specialist				
				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.						
	•	•	•		•	•	•		•	•

				Required Medical						Prerequisite Th	herapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria		Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required	
BELIMUMAB (BENLYSTA) (IV	1 - All FDA-approved		Severe active central nervous	Diagnosis of active,	Coverage is provided for	By or in consultation with a	12 months	For reauth: documentation	0	1	
FORMULATION)	Indications.		system lupus. Combination	autoantibody-positive,	members 5 years of age and	rheumatologist or		from the prescriber indicating			
			therapy with other biologics	systemic lupus erythematosus	older	hematologist		stabilization or improvement			
			or IV cyclophosphamide.	(SLE) or lupus nephritis. Must				in condition.			
				have ANA of at least 1:80 or							
				anti-dsDNA of at least 30							
				IU/ml to support being							
				autoantibody positive. Must							
				be currently taking or has							
				tried and failed or had an intolerance or							
				contraindication to at least							
				one standard therapy for							
				systemic lupus erythematosus							
				(e.g. corticosteroids,							
				antimalarials, NSAIDS, or							
				immunosuppressives) or lupus							
				nephritis (e.g. corticosteroids,							
				mycophenolate,							
				cyclophosphamide,							
				azathioprine). Diagnosis of							
				active lupus nephritis.							
				Documentation of a biopsy-							
				proved lupus nephritis Class							
				III, IV or V.							
						- to the state of	10 11				
BELIMUMAB (BENLYSTA) (SQ)			Severe active central nervous	I =	Coverage is provided for	1 .	12 months	For reauth: documentation	0	1	
	Indications.		system lupus. Combination therapy with other biologics	autoantibody-positive, systemic lupus erythematosus	members 5 years of age and	rheumatologist, hematologist, or nephrologist		from the prescriber indicating stabilization or improvement			
			or IV cyclophosphamide.	(SLE) or lupus nephritis. Must	older.	or nephrologist		in condition.			
			or iv cyclophosphannide.	have ANA of at least 1:80 or				in condition.			
				anti-dsDNA of at least 30							
				IU/ml to support being							
				autoantibody positive. Must							
				be currently taking or has							
				tried and failed or had an							
				intolerance or							
				contraindication to at least							
				one standard therapy for							
				systemic lupus erythematosus							
				(e.g. corticosteroids,							
				antimalarials, NSAIDS, or							
				immunosuppressives) or lupus							
				nephritis (e.g. corticosteroids,							
				mycophenolate,							
				cyclophosphamide,							
				azathioprine). Diagnosis of							
				active lupus nephritis.							
				Documentation of a biopsy- proved lupus nephritis Class							
				III, IV or V.							
				iii, iv Oi v.							
BELUMOSUDIL (REZUROCK)	3 - All Medically-accepted			Diagnosis. For a diagnosis of	GVHD: age 12 years or older	By or in consultation with an	12 months	For reauth: documentation of	0	1	
, ,	Indications.			chronic Graft versus host	,	oncologist, hematologist, or		improvement or stabilization.			
				disease (GVHD), after a trial		transplant specialist					
				and failure of at least two							
				prior lines of systemic							
				therapy.							

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
BENRALIZUMAB (FASENRA)	1 - All FDA-approved			Diagnosis. For severe		By or in consultation with an	12 months	For reauth: documentation of	0	1
	Indications.			eosinophilic asthma:	older. For EGPA: 18 years or	allergist, immunologist,		improvement (e.g. reduced		
				eosinophil blood count	older.	pulmonologist, or		symptoms, reduced		
				greater than or equal to		rheumatologist.		exacerbations, need for oral		
				150cells/microliter.				steroids).		
				Documentation of inadequate	•					
				response, intolerance, or						
				contraindication to a high-						
				dose ICS in combination with						
				a LABA. Meets one of the						
				following within the past year	:					
				one or more acute asthma-						
				related ED visit(s), one or						
			•	more acute inpatient visits						
				where asthma was the						
				principal diagnosis, or two or						
				more acute asthma						
				exacerbations requiring oral						
				systemic steroids. For						
			•	eosinophilic gramunlomatosis						
				with polyangiitis (EGPA): must						
				have asthma, must have						
			•	eosinophil blood count						
				greater than or equal to 1,000	1					
				cells/microliter or greater						
				than 10 percent of leukocytes	,					
				must have relapsing or						
				refractory disease with						
				maximally tolerated dose of						
				corticosteroids unless						
				contraindicated.						
BEREMAGENE GEPERPAVEC	1 All EDA approved			Diagnosis of Dystrophic	Coverage is provided for	Py or in consultation with a	6 months	Reauthorization: must have	0	0
(, , , , , , , , , , , , , , , , , , ,	1 - All FDA-approved			Diagnosis of Dystrophic Epidemolysis Bullosa (DEB)	members 6 months of age or	By or in consultation with a	6 months	documentation from	0	ľ
(VYJUVEK)	Indications.			with a mutation in the	older.	dermatologist		prescriber indicating		
				collagen type VII alpha 1 chair				improvement in condition.		
				(COL7A1) gene confirmed by				Improvement in condition.		
				genetic testing. Must have a						
				wound with no evidence or						
				history of squamous-cell carcinoma or active infection.						
				carcinoma or active injection.						
BIRCH TRITERPENES	Pending CMS review	+		Diagnosis of Dystrophic	Coverage is provided for	By or in consultation with a	6 months	Reauthorization: must have	0	0
(FILSUVEZ)	T CHAINS CIVIS TEVIEW			Epidemolysis Bullosa (DEB) or		dermatologist	o months	documentation from	ľ	ľ
(1.1L30 V LZ)				junctional epidermolysis	older.	acimatologist		prescriber indicating		
				bullosa (JEB) with an open	J.W.C.I.			improvement in condition.		
				wound.				improvement in condition.		
BOSENTAN (TRACLEER)	Pending CMS review	<u> </u>	Pregnancy	Diagnosis. Pulmonary arterial		Prescribed by or in	Initial authorization: 3 months	For reauth: documentation	0	0
- John Million College	. Sa o civio i cvicv		•	hypertension (PAH) WHO		consultation with cardiologist		from prescriber that	-	
			•	Group I confirmed by chart		or pulmonologist.		demonstrates member is		
				documentation of right-heart		S. paintonologist.		tolerating and receiving		
				catheterization (RHC)				clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than				caemone		
				20 mmHg, pulmonary vascular						
				resistance greater than 2						
				wood units, and mean						
				pulmonary capillary wedge						
				pressure less than or equal to						
				15 mmHg. If provider						
				indicates RHC is not						
				recommended, must have						
1	1		1			I	1		1	
				Idocumentation of an						
				documentation of an echocardiography.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
BREXPIPRAZOLE (REXULTI)	Pending CMS review			Diagnosis. Documentation of	Members 13 years of age or		12 months		0	1
				trial and failure of at least two	older.					
				of the following generic						
				atypical antipsychotics:						
				olanzapine, quetiapine,						
				paliperidone, risperidone,						
				aripiprazole, ziprasidone,						
				asenapine, or lurasidone.						
BRIVARACETAM (BRIVIACT)	1 - All FDA-approved			Diagnosis. Must have had an		By or in consultation with a	12 months		0	1
	Indications.			inadequate response or		neurologist				
				intolerance to two generic						
				antiepileptic drugs (e.g.						
				valproate, lamotrigine,						
BUDGGONIBE (FOUND)	4 411504	_		topiramate, clobazam).		<u> </u>	2			1
BUDESONIDE (EOHILIA)	1 - All FDA-approved			Diagnosis. For eosinophilic	Coverage is provided for	1 '	3 months	Reauth: use beyond 3 months	0	
	Indications.			esophagitis (EoE): must have	members 11 years of age or	allergist or gastroenterologist.		has not been studied.		
				at least 15 intraepithelial	older.					
				eosinophils per high-power						
				field (eos/hpf) following a						
BUDESONIDE EXTENDED	1 All FDA approved			treatment course with a PPI.	Member must be 18 years of	By or in consultation with a	0 wooks	For reauth: must have	0	1
RELEASE TABLETS (UCERIS)	1 - All FDA-approved Indications.			Diagnosis. Must have a trial and failure, a	age or older.	rheumatologist or	8 weeks	documentation from	0	1
RELEASE TABLETS (OCERTS)	ilidications.			contraindication, or an	age of older.	gastroenterologist.		prescriber indicating		
				intolerance to two (2) of the		gastroenterologist.		stabilization or improvement		
				following therapy options:				in condition.		
				topical mesalamine, oral				in condition.		
				aminosalicylate or						
				corticosteroids with						
				inadequate response or side						
				effects/toxicity unless						
				contraindicated.						
BUROSUMAB-TWZA	1 - All FDA-approved		Use with oral phosphate or	Diagnosis. For X-linked		By or in consultation with a	12 months	Reauthorization:	0	0
(CRYSVITA)	Indications.		active vitamin D analogs	hypophosphatemia:		physician who is experienced		Documentation current		
(,				confirmation of the diagnosis		in the management of		(within the past 12 months)		
				by at least one of the		patients with metabolic bone		serum phosphorus level is not		
				following: A genetic test		disease.		above the upper limit of the		
				showing a PHEX gene				laboratory normal reference		
				mutation (phosphate				range and documentation the		
				regulating gene with				member has had a positive		
				homology to endopeptidase				clinical response or		
				on the X chromosome) or				stabilization in their disease.		
				Serum fibroblast growth						
				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						
	_1			provided).	<u> </u>	L	<u> </u>			l

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
BUT/APAP/CAF TAB	3 - All Medically-accepted			Diagnosis. This Prior	Coverage is provided for		12 months		0	0
	Indications.			Authorization requirement	members 12 years of age or					
				only applies to members	older.					
				when a non-FDA approved						
				diagnosis is submitted. FDA-						
				approved diagnosis codes						
				submitted will pay without						
				prior authorization						
				requirement.						
BUTAL/APAP TAB 50-325MG	3 - All Medically-accepted			Diagnosis. This Prior	Coverage is provided for		12 months		0	0
	Indications.			Authorization requirement	members 12 years of age or					
				only applies to members	older.					
				when a non-FDA approved						
				diagnosis is submitted. FDA-						
				approved diagnosis codes						
				submitted will pay without						
				prior authorization						
				requirement.						
C1 ESTERASE INHIBITOR	1 - All FDA-approved			Diagnosis of HAE is confirmed		Prescribed by or in	Initial: 6 months	For reauth: must have	0	0
(HAEGARDA)	Indications.			by laboratory values obtained		consultation with an	Reauthorization: 12 months	documentation from		
				on two separate instances	older.	allergist/immunologist,		prescriber indicating		
				(laboratory reports must		hematologist, dermatologist		improvement in condition.		
				contain reference ranges). For	1					
				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-INF	1					
				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.						
CANINADIDIOI (EDIDIOI EV)	1 All FDA			Diamonia Marritaria III	Manufacture	December assemble at 191	12		0	
CANNABIDIOL (EPIDIOLEX)	1 - All FDA-approved			Diagnosis. Must have had an		By or in consultation with a	12 months		U	
	Indications.			inadequate response or	age or older	neurologist				
				intolerance to one generic						
CARGLUMIC ACID	1 All EDA approved			antiepileptic drug.			12 months		0	10
	1 - All FDA-approved			Diagnosis. This Prior			12 months		U	ال
(CARBAGLU)	Indications.			Authorization requirement						
				only applies to members						
				when a non-FDA approved						
				diagnosis is submitted at the point of sale. FDA-approved						
					j .					
				diagnosis codes submitted wil pay without prior	Ϊ					
				authorization requirement.						
CARIPRAZINE (VRAYLAR)	1 - All FDA-approved		+	Diagnosis. Documentation of	Members 18 years of age or		12 months		0	1
CANIFINALINE (VINATEAN)	Indications.			trial and failure of at least two			בב וווטוונווט			
	maications.			of the following generic	older.					
				atypical antipsychotics:						
				olanzapine, quetiapine,						
				paliperidone, risperidone,						
				aripiprazole, ziprasidone,						
				aripiprazoie, ziprasidone, asenapine, or lurasidone.						
<u></u>	_1	1	1	asenapine, or rarasidone.	1	ı	1	1	1	1

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
CENOBAMATE (XCOPRI)	1 - All FDA-approved			Diagnosis. Must have had an		By or in consultation with a	12 months		0	1
	Indications.			inadequate response or		neurologist				
				intolerance to two generic						
				antiepileptic drugs (e.g.						
				valproate, lamotrigine,						
				topiramate, clobazam).						
CEQUR	1 - All FDA-approved			Must have documentation of			12 months		0	1
	Indications.			previous insulin use.						
CYSTEAMINE (CYSTAGON)	1 - All FDA-approved			Diagnosis. Must have		By or in consultation with a	Initial: 3 months	For reauth: must have	0	0
	Indications.			documentation of CTNS gene		nephrologist or physician who	Reauthorization: 12 months	documentation from		
				mutation, elevated white		specializes in the treatment of	•	prescriber indicating		
				blood cell cystine levels		inherited metabolic disorders		improvement in condition and	1	
				greater than 2nmol per half-		innerited metabolic disorders		a reduction in WBC cystine		
				cystine per mg of protein, or				levels since starting treatmen		
				cystine corneal crystals by slit				with oral cysteamine		
								with oral cysteannile		
DALFAMPRIDINE (AMPYRA)	Pending CMS review		History of seizure disorder,	lamp examination. Diagnosis of multiple sclerosis	. Coverage is provided for	Neurologist	Initial: 3 months	For reauthorization: must	0	0
DALFAIVIF KIDINE (AIVIPTKA)	rending Civis review		•		•	INCUIDIOSIST		have documentation from	٥	ľ
				Chart documentation of	members 18 years of age or		Reauthorization: 12 months			
				baseline motor disability or	older.			prescriber indicating		
			equal to 50 mL/min).	dysfunction.				stabilization or improvement		
								in condition.	_	
DARBEPOETIN ALFA	1 - All FDA-approved		Uncontrolled hypertension	Diagnosis. Must have Hgb			6 months	For reauth for CKD on dialysis:	: 0	0
(ARANESP)	Indications.			level less than 10 g/dL.				must have a Hgb less than or		
								equal to 11g/dl. For reauth for		
								CKD not on dialysis: must have	е	
								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 othe		
								dx must meet initial criteria.		
DEFERASIROX (EXJADE)	1 - All FDA-approved		Glomerular Filtration Rate less	Diagnosis. For chronic iron		Prescribed by or in	12 months	For reauth: documentation	0	0
	Indications.		than 40mL/min/1.73 m2.	overload due to blood		consultation with a		from prescriber indicating		
			Concomitant advanced	transfusions: pretreatment		hematologist		stabilization or improvement		
			malignancy or high risk	serum ferritin level is greater				in condition.		
				than 1000 mcg/L. For chronic						
				iron overload due to non-						
				transfusion-dependent						
				thalassemia (NTDT)		1				
				syndromes: pretreatment						
				serum ferritin level is greater		1				
				than 300 mcg/L and a liver						
				iron concentration of at least		1	1			
				5mg iron per gram dry weight	.					
DEFERIPRONE (FERRIPROX)	1 - All FDA-approved			Diagnosis. Must have		Prescribed by or in	12 months	For reauth: documentation	0	1
	Indications.			documentation of a trial and		consultation with a		from prescriber indicating		
				failure of Exjade (this requires	1	hematologist	1	stabilization or improvement		
				a PA) unless contraindicated .				in condition.		
DENIOCURAR (VOEVA)	O All Mardin II			Diamente		December 1	Constitution			
DENOSUMAB (XGEVA)	3 - All Medically-accepted			Diagnosis.		Prescribed by or in	6 months		U	U
	Indications.					consultation with a	1			
				1		hematologist or oncologist				

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses		Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
	Pending CMS review		•	Diagnosis. For chorea: must		By or in consultation with a		For reauthorization: must	0	1
(AUSTEDO)				have confirmed Huntington's	· -	neurologist or psychiatrist		have documentation from		
			•		older.			prescriber indicating		
				Disease Mutation analysis				stabilization or improvement		
			tetrabenazine, or valbenazine.	•				in condition.		
				indicating expanded CAG						
				repeat of greater than or						
				equal to 36 in the Huntington						
				gene) or a positive family history of Huntington's						
				Disease with autosomal						
				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						
DEUTIVACAFTOR/TEZACAFTO	1 - All FDA-annroved			Diagnosis. Documentation of	Coverage is provided for	By or in consultation with a	12 months	For reauthorization:	0	0
R/VANZACAFTOR (ALYFTREK)				genetic test confirming the		cystic fibrosis specialist or	12 months	documentation indicating	·	
Try vy aves test a ront (y terr riverty)	maicacións.			member has at least one	older	pulmonologist		stabilization or improvement		
				F508del mutation or another	0.00	pa		in condition.		
				responsive mutation in the						
				CFTR gene.						
DEXTROMETHORPHAN-	1 - All FDA-approved			Diagnosis. Pseudobulbar	Coverage is provided for	By or in consultation with	Initial: 3 months	For reauthorization:	0	0
QUINIDINE (NUEDEXTA)	Indications.			affect (PBA): documentation	members 18 years of age and	neurologist	Reauthorization: 12 months	Documentation indicating a		
				supporting the following:	older.			decrease in the number of		
				involuntary outbursts of				laughing and/or crying		
				laughing and/or crying that				episodes since starting the		
				are incongruent or				medication.		
				disproportionate to the						
				member's emotional state						
				AND other possible conditions						
				that could result in emotional						
				lability (e.g. depression, bipolar disorder,						
				1						
				schizophrenia, epilepsy) have been ruled out. Must have						
				underlying neurological						
				disorder such as amyotrophic						
				lateral sclerosis, multiple						
				sclerosis, Alzheimer's and						
				related diseases, Stroke,						
				Traumatic Brain Injury, or						
				Parkinsonian Syndrome.						
DEXTROMETHORPHAN/BUPR	1 - All FDA-approved			Diagnosis. Documentation of			12 months		0	1
OPION (AUVELITY)	Indications.			trial and failure of at least two	members 18 years of age or					
				generic antidepressants	older.					
				alternatives such as an SSRI,						
				SNRI, bupropion, trazodone or						
				mirtazapine.						
	1 - All FDA-approved	ĺ	1	Diagnosis. Must be using a	1	By or in consultation with a	12 months		0	1
DIAZEPAM (VALTOCO)										
	Indications.			maintenance antiepileptic drug.		neurologist				

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
DIAZOXIDE CHOLINE (VYKAT	1 - All FDA-approved			Diagnosis. Must have a	Member must be 4 years of	By or in consultation with an	Initial: 6 months	For reauth: must have	0	0
XR)	Indications.			diagnosis of Prader-Willi	age or older.	endocrinologist or geneticist	Reauthorization: 12 months	documentation from		
				syndrome (PWS) confirmed by	, -			prescriber indicating		
				genetic testing and have				stabilization or improvement		
				symptoms associated with				in hyperphagia symptoms.		
				hyperphagia (i.e. persistent				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
				sensation of hunger, food						
				preoccupations, an extreme						
				drive to consume food, food-						
				related behavior problems,						
				lack of normal satiety). Must						
				have baseline fasting plasma						
DUIVED OF DOOR ANALYS NACAL	4. All EDA		Name have suitable because to be a con-	glucose or hemoglobin A1c.	Commence in a second and form		42	For any other description		
DIHYDROERGOTAMINE NASAL				Diagnosis. Documentation of			12 months	For reauth: documentation	0	1
SPRAY (MIGRANAL)	Indications.			trial and failure of 1	members 18 years of age and			from prescriber indicating		
				medication from each of the				stabilization or improvement		
				following classes: a NSAID and				in condition.		
			The state of the s	a triptan unless						
			clinical symptoms or findings	contraindicated.						
1			consistent with coronary							
			artery vasospasm (including							
			Prinzmetal's variant angina or							
			uncontrolled hypertension).							
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
DORNASE ALFA	1 - All FDA-approved			Diagnosis.		By or in consultation with a	12 months	For reauth: must have	0	0
(PULMOZYME)	Indications.					pulmonologist or cystic		documentation from		
,						fibrosis specialist		prescriber indicating		
								stabilization or improvement		
								in condition.		
DRONABINOL	1 - All FDA-approved			Diagnosis. Nausea and			12 months	in condition.	n	1
DRONABINGE	Indications.			vomiting associated with			12 months		ľ	
	malcations.			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.						
DROXIDOPA (NORTHERA)	1 - All FDA-approved			Diagnosis. Documentation of a			2 weeks	For reauth: rationale from the	0	1
	Indications.			clinical diagnosis of	members 18 years of age and			provider for continuing		
1				symptomatic neurogenic	older.			therapy beyond 2 weeks		
1				orthostatic hypotension						
1				caused by one of the						
				following: Primary autonomic						
				failure (Parkinson's disease,						
				multiple system atrophy, or						
				pure autonomic failure),						
				dopamine beta-hydroxylase						
1				deficiency or non-diabetic						
				autonomic neuropathy. Must						
				have a trial of midodrine with						
				inadequate response or						
				significant side effects/toxicity	1					
				unless contraindicated.						
						1				

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
DUPILUMAB (DUPIXENT)	Pending CMS review			Diagnosis. For asthma: must	For atopic dermatitis: 6	1 .	12 months	Reauth for asthma and COPD:	0	1
				have either moderate to		allergist, dermatologist,		documentation of		
				severe eosinophilic phenotype		immunologist, pulmonologist,		improvement (e.g. reduced		
				with an eosinophil count	polyps: 12 years of age or	ear-nose/throat specialist, or		symptoms, reduced		
				greater than or equal to 150	older. For eosinophilic	gastroenterologist.		exacerbations, need for oral		
				cells/microliter or oral	esophagitis: 1 year or older.			steroids). Reauth for all other		
				corticosteroid dependent	For all other indications: 18			indications: documentation		
				persistent asthma (chronic	years or older.			from prescriber indicating		
				oral corticosteroid use).				stabilization or improvement		
				Documentation of recent use				in condition.		
				and failure to respond to						
				inhaled steroid in combo with						
				long acting beta agonist. Mus	t					
				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	³					
				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 nasa	'					
				polyps: history of trial and						
				failure of Xhance (fluticasone						
				propionate). Must be used as						
				add-on maintenance therapy.			1.0			
EDARAVONE (RADICAVA ORS)				Diagnosis of Amyotrophic	Coverage is provided for	By or in consultation with a	12 months	Reauth: must provide	U	O
	Indications.				members 18 years of age and	neurologist		documentation of clinical		
				have normal respiratory	older			benefit based on the		
				function (defined as a forced				prescriber's assessment and		
				vital capacity (FVC) of at least				an ALSFRS-R score within the		
				80%), must be able to perform				past 12 months		
				activities of daily living (ADLs)						
				such as eating and moving						
				around independently, must						
				provide a recent ALSFRS-R						
	1			score.		L				

·	ndication Indicator	Off-Label Uses	Exclusion Criteria							
EECADTICIMOD 4		OII EUDEI OSCS	exclusion criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
LEGAN HUNDUUD 1-	- All FDA-approved			Diagnosis. Memember must	Member must be 18 years of	By or in consultation with a	12 months	For reauthorization:	0	1
ALFA/HYALURONIDASE-QVFC Ind				have generalized myasthenia		neurologist.		Documentation from the		
(VYVGART HYTRULO)				gravis (gMG) who are anti-		_		provider that the member has		
				acetylcholine receptor (AChR)				experienced improvement in		
				antibody positive or chronic				signs and symptoms of		
				inflammatory demyelinating				generalized myasthenia gravis		
				polyneuropathy (CIDP). The				(for example, speech,		
				requested agent must not be				swallowing, mobility, or		
				used in combination with				respiratory function). The		
				another myasthenia gravis				member has also experienced		
				medication. The member has				a decrease in the number of		
				experienced therapeutic				exacerbations of generalized		
				failure, contradindication or				myasthenia gravis. For CIDP,		
				intolerance to generic				the member has experineced		
				pyridostigmine. For CIDP, the				improvement in their		
				member has experienced				functional ability or strength		
				progressive symptoms for at				from baseline.		
				least two (2) months. The						
				member has progressive or						
				relapsing motor sensory						
				dysfunction of more than one						
				limb or a peripheral nerve						
				nature, developing over at						
				least 2 months. The member						
				has hypo-or areflexia (usually						
				involves all four limbs). The						
				member has nerve conduction						
				studies strongly supportive of						
				demyelination and meets one						
				of the following: motor distal						
				latency prolongation in at						
				least 2 nerves, reduction of						
				motor conduction velocity in						
				at least 2 nerves, prolongation						
ELAPEGADEMASE-LVLR Per	ending CMS review			Diagnosis. Must have a		By or in consultation with an	12 months	For reauth: must have	0	0
(REVCOVI)				diagnosis of adenosine		immunologist		documentation from		
				deaminase severe combined				prescriber indicating		
				immunodeficiency disease				stabilization or improvement		
				(ADA-SCID) confirmed by				in condition.		
				either 1) genetic testing or 2)						
				absent or very low adenosine						
				deaminase activity in red						
				blood cells (less than 1						
				percent of normal) and						
				presence of either						
				deoxyadenosine triphosphate						
				(dATP) or deoxyadenine						
1				nucleotides (dAXP) in red						
1				blood cells. Must have						
				severely impaired immune						
				function (e.g. lymphopenia,						
				extensive dermatitis,						
				persistent diarrhea, recurrent						
				pneumonia, life threatening						
1				illness caused by opportunistic						
				infections.						
ELEXACAFTOR/TEZACAFTOR/I 1 - A				Diagnosis. Documentation of				For reauthorization:	0	0
VACAFTOR (TRIKAFTA) Ind	ndications.				members 2 years of age and	cystic fibrosis specialist or		documentation from		
					older	pulmonologist		prescriber indicating		
				F508del mutation in the CFTR				stabilization or improvement		
				gene or a mutation in the				in condition.		
				CFTR gene that is responsive						
į l		1		based on in vitro data.						

Diagnosis, For TP, documentation of indequate response to conflication of independent	Part B Prerequisite Required 0 1
documentation of inadequate response to contractive distribution of improvement in justicet count from baseline. For hepatologist or improvement in justicet count from baseline. For hepatologist or hepatolo	
response to corticotteroids or immunoglobilities and documentation of a platelet count feat which and a documentation of a platelet count less that or equal to 3,000/microliter, For chronic hepatistic, General feat of the feather o	
immunoglobulins and documentation of patiete count test than or equal to 3,000/microliter, For drovinc hepatilitis C, documentation that thromotopyopinis prevents the initiation of interfaron-based therapy or limits the Heapy, and documentation of a platetet count test than 7,5000/microliter, For severe application and documentation of a platetet count test than 7,5000/microliter, For severe application of interfaron-based therapy and documentation of a platetet count test than 8,0000/microliter, For severe application of the following the member has had an insufficient resonance to the following the member has had an insufficient resonance to the member has had an insufficient remains with immunosuppressive therapy. EPDETIN ALFA-EPIUX A.F. A	
documentation of a platelet count less that on equal to 30,000/microlleter, For chronic hepetitists (C documentation that the make is still on antiviral therapy. In the common of the properties of the country of the initiation of interferon-based therapy or limits the adjust of maintain interferon-based therapy or limits the adjust of maintain interferon-based therapy, and documentation of a platelet country is a platelet country and interferon-based therapy, and documentation of a platelet country is a platelet country in the properties of the following the member has had an insufficient responds to minimal that is a platelet country is a platelet country in the properties of the following the member has had an insufficient responds to minimal that is a platelet country in the properties of the following the member has had an insufficient responds to minimal that is a platelet country in the properties of the following the member of the following the f	
count less than or equal to 3,000/microliter - For cironic hepatitis C, documentation that thromoporyopenia 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, 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. EPOETIN ALFA-EPBIX 3 - All Medically-accepted (Indications. EPOETIN ALFA-EPBIX (B, Tall Medically-accepted Indications.) Indications. Uncontrolled hypertension Diagnosis. For Reduction of Allogenic Red Blood Cell Transfusions in Members (Indications.) Transfusions in Members (Indications.) Octoo not odalysis: nurst have a fligb less than or equal to 10 11g/d. For reauth for CXD on ot on dialysis: 10 must have a fligb less than or equal to 10 light, shows caller, knows caller (Nonacradice, Knows caller). The member is still on antiviral therapy.	
BODO/microliter, For chronic hepatitis, Gocumentation that thrombocytopenia prevents he initiation of interferon-based therapy or limiter feron-based therapy or limiter feron-based therapy or limiter feron-based therapy or limiter feron-based therapy, and documentation of a platelet count less than 7,000/microliter and one of the following the member has had an insufficient response to the following the member has had an insufficient response to the medication in combination with immunosuppressive therapy or the members will be using the medication in combination with immunosuppressive therapy. EPOETIN ALFA-EPBIX [RETACRIT] Uncontrolled hypertension of the following the members will be using the medication in combination with immunosuppressive therapy. EPOETIN ALFA-EPBIX [RETACRIT] Indications. EPOETIN ALFA-EPBIX [RETACRIT] Uncontrolled hypertension of the following the members will be using the medication in combination with immunosuppressive therapy. EPOETIN ALFA-EPBIX [RETACRIT] Granulation of the following the members of the following themselves themselves the following themselves	
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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 35,000/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. EPOETIN ALFA-EPBX 3- All Medically-accepted (RETACRIT) Indications. Diagnosis. For Reduction of Allogenic Red Blood Cell Transfusions in Members Undergoing Elective, Noncardiale, Nonsexular (Noncardiale, Nonvascular Hgb less than or equal to 10)	
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### Special Research	
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. EPOETIN ALFA-EPBX [RETACRIT] 3 - All Medically-accepted Uncontrolled hypertension Diagnosis. For Reduction of Allogeneic Red Blood Cell Transfusions in Members Undergoing Elective, Undergoing Elective, Noncardiac, Nonvascular Hgb less than or equal to 10 Hgb less than	
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EPOETIN ALFA-EPBX (RETACRIT) Indications. Or the members will be using the medication in combination with immunosuppressive therapy. Diagnosis. For Reduction of Allogeneic Red Blood Cell Transfusions in Members Undergoing Elective, Noncardiac, Nonvascular Noncardiac, Nonvascular	1
the medication in combination with immunosuppressive therapy. EPOETIN ALFA-EPBX (RETACRIT) Indications. Uncontrolled hypertension Diagnosis. For Reduction of Allogeneic Red Blood Cell Transfusions in Members Undergoing Elective, Noncardiac, Nonvascular Noncardiac, Nonvascular The medication in combination with immunosuppressive therapy. 6 months For reauth for CKD on dialysis: 0 must have a Hgb less than or equal to 11g/dl. For reauth for CKD on on dialysis: must have Hgb less than or equal to 10	
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EPOETIN ALFA-EPBX (RETACRIT) Immunosuppressive therapy. Uncontrolled hypertension Diagnosis. For Reduction of Allogeneic Red Blood Cell Transfusions in Members Undergoing Elective, Noncardiac, Nonvascular Diagnosis. For Reduction of Allogeneic Red Blood Cell Transfusions in Members Undergoing Elective, Noncardiac, Nonvascular	
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Transfusions in Members Undergoing Elective, Noncardiac, Nonvascular Transfusions in Members Undergoing Elective, Noncardiac, Nonvascular Equal to 11g/dl. For reauth for CKD not on dialysis: must have Hgb less than or equal to 10	10
Undergoing Elective, Noncardiac, Nonvascular CKD not on dialysis: must have Hgb less than or equal to 10	
Noncardiac, Nonvascular Hgb less than or equal to 10	
Surgery: must have g/dl. For reauth for zidovudine	
hemoglobin (Hgb) greater treated members and	
than 10 and less than or equal pediatric members with CKD:	
to 13 g/dL, be at high risk for must have a Hgb less than or	
perioperative blood loss from equal to 12 g/dl. Reauth for all	
surgery, and documentation other dx must meet initial	
that erythropoietin therapy criteria.	
will be used to decrease the	
need for transfusions	
associated with surgery in	
members unwilling or unable	
to undergo autologous blood	1
donation prior to surgery. All	1
other dx must have Hgb level	1
	1
less than 10 g/dL.	1
EDENILIMAD ACCE (AIMOVIC) Bonding CMS review	
ERENUMAB-AOOE (AIMOVIG) Pending CMS review Diagnosis. For episodic Coverage is provided for Initial: 6 months For reauth: Provider 0	l ^v ¹
migraine: Provider attestation members 18 years of age and Reauthorization: 12 months attestation the member is	1
the member has 4 to 14 older having a reduced number of	1
headache days per month. For migraine/headache days per	1
chronic migraine: Provider month or a decrease in	1
attestation the member has at migraine/headache severity. A	1
least 15 headache days per migraine is defined as a	1
month for 3 or more months headache that has at least	1
with at least 8 migraine days two of the following	1
per month. For both: Must characteristics: unilateral	1
have a trial and failure of one location, pulsating/throbbing	1
beta-blocker and one quality, moderate or severe	1
anticonvulsant unless intensity (inhibits or prohibits	1
contraindicated or intolerant.	1
by routine activity, nausea	1
	1
and/or vomiting, photophobia	
and phonophobia.	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ESLICARBAZEPINE (APTIOM)	1 - All FDA-approved			Diagnosis. Must have had an		By or in consultation with a	12 months		0	1
	Indications.			inadequate response or		neurologist				
				intolerance to two generic						
				antiepileptic drugs (e.g.						
				valproate, lamotrigine,						
				topiramate, clobazam).						
ETANERCEPT (ENBREL)	3 - All Medically-accepted			Diagnosis. For rheumatoid	Member must be 2 years of	By or in consultation with a	12 months	For reauth: must have	0	1
	Indications.			arthritis (RA): history of trial	age or older.	rheumatologist or		documentation from		
				and failure, contraindication,		dermatologist.		prescriber indicating		
				or intolerance to a three-				stabilization or improvement		
				month trial with methotrexate	e			in condition.		
				or another DMARD. For						
				juvenile idiopathic arthritis						
				(JIA) with polyarthritis: history	,					
				of trial and failure,						
				contraindication, or						
				intolerance to a 3 month trial						
				with methotrexate,						
				leflunomide, or sulfasalazine.						
				For JIA with oligoarthritis,						
				enthesitis and/or sacroilitis:						
				history of trial and failure,						
				contraindication, or						
				intolerance to at least a 4						
				week trial of 2 different						
				NSAIDS. For ankylosing						
				spondylitis (AS): history of tria	al					
				and failure, contraindication,						
				or intolerance to a four-week						
				trial each of at least 2 NSAIDs.						
				For plaque psoriasis: minimun						
				BSA involvement of at least	''					
				3% (not required if on palms,						
				soles, head/neck, genitalia), a						
				history of trial and failure of						
				ONE of the following: 1)						
				topical therapy (e.g.						
				corticosteroid, calcineurin						
				inhibitor, vitamin D analog), 2)					
				phototherapy, 3) systemic						
ETRASIMOD (VELSIPITY)	1 - All FDA-approved			Diagnosis. For ulcerative	Coverage is provided for	By or in consultation with a	12 months	For reauth: must have	0	1
	Indications.				members 18 years of age and	gastroenterologist		documentation from		
				failure, contraindication, or	older			prescriber indicating		
				intolerance to 2 of the				stabilization or improvement		
				following therapy options:				in condition.		
				aminosalicylates,						
				corticosteroids or						
				immunomodulators with						
				inadequate response or side						
				effects/toxicity unless						
				contraindicated.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
Group EVOLOCUMAB (REPATHA)	Indication Indicator 1 - All FDA-approved Indications.	Off-Label Uses				Prescriber Restriction	Coverage Duration 12 months	Other Criteria Extreme risk: must have one of the following: progressive atherosclerotic cardiovascular disease (ASCVD), including unstable angina, that persists after achieving an LDL-C less than 70 mg/dL, or established clinical cardiovascular disease in individuals with diabetes, stage 3 or 4 chronic kidney disease (CKD), or heterozygous familial hypercholesterolemia (HeFH), or a history of premature ASCVD (less than 55 years of age for males, less than 65 for females) . For reauthorization: Provider attests member had improvement in LDL from baseline.	0	
FECAL MICROBIOTA SPORES, LIVE-BRPK (VOWST)	1 - All FDA-approved Indications.			Documentation of a recent diagnosis of recurrent Clostridioides difficile infection (CDI) -AND- Will be used for prophylaxis and not treatment of recurrent CDI -AND- Attestation that antibiotic treatment for the most recent recurrent CDI is complete or will be completed.			1 month	For reauthorization, attestation of recurrent CDI episodes after administration of the initial fecal microbiota product -AND- Will be used for prophylaxis and not treatment of recurrent CDI -AND- Attestation that antibiotic treatment for the most recent recurrent CDI is complete or will be completed.	0	0
FENFLURAMINE (FINTEPLA)	1 - All FDA-approved Indications.			_	Member must be 2 years of age or older	By or in consultation with a neurologist	12 months	eompicted.	0	1
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 longacting 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.		1
FILGRASTIM-SNDZ (ZARXIO)	3 - All Medically-accepted Indications.			Diagnosis.			6 months	For reauthorization: must have documentation from prescriber indicating stabilization or improvement in condition.	0	0

Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Required Medical Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Prerequisite Therapy Required
Group		Off-Label Uses	Exclusion Criteria		-	Prescriber Restriction	_		Part B Prerequisite	Required
FLUTICASONE PROPIONATE	1 - All FDA-approved			Diagnosis.	Coverage is provided for		12 months	For reauthorization: must	0	0
(XHANCE)	Indications.				members 18 years of age or			have documentation from		
					older.			prescriber indicating		
								stabilization or improvement		
								in condition.		
GALCANEZUMAB-GNLM	Pending CMS review			Diagnosis. For episodic	Coverage is provided for		Initial: 6 months	For reauth: Provider	0	1
(EMGALITY)				migraine: Provider attestation	members 18 years of age and		Reauthorization: 12 months	attestation the member is		
				the member has 4 to 14	older			having a reduced number of		
				headache days per month. For	r			migraine/headache days per		
				chronic migraine: Provider				month or a decrease in		
				attestation the member has a	+			migraine/headache severity. A	A	
				least 15 headache days per				migraine is defined as a		
				month for 3 or more months				headache that has at least		
				with at least 8 migraine days				two of the following		
				per month. For both: Must				characteristics: unilateral		
				have tried and failed one beta	1			location, pulsating/throbbing		
				blocker for at least 2 months				quality, moderate or severe		
				and one anticonvulsant for at				intensity (inhibits or prohibits		
				least 2 months unless				daily activities), is aggravated		
				contraindicated or intolerant.				by routine activity, nausea		
				For cluster headache: Provide				and/or vomiting, photophobia		
				attestation the member has a	t			and phonophobia. A cluster		
				least one cluster attack every				headache is defined as at least	t	
				other day and no more than 8				5 severe to very severe		
				attacks a day. Must have a				unilateral headache attacks		
				trial and failure of either				lasting 15 to 180 minutes		
				verapamil for at least 2 weeks				untreated. Headaches occur		
				or a one-time subocciptal				once every other day to 8		
				steroid injection unless				times a day. The pain is		
				contraindicated or intolerant.				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.		
GANAXOLONE (ZTALMY)	1 - All FDA-approved			Diagnosis. Must have chart	Coverage is provided for	By or in consultation with a	12 months	For reauth: must have	0	0
GANAXOLONE (ZTALIVIT)	Indications.			documentation of a diagnosis		neurologist	12 months	documentation from	o .	Ü
	illuications.					neurologist				
				of CDKL5 deficiency disorder,				prescriber indicating		
				including documentation of a				improvement in condition or		
				CDKL5 gene mutation. Must				the member continues to		
				provide documentation of				beneift from therapy as		
				baseline seizure frequency.				evidenced by chart		
								documentation of		
				1				improvement in seizure		
				1				frequency from baseline.		
GLECAPREVIR-PIBRENTASVIR	1 - All FDA-approved		Members with moderate or	Criteria will be applied	Coverage is provided for	By or in consultation with a	Criteria will be applied		0	0
(MAVYRET)	Indications.		severe hepatic impairment	consistent with current	members who are age-	gastroenterologist,	consistent with current			
ľ '			(Child-Pugh C).	AASLD/IDSA guidance and/or	_	hepatologist, infectious	AASLD/IDSA guidance and/or			
			Coadministration with	FDA approved labeling		disease, HIV or transplant	FDA approved labeling			
			atazanavir and rifampin.	. 27. approved idociiilg	FDA-approved labeling.	specialist.				
GLP-1 RECEPTOR AGONISTS	1 - All FDA-approved	1	atazanavn ana mampin.	Diagnosis of Type 2 diabetes	. S. Capproved labelling.	apecianot.	12 months		0	lo
GLI I RECEFIOR AGONISTS	Indications.			or documented prior therapy			12 111011(113			ľ
	mulcations.			•				1		1
				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				1		1
				submitted at the point of sale				1		1
				OR 2. a pharmacy claims				1		1
				•				1		1
				history of a Type 2 diabetes						
				medication within the past						
				130 days.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
GLYCEROL PHENYLBUTYRATE	1 - All FDA-approved			Diagnosis. Documentation		By or in consultation with a	12 months	For reauthorization: must	0	1
(RAVICTI)	Indications.			member has urea cycle		physician who specializes in		have documentation from		
				disorders (UCDs). Must have a	1	the treatment of inherited		prescriber indicating		
				trial of sodium phenylbutyrate		metabolic disorders.		stabilization or improvement		
				with inadequate response or				in condition.		
				significant side effects/toxicity	/					
				unless contraindicated.						
GUSELKUMAB (TREMFYA)	Pending CMS review			Diagnosis. For plaque psoriasis	•	By or in consultation with a	12 months	For reauth: must have	0	1
				(PsO): minimum BSA	members 18 years of age and	_		documentation from		
				involvement of at least 3%	older	dermatologist, or		prescriber indicating		
				(not required if on palms,		gastroenterologist.		stabilization or improvement		
				soles, head/neck, genitalia), a				in condition.		
				history of trial and failure of						
				ONE of the following: 1)						
				topical therapy (e.g.						
				corticosteroid, calcineurin						
				inhibitor, vitamin D analog), 2)					
				phototherapy, 3) systemic						
				treatment (e.g. methotrexate,	,					
				cyclosporine, oral retinoids).						
				For Crohns (CD): history of						
				trial and failure,						
				contraindication, or						
				intolerance to one of the						
				following therapy options:						
				aminosalicylates,						
				corticosteroids, or						
				immunomodulators (e.g.,						
				azathioprine, 6-						
				mercaptopurine) with						
				inadequate response or side						
				effects/toxicity unless						
				contraindicated. For						
				Ulcerative Colitis (UC): history						
				of trial and failure,						
				contraindication, or						
				intolerance to one of the						
				following therapy options:						
				aminosalicylates,						
				corticosteroids or						
				immunomodulator (e.g.,						

		0111111		Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
ICATIBANT ACETATE	Pending CMS review			Diagnosis of HAE is confirmed		By or in consultation with an	12 months	For reauthorization:	0	0
				by laboratory values obtained		allergist, immunologist,		documentation from		
				on two separate instances	older.	hematologist, or		prescriber indicating		
1				(laboratory reports must		dermatologist		stabilization or improvement		
1				contain reference ranges). For				in condition.		
1				Type I HAE: Low C4 level and						
1				low C1-INH antigenic level. For						
1				Type II HAE: Low C4 level and						
1				Normal or elevated C1-INH						
1				antigenic level and low C1-INH	1					
1				functional level. There is a						
1				documented history of at						
1				least one symptom of a						
1				moderate to severe HAE						
1				attack (i.e. moderate to						
1				severe abdominal pain, facial						
1				swelling, airway swelling) in						
1				the absence of hives or a						
1				medication known to cause						
1				angioedema. Member must						
1				not be taking any medications						
1				that may exacerbate HAE,						
1				including angiotensin-						
1										
1				converting enzyme (ACE) inhibitors, tamoxifen, or						
1										
1				estrogen-containing						
1				medications.						
ILOPERIDONE (FANAPT)	1 - All FDA-approved			Diagnosis. Documentation of	Coverage is provided for		12 months		0	1
1201 211120112 (1711111111)	Indications.			trial and failure of at least two			12 1110110113			
1	indications.			of the following generic	older.					
1					older.					
1				atypical antipsychotics:						
1				olanzapine, quetiapine,						
1				paliperidone, risperidone,						
1				aripiprazole, ziprasidone,						
				asenapine, or lurasidone.						
INCOBOTULINUMTOXINA	1 - All FDA-approved			Diagnosis.			12 months	For reauthorization:	0	0
(XEOMIN)	Indications.							documentation from		
1								prescriber indicating		
1								stabilization or improvement		
								in condition.		
INCRETIN MIMETIC	Pending CMS review			This prior authorization			12 months	Reauthorization: Provider	0	0
DUPLICATE THERAPY				requirement applies to				attestation the member		
1				members on a DPP-4 inhibitor	•			continues to benefit from the		
1				and a GLP-1 receptor agonist.				combination of medications		
1				Diagnosis. Provider must				and this outweighs any		
1				acknowledge that the benefit				potential risks.		
1				of the combination of the						
1				medications outweighs the						
1				potential risks.						
1				Documentation of both of the						
1				following: 1. the member has						
1				tried and failed therapy with a						
1				GLP-1 receptor agonist	'[
1										
1				without concurrent use of a						
1				DPP-4 inhibitor. 2. clinical						
				rationale for concurrent use o	Ť					
-	I		1	a DPP-4 inhibitor and GLP-1					1	
1										
				receptor agonist.						

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

				Required Medical					Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	-	Prescriber Restriction	 Other Criteria	Part B Prerequisite	Required
IPTACOPAN (FABHALTA)	1 - All FDA-approved		•	Diagnosis. For paroxysmal		For PNH: by or in consultation	For reauth (PNH): must have	0	1
	Indications.		unresolved serious infection	nocturnal hemoglobinuria	members 18 years of age and	_	documentation from		
			caused by encapsulated	(PNH): confirmed diagnosis of		oncologist, immunologist, or	prescriber indicating		
				PNH by flow cytometry		genetic specialist. For IgAN: by	improvement in condition, if		
				testing. Flow Cytometry pathology report must be		or in consultation with a nephrologist.	member required blood transfusions at baseline must		
				supplied and demonstrate at		nephrologist.	have a decreased requirement		
				least 2 different GPI protein			or no longer require blood		
				deficiencies within 2 different			transfusions.		
				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	1				
				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. For					
				immunoglobulin A					
				nephropathy (IgAN): must					
				have diagnosis confirmed by					
				biopsy, must be at risk of					
				rapid disease progression					
				[e.g., proteinuria greater than					
				0.75 g/day or Urinary Protein-					
				to-Creatinine Ratio (UPCR)					
				greater than or equal to 1.5					
				g/g],must have attestation					
IVABRADINE (CORLANOR)	1 - All FDA-approved		· ·	Diagnosis. For Adult Chronic	CHF: coverage is provided for	· ·	For reauthorization:	0	1
	Indications.		failure, blood pressure less than 90/50 mmHG, sick sinus	Heart Failure (CHF): Must		cardiologist	documentation from prescriber indicating		
			syndrome, sinoatrial block, or		older. DCM: coverage is provided for members 6		stabilization or improvement		
				equal to 35%, member is in	months of age or older.		in condition.		
				sinus rhythm and has a resting	_		in condition.		
			pacemaker is present, resting						
				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					
			pacemaker), concomitant use						
			_	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					
Ī			1	70 for 5-18 years of age).	I				

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
IVACAFTOR (KALYDECO)	1 - All FDA-approved			Diagnosis. Documentation of		By or in consultation with a	12 months	For reauthorization:	0	0
	Indications.			genetic test confirming the		pulmonologist or cystic		documentation from		
				member has at least one		fibrosis specialist		prescriber indicating		
				mutation in the CFTR gene				stabilization or improvement		
				that is responsive to ivacaftor				in condition.		
				based on clinical and/or in						
				vitro assay data.						
L-GLUTAMINE (ENDARI)	Pending CMS review			Diagnosis. Must be used to	Coverage is provided for	By or in consultation with a	12 months	For reauthorization:	0	1
				reduce the acute	-	physician who specializes in		Documentation there has		
				complications of sickle cell	older	SCD (e.g. a hematologist)		been a reduction in vaso-		
				disease (SCD) and the				occlusive painful events or an		
				member must have				improvement in condition.		
				experienced at least 2 painful						
				episodes of sickle cell crises						
				(SCC) in the previous 12						
				months. Member has had an						
				adequate trial of at least 90						
				days of oral hydroxyurea						
				unless the member has tried						
				and failed or has a						
				contraindication to						
				hydroxyurea. Must not be						
				used in combination with						
				Oxbryta (voxelotor) or						
				Adakveo (crizanlizumab-						
	1			tmca).				<u> </u>		
LANREOTIDE (SOMATULINE	1 - All FDA-approved			Diagnosis. For acromegaly:	Coverage is provided for	By or in consultation with an	For oncology indications: 6	For reauth: documentation of	0	0
DEPOT)	Indications.			must have inadequate	members 18 years of age and	endocrinologist or oncologist	months. All other indications:	improvement or stabilization.		
				response to surgery or	older.		12 months			
				radiotherapy or						
				documentation that these						
				therapies are inappropriate,						
				must have the following						
				baseline labs: elevated serum						
				IGF-1 level for gender/age						
				range (including lab reference						
				range) and elevated growth						
				hormone level defined as GH						
				at least 1ng/mL during oral						
				glucose tolerance test.						
LEMIQUICID (IOENIA)	1 All EDA commerced	-		Diamagia of activated	Coverno is musuided for	D	12 months		0	1
LENIOLISIB (JOENJA)	1 - All FDA-approved			Diagnosis of activated phosphoinositide 3-kinase	Coverage is provided for	By or in consultation with a	12 months		0	1
	Indications.			1	members 12 years of age or	hematologist, immunologist,				
				delta syndrome (APDS). Must have genetic testing	oluer.	or geneticist.				
				confirming the PI3K delta						
				mutation with a documented						
				variant in either PIK3CD or						
				PIK3R1. Documentation of						
				inadequate response to						
				immunoglobulins.						
LETERMOVIR (PREVYMIS)	1 - All FDA-approved		Use with pimozide or ergot	Diagnosis. Must have received		By or in consultation with a	200 days post-transplant	For reauth: no reauthorization	0	0
(i NEV IIVII)	Indications.		alkaloids. Use with	either an allogeneic		hematologist, infectious		after initial coverage period.	· *	Ĭ
	dications.		pitavastatin and simvastatin	hematopoietic stem cell		disease or transplant		a.ser misiai coverage periou.		
			when co-administered with	transplant (HSCT) and have		specialist.				
			cyclosporine.	tested CMV-seropositive						
			-, 5.55,5	(Recipient positive, R+) or						
				received a kidney transplant						
				and be at high risk (donor						
				CMV seropositive						
				D+/recipient CMV						
				seronegative R-). Must be						
				used for prophylaxis of CMV						
				infection.						
		-1		Innection.	1	!	1	į.	1	1

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria		Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
LEUPROLIDE ACETATE	Pending CMS review				CPP: only approved up to age		Prostate cancer and	For reauth: documentation	0	1
				•	11 years in females and age 12 years in males		endometriosis: 6 months. Fibroids: 3 months. CPP: 12	indicating stabilization or improvement in condition. For		
				contraindication to 2	12 years in males		months	endometriosis, a single		
				conventional treatments such			months	retreatment course of not		
				as oral contraceptives, non				more than six months may be		
				steroidal anti-inflammatory				administered after the initial		
				agents, progestins, or danazol				course of treatment if		
				For CPP: Documentation that				symptoms recur		
				the age of onset of secondary						
				sexual characteristics						
				occurred at less than 8 years						
				of age in a female child or less						
				than 9 years of age in a male child.						
				cilia.						
LEVACETYLLEUCINE	1 - All FDA-approved			Diagnosis. Documentation the			12 months	Reauthorization:	0	0
(AQNEURSA)	Indications.			diagnosis was confirmed by				Documentation the member		
•				genetic testing demonstrating				is experiencing an		
				one of the following: 1. a				improvement or stabilization		
				mutation in both alleles of				in disease.		
				NPC1 or NPC2 OR 2. mutation						
				in one allele and either a						
				positive filipin-staining or						
				elevated cholestance						
				triol/oxysterols (greater than						
				2x ULN). Documentation the member has at least one						
				neurological symptom of NPC						
				(e.g. decrease in motor skills,						
				ataxia, seizures, etc.). Must						
				not be used in combination						
				with Miplyffa.						
LEVETIRACETAM (SPRITAM)	Pending CMS review			Diagnosis. Must have had an		By or in consultation with a	12 months		0	1
					members 4 years of age and	neurologist.				
				_	older weighing more than					
				levetiracetam and at least one of the following generic	ZUKg.					
				anticonvulsant drugs:						
				phenytoin, carbamazepine,						
				oxcarbazepine, gabapentin,						
				lamotrigine, valproate, or						
				topiramate.						
LEVOMILNACIPRAN (FETZIMA)) 1 - All FDA-approved			Diagnosis. Documentation of	Coverage is provided for		12 months		0	1
	Indications.			trial and failure of at least two	members 18 years of age and					
				1 -	older.					
				alternatives such as an SSRI,						
				SNRI, bupropion, trazodone or						
		1	1	mirtazapine			1.0			
LIDOCAINE PATCH	3 - All Medically-accepted			Diagnosis. This Prior			12 months		0	0
	Indications.			Authorization requirement						
				only applies to members when a non-FDA approved						
				diagnosis is submitted at the						
				point of sale. FDA-approved						
				diagnosis codes submitted will						
				pay without prior						
				authorization requirement.						
OTILANER (XDEMVY)	1 - All FDA-approved			Diagnosis of Demodex	Member must be 18 years of	Prescribed by or in	6 weeks		0	0
	Indications.			blepharitis confirmed by both	-	consultation with an				
				of the following: 1. Member		optometrist or				
				has at least mild erythema or		ophthalmologist				
				itching of the upper eyelid						
				margin. 2. Mite presence (e.g.						
				collarettes) confirmed by slit						
	1		1	lamp examination of the	1	1				
				eyelashes.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
LUMACAFTOR/IVACAFTOR	1 - All FDA-approved			Diagnosis. Documentation of	a	By or in consultation with a	12 months	For reauthorization:	0	0
(ORKAMBI)	Indications.			genetic test confirming that		pulmonologist or cystic		documentation from		
				the member is homozygous		fibrosis specialist		prescriber indicating		
				for the F508del mutation in				stabilization or improvement		
				the CFTR gene (has two copie	s			in condition.		
				of the F508del mutation in the	e					
				CFTR gene).						
LUMATEPERONE (CAPLYTA)	1 - All FDA-approved			Diagnosis. Documentation of	Members 18 years of age or		12 months		0	1
	Indications.			trial and failure of at least two	older.					
				of the following generic						
				atypical antipsychotics:						
				olanzapine, quetiapine,						
				paliperidone, risperidone,						
				aripiprazole, ziprasidone,						
				asenapine, or lurasidone.						
MACITENTAN (OPSUMIT)	Pending CMS review		Pregnancy	Diagnosis. Pulmonary arterial		Prescribed by or in	Initial: 3 months Reauth: 12	For reauth: documentation	0	0
, , ,			,	hypertension (PAH) WHO		consultation with cardiologist		from prescriber that		
				Group I confirmed by chart		or pulmonologist.		demonstrates member is		
				documentation of right-heart				tolerating and receiving		
				catheterization (RHC)				clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than						
				20 mmHg, pulmonary vascula						
				resistance greater than 2	`					
				wood units, and mean						
				pulmonary capillary wedge						
				pressure less than or equal to						
				15 mmHg. If provider						
				indicates RHC is not						
				recommended, must have						
				documentation of						
				echocardiography.						
MARALIXIBAT (LIVMARLI)	1 - All FDA-approved		PFIC type 2 patients with	Diagnosis of pruritis caused by	,	By or in consultation with a	12 months	For reauth: documentation of	F O	1
WARALINBAT (LIVIVIARLI)	Indications.		specific ABCB11 variants	progressive familial	⁷	hepatologist or	12 months	improvement in pruritis.		
	maications.		• •	intrahepatic cholestatis (PFIC)		gastroenterologist.		Improvement in prantis.		
				or Allagile syndrome (ALGS)	'	gasti deriter diogist.				
				which has been confirmed by						
			export pump (BSEF) protein.	genetic testing.						
				Documentation of trial and						
				failure of ursodiol and anothe	_					
				medication for cholestatic						
				pruritis (e.g. cholestyramine,						
MADIDAVID (LIVITENCITY)	1 All EDA approved			rifampin).		Dy or in consultation with a	2 months	For reauthorization:	10	1
MARIBAVIR (LIVTENCITY)	1 - All FDA-approved			Diagnosis of post-transplant		By or in consultation with a	3 months		٥	1
	Indications.			(solid organ or hematopoietic		hematologist, oncologist,		documentation from		
				stem cell) cytomegaloviris		infectious disease physician,		prescriber indicating		
				(CMV) infection/disease that		or transplant specialist.		stabilization or improvement		
				is refractory to treatment with	m			in condition.		
				ganciclovir, valganciclovir,						
				cidofovir, or foscarnet. Must						
				weight at least 35 kg. Must						
				not be used concomitantly						
				with ganciclovir or						
				valganciclovir.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
MAVORIXAFOR (XOLREMDI)	1 - All FDA-approved Indications.			diagnosis 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/mL or absolute lymphocyte count (ALC) less than or equal to 650 cells/mL. Documentation of symptoms and complications associated with WHIM syndrome (e.g. warts, hypogammaglobulinemia, recurrent infections, 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.		suspected neoplasia, closed epiphyses.	myelokathexis) Diagnosis. Growth chart and documentation that epiphyse are open. For growth hormone deletion: must have growth hormone (GH) gene deletion in gene GH1 and developed neutralizing antibodies to GH therapy. For growth failure due to severe IGF-1 deficiency: must have do f severe IGF-1 deficiency (defined as having all of the following: height below or equal to 3.0 standard deviation (SD) of the mean for age and sex, basal IGF-1 SD of less than or equal to 3.0 based on lab reference range, normal or elevated GH defined as stimulated serum GH level of greater than 10ng/mL or basal serum GH level greater than 5ng/mL).	older.	By or in consultation with an Endocrinologist	12 months	For reauth, must include a recent progress note from prescriber indicating growth and maturation as a result of treatment and that epiphyses have not closed.	0	0
METHYLNALTREXONE (RELISTOR)	1 - All FDA-approved Indications.		gastrointestinal obstruction and members at an increased risk of recurrent obstruction.		e members 18 years of age and older.		12 months	For reauth: documentation from the prescriber indicating an improvement in condition (both diagnoses) and must continue to be on opioid therapy (non-cancer pain).	0	1

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

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
	Pending CMS review			Diagnosis. For multiple		By or in consultation with a	12 months	For reauthorization: must	0	1
THERAPIES				sclerosis (MS), must have		neurologist or		have documentation from		
'				relapsing Multiple Sclerosis		gastroenterologist		prescriber indicating		
'				(including clinically isolated				stabilization or improvement		
'				syndrome, relapsing-remitting				in condition.		
'				disease, and active secondary						
'				progressive disease) and						
'				functional status must be						
'				preserved and patient is						
'				either still able to walk at least	t					
'				a few steps or alternatively						
'				must have some functional						
'				arm/hand use consistent with						
'				performing activities of daily						
'				living. For ulcerative colitis						
'				(UC): must have history of tria	1					
'				and failure, contraindication						
'				or intolerance to an						
'				immunomodulator (i.e.,						
'				Azathioprine, 6-						
'				Mercaptopurine,						
'				Methotrexate).						
NETARSUDIL (RHOPRESSA)	1 All EDA amanayad	 		Diagnosis. Member must have	Coverage is reversible differen		12 months	For reauthorization: must	0	4
· · · · · · · · · · · · · · · · · · ·	1 - All FDA-approved			a baseline intraocular			12 months		ľ	1
'	Indications.			pressure of less than 30	members 18 years of age and older.			have documentation from prescriber indicating		
'				I.				stabilization or improvement		
'				mmHg. Documentation of tria and failure, contraindication,	1			in condition.		
'				or intolerance to timolol and				in condition.		
'										
'				latanoprost.						
NINTEDANIB (OFEV)	Pending CMS review	 		Diagnosis. For a diagnosis of	Coverage provided for	By or in consultation with a	Initial: 6 months, Reauth: 12	For reauth: must have	0	0
WINTEDANIB (OF EV)	Tending civis review			Idiopathic Pulmonary Fibrosis	= :	pulmonologist	months	documentation from	o de la companya de l	o .
'				(IPF): Must have diagnosis	older.	paintonologist	months	prescriber indicating that		
'				confirmed by either high-	older.			member still is a candidate for		
'				resolution computed				treatment.		
'				tomography (HRCT) or surgica	1			in each neme.		
'				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	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						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
NITISINONE (ORFADIN)	1 - All FDA-approved			Diagnosis of hereditary		By or in consultation with a	12 months	For reauth: Documentation	0	0
	Indications.			tyrosinemia type 1 (HT-1)		gastroenterologist, a		from the prescriber indicating		
				confirmed by newborn		hematologist, a nephrologist,		improvement or stabilization		
				screening for HT-1 with		or a physician who specializes		in the member's condition		
				positive succinylacetone test,		in the treatment of inherited				
				genetic DNA testing showing		metabolic disorders.				
				fumarylacetoacetate						
				hydrolase (FAH) gene						
				mutation or elevated blood or	r 					
				urine succinylacetone or						
				succinylacetoacetate (SA)						
				level. Test results with						
				reference range if applicable						
				is required.						
NITROGLYCERIN 0.4%	1 - All FDA-approved		Severe anemia (defined as	Diagnosis. Must provide	Coverage is provided for		Initial: 2 months	For reauthorization:	0	0
OINTMENT (RECTIV)	Indications.			documentation that chronic	members 18 years of age or		Reauthorization: 12 months	documentation from		
1				anal fissure symptoms have	older.			prescriber indicating		
			pressure. Concomitant use of	persisted for at least 6 weeks.				stabilization or improvement		
			a phosphodiesterase type 5					in condition.		
			(PDE5) inhibitor such as							
			sildenafil (Revatio, Viagra),							
			tadalafil (Adcirca, Cialis), or							
			vardenafil (Levitra, Staxyn).							
ODEVIXIBAT (BYLVAY)	1 - All FDA-approved			Diagnosis of pruritis caused by	/	By or in consultation with a	12 months	For reauth: documentation of	0	1
	Indications.		'	progressive familial		hepatologist or		improvement in pruritis.		
			resulting in non-functional or	The state of the s		gastroenterologist.				
				or Allagile syndrome (ALGS)						
			export pump (BSEP) protein.	which has been confirmed by						
				genetic testing.						
				Documentation of trial and						
				failure of ursodiol and anothe	r					
				medication for cholestatic						
				pruritis (e.g. cholestyramine,						
				rifampin).						
OLANZAPINE/SAMIDORPHAN	1 - All FDA-approved			Diagnosis. Documentation of	Coverage is provided for		12 months		0	1
(LYBALVI)	Indications.			trial and failure of at least two						
				of the following generic	older.					
				atypical antipsychotics:						
				olanzapine, quetiapine,						
				paliperidone, risperidone,						
				aripiprazole, ziprasidone,						
				asenapine, or lurasidone. If						
				the member is 65 and older						
				and not in hospice care and						
				taking this medication at the						
				same time as another						
				anticholinergic medication,						
				must provide documentation						
				of the following: 1. Provider						
				must acknowledge that the						
				benefit or the combination of						
				medication outweighs the						
				potential risks, 2. The membe	r					
				has tried and failed						
				monotherapy, 3. Clinical						
				rationale for use of 2 or more						
				anticholinergic medications.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
OLEZARSEN (TRYNGOLZA)	1 - All FDA-approved			Diagnosis. Confirmation of the	e Coverage is provided for	By on in consultation with a	12 months	For reauthorization:	0	0
	Indications.			diagnosis by at least one of	members 18 years of age and			documentation indicating		
				the following: 1. a genetic tes	t older	cardiologist, or		stabilization or improvement		
				2. a North American Familial		endocrinologist		in condition.		
				Chylomicronemia Syndrome						
				(NAFCS) score of greater than	1					
				or equal to 60. 3. fasting						
				triglycerides greater than 10						
				mmol/I or 880mg/dI and						
				symptoms of the disease (e.g	.					
				acute pancreatitis,						
1				hepatosplenomegaly,						
				abdominal pain, lipemia						
				retinalis)						
							1.2			
OMALIZUMAB (XOLAIR)	Pending CMS review			Diagnosis. For moderate to		By or in consultation with, for	12 months	For reauthorization:	0	
1				severe allergic asthma: recen	^t	Urticaria: allergist,	1	documentation from		
				total serum IgE level of		dermatologist, immunologist.	1	prescriber indicating		
				greater than 30 IU/ml and the	²	Asthma: pulmonologist or	1	stabilization or improvement		
				pre-treatment IgE levels do		allergist. Nasal Polyps:		in condition.		
				not exceed manufacturers		allergist, ear/nose/throat				
				dosing recommendations.		specialist, or immunologist.				
				Documentation of recent use		Allergy: allergist or				
				and failure to respond to		immunologist.				
				inhaled steroid in combo with	1					
				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 weigh	.					
				and IgE level. For chronic	`I		1			
				spontaneous urticaria (CSU):			1			
				must have chart			1			
				documentation showing			1			
				history of urticaria w/						
				presence of hives, must have			1			
				trial of one 2nd generation H						
OMAVELOXOLONE	Pending CMS review			Diagnosis of Friedreich's	Coverage is provided for	By or in consultation with a	12 months		0	0
(SKYCLARYS)	I CHAINS CIVIS TEVIEW			ataxia that has been	members 16 years of age or	neurologist.	12 111011(113		ľ	ľ
(SKICLAKIS)				confirmed by genetic testing.		incurologist.	1			
				Must have a modified	oluci.		1			
				Friedreich's Ataxia Rating			1			
				Scale (mFARS) score between	.1		1			
				20 and 80. Must have a left	1		1			
				ventricular ejection fraction of	of .		1			
				at least 40%.			1			
OMNIPOD POD	1 - All FDA-approved			Must have documentation of			12 months		10	1
OWNINITOD POD	Indications.			previous insulin use.			112 IIIOIIUIS		٦	*
	mulcations.			Threstons manificuse.	L	1	L			

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria		Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
·	1 - All FDA-approved			Diagnosis. For migraine	0		12 months	For reauth: documentation	0	1
(BOTOX)	Indications.			prophylaxis: must have		appropriate specialist (i.e		from prescriber indicating		
				adequate trial of two migraine	,	dermatologist, neurologist,		stabilization or improvement		
				prophylactic agents each from		urologist).		in condition.		
				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.						
ONCOLOGY MEDICATIONS	3 - All Medically-accepted			Diagnosis. For Bosulif, Iclusig,		1 .	6 months	Reauth: documentation that	0	1
	Indications.			and Tasigna for CML: must		oncologist, hematologist,		disease progression has not		
				have had an inadequate		neurologist, transplant		occurred.		
				response or intolerance to		specialist, allergist, or				
				imatinib or dasatinib. For		immunologist.				
				Brukinsa and Jaypirca for						
				CLL/SLL: must have had an						
				inadequate response or intolerance to Calquence or						
				Imbruvica.						
ORAL BENZODIAZEPINES	3 - All Medically-accepted			Prior authorization is only			12 months	Reauth: For ongoing opioid	0	1
OTO LE BETTE OBDITE ET TITLES	Indications.			required for requests greater				and benzodiazepine therapy:		
				than a 14 day supply in a 30				Documentation to taper the		
				day period and for members				benzodiazepine or opioid. If a		
				not in hospice care. Diagnosis.				taper is not appropriate at this	;	
				For seizure disorder:				time, documentation of when		
				documentation the member				the taper will be reevaluated.		
				has tried and failed or had an				For all other ongoing therapy:		
				intolerance or				documentation the member		
				contraindication to at least				has been treated with the		
				one non-benzodiazepine				requested agent within the		
				anticonvulsant. For sleep disorder: documentation the				past 90 days		
				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-traumation						
				stress disorder, etc.):						
				documentation of one of the						
				following: 1. the member tried	1					
				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:						
PALOVAROTENE (SOHONOS)	1 - All FDA-approved				Members assigned female at	Prescribed by or in	12 months		0	0
	Indications.			presence of ACVR1 mutation.	_	consultation with an				
						orthopedist or				
					male at birth must be 10 years	rheumatologist.				
					and older.					

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
PASIREOTIDE (SIGNIFOR) PEGFILGRASTIM-BMEZ	1 - All FDA-approved Indications. 3 - All Medically-accepted			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	By or in consultation with an Endocrinologist	12 months 6 months	For reauth: documentation of improvement or stabilization. For reauth: documentation	· ·	0
(ZIEXTENZO)	Indications.							from prescriber that demonstrates member is tolerating and receiving clinical benefit from treatment		
PEGVISOMANT (SOMAVERT)	1 - All FDA-approved Indications.			Diagnosis of acromegaly. Mus 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.	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	1

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
PIMAVANSERIN (NUPLAZID)	1 - All FDA-approved			_	Coverage is provided for	By or in consultation with a	12 months		0	0
	Indications.				members 18 years of age or	neurologist or psychiatrist				
				hallucinations and delusions associated with Parkinson's	older.					
				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.						
PIRFENIDONE (ESBRIET)	1 - All FDA-approved					Pulmonologist	· ·	For reauth: must have	0	0
	Indications.				members age 18 years and older.		months	documentation from prescriber indicating that		
				confirmed by either high-	older.			member still is a candidate for		
				resolution computed				treatment.		
				tomography (HRCT) or surgical						
				lung biopsy. Must have all						
				other diagnoses ruled out						
				(e.g., domestic and						
				occupational environmental						
				exposures, connective tissue						
				disease, and drug toxicity). Must have forced vital						
				capacity (FVC) greater than or						
				equal to 50% and a percent						
				predicted diffusing capacity of						
				the lungs for carbon						
				monoxide (DLCO) greater than						
	<u> </u>	 	ļ	or equal to 30%		ļ	<u> </u>			
POLYPHARMACY - MULTIPLE	Pending CMS review				Prior authorization only		12 months	Reauthorization:	0	0
ACH MEDICATIONS					applies to enrollees aged 65			Documentation of one of the		
				members on 2 or more unique anticholinergic medications.	or older not in nospice care.			following: 1. attempt to taper of one of the medications OR		
				Diagnosis. Provider must				2. documentation of why		
				acknowledge that the benefit				tapering one of the		
				of the combination of the				medications is not		
				medications outweighs the				appropriate at this time.		
				potential risks.				Provider attestation the		
				Documentation of both of the				member continues to benefit		
				following: 1. the member has				from the combination of		
				tried and failed monotherapy.				medications and this		
				2. clinical rationale for use of 2 or more anticholinergic				outweighs any potential risks.		
				medications.						
				inculcutions.						
	•	•	•			•	•	•		

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses		Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
POSACONAZOLE (NOXAFIL)	1 - All FDA-approved		Coadministration with	Diagnosis. For oropharyngeal			12 months		0	1
	Indications.		sirolimus, ergot alkaloids (e.g.,	candidiasis, must have at least						
			ergotamine,	a 2 week trial of fluconazole						
			dihydroergotamine), HMG-	with an insufficient response,						
				intolerable side effect, or have	,					
			are primarily metabolized	a contraindication.						
			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.							
PRAMLINTIDE (SYMLIN)	1 - All FDA-approved			Diagnosis of Type 1 or Type 2			12 months	For reauth: if the patient has	0	1
,	Indications.			Diabetes Mellitus.				been receiving Symlin for at		
				Documentation the member				least 3 months, patient		
				uses mealtime insulin and has				demonstrated a reduction in		
				failed to achieve desired				HbA1c since starting therapy		
				glycemic control despite				with Symlin.		
				optimal insulin therapy. Initial				The symmetry		
				A1C greater than or equal to						
				6.5.						
PREGABALIN (LYRICA)	1 - All FDA-approved			Diagnosis. For fibromyalgia:	For partial onset seizures,		12 months		0	1
, ,	Indications.			must have trial and failure or	coverage is provided for					
				contraindication to	members 1 month of age and					
				gabapentin at a dose of at	older. For fibromyalgia, PHN,					
				least 1200mg/day or	DPN, and neuropathic pain					
				maximally tolerated dose in	associated with spinal cord					
				intolerant patients AND either						
				duloxetine or muscle relaxant						
				unless contraindicated. For	or older.					
				PHN: must have trial and						
				failure, intolerance, or						
				contraindication to						
				gabapentin. For DPN: must						
				have documented pharmacy						
				claim history or prior therapy						
				with a diabetic medication OR						
				a medical/lab claim or						
				physician chart note of						
				diabetes diagnosis and must						
				have trial and failure,						
				intolerance, or						
				contraindication to						
				gabapentin.						
				Basapentin.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
PURIFIED CORTROPHIN GEL	1 - All FDA-approved		Members with scleroderma,	Diagnosis. For acute		Must be prescribed by or in	1 month	For allergic states such as	1	1
(CORTICOTROPIN) INJECTION	Indications.		osteoporosis, systemic fungal	exacerbation of multiple		consultation with a		serum sickness or transfusion		
			infections, ocular herpes	sclerosis, member must have		neurologist or physician that		reaction due to serum protein		
				tried and failed or have a		specializes in the treatment of	1	reaction, member must have		
			history of or the presence of a	contraindication to 2		multiple sclerosis, a		tried and failed 2		
			peptic ulcer, congestive heart	corticosteroids (e.g. IV		rheumatologist, allergist,		corticosteroids (e.g. IV		
			failure, hypertension, or	methylprednisolone, IV		dermatologist, immunologist,		methylprednisolone, IV		
			•	dexamethasone, or high dose		ophthalmologist,		dexamethasone, or high dose		
			from porcine sources, primary			pulmonologist, nephrologist		oral steroids) or has a		
			adrenocortical insufficiency or	documentation or claims				contraindication to		
			**	verifying the member is on a				corticosteroid therapy. If the		
			are excluded.	medication for the treatment				member has a diagnosis of		
				of multiple sclerosis. For RA				atopic dermatitis, the		
				(incl. Juvenile RA), psoriatic				member is concurrently		
				arthritis, ankylosing				receiving maintenance		
				spondylitis, acute gouty				therapy with one (1) of the		
				arthritis: must be using as				following, or is		
				adjunctive therapy for short-				contraindicated to all: topical		
				term administration (to tide				corticosteroid, topical		
				over an acute episode or				calcineurin inhibitor (e.g.,		
				exacerbation) and have a trial				tacrolimus, pimecrolimus),		
				of 2 IV steroids w/ inadeq				topical PDE-4 inhibitor or		
				response or signif side				Dupixent (dupilumab). For a		
				effects/toxicity. The member				diagnosis of serum sickness,		
				is concurrently receiving				must provide laboratory		
				maintenance therapy with at				documentation		
				least one of the following: an NSAID, DMARD (e.g.				demonstrating neutropenia,		
				methotrexate, leflunomide,				development of reactive		
				sulfasalazine) or biologic (e.g.				plasmacytoid lymphocytes, and elevated erythrocyte		
				adalimumab, etanercept,				sedimentation rate or C-		
				infliximab, tofacitinib). For				reactive protein. For		
				collagen disease, member				ophthalmic diseases such as		
				must have tried and failed or				severe acute and chronic		
RESMETIROM (REZDIFFRA)	1 - All FDA-approved		Members with	Diagnosis. Medication will be	Coverage is provided for	By or in consultation with a	12 months	For reauth: must have chart	0	0
	Indications.		decompensated cirrhosis	used for the treatment of	members 18 years of age and			doc of ALL the following: the		
			-	adults with noncirrhotic		gastroenterologist		member has experienced		
				nonalcoholic steatohepatitis				improvement or stabilization		
				(NASH) with moderate to				of fibrosis as demonstrated by		
				advanced liver fibrosis (stage				non-invasive testing (NIT), no		
				F2 to F3 fibrosis) which has				evidence of cirrhosis (stage F4		
				been confirmed by one of the				fibrosis) by imaging or liver		
				following: 1) Liver biopsy				biopsy or one or more liver-		
				within the past 3 years with a				related complications		
				NAFLD Activity Score (NAS) of				associated with cirrhosis (e.g.,		
				at least 4 and a score of at				variceal bleeding, ascites,		
				least 1 in each NAS				hepatic encephalopathy, etc.),		
				component (steatosis,				must have attestation from		
				ballooning degeneration, and				prescriber that the member		
			•	lobular inflammation), 2) FIB-4				does not have significant		
				greater than 2.67 3) FIB-4				alcohol use, hepatic		
				greater than 1.3 AND at least				decompensation or HCC and is		
				ONE of the following: VTCE 8.5]			continuing requested		
				20 kPa, ELF 9-11.3 or				medication in conjunction		
				controlled attenuation				with diet and exercise.		
				parameter (CAP) greater than						
				or equal to 280 dB.m-1 OR 4)						
				MRI with an MRI-PDFF greater than or equal to 8% liver fat.						
			•	Must have at least two of the						
				following cardiometabolic risk						
				factors: BMI greater than or						
				equal to 25 kg/m2,						
				hypertension, dyslipidemia,						
				prediabetes, or type 2						
			•	diabetes. Must not have						
			•	evidence of cirrhosis (stage F4						
1				fibrosis) by imaging or liver						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
RIFAXIMIN (XIFAXAN)	1 - All FDA-approved Indications.	UII-Label Uses	Exclusion Citteria	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 medication used in the treatment of IBS-(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	Other Criteria	0	
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 an of the CAPS-typical symptom urticaria-like rash, cold-triggered episodes, sensorineural hearing loss, musculoskeletal symptoms, chronic aseptic meningitis an skeletal abnormalities. Member must have documented baseline inflammatory markers including serum C-reactive protein and serum amyloid A For Deficiency of Interleukin-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 a least 1 month,	n 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.		

				Required Medical						Prerequisite Therapy
•	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	-	Other Criteria	Part B Prerequisite	Required
RIMEGEPANT (NURTEC ODT)	Pending CMS review			Diagnosis. For episodic	Coverage is provided for		For episodic migraine initial: 6		0	1
				_	members 18 years of age and		months. For acute migraine	attestation the member is		
				the member has 4 to 14	older.		and reauthorization: 12	having a reduced number of		
				headache days per month.			months	migraine/headache days per		
				Must have a trial and failure				month or a decrease in		
				of one beta-blocker and one				migraine/headache severity. A	A	
				anticonvulsant unless				migraine is defined as a		
				contraindicated or intolerant.				headache that has at least		
				For acute treatment of				two of the following		
				migraine: Must have a history				characteristics: unilateral		
				of trial and failure,				location, pulsating/throbbing		
				contraindication or				quality, moderate or severe		
				intolerance to at least one				intensity (inhibits or prohibits		
				triptan.				daily activities), is aggravated		
								by routine activity, nausea		
								and/or vomiting, photophobia		
								and phonophobia.		
DIOCICIIAT (A DENADAC)	Danding Chac and		Courses and the section of the secti	Diamenta Bularra		December of the sector	Initials 2 manually B 11 C2	Farmanikh dan er et et		
RIOCIGUAT (ADEMPAS)	Pending CMS review		Coverage will not be provided			Prescribed by or in	· ·	For reauth: documentation	U	U
				hypertension (PAH) WHO		consultation with cardiologist	•	from prescriber that demonstrates member is		
			(nitrates in any form) or a PDE			or pulmonologist.				
				documentation of right-heart				tolerating and receiving clinical benefit from		
				catheterization (RHC)			•			
				indicating a mean pulmonary				treatment		
				arterial pressure greater than						
				20 mmHg, pulmonary vascular						
				resistance greater than 2 wood units, and mean						
				*						
				pulmonary capillary wedge pressure less than or equal to						
				15 mmHg. If provider						
				indicates RHC is not						
				recommended, must have						
				documentation of						
RISANKIZUMAB-RZAA	Pending CMS review			echocardiography. Diagnosis. For plaque	Member must be 18 years of	By or in consultation with a	12 months	For reauthorization: must	0	1
(SKYRIZI)	r criding civis review			psoriasis: minimum BSA		rheumatologist, dermatologist		have documentation from		
(6.1.1.1.2.1)				involvement of at least 3%	age or order.	or gastroenterologist.		prescriber indicating		
				(not required if on palms,		or gusti denter diegisti		stabilization or improvement		
				soles, head/neck, genitalia), a				in condition.		
				history of trial and failure of						
				ONE of the following: 1)						
				topical therapy (e.g.						
				corticosteroid, calcineurin						
				inhibitor, vitamin D analog), 2)						
				phototherapy, 3) systemic						
				treatment (e.g. methotrexate,						
				cyclosporine, oral retinoids).						
				For Crohns (CD): history of						
				trial and failure,						
				contraindication, or						
				intolerance to one of the						
				following therapy options:						
				aminosalicylates,						
				corticosteroids, or						
				immunomodulators (e.g.,						
				azathioprine, 6-						
				mercaptopurine) with						
				inadequate response or side						
				effects/toxicity unless						
				contraindicated. For						
				Ulcerative Colitis (UC): history						
				of trial and failure,						
				contraindication, or						
				intolerance to one of the						
				following therapy options:						
				aminosalicylates,						
				corticosteroids or						
				immunomodulator (e.g.,						
	l .	1	1		I	1		1	L	

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
RISDIPLAM (EVRYSDI)	Pending CMS review		Coverage will be not be	Diagnosis. Must have a		Prescribed by or in	12 months	For reauth: documentation	0	0
			provided to members who are			consultation with neurologist,		the member is responding to		
				autosomal recessive SMA.		or pediatric neurologist.		the medication as		
			nusinersen.	Chart documentation of				demonstrated by clinically		
				confirmatory genetic testing				significant improvement or		
				demonstrating one of the				maintenance of function from		
				following in the SMN1 gene is				pretreatment baseline status		
				required: 1) homozygous gene				using the same exam as		
				deletion, 2) homozygous gene				performed at baseline		
				mutation, 3) compound				assessment (progression,		
				heterozygote gene mutation.				stabilization, or decreased		
				Must provide chart				decline in motor function).		
			•	documentation of baseline				Must not be used		
				motor function score from				concurrently with Spinraza		
				ONE of the following				(nusinersin) or other SMN2		
				assessments: Hammersmith				modifying agents.		
				Functional Motor Scale						
				Expanded (HFMSE),						
				Hammersmith Infant						
				Neurologic Exam (HINE),						
			•	Upper limb module (ULM)						
				score, Childrens Hospital of						
			•	Philadelphia Infant Test of						
			•	Neuromuscular Disorders						
				(CHOP INTEND), or Six-minute						
				walk test. Must not be used						
				concurrently with Spinraza						
			•	(nusinersin) or other SMN2						
				modifying agents.						
ROZANOLIXIZUMAB-NOLI	1 - All FDA-approved	+	+	Diagnosis. Memember must	Member must be 18 years of	By or in consultation with a	12 months	For reauthorization:	0	1
(RYSTIGGO)	Indications.			have generalized myasthenia		neurologist.		Documentation from the	O	1
(K1311ddO)	indications.			gravis (gMG) who are anti-	age of older.	neurologist.		provider that the member had	1	
				acetylcholine receptor (AChR)				a positive clinical response	4	
				or antimuscle-specific tyrosine				and tolerates therapy		
				kinase (MuSK) antibody				supported by at least one of		
			•	positive. The requested agent				the following: a 2 point		
				must not be used in				improvement in the member's		
				combination with another				total MG-ADL score OR a 3 or		
				myasthenia gravis				more point improvement in		
				medication.Documentation of				QMG total score.		
				a Myasthenia Gravis				Givio total score.		
				Foundation of America Clinical	1					
				Classification class II to IVa.	'					
				Must have a Myasthenia						
			•	Gravis-Specific Activities of						
				Daily Living (MG-ADL) total						
				score greater than or equal to						
				3 with at least 3 points from						
			•	non-ocular symptoms.						
				Member must have						
				laboratory testing						
				demonstrating IgG levels of at						
				least 5.5 g per Liter.						
				Documentation of a baseline						
			•	Quantitative Myasthenia						
				Gravis (QMG) scale score.						
			•	Must have documentation of						
				one of the following: failed						
			•	treatment over 1 year or more						
				with 2 or more						
				immunosuppressive therapies						
				either in combination or as						
				monotherapy (e.g.						
L	1		ı		ı	l .	I.	1	1	1

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
RUFINAMIDE (BANZEL)	1 - All FDA-approved		Not covered for patients with	Diagnosis. Must have had an	Coverage is provided for	By or in consultation with a	12 months		0	1
	Indications.		Familial Short QT Syndrome	inadequate response or	members 1 year of age or	neurologist.				
				intolerance two generic	older.					
				anticonvulsant drugs (e.g.						
				lamotrigine, valproate,						
				topiramate, felbamate,						
				clobazam). Must be using						
				rufinamide as adjunctive						
				therapy to other antiepileptic						
				drugs (which can include						
				medication from trial above).			1		-	
RUXOLITINIB (JAKAFI)	1 - All FDA-approved			Diagnosis. Intermediate or	GVHD: age 12 years or older	By or in consultation with an	6 months	For reauthorization: must	0	1
	Indications.			high-risk myelofibrosis		oncologist, hematologist, or		have documentation from		
				includes primary	older	transplant specialist		prescriber indicating		
				myelofibrosis, post-				stabilization or improvement		
				polycythemia vera				in condition.		
				myelofibrosis, and post- essential thrombocythemia						
				myelofibrosis. For						
				Polycythemia vera, must have trial and failure, intolerance,						
				or contraindication of						
				hydroxyurea. For acute Graft						
				versus host disease (aGVHD),						
				must have a trial and failure,						
				intolerance, or						
				contraindication to						
				corticosteroids. For chronic						
				Graft versus host disease						
				(cGVHD), must have a trial						
				and failure of at least two						
				prior lines of systemic						
				therapy.						
				incrapy.						
SAPROPTERIN	1 - All FDA-approved			Diagnosis. For treatment of			Initial: 3 months, Reauth: 12	For reauthorization, must	0	0
DIHYDROCHLORIDE	Indications.			Hyperphenylalaninemia.			months	maintain Phe levels below		
				Clinically diagnosed with				member's baseline levels.		
				hyperphenylalaninemia due to						
				tetrahydrobiopterin						
				responsive phenylketonuria.						
				Phe levels must be greater						
				than 6 mg/dL (360						
				micromol/L).						
SATRALIZUMAB-MWGE	Pending CMS review		Active hepatitis B infection,	For Neuromyelitis Optica	Coverage is provided for	By or in consultation with a	12 months	For reauth: documentation of	1	1
(ENSPRYNG)			active or untreated latent	Spectrum Disorder (NMOSD):	members 18 years of age and	neurologist or		stabilization or improvement		
			tuberculosis	positive test for AQP4-IgG	older	ophthalmologist		in condition		
				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 an						
				adequate trial of at least 90						
				days of azathioprine,						
i				mycophenolate mofetil,						
						1		1		
				rituximab or any of its						
				biosimilars with						
				biosimilars with documentation of inadequate						
				biosimilars with						
				biosimilars with documentation of inadequate						
				biosimilars with documentation of inadequate response or contraindication						
				biosimilars with documentation of inadequate response or contraindication to therapies. Must not be						
				biosimilars with documentation of inadequate response or contraindication to therapies. Must not be using the requested agent in						
				biosimilars with documentation of inadequate response or contraindication to therapies. Must not be using the requested agent in combination with rituximab,						

				Required Medical						Prerequisite Therapy
•	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction		Other Criteria	Part B Prerequisite	Required
SECUKINUMAB (COSENTYX)	1 - All FDA-approved			Diagnosis. Must have a history	, -	By or in consultation with a	12 months	For reauth: must have	0	1
	Indications.			of trial and failure to one of	older.	rheumatologist,		documentation from		
				the following that shares the		gastroenterologist, or		prescriber indicating		
				same FDA-approved		dermatologist.		stabilization or improvement		
				indication: Enbrel, Hadlima,				in condition.		
				Humira, Otezla, Rinvoq,						
				Skyrizi, Spevigo, Stelara,						
				Tremfya, Xeljanz. For						
				ankylosing spondylitis (AS),						
				non-radiographic axial						
				spondyloarthritis (nr-axSpA),						
				and enthesitis-related arthritis	5					
				(ERA): history of trial and						
				failure, contraindication, or						
				intolerance to a four-week						
				trial with an NSAID. 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 hidradenitis supperativa						
				(HS): moderate to severe						
				disease with 3 active						
				abscesses, inflammatory						
				nodules, or lesions.						
				riodules, or lesions.						
SELEXIPAG (UPTRAVI)	Pending CMS review			Diagnosis. Pulmonary arterial		Prescribed by or in	Initial authorization: 3 months	Reauthorization:	0	0
3222xii 713 (31 110 tt),	l chang civis review			hypertension (PAH) WHO		•	Reauthorization: 12 months			
				Group I confirmed by chart		or pulmonologist.		prescriber that demonstrates		
				documentation of right-heart				member is tolerating and		
				catheterization (RHC)				receiving clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than				licatinent		
				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						
CH DENIASH CITE ATS	Danding ChAC :		Coverage codilis and a second	echocardiography.		Dunnauth and law at	Initials 2	Famina and the state of the sta		0
	Pending CMS review		Coverage will not be provided			Prescribed by or in		For reauth: documentation	U	U
(REVATIO)				hypertension (PAH) WHO		consultation with a	months	from prescriber that		
				Group I confirmed by chart		pulmonologist or cardiologist		demonstrates member is		
				documentation of right-heart				tolerating and receiving		
				catheterization (RHC)				clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than						
				20 mmHg, pulmonary vascular	1					
				resistance greater than 2						
				wood units, and mean						
1				pulmonary capillary wedge						
				pressure less than or equal to						
				15 mmHg. If provider						
				indicates RHC is not						
1				recommended, must have						
				documentation of						
				echocardiography.						
	•	•	•		•	•	•	•	•	•

Prerequisite Therapy						Required Medical				
Required	Part B Prerequisite	Other Criteria	Coverage Duration	Prescriber Restriction	Age Restriction	Information	Exclusion Criteria	Off-Label Uses	Indication Indicator	Group
0	0	Reauthorization: must have	Initial: 3 months,	By or in consultation with a	Coverage is provided for	Diagnosis. For excessive			1 - All FDA-approved	SODIUM OXYBATE (XYREM)
		documentation from	Reauthorization: 12 months	neurologist or sleep specialist	members 7 years of age or	daytime sleepiness associated			Indications.	
		prescriber indicating			older	with narcolepsy: a sleep study				
		stabilization or improvement				(e.g. polysomnogram, multiple				
		in condition.				sleep latency Test) confirming				
						diagnosis. For cataplexy				
						associated with narcolepsy: a				
						sleep study confirming the				
						diagnosis.				
0	0		12 months	By or in consultation with		Diagnosis.			1 - All FDA-approved	SODIUM PHENYLBUTYRATE
				physician who specializes in					Indications.	
				the treatment of inherited						
				metabolic disorders, a						
				hematologist or a						
			Critorio will be analiad	nephrologist.	Coverage is presided for	Critorio will bo analia d			1 All EDA operational	COFOCULIVID VELDATACVID
U	U		Criteria will be applied	By or in consultation with a		Criteria will be applied			1 - All FDA-approved	SOFOSBUVIR-VELPATASVIR
			consistent with current	gastroenterologist,	members who are age-	consistent with current			Indications.	(EPCLUSA)
			AASLD/IDSA guidance and/or	hepatologist, infectious	appropriate according to	AASLD/IDSA guidance and/or				
			FDA approved labeling	disease, HIV or transplant specialist.	AASLD/IDSA guidance and/or FDA-approved labeling.	FDA approved labeling				
		For reauth for pediatric GHD,	6 months	By or in consultation with an	rda-approved labelling.	Diagnosis Growth chart	Coverage will not be provided	+	Panding CMS raviow	SOMATROPIN (GENOTROPIN)
ľ	Ů	Turner and Noonan	o months	endocrinologist or		required for all diagnoses	for members with active		renaing civis review	SOIVIATROPIN (GENOTROPIN)
	.	syndromes, SGA, Prader-Willi		neonatologist.		except Adult Growth	malignancy, active			
		syndrome, and ISS:		lieonatologist.		Hormone Deficiency (GHD).	proliferative or severe non-			
		Documentation the patient				Documentation that	proliferative diabetic			
		has open epiphyses. For				epiphyses are open for all	retinopathy, pediatric			
	+	reauth for adult GHD: current				pediatric indications. For				
	'	IGF-1 level is normal for age				pediatric GHD: a height				
		and gender (does not apply to				greater than or equal to 2				
	3	patients with structural				standard deviations below the	obese or have severe			
		abnormality of the				mean for age and gender,	respiratory impairment.			
	2	hypothalamus/pituitary and 3				documentation of growth	respiratory impairment.			
	1	or more pituitary hormone				velocity, skeletal maturation,				
		deficiencies and childhood-				2 provocative stimulation				
		onset growth hormone				tests which demonstrate GHD				
		deficiency with congenital				through peak growth				
		abnormality of the				hormone concentrations less				
		hypothalamus/pituitary). For				than 10 ng/ml or IGF-1 or				
		reauth for Prader Willi:				IGFBP-3 levels or only one				
		documentation growth				stim test is needed in the				
		_								
	r					I'				
						to 2 standard deviations				
						•				
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						_				
•		1	1	ĺ	1	documentation that catch up	1	1		
		hormone has resulted in an increase in lean body mass or decrease in fat mass.				presence of a pituitary abnormality. For Small for Gestational Age (SGA), a height greater than or equal				

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
SOTATERCEPT-CSRK	Pending CMS review			Diagnosis. Pulmonary arterial		Prescribed by or in	Initial: 3 months, Reauth: 12	For reauth: documentation	0	0
(WINREVAIR)				hypertension (PAH) WHO		consultation with cardiologist	months	from prescriber that		
				Group I confirmed by chart		or pulmonologist		demonstrates member is		
				documentation of right-heart				tolerating and receiving		
				catheterization (RHC)				clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than						
				20 mmHg, pulmonary vascular						
				resistance greater than 2						
				wood units, and mean						
				pulmonary capillary wedge						
				pressure less than or equal to 15 mmHg. If provider						
				indicates RHC is not						
				recommended, must have						
				documentation of						
				echocardiography. Must be						
				used in combination with						
				standard of care therapy (e.g.						
				ERA or PDE-5 inhibitor)						
SPARSENTAN (FILSPARI)	Pending CMS review			Diagnosis of primary	Coverage is provided for	By or in consultation with a	Initial: 6 months. Reauth: 12	For reauth: must have a	0	1
				immunoglobulin A		nephrologist.	•	decrease from baseline in		
				nephropathy (IgAN) that has		, -		total urine protein or UPCR.		
				been confirmed by biopsy.						
				Must have an eGFR rate of at						
				least 30 ml/min/1.73m^2.						
				Must have a total urine						
				protein of at least 1.0 g/day.						
				Must be at risk of rapid						
				disease progression defined as	5					
				having a urine protein-to-						
				creatinine ratio (UPCR) of at						
				least 1.5 g/g. Must have tried						
				and failed a stable and						
				maximum tolerated dose of						
				both 1) an ACE inhibitor or						
				ARB and 2) an SGLT-2 inhibito						
SPESOLIMAB-SBZO (SPEVIGO)	Pending CMS review			(e.g. Farxiga). Diagnosis. For treatment of a	Coverage is provided for	By or in consultation with a	For a flare: one treatment	For reauth: documentation of	0	ln
SI ESOLIVIAD SBZO (SI EVIGO)	T chang civis review			generalized pustular psoriasis		dermatologist	course (up to 2 infusions over			0
				(GPP) flare, must have a	older and weighing at least 40		2 weeks). For maintenance: 12			
				moderate-to-severe flare	kg.		months	mares write on treatment		
				confirmed by both of the						
				following: presence of fresh						
				pustules AND at least 5% BSA						
				covered with erythema and						
				pustules. For treatment of						
				GPP when not experiencing a						
				flare, must have a history of a	t					
				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,						
CTIDIDENITOL (DIACONALT)	1 All EDA approved		+	cyclosporine).	Member must be 6 months of	By or in consultation with a	12 months		10	1
STIRIPENTOL (DIACOMIT)	1 - All FDA-approved Indications.			Diagnosis. Must have had an		By or in consultation with a neurologist	12 MONTHS		U	1
	inulcations.			inadequate response or intolerance to two generic	age of older	neurologist				
				antiepileptic drugs (e.g.						
				valproate, topiramate,						
				clobazam). Must be using in						
				combination with clobazam.						
	1	1	1	100 mondation with clobazaili.	1	1	1	1	1	1

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
SUZETRIGINE (JOURNAVX)	1 - All FDA-approved			Must have a diagnosis of	Coverage is provided for		14 Days	For reauthorization:	0	1
	Indications.			moderate-to-severe acute	members 18 years of age and			Documentation that the		
				pain. The prescriber attests	older			member is experiencing a new	<i>y</i>	
				that the episode of acute pain				episode of moderate-to-		
				is anticipated to last less than				severe acute pain, separate		
				one month and the member				and distinct from the previous		
				has tried and failed within the				episode. The prescriber		
				previous 30 days or has a				attests that the episode of		
				contraindication to either				acute pain is anticipated to		
				TWO alternative pain				last less than one month and		
				medications for moderate				the member has tried and		
				pain (e.g. acetaminophen,				failed within the previous 30		
				NSAIDs) or ONE alternative				days or has a contraindication		
				pain medication for severe				to either TWO alternative pair	n	
				pain (e.g. NSAID, opioid).				medications for moderate		
								pain (e.g. acetaminophen,		
								NSAIDs) or ONE alternative		
								pain medication for severe		
								pain (e.g. NSAID, opioid).		
TADALAFIL (ADCIRCA)	Pending CMS review		_	Diagnosis. Pulmonary arterial		Prescribed by or in	Initial: 3 months, Reauth: 12	For reauth: documentation	0	0
			for patients taking nitrates	hypertension (PAH) WHO		consultation with a	months	from prescriber that		
				Group I confirmed by chart		pulmonologist or cardiologist		demonstrates member is		
			1 - · · · · · · · · · · · · · · · · · ·	documentation of right-heart				tolerating and receiving		
			(e.g. Adempas).	catheterization (RHC)				clinical benefit from		
				indicating a mean pulmonary				treatment		
				arterial pressure greater than						
				20 mmHg, pulmonary vascular	-					
				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.						
TADALAFIL (CIALIS)	1 - All FDA-approved			Diagnosis of benign prostatic			12 months		0	1
	Indications.			hyperplasia (BPH) and must						
				have a trial and failure of at						
				least two alternative						
				medications in the following						
				classes: alpha-1 adrenergic						
				blockers or 5-alpha reductase						
				inhibitors.						

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
TAFAMIDIS (VYNDAMAX)	1 - All FDA-approved			Diagnosis. The diagnosis is	Coverage is provided for	Prescribed by or in	12 months	For reauthorization:	0	0
	Indications.			confirmed by presence of	members 18 years of age or	consultation with a		documentation from		
				amyloid deposits on biopsy	older.	cardiologist or physician who		prescriber indicating		
				analysis from cardiac or non-		specialized in the treatment of	f	stabilization or improvement		
				cardiac sites (e.g., fat aspirate	,	amyloidosis		in condition.		
				gastrointestinal sites, salivary						
				glands, bone marrow) or by						
				technetium-labeled bone						
				scintigraphy tracing. For						
				members with hereditary						
				ATTR-CM, presence of a						
				mutation of the TTR gene was						
				confirmed. For members with						
				wild type ATTR-CM, presence						
				of transthyretin precursor						
				proteins was confirmed by						
				immunohistochemical						
				analysis, scintigraphy, or mass						
				spectrometry. Documentation						
				the member has a New York						
				Heart Association Class I, II or						
				III heart failure. Must not be						
				used in combination with a						
				TTR-lowering agent (e.g.						
				patisiran, inotersen,						
				vutrisiran)						
TASIMELTEON (HETLIOZ)	1 - All FDA-approved			Diagnosis. Must submit chart	Coverage is provided for	By or in consultation with a	12 months	For Reauth: documentation	0	0
	Indications.			documentation describing	members 3 years of age or	neurologist or a physician who		from prescriber indicating		
				how diagnosis was confirmed	older.	specializes in sleep medicine		stabilization or improvement		
				(e.g. sleep-wake logs,				in condition.		
				melatonin secretion						
				abnormalities, or progress						
				notes, etc.)						
TEDUGLUTIDE (GATTEX)	1 - All FDA-approved		Active intestinal obstruction	Diagnosis. For diagnosis of		By or in consultation with a	12 months	For reauthorization: must	0	0
	Indications.		or active gastrointestinal	short bowel syndrome,		gastroenterologists		have documentation from		
			malignancy.	member must be receiving				prescriber indicating		
				parenteral support.				stabilization or improvement		
								in condition.		
TELOTRISTAT (XERMELO)	1 - All FDA-approved			Diagnosis.		By or in consultation with an	6 months	For reauth: documentation of	0	0
	Indications.				members 18 years of age and	oncologist		improvement or stabilization.		
					older.					

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
TETRABENAZINE (XENAZINE)	1 - All FDA-approved		Uncontrolled depression,	Diagnosis. Must have	Coverage is provided for	By or in consultation with a	12 months	Maximum dose approved is	0	0
	Indications.		actively suicidal. Currently	confirmed Huntington's	members 18 years of age or	neurologist		100mg/day. For		
				disease either by Huntington	older.			reauthorization: must have		
			inhibitor or reserpine. Hepatic					documentation from		
			impairment. Concurrent use	(with laboratory result				prescriber indicating		
			of deutetrabenazine or	indicating expanded CAG				stabilization or improvement		
			valbenazine.	repeat of greater than or				in condition.		
				equal to 36 in the Huntington						
				gene) or a positive family						
				history of Huntington's						
				Disease with autosomal						
				dominant inheritance pattern						
				Must have clinical signs of						
				Huntington's Disease to						
				include chart documentation						
				of a clinical work-up showing						
				one or more of the following						
				signs: motor (e.g. finger						
				tapping, rigidity), oculomotor,						
				bulbar (e.g. dysarthria,						
				dysphagia), affective (e.g.						
				depression), cognitive. Must						
				have chart documentation of						
				chorea. For doses greater						
				than 50mg/day: must have						
				chart documentation of a trial						
				of 50mg/day dose with						
				inadequate response OR must						
				be CYP2D6 intermediate or	`					
				extensive metabolizer (as						
				documented through CYP2D6						
				genotyping results).						
				genotyping results).						
TOCILIZUMAB	1 - All FDA-approved			Diagnosis. Must have a history	Must be 2 years of age or	By or in consultation with a	CRS: 1 month, all other	For CRS reauth: must meet	0	1
TOCILIZOWIAB	Indications.			of trial and failure to one of		rheumatologist, oncologist,	indications: 12 months	initial criteria and provide	O	*
	indications.			the following that shares the	older.	hematologist, or	indications. 12 months	clinical rationale for additiona		
				same FDA-approved		pulmonologist.		treatment. For all other		
				indication: Enbrel, Hadlima,		pullionologist.		reauths: must have		
				Humira, Otezla, Rinvoq,				documentation of stabilization		
				Skyrizi, Spevigo, Stelara,				or improvement in condition.	1	
								or improvement in condition.		
				Tremfya, Xeljanz. 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,						
			1	contraindication, or						
				intolerance to at least a 4						
				week trial of 2 different						
				NSAIDS. For cytokine release						
			1	syndrome (CRS): must have						
				severe or life-threatening						
				disease induced by CAR-T						
				therapy. For giant cell arteritis	5					
				(GCA): history of trial and						
				failure, contraindication, or						
				intolerance to			1			1

TOEVAPTAN (IYNARQUE) Pending CMS review History of significant liver impairment or injury (not including uncomplicated polycystic liver disease), concomitant use of strong corporations, undill blook addition abnormal blook addition as one or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria Diagnosis. Must have history of free high review in from the prescriber indicating incomplicate in the prescriber indicating incomplicate of the following criteria defining risk or fapidly progressing disease: (13 age 55 or younger and 65ff between 25 and 44 mt/min/1.73m-2 plus eff-R decline of greater than or equal to 5750 mt, and less than \$1,173m-2 plus (21 age 55 to 55 or Sm. and the sm. and th	Part B Prerequisite Require 0 1 0 0	ired
Indications. In		
TOLVAPTAN (IYNARQUE) Pending CMS review History of significant liver impairment or injury (not including uncomplicated polycystic liver disease), concomitant use of strong CYP3A inhibitors, uncorrected abnormal blood sodium concentrations, unable to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria August 10 (20 m.//min/1.73m-2/) (20) a estimated CTG greater than or equal to 750 ml., and less than 51 years of age, (4) Mayo classification of 1C, 1D, or 1E disease.	0 0	
Intolerance to a TNF blocker. Diagnosis. Must meet one of 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, hyppovolemia, uncorrected urinary outflow obstruction, anuria Intolerance to a TNF blocker. Diagnosis. Must meet one of the following criteria defining risk of rapidly progressing disease: (1) age 55 or younger and 44 mL/min/1.73mr² plus eGFR decline of greater than 2 viniary outflow obstruction, anuria Intolerance to a TNF blocker. Diagnosis. Must meet one of the following criteria defining risk of rapidly progressing disease: (1) age 55 or younger and 44 mL/min/1.73mr² plus eGFR decline of greater than 2 viniary outflow obstruction, anuria EGFR decline of greater than or equal to 80 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.	0 0	
TOLVAPTAN (JYNARQUE) Pending CMS review History of significant liver impairment or injury (not including uncomplicated polycystic liver data defining risk of rapidly progressing data polycystic liver data defining risk of rapidly progressing and older Diagnosis. Must meet one of the following criteria defining risk of rapidly progressing age or older data polycystic liver disease), disease; (1) age 55 or younger and eGFR between 25 and 65 ml/min/1.73m^2, plus ego for older data polycystic liver data defining risk of rapidly progressing and eGFR between 25 and 65 ml/min/1.73m^2, plus ego for older data polycystic liver data defining risk of rapidly progressing and eGFR between 25 and 65 ml/min/1.73m^2, plus ego for older data polycystic liver data defining risk of rapidly progressing and eGFR between 25 and 65 ml/min/1.73m^2, plus ego for older data polycystic liver data defining risk of rapidly progressing and eGFR between 25 and 65 ml/min/1.73m^2, plus ego for older data polycystic liver data defining risk of rapidly progressing and elegate than elegated and eGFR between 25 and 44 ml/min/1.73m^2, plus ego for older data polycystic liver	0 0	
of age and older TOLVAPTAN (JYNARQUE) Pending CMS review History of significant liver impairment or injury (not including uncomplicated polycystic liver disease), concomitant or expensed abnormal blood sodium concentrations, unable to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria And 4 mt/min/1.73m^2 plus GFR decline of greater than equal to 6 mt/min, total kidney volume greater than of equal to 750 mt., and leases. Of age and older Member must be 18 years of the following criteria defining risk of rapidly progressing disease: (1) age 55 or younger and eGFR between 25 and 65 mt/min/1.73m^2 plus GFR decline of greater than or equal to 60 mt/min, total kidney volume greater than or equal to 750 mt., and less than 51 years of age, (4) Mayo classification of 1C, 1D, or 1E disease.	0 0	
History of significant liver impairment or injuny (not impairment or injuny (not impairment or injuny) (not including uncomplicated polycystic liver disease), concomitant use of strong CYP3 in inhibitors, uncorrected abnormal blood sodium concentrations, naturia See or espond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria Mistory of significant liver impairment or injuny (not impairment or injuny) (and including uncorrected urinary outflow obstruction, anuria History of significant liver impairment or injuny (not impairment or injuny) (and including uncorrected urinary outflow obstruction, anuria History of significant liver impairment or injuny (not impairment or injuny) (and including uncorrected urinary outflow obstruction, anuria History of significant liver impairment or injuny (not including uncorrected urinary outflow obstruction, anuria History of significant liver impairment or injuny (not including uncorrected urinary outflow obstruction, anuria of the following greater than or equal to 750 mL, and less than 51 years of age, (4) Mayo classification of 1C, 1D, or 1E disease.	0 0	
impairment or injury (not including uncomplicated polycystic liver disease). CYP3A inhibitors, uncorrected abnormal blood sodium concentrations, unable to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria Winding 1.73m^2 (2) age 56 and 44 mJ/min/1.73m^2 plus effR decline of 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.		
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		
disease: (1) age 55 or younger and eGFR between 25 and 65 mt/min/1.73m^2, (2) age 56 to 65 and eGFR between 25 and 4 mt/min/1.73m^2 plus eGFR decline of greater than curiary outflow obstruction, anuria disease: (1) age 55 or younger and eGFR between 25 and 65 mt/min/1.73m^2 plus eGFR decline of greater than cequal to 60 mt/min, total kidney volume greater than or equal to 550 mt, and less than 51 years of age, (4) Mayo classification of 1C, 1D, or 1E disease.		
concomitant use of strong CYP3A inhibitors, uncorrected abnormal blood sodium concentrations, unable to to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria and eGFR between 25 and 65 mt/min/1.73m^2, (2) age 56 to 65 and eGFR between 25 and 44 mt/min/1.73m^2 plus eGFR decline of greater than 2.0 mt/min/1.73m^2/year, (3) estimated CrCl greater than or equal to 60 mt/min, total kidney volume greater than or equal to 750 mt, and less than 51 years of age, (4) Mayo classification of 1C, 1D, or 1E disease.		
CYP3A inhibitors, uncorrected abnormal blood sodium concentrations, unable to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria CYP3A inhibitors, uncorrected abnormal blood sodium concentrations, unable to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria CYP3A inhibitors, uncorrected 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.		
abnormal blood sodium concentrations, unable to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuría anuría to 65 and eGFR between 25 and 44 mL/min/1.73m^2 plus eGFR decline of greater than eGFR decline of 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.		
concentrations, unable to sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria anuria 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.		
sense or respond to thirst, hypovolemia, uncorrected urinary outflow obstruction, anuria selfe 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.		
hypovolemia, uncorrected urinary outflow obstruction, anuria 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.		
urinary outflow obstruction, anuria 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.		
anuria 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.		
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.		
equal to 750 mL, and less than 51 years of age, (4) Mayo classification of 1C, 1D, or 1E disease.		
51 years of age, (4) Mayo classification of 1C, 1D, or 1E disease.		
classification of 1C, 1D, or 1E disease.		
disease.		
	<u> </u>	
TRIENTINE HCL (SYPRINE) 1 - All FDA-approved Diagnosis. Must have a trial of By or in consultation with a 12 months For reauth: must have	⁰	
Indications. penicillamine (Depen) with an gastroenterologist, an documentation from		
inadequate response or ophthalmologist or a prescriber indicating		
significant side effects/toxicity physician who specializes in improvement in condition.		
or must have a the treatment of inherited		
contraindication to this metabolic disorders		
therapy.	1	
TROFINETIDE (DAYBUE) Pending CMS review 0 Diagnosis. Documentation of a Coverage is provided for By or in consultation with a 12 months For reauth: must have chart	0	
diagnosis of typical Rett members 2 years of age or pediatric neurologist or documentation from the syndrome according to the older. neurologist provider of clinically		
syndrome according to the older. neurologist provider of clinically Rett Syndrome Diagnostic neurologist meaningful improvement or		
Criteria with a documented stabilization in at least one		
disease-causing mutation in sign or symptom of Rett		
the MECP2 gene (a copy of syndrome from baseline.		
the MECF2 gene (a copy of the MecF2 gene (a copy of the genetic testing report		
must be provided).		
UBROGEPANT (UBRELVY) 1 - All FDA-approved Diagnosis. Must have a history Coverage is provided for 12 months For reauth: documentation of	10	
Indications.		
contraindication, or older.		
intolerance to at least one		
triptan.		
UPADACITINIB (RINVOQ) 1 - All FDA-approved Diagnosis. For rheumatoid For PsA and and polyarticular By or in consultation with a 12 months For reauthorization: must	0 1	
Indications.		
arthritis (PsA), ankylosing years or older, For atopic dermatologist, or prescriber indicating		
spondylitis (AS), non- dermatitis: 12 years or older. gastroenterologist. stabilization or improvement		
radiographic axial All other indications: 18 years in condition.		
spondyloarthritis (nr-axSpA), and older.		
ulcerative colitis (UC), and		
Crohn's disease: history of		
trial and failure,		
contraindication, or		
intolerance to a TNF blocker.		
For atopic dermatitis (AD):		
history of trial and failure,		
contraindication, or		
intolerance to 2 systemic		
products (immunosuppressant		
or biologic). For giant cell		
arteritis (GCA): history of trial		
and failure, contraindication,		
or intolerance to		
corticosteroids.		

				Required Medical						Prerequisite Therapy
·	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
USTEKINUMAB (STELARA) SQ	Pending CMS review			Diagnosis. For plaque psoriasis		By or in consultation with a	12 months	For reauth: must have	0	1
				(PsO): minimum BSA	older.	rheumatologist,		documentation from		
				involvement of at least 3%		gastroenterologist, or		prescriber indicating		
				(not required if on palms,		dermatologist.		stabilization or improvement		
				soles, head/neck, genitalia), a				in condition.		
				history of trial and failure of						
				ONE of the following: 1)						
				topical therapy (e.g.						
				corticosteroid, calcineurin						
				inhibitor, vitamin D analog), 2)					
				phototherapy, 3) systemic						
				treatment (e.g. methotrexate,	,					
				cyclosporine, oral retinoids).						
				For Crohns (CD): history of						
				trial and failure,						
				contraindication, or						
				intolerance to one of the						
				following therapy options:						
				aminosalicylates,						
				corticosteroids, or						
				immunomodulators (e.g.,						
				azathioprine, 6-						
				mercaptopurine) with						
				inadequate response or side						
				effects/toxicity unless						
				contraindicated. For						
				Ulcerative Colitis (UC): history						
				of trial and failure,						
				contraindication, or intolerance to one of the						
				following therapy options:						
				aminosalicylates,						
				corticosteroids or						
\(\(\alpha\) \(\beta\) \(\	4 411 504			immunomodulator (e.g.,		, i	42	5 11 1 11		
VALBENAZINE (INGREZZA)	1 - All FDA-approved			Diagnosis. For chorea: must	Coverage is provided for	By or in consultation with a	12 months	For reauthorization: must	0	0
	Indications.			have confirmed Huntington's disease either by Huntington		neurologist or psychiatrist		have documentation from prescriber indicating		
				Disease Mutation analysis	older			stabilization or improvement		
				(with laboratory result				in condition.		
				indicating expanded CAG				in condition.		
				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	<u>'</u>					
				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						
_		I		1 Journal of Weile	<u>i</u>	I	<u>I</u>	<u>l</u>	1	I

				Required Medical						Prerequisite Therapy
Group	Indication Indicator	Off-Label Uses	Exclusion Criteria	Information	Age Restriction	Prescriber Restriction	Coverage Duration	Other Criteria	Part B Prerequisite	Required
VERICIGUAT (VERQUVO)	1 - All FDA-approved			Diagnosis. Must have a left		Prescribed by or in	12 months	Reauthorization:	0	1
venesom (venegovo)	Indications.			ventricular ejection fraction		consultation with cardiologist.		documentation from		
				(LVEF) less than or equal to				prescriber indicating		
				45%. Must have had a				stabilization or improvement		
				hospitalization for heart				in condition.		
				failure within the past 6				in condition.		
				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.						
VIGABATRIN	1 - All FDA-approved			Diagnosis. Must undergo	Coverage is provided for	By or in consultation with a	12 months		0	1
VIGADATINIIV	Indications.			vision testing prior to	members 1 month of age or	neurologist.	12 months		ľ	
	illuications.				_	neurologist.				
				beginning treatment. For	older.					
				Refractory Complex Partial						
				Seizures: must have						
				inadequate response to at						
				least two of the following						
				anticonvulsant drugs:						
				levetiracetam, phenytoin,						
				carbamazepine,						
				oxcarbazepine, gabapentin,						
				lamotrigine, valproate, or						
				topiramate. Must be using						
				vigabatrin in combination with	n l					
				at least one other						
				anticonvulsant medication						
				(which can include medication	וו					
				from trial above).						
VORICONAZOLE INJECTION	1 - All FDA-approved			Diagnosis.	2 years of age or older	Prescribed by or in	12 months		0	0
(VFEND)	Indications.					consultation with an				
						infectious disease specialist				
VORTIOXETINE (TRINTELLIX)	1 - All FDA-approved			Diagnosis. Documentation of	Coverage is provided for	·	12 months		0	1
,	Indications.				members 18 years of age and					
				generic antidepressants	older.					
				alternatives such as an SSRI,	older.					
				•						
				SNRI, bupropion, trazodone o						
	4 40 = 5		-	mirtazapine	+	<u> </u>	1000	<u> </u>	<u> </u>	
VOSORITIDE (VOXZOGO)	1 - All FDA-approved		1	Diagnosis confirmed by			12 Months	For reauth: documentation of	U	0
	Indications.		1	documentation of one of the		consultation with an		both of the following: 1.		
				following: 1. genetic testing		endocrinologist, geneticists,		improvement or stabilization.		
				showing mutation in the		or other practitioner with		2. The member's epiphyses		
				FGFR3 gene or 2. radiographic	:	expertise in the management		remain open.		
			1	assessment confirming		of achondroplasia		1		
			1	achondroplasia (e.g. short,						
			1	robust tubular bones, squared	d					
			1		'					
			1	off iliac wings, flat horizontal						
			1	acetabule, ect.).						
			1	Documentation the member						
			1	has open epiphyses.						
XANOMELINE/TROSPIUM (COBENFY)	1 - All FDA-approved		1	Diagnosis. Documentation of			12 months		0	1
	Indications.			trial and failure of at least two	older.			1		
				of the following generic				1		
				atypical antipsychotics:				1		
				olanzapine, quetiapine,				1		
			1							
			1	paliperidone, risperidone,						
				aripiprazole, ziprasidone,						
	i	I		asenapine, or lurasidone.	1					

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