Samaritan Health Plans

Prior Authorization Criteria

Samaritan Choice

PLEASE READ: This document contains information about the criteria for coverage for this plan.

Updated on 5/10/2022. For more recent information or other questions, please contact Pharmacy Services at **541-768-4550** or toll free **800-832-4580** (TTY 800-735-2900) or visit **samhealthplans.org**. Pharmacy Services is available Monday through Friday, from 8 a.m. to 5 p.m.

Abatacept (Orencia)

Products Affected

- **ORENCIA**
- **ORENCIA CLICKJECT**

PA Criteria	Criteria Details
Covered Uses	Adult Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Adult Psoriatic Arthritis (PsA), Prophylaxis for Acute Graft versus Host Disease (aGVHD)
Exclusion Criteria	
Required Medical Information	**Adult Rheumatoid Arthritis (RA)** Diagnosis of moderately to severely active rheumatoid arthritis AND trial and failure, contraindication, or intolerance to ONE nonbiologic disease-modifying antirheumatic drug (DMARD) (e.g., methotrexate [Rheumatrex/Trexall], Arava [leflunomide], Azulfidine [sulfasalazine]) AND trial and failure, contraindication, or intolerance to TWO of the following, or attestation demonstrating a trial may be inappropriate Cimzia (certolizumab pegol) Humira (adalimumab) Rinvoq (upadacitinib) Simponi (golimumab) Xeljanz/XR (tofacitinib/ER). **Polyarticular Juvenile Idiopathic Arthritis (PJIA)** Diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis AND trial and failure, contraindication, or intolerance to ONE of the following nonbiologic disease modifying anti-rheumatic drugs (DMARDs): Arava (leflunomide) methotrexate (Rheumatrex/Trexall) AND trial and failure, contraindication, or intolerance to Humira (adalimumab), or attestation demonstrating a trial may be inappropriate. **Adult Psoriatic Arthritis (PsA)** Diagnosis of active psoriatic arthritis (PsA) AND trial and failure, contraindication, or intolerance to TWO of the following : Cimzia (certolizumab pegol) Humira (adalimumab) Simponi (golimumab) Stelara (ustekinumab) Tremfya (guselkumab) Skyrizi (risankizumab-rzaa) Rinvoq (upadacitinib) Xeljanz/XR (tofacitinib/ER) **Prophylaxis for Acute Graft versus Host Disease (aGVHD)** Used for prophylaxis of acute graft versus host disease (aGVHD) AND patient is 2 years of age or older AND patient will receive hematopoietic stem cell transplantation (HSCT) from a matched or 1 allele-mismatched unrelated donor AND recommended antiviral prophylactic treatment for Epstein-

PA Criteria	Criteria Details
	Barr Virus (EBV) reactivation (e.g., acyclovir) will be administered prior to Orencia and continued for six months after HSCT AND Used in combination with both of the following: calcineurin inhibitor (e.g., cyclosporine, tacrolimus) methotrexate.
Age Restrictions	**Prophylaxis for Acute Graft versus Host Disease (aGVHD):** 2 years of age or older
Prescriber Restrictions	**(RA) (PJIA):** Prescribed by or in consultation with a rheumatologist **(PsA):** Prescribed by or in consultation with a dermatologist or rheumatologist
Coverage Duration	**RA, PJIA, PsA:** Initial: 12 months. Renewal: 12 months **aGVHD:** Initial: 2 months. Renewal: N/A
Other Criteria	Renewal Criteria: Documented positive clinical response to therapy

Actemra (Tocilizumab SC)

Products Affected

Products Affected

- ACTEMRA INJ 80MG/4ML
- ACTEMRA INJ 200/10ML
- ACTEMRA INJ 400/20ML
- ACTEMRA INJ 162/0.9
- ACTEMRA INJ ACTPEN

PA Criteria	Criteria Details
Covered Uses	Rheumatoid arthritis, Systemic Juvenile Idiopathic Arthritis (SJIA), Polyarticular Juvenile Idiopathic Arthritis (PJIA), Cytokine Release Syndrome, Giant Cell Arteritis (GCA), Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
Exclusion Criteria	
Required Medical Information	**Rheumatoid Arthritis (RA):** Diagnosis of moderately to severely active rheumatoid arthritis AND trial and failure, contraindication, or intolerance to ONE nonbiologic disease-modifying antirheumatic drug (DMARD) (e.g., methotrexate [Rheumatrex/Trexall], Arava [leflunomide], Azulfidine [sulfasalazine]) AND trial and failure, contraindication, or intolerance to TWO of the following, or attestation demonstrating a trial may be inappropriate* *Includes attestation that a total of two TNF inhibitors have already been tried in the past, and the patient should not be made to try a third TNF inhibitor. **Systemic Juvenile Idiopathic Arthritis (SJIA):** Diagnosis of active systemic juvenile idiopathic arthritis AND Trial and failure, contraindication, or intolerance to ONE of the following: Non-steroidal anti-inflammatory drug (NSAID) (e.g., ibuprofen, naproxen), Systemic glucocorticoid (e.g., prednisone), methotrexate. **Polyarticular Juvenile Idiopathic Arthritis (PJIA):** Diagnosis of active polyarticular juvenile idiopathic arthritis AND Trial and failure, contraindication, or intolerance to ONE of the following nonbiologic disease modifying anti-rheumatic drugs (DMARDs): Arava (leflunomide), methotrexate (Rheumatrex/Trexall) AND Trial and failure, contraindication, or intolerance to Humira (adalimumab), or attestation demonstrating a trial may be inappropriate* * Includes attestation that a

PA Criteria	Criteria Details
	total of two TNF inhibitors have already been tried in the past, and the patient should not be made to try a third TNF inhibitor. **Giant Cell Arteritis (GCA):** Diagnosis of giant cell arteritis AND trial and failure, contraindication, or intolerance to a glucocorticoid. **Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD):** Diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD) as documented by the following: exclusion of other known causes of interstitial lung disease (ILD) (e.g., domestic and occupational environmental exposures, connective tissue disease, drug toxicity) AND one of the following: In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (e.g., fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on high-resolution computed tomography (HRCT) revealing SSc-ILD or probable SSc-ILD OR In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD. **Cytokine Release Syndrome (CRS) Risk due to CAR T-Cell Therapy:** Patient will receive or is receiving chimeric antigen receptor (CAR) T-cell immunotherapy (i.e., Kymriah [tisagenlecleucel], Yescarta [axicabtagene ciloleucel])
Age Restrictions	
Prescriber Restrictions	**(RA) (SJIA) (PJIA) (GCA):** Prescribed by or in consultation with a rheumatologist. **(SSc-ILD):** Prescribed by or in consultation with a pulmonologist or rheumatologist. **Cytokine Release Syndrome (CRS) Risk due to CAR T-Cell Therapy:** Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	**(RA) (SJIA) (PJIA) (GCA) (SSc-ILD):** Initial: 12 months; Renewal: 12 months **Cytokine Release Syndrome (CRS) Risk due to CAR T-Cell Therapy:** Initial: 2 months.
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy.

Adalimumab (Humira)

Products Affected

- HUMIRA PEDIA INJ CROHNS
- HUMIRA PEN INJ 80/0.8ML
- HUMIRA PEN KIT CD/UC/HS
- HUMIRA PEN KIT PED UC
- HUMIRA PEN KIT CD/UC/HS
- HUMIRA INJ 40/0.4ML
- HUMIRA PEN INJ 40/0.4ML
- HUMIRA INJ 20/0.2ML
- HUMIRA INJ 10/0.1ML
- HUMIRA PEN KIT PS/UV
- HUMIRA PEDIA INJ CROHNS
- HUMIRA KIT 40MG/0.8
- HUMIRA PEN INJ 40MG/0.8
- HUMIRA PEN INJ CD/UC/HS
- HUMIRA PEN INJ PS/UV

PA Criteria	Criteria Details
Covered Uses	Rheumatoid arthritis (RA), Polyarticular Juvenile idiopathic arthritis (PJIA), Psoriatic arthritis (PsA), Ankylosing spondylitis (AS), Crohn's disease (CD), Ulcerative Colitis, Plaque psoriasis, Hidradenitis Suppurativa, Uveitis (UV)
Exclusion Criteria	
Required Medical Information	**Rheumatoid arthritis (RA):** Diagnosis of moderately to severely active RA AND trial and failure, contraindication, or intolerance to one non-biologic disease-modifying antirheumatic drug (DMARD) [e.g., methotrexate (Rheumatrex/Trexall), Arava (leflunomide), Azulfidine (sulfasalazine)]. **Polyarticular Juvenile idiopathic arthritis (PJIA):** Diagnosis of moderate to severely active polyarticular JIA AND trial and failure, contraindication, or intolerance to one of the following non-biologic disease-modifying antirheumatic drugs (DMARDs): Arava (leflunomide), methotrexate (Rheumatrex/Trexall). **Psoriatic arthritis (PsA):** Diagnosis of active PsA **Ankylosing spondylitis (AS):** Diagnosis of active ankylosing spondylitis AND trial and failure, contraindication, or intolerance to two NSAIDs (e.g., diclofenac, ibuprofen, indomethacin, meloxicam, naproxen) **Crohn's disease (CD):** Diagnosis of moderately to severely active Crohn's disease AND trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine

PA Criteria	Criteria Details
	(Purinethol), azathioprine (Imuran), corticosteroids (e.g., prednisone, methylprednisolone), methotrexate (Rheumatrex, Trexall). **Ulcerative Colitis (UC):** Diagnosis of moderately to severely active ulcerative colitis AND trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine (Purinethol), Aminosalicylate [e.g., mesalamine (Asacol, Pentasa, Rowasa), olsalazine (Dipentum), sulfasalazine (Azulfidine, Sulfazine)], Azathioprine (Imuran), Corticosteroids (e.g., prednisone, methylprednisolone). **Plaque Psoriasis (PP):** Diagnosis of moderate to severe chronic plaque psoriasis **Hidradenitis Suppurativa (HS):** Diagnosis of moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III) **Uveitis (UV):** Diagnosis of non-infectious uveitis AND uveitis is classified as one of the following: intermediate, posterior or panuveitis.
Age Restrictions	
Prescriber Restrictions	**(RA) (PJIA) (AS):** Prescribed by or in consultation with a rheumatologist **(PsA):** Prescribed by or in consultation with one of the following: Dermatologist or Rheumatologist. **(CD) (UC):** Prescribed by or in consultation with a gastroenterologist **(PP), (HS):** Prescribed by or in consultation with a dermatologist **(UV):** Prescribed by or in consultation with one of the following: ophthalmologist or rheumatologist
Coverage Duration	**(RA), (PJIA), (PsA), (PP), (AS), (CD), (HS), (UV)** Initial: 12 months; Renewal: 12 months **(UC):** Initial: 12 weeks; Renewal: 12 months
Other Criteria	Renewal Criteria: **(UC):** One of the following: For patients who initiated Humira therapy within the past 12 weeks: Documentation of clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on Humira therapy for longer than 12 weeks: Documentation of positive clinical response to therapy **(PP):** Documentation of positive clinical response to therapy as evidenced by ONE of the following: reduction the body surface area (BSA) involvement from baseline OR improvement in symptoms (e.g., pruritus, inflammation) from baseline **(RA), (PJIA), (PsA), (CD), (HS), (UV):** Documentation of positive clinical response to therapy.

Alirocumab (Praluent)

Products Affected

- Praluent

PA Criteria	Criteria Details
Covered Uses	Adjunctive treatment for homozygous familial hypercholesterolemia (HoFH).
Exclusion Criteria	
Required Medical Information	Clinical ASCVD: • Documented history of clinical ASCVD or has experienced a cardiovascular event AND Documentation of a current LDL greater than or equal to 70 mg/dl AND • Documentation of at least one of the following: o Member is receiving maximally tolerated statin therapy (or is statin intolerant) AND o is receiving ezetimibe or documented intolerance to ezetimibe Primary or familial hyperlipidemia: • Documentation of an untreated (i.e., prior to lipid lowering therapy) LDL greater than 190 mg/dL AND • Documentation of current LDL greater than 100 mg/dL AND • Documentation of at least one of the following: o Member is receiving maximally tolerated statin therapy (or is statin intolerant) AND o Is receiving ezetimibe or documented intolerance to ezetimibe Homozygous Familial Hyperlipidemia: • Documentation of an untreated (i.e., prior to lipid lowering therapy) LDL greater than 190 mg/dL AND • Documentation of current LDL greater than 100 mg/dL AND • Documentation of at least one of the following: o Member is receiving maximally tolerated statin therapy (or is statin intolerant) AND o Is receiving ezetimibe or documented intolerance to ezetimibe

PA Criteria	Criteria Details
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Ambrisentan (Letairis)

Products Affected

- AMBRISENTAN

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	• Pregnancy. • Idiopathic pulmonary fibrosis, including idiopathic pulmonary fibrosis with pulmonary hypertension (WHO Group 3).
Required Medical Information	Diagnosis of pulmonary arterial hypertension (PAH) World Health Organization (WHO Group 1) confirmed by right heart catheterization OR patient is currently on any therapy for the diagnosis of PAH. Documented failure or incomplete response to or being co-prescribed with tadalafil
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy. Note: Letairis (ambrisentan) has a black box warning for embryo-fetal toxicity. Because of the risks of birth defects, Letairis is available for females only through a special restricted distribution program under a Risk Evaluation and Mitigation Strategy (REMS).

Apremilast (Otezla)

Products Affected

- **OTEZLA**

PA Criteria	Criteria Details
Covered Uses	Plaque Psoriasis, Psoriatic Arthritis, Oral Ulcers Associated with Behcet's Disease
Exclusion Criteria	
Required Medical Information	Diagnosis of moderate to severe plaque psoriasis OR Diagnosis of active psoriatic arthritis OR Diagnosis of Behçet's Disease AND Patient has active oral ulcers.
Age Restrictions	
Prescriber Restrictions	Plaque psoriasis: Prescribed by or in consultation with a dermatologist. Psoriatic arthritis: Prescribed by or in consultation with a dermatologist or rheumatologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: PP: Documentation of positive clinical response to therapy as evidenced by ONE of the following: Reduction the body surface area (BSA) involvement from baseline OR improvement in symptoms (e.g., pruritus, inflammation) from baseline. PA: Documentation of positive clinical response to therapy (e.g., improvement in number of swollen/tender joints, pain, or stiffness). Behçet's Disease: Documentation of positive clinical response to therapy (e.g., reduction in pain from oral ulcers or reduction in number of oral ulcers).

Aripiprazole (Abilify)

Products Affected

- ARIPIPRAZOLE

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosed with Major Depressive Disorder (MDD): Failure or intolerance to at least 2 first line antidepressant agents AND prescribed for concurrent use with an antidepressant OR patient is new to the plan and has been receiving aripiprazole therapy for greater than 4 weeks. Diagnosed with schizophrenia, Bipolar I Disorder with acute manic or mixed episodes, irritability due to autism spectrum disorder, Tourette's disorder, Attention-deficit/hyperactivity disorder (ADHD), or Conduct disorder with aggression AND failure or intolerance to any generic atypical antipsychotic: quetiapine, ziprasidone, risperidone, olanzapine, or clozapine OR member is new to plan and has been receiving aripiprazole therapy with success.
Age Restrictions	Irritability in autism, conduct disorder, and Tourette's disorder: greater than or equal to 6 years. Bipolar I disorder: greater than or equal to 10 years. Schizophrenia: greater than or equal to 13 years. ADHD: greater than or equal to 8 years.
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Avonex Pen

Products Affected

- **AVONEX PEN**
- **AVONEX PREFILLED**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of a relapsing form of Multiple Sclerosis (i.e., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	QL: 1 kit (4 syringes) per 28 days

Bosentan (Tracleer)

Products Affected

- BOSENTAN

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	• Female and pregnant. • Concomitant use with glyburide or cyclosporine.
Required Medical Information	Pulmonary arterial hypertension (PAH): Diagnosed with PAH WHO Group 1 confirmed by right heart catheterization. Documentation of NYHA Functional Classification II, III, or IV symptoms AND documented normal liver function tests prior to initiation.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

BUTRANS, BUPRENORPHINE PATCH, BELBUCA

Products Affected

- **BELBUCA**
- BUPRENORPHINE PATCH

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Cancer or End-of-Life Care: Patient is being treated for cancer related pain or pain associated with end-of-life. Documented trial and failure of, scheduled short-acting opioid therapy AND documented trial and failure or contraindication to long-acting morphine sulfate therapy. Documented trial/failure of, or reason why fentanyl is not appropriate. Other Chronic Pain: Documented above the line diagnosis, FDA indicated, or guideline supported condition. Documented severe chronic pain (greater than 3mo) that is severe enough to require around the clock analgesic therapy AND documented trial and failure or contraindication to short-acting opioid therapy AND documented trial and failure of, or contraindication to long-acting morphine sulfate therapy. Documented trial and failure of, or reason why fentanyl is not appropriate.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial cancer/end of life: 12 months. Initial non-cancer/end of life: 6 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy.

C1 Inhibitor (Cinryze)

Products Affected

- **CINRYZE**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Hereditary angioedema (HAE): Diagnosed with HAE. Prescribed for routine prophylaxis against angioedema attacks.
Age Restrictions	
Prescriber Restrictions	HAE (prophylaxis, treatment): Prescribed by an immunologist, allergist, or rheumatologist
Coverage Duration	Initial: 12 months. Renewal: 12 months
Other Criteria	Renewal Criteria: Documentation of continued need/effectiveness.

Certolizumab Pegol (Cimzia)

Products Affected

- CIMZIA KIT 200MG
- CIMZIA PREFL KIT 200MG/ML
- CIMZIA START KIT 200MG/ML

PA Criteria	Criteria Details
Covered Uses	Crohn's Disease, Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Plaque Psoriasis, Non-radiographic Axial Spondyloarthritis
Exclusion Criteria	
Required Medical Information	**Crohn's Disease (CD):** Diagnosis of moderately to severely active Crohn's disease AND Trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: 6-mercaptopurine (Purinethol), Azathioprine (Imuran), Corticosteroids (e.g., prednisone, methylprednisolone), Methotrexate (Rheumatrex, Trexall). **Rheumatoid Arthritis (RA):** Diagnosis of moderately to severely active RA AND trial and failure, contraindication or intolerance to one non-biologic DMARD [e.g., Rheumatrex/Trexall (methotrexate), Arava (leflunomide), Azulfidine (sulfasalazine)]. **Psoriatic Arthritis (PsA):** Diagnosis of active psoriatic arthritis. **Ankylosing Spondylitis (AS):** Diagnosis of active ankylosing spondylitis AND Trial and failure, contraindication, or intolerance to two NSAIDs. **Plaque Psoriasis (PsO):** Diagnosis of moderate to severe plaque psoriasis. **Non-radiographic Axial Spondyloarthritis:** Diagnosis of active non-radiographic axial spondyloarthritis AND patient has objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) AND trial and failure, contraindication, or intolerance to two NSAIDs.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	**CD:** Prescribed by or in consultation with a gastroenterologist **RA, AS, Non-radiographic Axial Spondyloarthritis:** Prescribed by or in consultation with a rheumatologist **PsA:** Prescribed by or in consultation with one of the following: Dermatologist or Rheumatologist **PsO:** Prescribed by or in consultation with a dermatologist
Coverage Duration	**CD:** Initial: 16 weeks; Renewal: 12months **RA, PsA, AS, PsO, Non-radiographic Axial Spondyloarthritis:** Initial: 12 months; Renewal: 12 months
Other Criteria	Renewal Criteria **CD, RA, AS, PsA, Non-radiographic Axial Spondyloarthritis:** Documentation of positive clinical response to therapy. **PsO:** Documentation of positive clinical response to therapy as evidenced by ONE of the following: Reduction the body surface area (BSA) involvement from baseline OR Improvement in symptoms (e.g., pruritus, inflammation) from baseline

Continuous Glucose Monitor (CGM)

Products Affected

- **DEXCOM G6 RECEIVER**
- **DEXCOM G6 SENSOR**
- **DEXCOM G6 TRANSMITTER**
- **FREESTYLE LIBRE 14 DAY READER**
- **FREESTYLE LIBRE 14 DAY SENSOR**
- **FREESTYLE LIBRE 2 READER**
- **FREESTYLE LIBRE 2 SENSOR**
- **FREESTYLE LIBRE READER**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Patient has documented diagnosis of type 1 or type 2 diabetes mellitus. Patient must have ALL of the following: • Intensive insulin regimen (3 or more insulin injections per day, or use of continuous subcutaneous insulin infusion pump). • Patient consistently monitors blood glucose 3 or more times per day. • Patient is motivated and knowledgeable about use of continuous glucose monitoring, is adherent to diabetic treatment plan, and participates in ongoing education and support. • Member must have 1 OR more of the following: o Dawn phenomenon, known or suspected, Hypoglycemic unawareness (i.e., patient does not have symptoms with hypoglycemia). o Nocturnal hypoglycemia, known or suspected. o Postprandial hyperglycemia, known or suspected. o Significant change to diabetes treatment regimen (e.g., initiation of insulin, change from multiple-dose insulin to insulin pump therapy). o Unexplained hyperglycemia.
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	Initial: 6 months. Renewal: 6 months.
Other Criteria	

Cyclosporine ophthalmic emulsion (Restasis)

Products Affected

- **RESTASIS**
- **RESTASIS MULTIDOSE**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	The patient has a diagnosis of lack of tear production due to ocular inflammation associated with keratoconjunctivitis sicca AND ONE of the following: • The patient is not currently using a topical ophthalmic anti-inflammatory drug or punctal plug OR • The patients current use of topical ophthalmic anti-inflammatory drug or punctal plug will be discontinued before starting the requested agent AND The patient has previously tried or is currently using aqueous enhancements (e.g. artificial tears, gels, ointments) OR • The patient has a documented intolerance, contraindication, or hypersensitivity to aqueous enhancements. The patient is not currently using Xiidra OR the patients current use of Xiidra will be discontinued before starting Restasis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months.
Other Criteria	

Dimethyl Fumarate (Tecfidera)

Products Affected

- DIMETHYL FUMARATE
- DIMETHYL FUMARATE STARTER PACK

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Multiple sclerosis: Patient is diagnosed with relapsing forms of multiple sclerosis.
Age Restrictions	
Prescriber Restrictions	Prescribed by a neurologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Direct-Acting Antivirals (use in Hepatitis C)

Products Affected

- LEDIPASVIR-SOFOSBUVIR
- **MAVYRET**
- SOFOSBUVIR-VELPATASVIR
- **SOVALDI**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Treatment of Hepatitis C: • Expected survival from non-HCV-associated morbidities more than 1 year. • Must have all pretreatment testing completed: including genotype, HBV, HIV, and cirrhosis status. • Care must be provided by or in consultation with a specialist (hepatologist, gastroenterologist, or infectious disease specialist). • Attestation that the patient and provider will comply with case management to promote the best possible outcome for the patient and adhere to monitoring requirements required by the Oregon Health Authority, including measuring and reporting of a posttreatment viral load OR attestation from the patient and provider that they have opted out of OHA case management. Case management includes assessment of treatment barriers and offer of patient support to mitigate potential barriers to regimen adherence as well as facilitation of SVR12 evaluation to assess treatment success. • Documentation if the patient has a GT 1a infection or GT 3 infection AND the patient had a baseline NS5a resistance test that documents a resistant variant to Elbasvir/grazoprevir or Daclatasvir + sofosbuvir. Note: Baseline NS5A resistance testing is required. • Documentation of the prescribed regimen includes a NS3/4a protease inhibitor (glecaprevir, simeprevir, paritaprevir, voxilaprevir). • Documentation if the patient has moderate-severe hepatic impairment (Child-Pugh B or Child-Pugh C).

PA Criteria	Criteria Details
	• Documentation if the prescribed regimen for the retreatment after failure of a DAA due to noncompliance or loss of follow-up AND the prescribed drug regimen is a recommended regimen based on the patient's genotype, age, treatment status (retreatment or treatment naive) and cirrhosis status.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a hepatologist, gastroenterologist, or infectious disease specialist
Coverage Duration	Initial: 2-4 months.
Other Criteria	

Dupilumab (Dupixent)

Products Affected

- **DUPIXENT**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Moderate to severe Asthma with inadequate control of asthma symptoms with one of the following: inhaled corticosteroids and long acting beta2 agonist OR inhaled corticosteroids and long-acting muscarinic antagonist. Atopic Dermatitis: Diagnosed with severe atopic dermatitis as defined by having functional impairment (i.e., inability to use hands or feet for activities of daily living or significant facial involvement preventing normal social interaction) AND one or more of the following: • At least 10% of body surface area involvement OR hand, foot or mucous membrane involvement. Failed, contraindicated or intolerance to a 12-week trial of at least 2 prescription strength topical corticosteroids.
Age Restrictions	12 years and older.
Prescriber Restrictions	Atopic dermatitis: Prescribed by a dermatologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Emgality

Products Affected

- **Emgality**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of cluster headache AND None of the following exclusions: • ECG abnormalities compatible with an acute CV event • History of unstable angina, percutaneous coronary intervention, coronary artery bypass grafting, deep vein thrombosis, or pulmonary embolism within the past 6 months • History of stroke, intracranial or carotid aneurysm, intracranial hemorrhage, vasospastic angina, peripheral vascular disease AND Tried and Failed a 3-month trial of verapamil and topiramate.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Initial: 3 months Renewal: 6 months
Other Criteria	

Epoetin Alpha (Procrit, Epogen)

Products Affected

- **PROCRIT**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Uncontrolled hypertension. Pure Red Cell Aplasia (PRCA) that begins after treatment with epoetin alfa or other epoetin protein drugs. Multidose vials contain benzyl alcohol and are contraindicated in neonates, infants, pregnant women, and breastfeeding women.
Required Medical Information	Anemia due to Chronic Kidney Disease (CKD). Anemia with hematocrit less than 30% or hemoglobin less than 10g/dL within 30 days of request AND patient is on dialysis OR patient is not on dialysis but the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia in HIV Patients: Anemia with hematocrit less than 36% or hemoglobin is less than 12 g/dL collected within 30 days of request, Serum erythropoietin less than or equal to 500mU/mL. Patient is receiving zidovudine therapy or diagnosed with HIV. Anemia due to Chemotherapy: Anemia with hematocrit less than 30% & hemoglobin less than 10 g/dL collected within the prior 2 weeks of request. All other causes of anemia have been ruled out, cancer is a non-myeloid malignancy AND patient is concurrently on chemo OR will receive concomitant chemo for a minimum of 2 months OR anemia is caused by cancer chemo (will not be approved if patient is not receiving cancer chemotherapy). Preoperative for reduction of allogeneic blood transfusion: Patient scheduled for an elective, non-cardiac, non-vascular surgery. Perioperative hemoglobin is greater than 10 to less than or equal to 13 g/dL AND patient is at high risk of blood loss AND patient is unwilling or unable to donate autologous blood pre-operatively. Anemia in Myelodysplastic Syndrome (MDS): Diagnosis of MDS. Serum erythropoietin less than or equal to 500mU/mL OR diagnosis of transfusion dependent MDS.

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months. Preop Initial: 1 month.
Other Criteria	Renewal criteria: Patient has a documented continued need for therapy demonstrated by an improvement in the hematocrit and hemoglobin levels or by a significant decrease in transfusion requirements.

Erenumbab (Aimovig)

Products Affected

- **AIMOVIG 70 mg/mL**
- **AIMOVIG 140 mg/mL**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Experiences at least 4 migraines per month AND Trial and failure (defined as at least an 8-week trial) of 3 prophylactic medications from at least 2 different therapeutic classes including beta blockers, antidepressants, and anticonvulsants (e.g. propranolol, amitriptyline, topiramate). If member has chronic migraine (≥ 15 headache days & 8 migraine episodes per month) then trial and failure or intolerance to Botox • Allow for at least 30 days after Botox for CGRP approval
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Initial: 3 months. Renewal: 6 months.
Other Criteria	Renewal Criteria: shows reduction in monthly headache days by at least 2 days from pre-CGRP treatment baseline. Clinical documented improvement in migraine-related disability.

Etanercept (Enbrel)

Products Affected

- **ENBREL**
- **ENBREL SURECLICK**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	ALL: must have a negative tuberculin test (TB) AS: Patient has a documented diagnosis of ankylosing spondylitis. Clinical documentation showing an inadequate response, intolerance, or contraindication to one or more non-steroidal anti-inflammatory drugs NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures) or analgesic agents if NSAIDs do not completely control the pain, or sulfasalazine (if peripheral joint involvement is present). CD: Clinical documentation showing an inadequate response, intolerance, or contraindication to budesonide, mesalamine, or corticosteroids, or non-biologic DMARDs (i.e., azathioprine, methotrexate, mercaptopurine. JIA: Clinical documentation showing inadequate response, intolerance, or contraindication to one or more NSAID AND one or more non-biologic DMARD (i.e., methotrexate, sulfasalazine). PP: Patient has documented diagnosis of moderate to severe plaque psoriasis for at least 6 months with at least one of the following: • Incapacitation due to plaque location (e.g., head and neck, palms, soles, or genitalia) OR • Involvement of at least 10 percent of body surface area (BSA) OR • Psoriasis Area and Severity Index (PASI) score of 12 or greater, AND patient is free of any clinically important active infections AND clinical documentation of inadequate or non-candidate to a 3-month minimum trial of at least 1 systemic agent (e.g., immunosuppressive, retinoic acid derivatives, and/or methotrexate, AND did not respond or non-candidate to a 3-month minimum trial of phototherapy.
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Evolocumab (Repatha)

Products Affected

- **REPATHA**
- **REPATHA PUSHTRONEX SYSTEM**
- **REPATHA SURECLICK**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Clinical ASCVD: Documented history of clinical ASCVD or has experienced a cardiovascular event AND Documentation of a current LDL greater than or equal to 70 mg/dl AND Documentation of at least one of the following: • Member is receiving maximally tolerated statin therapy AND is receiving ezetimibe or documented intolerance to ezetimibe • Member is statin intolerant AND is receiving ezetimibe or documented intolerance to ezetimibe. Primary or familial hyperlipidemia: Documentation of an untreated (i.e., prior to lipid lowering therapy) LDL greater than 190 mg/dL AND Documentation of current LDL greater than 100 mg/dL AND Documentation of at least one of the following: • Member is receiving maximally tolerated statin therapy AND is receiving ezetimibe or documented intolerance to ezetimibe. • Member is statin intolerant AND is receiving ezetimibe or documented intolerance to ezetimibe.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	

Exkivity (mobocertinib)

Products Affected

- Exkivity

PA Criteria	Criteria Details
Covered Uses	Locally advanced or metastatic non-small cell lung cancer (NSCLC) with epidermal growth factor receptor (EGFR) exon 20 insertion mutations whose disease has progressed on or after platinum-based chemotherapy.
Exclusion Criteria	
Required Medical Information	Treatment being prescribed or supervised by a hematologist, or oncologist as appropriate for the type of cancer AND treatment supported for the diagnosis in NCCN guidelines AND treatment being used according to FDA indication AND prior trial and failure of contraindication to Rybrevant (amivantamab).
Age Restrictions	18 and older
Prescriber Restrictions	Oncologist or Hematologist
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Clinical documentation showing continued adherence and toleration with lack of disease progression

Ezetimibe (Zetia)

Products Affected

- EZETIMIBE

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Patient must be on maximum dosing of a first line HMG-CoA inhibitor and not successfully controlled. Hypercholesterolemia when a statin is contraindicated or not tolerated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Fingolimod (Gilenya)

Products Affected

- **GILENYA**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Multiple sclerosis: Patient is diagnosed with relapsing forms of multiple sclerosis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Fotivda

Products Affected

- **FOTIVDA**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of metastatic renal cell carcinoma AND Tried and failed at least two systemic therapies with at least one including a VEGF-TKI AND Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1 Maximum monthly dose of 21 per 28 days
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by oncologist
Coverage Duration	Initial: 3 months. Renewal: up to 12 months.
Other Criteria	Renewal Criteria: Clinical documentation of provider follow-up indicating safety and efficacy with medication adherence over previous approval duration

Fremanezumab-vfrm (Ajovy)

Products Affected

- **Ajovy**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Experiences at least 4 migraines per month AND Trial and failure (defined as at least an 8-week trial) of 3 prophylactic medications from at least 2 different therapeutic classes including beta blockers, antidepressants, and anticonvulsants (e.g. propranolol, amitriptyline, topiramate). If member has chronic migraine (≥ 15 headache days & 8 migraine episodes per month) then trial and failure or intolerance to Botox • Allow for at least 30 days after Botox for CGRP approval
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with a neurologist
Coverage Duration	Initial: 3 months. Renewal: 6 months.
Other Criteria	Renewal Criteria: shows reduction in monthly headache days by at least 2 days from pre-CGRP treatment baseline. Clinical documented improvement in migraine-related disability.

Glucagon-Like Peptide-1 (GLP-s) Receptor Agonist

Products Affected

- **BYDUREON BCISE**
- **BYETTA 10 MCG PEN**
- **BYETTA 5 MCG PEN**
- **TRESIBA FLEXTOUCH**
- **TRULICITY**
- **VICTOZA**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Patient must have clinically diagnosed Type 2 Diabetes. Patient must have adequate trial of, or contraindication to an SGLT-2 if member has HF or high risk/established ASCVD or a DPP-4 if no high risk/established ASCVD AND a maximal tolerated doses of metformin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months, Renewal: 12 months.
Other Criteria	

Golimumab (Simponi)

Products Affected

- SIMPONI INJ 50/0.5ML
- SIMPONI INJ 100MG/ML

PA Criteria	Criteria Details
Covered Uses	Rheumatoid Arthritis (RA) Psoriatic Arthritis (PsA) Ankylosing Spondylitis (AS) Polyarticular Juvenile Idiopathic Arthritis (PJIA) Ulcerative Colitis (UC)
Exclusion Criteria	
Required Medical Information	**Rheumatoid Arthritis (RA):** Diagnosis of moderately to severely active RA AND one of the following: Patient is receiving concurrent therapy with methotrexate (Rheumatrex, Trexall) OR Trial and failure, contraindication or intolerance to methotrexate (Rheumatrex, Trexall) **Psoriatic Arthritis (PsA):** Diagnosis of active PsA **Ankylosing Spondylitis (AS):** Diagnosis of active ankylosing spondylitis AND trial and failure, contraindication, or intolerance to two NSAIDs (e.g., diclofenac, ibuprofen, indomethacin, meloxicam, naproxen). **Polyarticular Juvenile Idiopathic Arthritis (PJIA):** Diagnosis of moderate to severely active PJIA AND trial and failure, contraindication, or intolerance to one of the following non-biologic disease-modifying antirheumatic drugs (DMARDs): Arava (leflunomide), methotrexate (Rheumatrex/Trexall). **Ulcerative Colitis (UC):** Diagnosis of moderately to severely active ulcerative colitis AND one of the following: patient is corticosteroid dependent (i.e., an inability to successfully taper corticosteroids without a return of the symptoms of UC) OR trial and failure, contraindication, or intolerance to one of the following conventional therapies: 6-mercaptopurine (Purinethol), Aminosalicylate [e.g., mesalamine (Asacol, Pentasa, Rowasa), olsalazine (Dipentum), sulfasalazine (Azulfidine, Sulfazine)], Azathioprine (Imuran), Corticosteroids (e.g., prednisone, methylprednisolone).
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	**(RA) (AS) PJIA):** Prescribed by or in consultation with a rheumatologist **(PsA):** Prescribed by or in consultation with one of the following: Dermatologist OR Rheumatologist **(UC):** Prescribed by or in consultation with a gastroenterologist
Coverage Duration	**(RA) (PsA) (AS) PJIA)** Initial: 12 months; Renewal: 12 months **(UC)** Initial: 10 weeks; Renewal: 12 months
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy.

Grass Pollen Allergen Extract -Timothy Grass (Grastek)

Products Affected

- **GRASTEK**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Grass pollen-induced allergic rhinitis.
Age Restrictions	
Prescriber Restrictions	Prescribed by Allergy and Immunology specialist.
Coverage Duration	Initial: 3 months. Renewal: 3 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Ibrutinib (Imbruvica)

Products Affected

- **IMBRUVICA**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Documentation of one of the following: • Diagnosis of Mantle Cell Lymphoma (MCL) AND patient has relapsed or is refractory to at least one prior therapy for the treatment of MCL. • Diagnosis of Chronic Lymphocytic Leukemia (CLL) OR Small Lymphocytic Lymphoma (SLL). • Diagnosis of Marginal Zone Lymphoma (MZL) AND patient has received at least one prior anti-CD20- based therapy. • Diagnosis of Waldenstrms macroglobulinemia (WM) of Waldenstrms macroglobulinemia/lymphoplasmacytic lymphoma.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an oncologist or hematologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Infliximab (Remicade)

Products Affected

- **REMICADE**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Ankylosing Spondylitis: Clinically diagnosed ankylosing spondylitis. Failed/ intolerant to at least one DMARD. Failed/ intolerant to Methotrexate. Failed/ intolerant to Enbrel. Crohn's Disease/Fistulizing Crohn's disease: Clinically diagnosed Crohn's disease. Failed/Intolerant to at least one corticosteroid. Failed/Intolerant to at least of the following: osulfasalazine (Azulfindine) omesalazine (Asacol, Pentasa). Failed/Intolerant to at least one of the following: azathioprine (Imuran), 6-mercaptopurine (Purinethol), methotrexate. Plaque Psoriasis: Clinically diagnosed plaque psoriasis. Failed/ intolerant to corticosteroids. Failed/ intolerant to Methotrexate. Failed/ intolerant to Enbrel. Moderate to severe psoriasis is defined as having functional impairment and one or more of the following: At least 10% of body surface area involved and or hand foot or mucous membrane involvement. Psoriatic Arthritis: Clinically diagnosed psoriatic arthritis. Failed/ intolerant to corticosteroids. Failed/ intolerant to Methotrexate. Failed/ intolerant to Enbrel or Humira. Rheumatoid Arthritis: Clinically diagnosed rheumatoid arthritis. Failed/ intolerant to at least one DMARD. Failed/ intolerant to Enbrel or Humira if the patient is less than 65 years old. Ulcerative Colitis: Clinically diagnosed ulcerative colitis Failed/intolerant to one aminosalicylate, oral mesalamine (Asacol, Pentasa), topical mesalamine (Rowasa enema, suppository and Canasa suppository), sulfasalazine (Azulfidine), olsalazine (Dipentum), or balsalazide (Colazal). Failed/intolerant to corticosteroids. Failed/intolerant to azathiprine and mercaptopurine.

PA Criteria	Criteria Details
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Insulin Degludec (Tresiba)

Products Affected

- **TRESIBA FLEXTOUCH**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	(both U-100 & U-200) Must have tried and failed basaglar or have documented intolerance or contraindication to basaglar AND have significant barriers to standardized administration requiring flexibility in dose timing. (U-200) Patient must require greater than 160 units of insulin per dose AND have difficulty with multiple daily injections.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness

Interferon Alfa-2b (Intron A)

Products Affected

- **INTRON A**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	• Decompensated liver disease. • Autoimmune hepatitis. • Combination therapy with interferon alfa-2b and ribavirin is contraindicated in women who are pregnant & in males with pregnant partners. • Combination therapy with interferon alfa-2b and ribavirin is contraindicated in patients with hemoglobinopathies (e.g., thalassemia major, sickle-cell anemia).
Required Medical Information	Chronic hepatitis B: Diagnosed with chronic hepatitis B infection AND patient is without decompensated liver disease. Chronic hepatitis C: Diagnosed with chronic hepatitis C infection AND patient is without decompensated liver disease AND patient has not previously been treated with interferon AND is prescribed for use with ribavirin OR patient has intolerance or contraindication to ribavirin. Metastatic renal cell carcinoma (RCC): Diagnosed with metastatic RCC AND prescribed in combination with Avastin (bevacizumab). AIDS-related Kaposi sarcoma (KS): Diagnosed with AIDS-related KS. Condylomata acuminata (CA): Diagnosed with CA involving external surfaces of the genital & perianal areas. Follicular lymphoma (FL): Diagnosed with clinically aggressive follicular non-Hodgkin lymphoma. Prescribed in conjunction with anthracycline-containing combination chemotherapy. Hairy cell leukemia (HCL): Diagnosed with HCL. Melanoma: Diagnosed with malignant melanoma. Prescribed as adjuvant to surgical treatment who are free of disease but at high risk for systemic recurrence AND must be administered within 56 days of surgery.
Age Restrictions	Patient must be 18 years or older.

PA Criteria	Criteria Details
Prescriber Restrictions	Prescribed by a specialist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy.

Invega Hafyera

Products Affected

- **INVEGA HAFYERA**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Clinical documentation of a diagnosis of schizophrenia and trial and failure (defined by at least 6 months of treatment) of Invega Trinza or Invega Sustenna AND Clinical need or concern for adherence which could be improved upon with twice yearly dosing.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal criteria: Documentation of positive clinical response to therapy.

Ivermectin (Stromectol)

Products Affected

- IVERMECTIN

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	For treatment or prevention of Sars-CoV-2 infection (COVID-19).
Required Medical Information	Treatment of FDA approved diagnosis including Strongyloidiasis, Onchocerciasis, Infestation by Phthirus pubis, Scabies, Enterobiasis
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 months, renewals: reinfection 6 months
Other Criteria	

Ixekizumab (Taltz)

Products Affected

- **TALTZ**

PA Criteria	Criteria Details
Covered Uses	Plaque Psoriasis, Psoriatic Arthritis, Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis
Exclusion Criteria	
Required Medical Information	**Plaque Psoriasis (PP):** Diagnosis of moderate to severe plaque psoriasis AND Trial and failure, contraindication, or intolerance to ONE of the following: (Cimzia, Humira, Skyrizi, Stelara, Tremya). **Psoriatic Arthritis (PsA):** Diagnosis of active psoriatic arthritis AND Trial and failure, contraindication, or intolerance to ONE of the following: (Cimzia, Humira, Simponi, Stelara, Tremfya) **Ankylosing Spondylitis (AS):** Diagnosis of active ankylosing spondylitis AND Trial and failure, contraindication, or intolerance to TWO non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, indomethacin, meloxicam, naproxen) AND Trial and failure, contraindication, or intolerance to ONE of the following: (Cimzia, Humira, Simponi) **Non-radiographic Axial Spondyloarthritis:** Diagnosis of active non-radiographic axial spondyloarthritis AND Patient has objective signs of inflammation (e.g., C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) AND Trial and failure, contraindication, or intolerance to TWO non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, meloxicam, naproxen) AND Trial and failure, contraindication, or intolerance to Cimzia.
Age Restrictions	
Prescriber Restrictions	**Plaque Psoriasis (PP):** Prescribed by or in consultation with a dermatologist **Psoriatic Arthritis (PsA):** Prescribed by or in consultation with a dermatologist or rheumatologist

PA Criteria	Criteria Details
	Ankylosing Spondylitis (AS): Prescribed by or in consultation with a rheumatologist **Non-radiographic Axial Spondyloarthritis:** Prescribed by or in consultation with a rheumatologist
Coverage Duration	Initial: 12 months; Renewal: 12 months
Other Criteria	**PsA, AS, Non-radiographic Axial Spondyloarthritis** Renewal Criteria: Documentation of positive clinical response to therapy. **Plaque Psoriasis (PP):** Renewal Criteria: Documentation of positive clinical response to therapy as evidenced by ONE of the following: Reduction of body surface area involvement from baseline or improvement in symptoms (e.g. pruritus, inflammation) from baseline.

Kalydeco

Products Affected

- **KALYDECO**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of Cystic Fibrosis with documentation showing at least one CFTR gene mutation that has shown to be responsive to Kalydeco
Age Restrictions	6 months of age and older
Prescriber Restrictions	Prescribed by pulmonologist
Coverage Duration	Initial: 3 months Renewal: 6 months
Other Criteria	

Lenvima (Lenvatinib)

Products Affected

- **Lenvima**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Endometrial carcinoma (EC): Has advanced EC that is not microsatellite instability-high (MIS-H) or mismatch repair deficient (dMMR) AND has tried at least one systemic therapy AND is not a candidate for curative therapy. Hepatocellular Cancer (HCC): Has unresectable or metastatic disease Renal Cell Carcinoma (RCC): Has advanced disease AND is either being used in combination with Keytruda OR an everolimus. Thyroid Carcinoma, differentiated (DTC): Diagnosed with differentiated thyroid carcinoma AMD disease is refractory to radioactive iodine therapy.
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by oncologist
Coverage Duration	Initial: 3 months Renewal: 6 months
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy

Lidoderm (Topical Anesthetic)

Products Affected

- LIDOCAINE EXTERNAL PATCH

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of post-herpetic neuralgia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months. Renewal: 3 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Lifitegrast (Xiidra)

Products Affected

- **XIIDRA**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	The patient has a diagnosis of lack of tear production due to ocular inflammation associated with keratoconjunctivitis sicca AND ONE of the following: • The patient is not currently using a topical ophthalmic anti-inflammatory drug or punctal plug OR • The patients current use of topical ophthalmic anti-inflammatory drug or punctal plug will be discontinued before starting the requested agent AND The patient has previously tried or is currently using aqueous enhancements (e.g. artificial tears, gels, ointments) OR • The patient has a documented intolerance, contraindication, or hypersensitivity to aqueous enhancements. The patient is not currently using Restasis OR the patients current use of Restasis will be discontinued before starting Xiidra.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months.
Other Criteria	

Linezolid (Zyvox)

Products Affected

- LINEZOLID
- LINEZOLID IN SODIUM CHLORIDE

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Clinically documented infection that is susceptible to linezolid if the patient has a severe allergy to beta lactamase inhibitors or any antibiotic that the organism is susceptible OR Clinically documented infection that is susceptible to linezolid if the patient has failed treatment with antibiotics that the organism is susceptible OR Clinically documented Vancomycin-Resistant Enterococcus faecium infection OR Clinically documented MRSA and has failed or is intolerant to Vancomycin if the organism is susceptible to Vancomycin.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with an Infectious Disease specialist.
Coverage Duration	Initial: length of treatment. Renewal: length of treatment.
Other Criteria	Renewal Criteria: Documentation of continued need.

Long Acting Opiates and Dolophine

Products Affected

- FENTANYL PATCH 72 HOUR 100 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 12 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 25 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 37.5 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 50 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 62.5 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 75 MCG/HR TRANSDERMAL
- FENTANYL PATCH 72 HOUR 87.5 MCG/HR TRANSDERMAL
- HYDROCODONE BITARTRATE ER
- HYDROMORPHONE HCL ER
- METHADONE HCL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 120 MG ORAL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 30 MG ORAL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 45 MG ORAL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 60 MG ORAL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 75 MG ORAL
- MORPHINE SULFATE ER BEADS CAPSULE EXTENDED RELEASE 24 HOUR 90 MG ORAL
- MORPHINE SULFATE ER ORAL CAPSULE EXTENDED RELEASE 24 HOUR
- MORPHINE SULFATE ER ORAL TABLET EXTENDED RELEASE
- **NUCYNTA ER**
- OXYCODONE HCL ER
- **OXYCONTIN**
- OXYMORPHONE HCL ER
- **XTAMPZA ER**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Cancer, end of life, or palliative care: No coverage restrictions. Non-cancer/end of life care: Documented use of current and/or recent usage of short-acting opioids for at least 15 days prior to long-acting opioids. • For opioid naive (14 or fewer days filled in previous 120 days): 7-day maximum quantity limit, equal to or less than 50 MED [morphine equivalents per day].

PA Criteria	Criteria Details
	• For opioid experienced (greater than or equal to 15 days filled in previous 120 days): equal to or less than 90 MED [morphine equivalents per day]. Restricted to 2 fills in a 60-day period for both naive and experienced.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	

Lorbrena (lorlatinib)

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Covered Uses	Treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors are anaplastic lymphoma kinase (ALK)-positive as detected by an FDA-approved test.
Exclusion Criteria	
Required Medical Information	Treatment being prescribed or supervised by a hematologist, or oncologist as appropriate for the type of cancer AND Treatment supported for the diagnosis in NCCN guidelines AND Treatment being used according to FDA indication AND Trial and failure of one of the following agents: • For diagnosis of ALK-positive arrangement-positive NSCLC, no prior treatment o Alecensa (alectinib) OR Alunbrig (brigatinib) • For diagnosis of ALK-positive arrangement-positive NSCLC when the ALK-rearrangment is discovered during first-line systemic therapy o Alunbrig (brigatnib), OR Zykadia (ceritinib)
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 6 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Clinical documentation showing continued adherence and toleration of Lorbrena with lack of disease progression

Lumakras (sotorasib)

Products Affected

- **LUMAKRAS**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Trial and failure of at least one prior systemic therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 3 months. Renewal: 3 months.
Other Criteria	Renewal Criteria: Clinical documentation of provider follow-up indicating safety and efficacy with medication adherence over previous approval duration.

Methylphenidate solution/chewable

Products Affected

- METHYLPHENIDATE HCL ORAL SOLUTION
- METHYLPHENIDATE HCL ORAL TABLET CHEWABLE

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Documentation that the member has difficulty swallowing pills and/or has tried and failed methylphenidate tablets.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal criteria: Documentation of positive clinical response to therapy.

Nurtec (Rimegepant)

Products Affected

- **Nurtec ODT**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	**Acute treatment:** Trial and failure or contraindication to 2 generic triptans. **Prophylaxis treatment**: Preventative treatment of episodic migraines AND patient has 4 to 18 migraine days per month but no more than 18 headache days per month AND trial and failure of at least 2 months intolerance or contraindication of two of the following sets: Elavil or Effexor; Depakote/Depakote ER or Topamax AND trial and failure of one of the following beta blocker: atenolol, propranolol, nadolol, timolol, or metoprolol AND not used in combination with an injectable CGRP inhibitor.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months; Renewal: 6 months
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy

Orkambi

Products Affected

- **ORKAMBI ORAL PACKET**
- **ORKAMBI ORAL TABLET**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Clinical documentation of cystic fibrosis diagnosis with homozygous F508del mutation.
Age Restrictions	2 years of age and older
Prescriber Restrictions	Prescribed by pulmonologist
Coverage Duration	Initial: 3 months Renewal: 6 months
Other Criteria	

Pancrelipase (Creon, Pancreaze)

Products Affected

- **PANCREAZE**
- **CREON**

PA Criteria	Criteria Details
Covered Uses	Cystic Fibrosis, pancreatectomy, Exocrine Pancreatic Cancer, Chronic Pancreatitis
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of cystic fibrosis. OR History of pancreatectomy. OR Diagnosis of exocrine pancreatic cancer. OR Diagnosis of chronic pancreatitis confirmed by imaging. OR Confirmed diagnosis of pancreatic insufficiency confirmed with one of the following methods: • Steatorrhea with fecal fat determination OR • Measurement of fecal elastase OR Secretin or CCK pancreatic function testing OR • Two of the following CFTR mutations (G542X, W1282X, R553X, 621+1G>T, 1717-1G>A, 3120+1G>A , R1162X, 3659delC, 1898+1G>A, 2184delA, 711+1G>T, F508del, I507del, G551D, N1303K, R560T).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months
Other Criteria	Renewal criteria: Documentation of positive clinical response to therapy

Palivizumab (Synagis)

Products Affected

- **SYNAGIS**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Infants born at less than or equal to 28 weeks 6 days gestational age and less than 12 months at the start of RSV season (November) OR Infants less than 12 months of age with chronic lung disease (CLD) of prematurity OR Infants less than or equal to 12 months of age with hemodynamically significant congenital heart disease (CHD) OR Infants and children less than 24 months of age with CLD of prematurity necessitating medical therapy (e.g., supplemental oxygen, bronchodilator, diuretic, or chronic steroid therapy) within 6 months prior to the beginning of RSV season. AAP also suggests that palivizumab prophylaxis may be considered in the following circumstances: Infants less than 12 months of age with congenital airway abnormality or neuromuscular disorder that decreases the ability to manage airway secretions. Infants less than 12 months of age with cystic fibrosis with clinical evidence of CLD and/or nutritional compromise. Children less than 24 months with cystic fibrosis with severe lung disease (previous hospitalization for pulmonary exacerbation in the first year of life or abnormalities on chest radiography or chest computed tomography that persist when stable) or weight for length less than the 10th percentile. Infants and children less than 24 months who are profoundly immunocompromised. Infants and children less than 24 months undergoing cardiac transplantation during RSV season.
Age Restrictions	Infants and children less than 24 months of age.
Prescriber Restrictions	
Coverage Duration	Initial: 6 months.
Other Criteria	

PEANUT POWDER (Palforzia)

Products Affected

- **PALFORZIA (12 MG DAILY DOSE)**
- **PALFORZIA (120 MG DAILY DOSE)**
- **PALFORZIA (160 MG DAILY DOSE)**
- **PALFORZIA (20 MG DAILY DOSE)**
- **PALFORZIA (200 MG DAILY DOSE)**
- **PALFORZIA (240 MG DAILY DOSE)**
- **PALFORZIA (3 MG DAILY DOSE)**
- **PALFORZIA (300 MG MAINTENANCE)**
- **PALFORZIA (300 MG TITRATION)**
- **PALFORZIA (40 MG DAILY DOSE)**
- **PALFORZIA (6 MG DAILY DOSE)**
- **PALFORZIA (80 MG DAILY DOSE)**
- **PALFORZIA INITIAL ESCALATION**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	History of severe or poorly controlled asthma
Required Medical Information	Confirmed positive skin test or peanut-specific serum IgE greater than 0.35 kUA/L Concurrent prescription with injectable epinephrine medical justification supports necessity for oral immunotherapy despite peanut avoidance.
Age Restrictions	Patient must be between 4 and 17 at therapy initiation
Prescriber Restrictions	Prescribed by allergist or immunologist enrolled in Palforzia REMS program
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Reauthorization: Currently receiving medication byway of previously approved SHP authorization or documents showing initial approval criteria was/has been met. For members who required use of injectable epinephrine while on Palforzia, must have medical justification that supports continued need for Palforzia. If greater than 18 years old, must have medical justification that supports continued need for oral immunotherapy despite peanut avoidance and documentation that initial dose escalation happened between age 4 and 17.

Pramlintide Acetate (Symlin)

Products Affected

- **SYMLINPEN 120**
- **SYMLINPEN 60**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Coverage is provided for the use of pramlintide as an adjunct treatment in type 1 and type 2 diabetic patients 18 or older who use mealtime insulin therapy and who meet all of the following criteria: • Are currently on mealtime insulin. • Have an HbA1c less than or equal to 9%. • Are monitoring blood glucose levels regularly and reliably (3 or more times per day). • Are capable of monitoring blood glucose levels pre- and post-meals and at bedtime. • Have failed to achieve adequate control of blood glucose levels despite individualized management of their insulin therapy. • Are receiving ongoing care under the guidance of a health care provider skilled in use of insulin and supported by the services of a diabetes educator.
Age Restrictions	Patient must be 18 years or older.
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Pregabalin (Lyrica)

Products Affected

- PREGABALIN

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of diabetic neuropathy, post-herpetic neuralgia, neuropathic pain associated with spinal cord injury, or fibromyalgia if the patient has experienced an inadequate treatment response, intolerance, or contraindication to gabapentin. Diagnosis of partial-onset seizures if the patient is currently receiving another anticonvulsant medication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Ranolazine (Ranexa)

Products Affected

- RANOLAZINE ER

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of chronic angina not controlled with other antianginal therapy. May be used with beta-blockers, nitrates, calcium channel blockers, anti-platelet therapy, lipid-lowering therapy, ACE inhibitors, and angiotensin receptor blockers.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Rezurock (belumosuil)

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosed with chronic graft-versus-host disease (cGVHD) AND who have tried and failed of at least two prior lines of systemic therapy for cGVHD AND not currently taking Imbruvica (ibrutinib)
Age Restrictions	12 years of age or older
Prescriber Restrictions	Prescribed by oncologist or transplant specialist
Coverage Duration	Initial: 3 months. Renewal: 6 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Ribavirin

Products Affected

- RIBAVIRIN INHALATION

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Chronic Hepatitis C Virus (HCV), Genotype 1 or 4: Chart notes / written medical summary documenting diagnosis of Chronic HCV are required. Recent lab reports documenting elevated HCV RNA are required, along with genotype. Chronic Hepatitis C Virus (HCV), Genotype 2,3, 5, or 6: Chart notes / written medical summary documenting diagnosis of Chronic HCV are required. Recent lab reports documenting elevated HCV RNA are required, along with genotype. Respiratory Syncytial Virus (RSV) Infection: Chart notes / written medical summary documenting diagnosis of RSV.
Age Restrictions	
Prescriber Restrictions	Request is initiated by a GI or infectious disease specialist.
Coverage Duration	Initial: 3 months.
Other Criteria	

Rifaximin (Xifaxan)

Products Affected

- **XIFAXAN**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of IBS with diarrhea or Hepatic Encephalopathy. For HE must have one of the following: used as add-on therapy to lactulose AND unable to achieve an optimal clinical response with lactulose monotherapy OR a history of contraindication or intolerance to lactulose.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	IBS-D Initial: 14 Days. Renewal: 30 Days. HE Initial: 12 months. Renewal: 12 months.
Other Criteria	

Rinvoq (Upadacitinib)

Products Affected

- **Rinvoq**

PA Criteria	Criteria Details
Covered Uses	Rheumatoid Arthritis & Psoriatic Arthritis
Exclusion Criteria	
Required Medical Information	**Rheumatoid Arthritis (RA)** Indicated for the treatment of adults with moderately to severely active rheumatoid arthritis who have had an inadequate response or intolerance to one or more TNF blockers. Limitation of Use: Use of Rinvoq in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine, is not recommended. **Psoriatic Arthritis (PsA**) Indicated for the treatment of adults with active psoriatic arthritis who have had an inadequate response or intolerance to one or more TNF blockers. Limitation of Use: Use of Rinvoq in combination with other JAK inhibitors, biologic DMARDs, or with potent immunosuppressants such as azathioprine and cyclosporine, is not recommended.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a rheumatologist **(RA& PsA)** or dermatologist **(PsA ONLY)**
Coverage Duration	Initial: 12 months. Renewal: 12 months
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy and patient is not receiving Rinvoq in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine).

Roflumilast (Daliresp)

Products Affected

- **DALIRESP**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of moderate to severe COPD and patient has chronic bronchitis and patient has tried and failed or has an intolerance or contraindication to two previous COPD therapies (Advair HFA, Advair Diskus, Breo Ellipta, Combivent Respimat, Anoro Ellipta, Dulera, Symbicort).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	COPD Initial: 12 months. CPOD Renewal: 12 months.
Other Criteria	COPD Renewal Criteria: Documentation of positive clinical response to Daliresp therapy.

Sacubitril/Valsartan (Entresto)

Products Affected

- **ENTRESTO**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	History of angioedema related to previous ACE inhibitor or ARB therapy; pregnancy
Required Medical Information	The patient has a diagnosis of New York Heart Association class II to IV heart failure AND The patient is receiving concomitant therapy with one of the following beta blockers: carvedilol, bisoprolol, sustained-released metoprolol, unless unable to tolerate or contraindicated AND The patient will discontinue use of any concomitant ACE inhibitor or ARB before initiating therapy. ACE inhibitors must be discontinued at least 36 hours prior to ENTRESTO.
Age Restrictions	
Prescriber Restrictions	Cardiologist or in consultation with a cardiologist
Coverage Duration	Initial: 12 months Renewal: 12 months
Other Criteria	

Sargramostim (Leukine)

Products Affected

- **LEUKINE**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Acute myelogenous leukemia (AML): To shorten time to neutrophil recovery and to reduce the incidence of severe and life-threatening infections and infections resulting in death following induction chemotherapy in older adults (greater than or equal to 55 years of age). Bone marrow transplant (allogeneic or autologous): For graft failure or engraftment delay. Myeloid reconstitution after allogeneic bone marrow transplantation: To accelerate myeloid recovery following transplantation in non-Hodgkin lymphoma (NHL), acute lymphoblastic leukemia (ALL), Hodgkin lymphoma. Febrile neutropenia Primary prophylaxis of neutropenia in patients receiving chemotherapy (outside transplant and AML) or who are at high risk for neutropenic fever. Peripheral stem cell transplantation: Mobilization of hematopoietic progenitor cells for leukapheresis and myeloid reconstitution following autologous peripheral stem cell transplantation. Acute Radiation Syndrome Treatment of radiation-induced myelosuppression of the bone marrow.
Age Restrictions	
Prescriber Restrictions	Requested by specialist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Scemblix (asciminib)

Products Affected

- **Scemblix**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Philadelphia positive CML that has been treated with at least two other TKIs OR Philadelphia positive CML with the T3151 mutation AND ECOG performance status of 0 or 1
Age Restrictions	Patient must be 18 years of age or older
Prescriber Restrictions	Prescribed by a hematologist or oncologist
Coverage Duration	Initial: 3 months Renewal: 6 months
Other Criteria	Clinical documentation of medication compliance and continued efficacy

Secukinumab (Cosentyx)

Products Affected

- **COSENTYX (300 MG DOSE)**
- **COSENTYX SENSOREADY (300 MG)**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	All: patient has a negative tuberculin test (TB) prior to initiating therapy. PP: Patient has documented diagnosis of moderate to severe plaque psoriasis for at least 6 months with at least one of the following: incapacitation due to plaque locations (e.g., head and neck, palms, soles, or genitalia), OR involvement of at least 10% of body surface area (BSA) OR psoriasis area and severity index (PASI) score of 12 or greater, AND patient is free of any clinically important active infections, AND patient did not respond adequately (or is not a candidate) to a 3-month trial of at least 1 systemic agent AND patient did not respond adequately (or is not a candidate) to a 3 month trial of phototherapy AND patient has had a trial and failure of Humira and Enbrel with clinical documentation. PA: Patient has active psoriatic arthritis for at least 6 months defined as: greater than 3 swollen joints AND greater than 3 tender joints AND patient has had an inadequate response, intolerance or contraindication (clinical documentation required) with the following, one or more non-steroidal anti-inflammatory drugs (NSAIDS) trialed at a max dose for at least 2 weeks AND one or more non-biologic disease modifying anti-rheumatic drugs AND patient has had a trial and failure of Humira OR Xeljanz OR Orencia. AS: Patient has had an inadequate response, intolerance or contraindication with the following, one or more non-steroidal anti-inflammatory drugs (NSAIDS) trialed at a max dose for at least 2 weeks OR analgesic agents if NSAIDs do not control pain OR sulfasalazine (if peripheral joint involvement is present).
Age Restrictions	Patient must be 18 years or older.
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Sildenafil Citrate (Revatio)

Products Affected

- SILDENAFIL CITRATE INTRAVENOUS
- SILDENAFIL CITRATE ORAL SUSPENSION RECONSTITUTED
- SILDENAFIL CITRATE ORAL TABLET

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Erectile dysfunction.
Required Medical Information	Clinical diagnosis of pulmonary arterial hypertension (PAH).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal criteria: Documentation of positive clinical response to therapy.

Skyrizi (Risankizumab)

Products Affected

- **Skyrizi**

PA Criteria	Criteria Details
Covered Uses	Plaque Psoriasis & Psoriatic Arthritis (PsA)
Exclusion Criteria	
Required Medical Information	**Plaque Psoriasis** Indicated for the treatment of moderate-to-severe plaque psoriasis. **Psoriatic Arthritis (PsA)** Indicated for the treatment of active psoriatic arthritis in adults.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a dermatologist or rheumatologist(PsA only)
Coverage Duration	Initial: 12 months. Renewal: 12 months
Other Criteria	Renewal Criteria: **Plaque Psoriasis**: Documentation of positive clinical response to therapy as evidenced by ONE of the following: Reduction the body surface area (BSA) involvement from baseline OR improvement in symptoms (e.g., pruritus, inflammation) from baseline. **PsA:** Documentation of positive clinical response to therapy.

Sodium-Glucose Co-Transporter 2 (Sglt2) Inhibitors

Products Affected

- **FARXIGA TABLET 10 MG ORAL**
- **JARDIANCE TABLET 10 MG ORAL**
- **JARDIANCE TABLET 25 MG ORAL**
-
- **FARXIGA TABLET 5 MG ORAL**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Trial and failure or contraindication to any of the following: metformin, glipizide-metformin, glyburide-metformin, pioglitazone-metformin OR one of the following generics or preferred brands: formulary ACEi or ARBs, spironolactone, eplerenone, or Entresto
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Somatropins

Products Affected

- **GENOTROPIN**
- **GENOTROPIN MINIQUICK**
- **HUMATROPE**
- **NORDITROPIN FLEXPRO**
- **NUTROPIN AQ NUSPIN 10**
- **NUTROPIN AQ NUSPIN 20**
- **NUTROPIN AQ NUSPIN 5**
- **OMNITROPE**
- **SAIZEN**
- **SAIZENPREP**
- **SEROSTIM**
- **ZORBTIVE**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	For children: Growth hormone deficiency in individuals less than 16 years of age or radiographic evidence of non-closure of epiphyseal plates. Appropriate medical work up: Assessment and evaluation must indicate absolute growth less than 4.5 cm per year without growth hormone. Subnormal growth, greater than or equal to 2 standard deviations below the mean for age. For adults: Biochemical diagnosis of adult growth hormone deficiency by means of a subnormal response to a standard growth hormone stimulation test (peak growth hormone Less than or equal to 5 mcg/L). Confirmatory testing may not be required in patients with congenital/genetic growth hormone deficiency or multiple pituitary hormone deficiencies due to organic diseases. Adult-onset: Patients who have adult growth hormone deficiency whether alone or with multiple hormone deficiencies (hypopituitarism) as a result of pituitary disease, hypothalamic disease, surgery, radiation therapy, or trauma. Turners Syndrome in females is an approved indication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Symdeko

Products Affected

- **SYMDEKO**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Clinical documentation of cystic fibrosis diagnosis with homozygous F508del mutation.
Age Restrictions	6 years of age and older
Prescriber Restrictions	Prescribed by a pulmonologist
Coverage Duration	Initial: 3 months Renewal: 6 months
Other Criteria	

Tadalafil (Cialis)

Products Affected

- TADALAFIL (PAH)

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Erectile dysfunction.
Required Medical Information	Clinical diagnosis of pulmonary arterial hypertension (PAH) or benign prostatic hyperplasia (BPH).
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal criteria: Documentation of positive clinical response to therapy.

Tazarotene

Products Affected

- Tazarotene 0.1% cream

PA Criteria	Criteria Details
Covered Uses	FDA approved indications
Exclusion Criteria	
Required Medical Information	**Psoriasis**: diagnosis of moderate to severe Psoriasis (10% BSA, hand, foot or mucous membrane involvement and functional impairment (IHN). Trial and failure of high potency topical corticosteroids or medical reason why they would be inappropriate **Other FDA approved indications (i.e., severe acne):** trial and failure/contraindication to two formulary alternatives used to treat the approved indication.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal criteria: Documentation of positive clinical response to therapy.

Tepmetko

Products Affected

- **Tepmetko**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of NSCLC containing MET exon 14-skipping alterations AND No EGFR-activating mutations predictive of sensitivity to anti-EGFR therapy AND No ALK rearrangements predictive of sensitivity to anti-ALK therapy AND Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1 Maximum daily dose of 2 tablets
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by oncologist
Coverage Duration	Initial: 3 months. Renewal: up to 12 months.
Other Criteria	Renewal Criteria: Clinical documentation of provider follow-up indicating safety and efficacy with medication adherence over previous approval duration

Terbinafine Hydrochloride (Lamisil)

Products Affected

- TERBINAFINE HCL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	For the treatment of onychomycosis of the toenail or fingernail due to dermatophytes (tinea unguium) AND patient is experiencing pain which limits normal activity (i.e., unable to wear shoes, difficulty walking, etc.), OR Member has diabetes, OR patient has peripheral vascular disease, OR patient is immunocompromised.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months. Renewal: 3 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Tibsovo (ivosidenib)

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Acute Myeloid Leukemia (AML): Test confirmed IDH1 mutation Cholangiocarcinoma: Test confirmed IHD1 mutation AND previous treatment with at least one chemotherapy regimen (e.g. FOLFOX)
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by an oncologist
Coverage Duration	Initial: 3 months. Renewal: 6 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Tofacitinib (Xeljanz)

Products Affected

- **XELJANZ**
- **XELJANZ XR**

PA Criteria	Criteria Details
Covered Uses	Rheumatoid Arthritis, Psoriatic Arthritis, Ulcerative Colitis, Polyarticular Juvenile Idiopathic Arthritis
Exclusion Criteria	
Required Medical Information	**Rheumatoid Arthritis (RA):** Diagnosis of moderately to severely active rheumatoid arthritis. Trial and failure, contraindication, or intolerance to ONE nonbiologic disease-modifying antirheumatic drug (DMARD) (methotrexate, leflunomide, or sulfasalazine) AND patient has had an inadequate response or intolerance to one or more TNF inhibitors (e.g., Cimzia, Humira, Simponi) AND patient is not receiving Xeljanz/XR in combination with a potent immunosuppressant (e.g azathioprine or cyclosporine). **Psoriatic Arthritis (PsA):** Diagnosis of active psoriatic arthritis (PsA) AND trial and failure, contraindication, or intolerance to one or more TNF inhibitors: Cimzia, Humira, Simpon AND patient is not receiving Xeljanz/XR in combination with a potent immunosuppressant (e.g azathioprine or cyclosporine). **Ankylosing Spondylitis (AS):** Indicated for the treatment of adult patients with active ankylosing spondylitis who have had an inadequate response or intolerance to TWO of the following, or attestation demonstrating a trial may be inappropriate**: • Cimzia (certolizumab pegol) • Humira (adalimumab) • Simponi (golimumab)TNF blockers AND trial and failure, contraindication, or intolerance to TWO nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, meloxicam, naproxen) AND patient is not receiving Xeljanz/XR in combination with a potent immunosuppressant (e.g azathioprine or cyclosporine). **Ulcerative Colitis (UC):** Diagnosis of moderately to severely active ulcerative colitis AND trial and failure, contraindication, or intolerance to ONE of the following conventional therapies: (purinethol, mesalamine, olsalazine, sulfasalazine, azathioprine, prednisone, or methylprednisolone) AND trial and failure, contraindication, or intolerance to TWO of the

PA Criteria	Criteria Details
	following: (Humira, Simponi, Stelara) AND patient is not receiving Xeljanz/Xeljanz XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine). **Polyarticular Juvenile Idiopathic Arthritis (PJIA):** Diagnosis of active polyarticular course juvenile idiopathic arthritis. Trial and failure, contraindication, or intolerance to leflunomide or methotrexate. Trial and failure, contraindication, or intolerance to Humira AND patient is not receiving Xeljanz/XR in combination with a potent immunosuppressant (e.g azathioprine or cyclosporine)
Age Restrictions	
Prescriber Restrictions	**Rheumatoid Arthritis (RA):** Prescribed by or in consultation with a rheumatologist **Psoriatic Arthritis (PsA):** Prescribed by or in consultation with a dermatologist or rheumatologist **Ulcerative Colitis (UC):** Prescribed by or in consultation with a gastroenterologist **Ankylosing Spondylitis (AS):** Prescribed by or in consultation with a rheumatologist **Polyarticular Juvenile Idiopathic Arthritis (PJIA):** Prescribed by or in consultation with a rheumatologist
Coverage Duration	**Rheumatoid Arthritis (RA):** Initial: 12 months. Renewal 12 months **Psoriatic Arthritis (PsA):** Initial: 12 months. Renewal 12 months **Ankylosing Spondylitis (AS):** Initial: 12 months. Renewal 12 months **Ulcerative Colitis (UC):** Initial: 4 months. Renewal 12 months **Polyarticular Juvenile Idiopathic Arthritis (PJIA):** Initial: 12 months. Renewal 12 months
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy and patient is not receiving Xeljanz/XR in combination with a potent immunosuppressant.

Tremfya (Guselkumab)

Products Affected

- TREMFYA INJ 100MG/ML

PA Criteria	Criteria Details
Covered Uses	Plaque Psoriasis Psoriatic Arthritis (PsA)
Exclusion Criteria	
Required Medical Information	**Plaque Psoriasis:** Diagnosis of moderate-to-severe plaque psoriasis **Psoriatic Arthritis (PsA):** Diagnosis of active psoriatic arthritis (PsA)
Age Restrictions	
Prescriber Restrictions	**Plaque Psoriasis:** Prescribed by or in consultation with a dermatologist **Psoriatic Arthritis (PsA):** Prescribed by or in consultation with one of the following: dermatologist OR rheumatologist
Coverage Duration	**Plaque Psoriasis:** Initial: 12months; Renewal: 12 months **Psoriatic Arthritis (PsA):** Initial: 12months; Renewal: 12 months
Other Criteria	Renewal Criteria: **Plaque Psoriasis:** Documentation of positive clinical response to therapy as evidenced by ONE of the following: reduction the body surface area (BSA) involvement from baseline OR improvement in symptoms (e.g., pruritus, inflammation) from baseline **Psoriatic Arthritis (PsA):** Documentation of positive clinical response to therapy.

Treprostinil (Orenitram)

Products Affected

- **ORENITRAM**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of pulmonary arterial hypertension with right heart catheterization and WHO functional class II through IV. Evidence of either an unfavorable acute response to vasodilators or evidence of being refractory to or unable to tolerate calcium channel blockers (e.g., extended release nifedipine or extended-release diltiazem). Documented failure or incomplete response to sildenafil or tadalafil/ambrisentan combination. Trial and failure of Remodulin or clinical justification for the need of an alternative route of administration.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy.

Treprostinil (Remodulin)

Products Affected

- TREPROSTINIL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of pulmonary arterial hypertension with right heart catheterization and WHO functional class II through IV. Evidence of either an unfavorable acute response to vasodilators or evidence of being refractory to or unable to tolerate calcium channel blockers (e.g., extended release nifedipine or extended-release diltiazem). Documented failure or incomplete response to sildenafil or tadalafil/ambrisentan combination.
Age Restrictions	
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist or pulmonologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy.

Treprostinil(Tyvaso)

Products Affected

- **TYVASO**
- **TYVASO REFILL**
- **TYVASO STARTER**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of pulmonary hypertension associated with interstitial lung disease (WHO Group 3). Any other indication would be required to try and fail formulary alternatives.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by pulmonologist or cardiologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy.

Trikafta

Products Affected

- **TRIKAFTA**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Clinical documentation of cystic fibrosis diagnosis with at least one F508del mutation (heterozygous or homozygous).
Age Restrictions	12 years of age and older
Prescriber Restrictions	Prescribed by pulmonologist
Coverage Duration	Initial: 3 months Renewal: 6 months
Other Criteria	

Truseltiq (infigratinib)

Products Affected

- **TRUSELTIQ (100MG DAILY DOSE)**
- **TRUSELTIQ (125MG DAILY DOSE)**
- **TRUSELTIQ (50MG DAILY DOSE)**
- **TRUSELTIQ (75MG DAILY DOSE)**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Confirmation of trial and failure of guideline directed therapy.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	Initial: 3 months. Renewal: 3 months.
Other Criteria	Renewal Criteria: Clinical documentation of provider follow-up indicating safety and efficacy with medication adherence over previous approval duration.

Ubrelvy

Products Affected

- **Ubrelvy**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of migraine AND Documentation member is on preventative therapy AND Trial and failure (defined as trial period of 6 weeks per agent) or contraindication to at least 3 generic oral formulary triptans used at up to maximally indicated dosing.
Age Restrictions	18 years of age and older
Prescriber Restrictions	
Coverage Duration	Initial: 3 months Renewal: 6 months
Other Criteria	

Ukoniq

Products Affected

- **Ukoniq**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of relapsed or refractory marginal zone lymphoma (MZL) or follicular lymphoma (FL) AND MZL: Must have received a prior therapy that included an anti-CD20 antibody agent OR FL: Must have received at least three prior therapies, including both an anti-CD20 antibody and an alkylating agent Maximum daily dose of 4 tablets
Age Restrictions	18 years of age and older
Prescriber Restrictions	Prescribed by oncologist
Coverage Duration	Initial: 3 months. Renewal: up to 12 months.
Other Criteria	Renewal Criteria: Clinical documentation of provider follow-up indicating safety and efficacy with medication adherence over previous approval duration

Ustekinumab (Stelara)

Products Affected

- **STELARA**

PA Criteria	Criteria Details
Covered Uses	Plaque Psoriasis, Psoriatic Arthritis, Crohn's Disease, Ulcerative Colitis
Exclusion Criteria	
Required Medical Information	PP: Diagnosis of moderate to severe plaque psoriasis. For Stelara SC 90mg/1 mL: patient weight is greater than 100 kg (220 lbs). PsA: Diagnosis of active psoriatic arthritis. For Stelara SC 90mg/1 mL: patient weight is greater than 100 kg (220 lbs) and has diagnosis of co-existent moderate to severe psoriasis. CD: Diagnosis of moderately to severely active Crohn's disease. Trial and failure, contraindication or intolerance to at least one tumor necrosis factor (TNF) blocker (e.g., infliximab, Humira, Cimzia) OR Trial and failure, contraindication, or intolerance to treatment with at least one immunomodulator or corticosteroid (e.g., Purinethol, azathioprine, cyclosporine, tacrolimus, methotrexate) OR continuation of prior Stelara therapy. UC: Diagnosis of moderately to severely active ulcerative colitis. Trial and failure, contraindication, or intolerance to treatment with at least ONE of the following: (Corticosteroid, Purinethol, azathioprine, mesalamine, olsalazine, sulfasalazine) OR Trial and failure, contraindication or intolerance to at least one biologic agent and/or tumor necrosis factor [TNF] blocker (e.g., Entyvio, infliximab, Humira, Cimzia) OR continuation of prior Stelara therapy.
Age Restrictions	
Prescriber Restrictions	PP: Prescribed by or in consultation with a dermatologist PsA: Prescribed by or in consultation with a dermatologist or rheumatologist CD: Prescribed by or in consultation with a gastroenterologist UC: Prescribed by or in consultation with a gastroenterologist

PA Criteria	Criteria Details
Coverage Duration	Initial: 12 months.
Other Criteria	Renewal Criteria: PP: Documentation of positive clinical response to therapy as evidenced by ONE of the following: Reduction the body surface area (BSA) involvement from baseline OR improvement in symptoms (e.g., pruritus, inflammation) from baseline. PsA: Documentation of positive clinical response to therapy (e.g., improvement in number of swollen/tender joints, pain, or stiffness). CD: Documentation of positive clinical response to therapy UC: Documentation of positive clinical response to therapy

Welireg (belzutifan)

Products Affected

- **WELIREG**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Confirmed diagnosis of Von Hippel-Lindau disease with VHL alteration confirmation AND require therapy for either associated renal cell carcinoma, associated pancreatic neuroendocrine tumors, or associated CNS hemangioblastoma AND confirmation that member is not eligible currently for surgery AND Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Prescribed by oncologist
Coverage Duration	Initial: 3 months. Renewal: 3 months
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy.

Xalkori (crizotinib)

Products Affected

- **Xalkori**

PA Criteria	Criteria Details
Covered Uses	Indicated for the treatment of patients with locally advanced or metastatic non-small cell lung cancer (NSCLC) with anaplastic lymphoma kinase (ALK)-positive or ROS1-positive. Indicated for the treatment of pediatric patients 1 year of age and older and young adults with relapsed or refractory, systemic anaplastic large cell lymphoma (ALCL) that is ALK-positive.
Exclusion Criteria	
Required Medical Information	NSCLC: Confirmed diagnosis of ALK-positive NSCLC or NSCLC with ROS1 rearrangement. ALCL: Confirmed diagnosis of ALK positive ALCL AND Trial and failure of at least one prior systemic therapy
Age Restrictions	NSCLC: 18 years of age or older. ALCL: 1 year and older.
Prescriber Restrictions	Prescribed by oncologist
Coverage Duration	Initial: 3 months. Renewal: 3 months
Other Criteria	Renewal Criteria: Clinical documentation of provider follow-up indicating safety and efficacy with medication adherence over previous approval duration

Xolair

Products Affected

- **XOLAIR**

PA Criteria	Criteria Details
Covered Uses	Severe Asthma, Nasal Polyps, Chronic Idiopathic Urticaria (CIU)
Exclusion Criteria	

Required Medical Information	**Severe asthma:**
	• Confirmed diagnosis of moderate to severe persistent asthma
	• Documentation of smoking status
	• Positive skin test or RAST to a perennial aeroallergen
	• Baseline IgE serum level within FDA label
	• Documentation of steps taken to avoid within reason environmental allergens and other triggers
	• Documented trial and failure of
	  o High dose inhaled corticosteroid with a long-acting beta agonist (e.g. Advair)
	  o Long acting anti-muscarinic (e.g., Spiriva)
	  o Leukotriene Inhibitor (e.g., Singulair)
	• Documented trial and failure of, or contraindication to allergen immunotherapy
	• Medical or claims history of compliance/adherence with prescribed asthma medications
	
	Nasal Polyps:
	• Documentation of recurrent nasal polyps after prior sinus surgery
	• Trial and failure of at least 2 intranasal corticosteroids and Sinuva nasal implant
	• Documented adherence to a nasal corticosteroid with Xolair intended as adjunct therapy
	• Documented risk of another sinus surgery, or a statement why sinus surgery is not medically appropriate
	
	Idiopathic chronic urticaria- refractory
	• Documentation of chronic spontaneous or idiopathic urticaria
	• Documented trial and failure (including dose escalation of both first and second-generation antihistamines) for at least 6 weeks
	  o (1st generation – doxepin, hydroxyzine)
	  o (2nd generation – Cetirizine, Levocetirizine, Fexofenadine, Loratadine, Desloratadine)

PA Criteria	Criteria Details
	○ Documented trial and failure of an H2 antihistamine (e.g., Famotidine, Cimetidine) Documented trial and failure (at least 4 weeks) of, or contraindication to a leukotriene inhibitor (e.g., Montelukast, Zafirlukast)
Age Restrictions	Asthma: 6 years of age and older CIU: 12 years of age and older Nasal Polyps: 18 years of age and older
Prescriber Restrictions	Asthma: Prescribed by or in consultation with a pulmonologist or immunologist CIU: Prescribed by or in consultation with an immunologist Nasal Polyps: Prescribed by or in consultation with an allergist or ENT
Coverage Duration	SA/NP Initial: 6 months. Renewal: 6 months. CIU Initial: 4 months. Renewal: 3 months.
Other Criteria	Renewal Criteria: Documentation of clinically significant improvement in symptoms.