Samaritan Health Plans

Prior Authorization Criteria

InterCommunity Health Network

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

Updated on 5/11/2022. 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	
Exclusion Criteria	
Required Medical Information	All: patient has a negative tuberculin test (TB) prior to initiating therapy. RA: Diagnosis of documented (via an accepted assessment instrument) moderately to severely active rheumatoid arthritis. History of failure to a 3-month trial of two non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine] at maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced (document drug, date, and duration of trial). PA: Documented diagnosis of active psoriatic arthritis. History of failure to a 3-month trial of methotrexate at maximally indicated dose, unless contraindicated or clinically significant adverse effects are experienced. JIA: Documented diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis with active systemic features of JIA (or any systemic activity in the absence of active joint involvement). Trial and failure of a 3-month trial of systemic corticosteroids. Trial of methotrexate or leflunomide for at least 3 months or contraindication to both.
Age Restrictions	RA and PA: 18 and older JIA: 2 years and older
Prescriber Restrictions	Rheumatologist, or Dermatologist if PA
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documented positive clinical response to therapy

Adalimumab (Humira)

Products Affected

- **HUMIRA**
- **HUMIRA PEDIATRIC CROHNS START**
- **HUMIRA PEN**
- **HUMIRA PEN-CD/UC/HS STARTER**
- **HUMIRA PEN-PEDIATRIC UC START**
- **HUMIRA PEN-PS/UV/ADOL HS START**
- **HUMIRA PEN-PSOR/UVEIT STARTER**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	ALL: must have a negative tuberculin test (TB). AS/axSpA: Patient has a documented diagnosis of ankylosing spondylitis or axial spondyloarthritis (radiographic or non-radiographic). Documentation of moderate to severe active disease at baseline via an assessment tool such as BASDAI AND clinical documentation showing an inadequate response, intolerance, or contraindication to at least two on-steroidal anti-inflammatory drugs - NSAIDs (trial at maximum dose for at least 3 months). CD: Clinical documentation showing an inadequate response, intolerance, or contraindication to budesonide, mesalamine, or corticorsteroids; 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). PsA: Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) with the following: One or more non-steroidal anti-inflammatory drugs NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures); AND One or more non-biologic disease modifying anti-rheumatic drugs DMARDs (i.e., methotrexate, sulfasalazine, leflunomide, cyclosporine). RA: Moderate to severe rheumatoid arthritis diagnosis AND Patient has had an inadequate response, intolerance, or contraindication (clinical

PA Criteria	Criteria Details
	documentation must be submitted demonstrating response to previous therapies) to one or more non-biologic- DMARDs (i.e., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) for at least 3 consecutive months. UC: Patient has a documented diagnosis of moderate to severe UC such as greater than or equal to 4 stools per day with or without blood and evidence of toxicity AND Patient has demonstrated corticosteroid dependence; OR Patient has had an inadequate response (clinical documentation must be submitted demonstrating response to previous therapies) or failed to tolerate oral corticosteroids AND immunosuppressants such as azathioprine, 6-mercaptopurine or 5-ASA. Uveitis (non-infectious): Patient has a documented diagnosis of non-infectious, intermediate, posterior or panuveitis AND clinical documentation showing an inadequate response, intolerance, or contraindication to one or more of the following: at least one month of topical or periocular steroid injections; oral corticosteroids; one immunomodulator such as mycophenolate, tacrolimus, cyclosporine, azathioprine or methotrexate. HS: Patient has a documented diagnosis of moderate to severe hidradenitis suppurative (Hurley stages II and III) characterized by recurrent, painful and suppurating lesions recurring at least twice in 6 months AND clinical documentation showing an inadequate response, intolerance, or contraindication to ALL of the following: oral antibiotics such as clindamycin, doxycycline, dapsone and rifampin; Intralesional corticosteroid injection; and Acitretin if no documented contraindications (trial at maximum dose for at least 3 months). 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., immunosuppressives, 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	Crohns Disease and Ulcerative Colitis: Gastroenterologist. Hidradenitis Suppurativa and Plaque Psoriasis: Dermatologist. Psoriatic Arthritis: Dermatologist or Rheumatologist. Rheumatoid Arthritis, Juvenile Idiopathic Arthritis: Rheumatologist. Ankylosing Spondylitis, Axial Spondyloarthritis: Rheumatologist. Uveitis: Ophthalmologist or Rheumatologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documented 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).

Anakinra (KINERET)

Products Affected

- **KINERET**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Treatment of moderately to severely active rheumatoid arthritis (RA) in adult patients who have failed one or more disease modifying antirheumatic drugs (DMARDs), including at least one TNF inhibitor (i.e., Humira). Treatment of neonatal onset multisystem inflammatory disease (NOMID), which is a cryopyrin associated periodic syndrome (CAPS).
Age Restrictions	Patient is greater than 18 years of age.
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Apremilast (Otezla)

Products Affected

- **OTEZLA**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of active psoriatic arthritis or moderate to severe plaque psoriasis. History of failure, contraindication, or intolerance to both Humira and Enbrel, OR for continuation of prior Otezla therapy.
Age Restrictions	
Prescriber Restrictions	Plaque psoriasis: Prescribed or in consultation with a dermatologist. Psoriatic arthritis: Prescribed or in consultation with a dermatologist or rheumatologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of positive clinical response to Otezla therapy.

Aprepitant (Emend)

Products Affected

- APREPITANT

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Prevention of acute nausea and vomiting associated with initial and repeat courses of highly emetogenic chemotherapy in conjunction with other antiemetic agents, such as dexamethasone and ondansetron. Prevention of delayed nausea and vomiting associated with highly emetogenic chemotherapy in conjunction with dexamethasone. Documentation of member receiving treatment with a moderate to highly emetogenic chemotherapy agent. Documentation member is receiving concurrent treatment with IV or oral ondansetron (Zofran), granisetron (Kytril) or palonosetron (Aloxi) AND dexamethasone.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy.

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.

Budesonide (Rhinocort Aqua)

Products Affected

- BUDESONIDE NASAL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Asthma diagnosis where allergies exacerbate asthmatic condition.
Age Restrictions	
Prescriber Restrictions	
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 of, 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.

Certolizumab Pegol (Cimzia)

Products Affected

- **CIMZIA**
- **CIMZIA PREFILLED**
- **CIMZIA STARTER KIT**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	AS: Clinically diagnosed active ankylosing spondylitis. Failed, contraindicated or intolerance to least 2 prescription strength NSAIDs with a minimum of a 12-week trial. RA: Diagnosis of moderate to severe active rheumatoid arthritis. Failed, contraindication or intolerance to a 12-week trial of one of the following DMARDs: Methotrexate, Leflunomide, Sulfasalazine, Hydroxychloroquine. PsA: Diagnosis of active psoriatic arthritis. Failed, contraindication or intolerance to a 12-week trial of one of the following DMARDs: Methotrexate, Leflunomide, Sulfasalazine, Hydroxychloroquine. CD: Diagnosis of moderate to severe active Crohn's disease. Failed, contraindication or intolerant to a 12-week trial of one of the following: 6-mercaptopurine, Azathioprine, Methotrexate, Corticosteroid (i.e., prednisone, methylprednisolone).
Age Restrictions	
Prescriber Restrictions	AS, RA: Prescribed by a rheumatologist. PsA: Prescribed by a rheumatologist or dermatologist. CD: Prescribed by a gastroenterologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Cetirizine (Zyrtec)

Products Affected

- CETIRIZINE TABLETS
- CETIRIZINE SOLUTION
- CETIRIZINE SYRUP

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Covered for allergy induced asthma.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Chloroquine Phosphate (Aralen)

Products Affected

- CHLOROQUINE PHOSPHATE

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Malaria suppression due to travel.
Required Medical Information	Treatment of Malaria or Extraintestinal amebiasis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months.
Other Criteria	

Cinacalcet Hydrochloride (Sensipar)

Products Affected

- CINACALCET HCL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Treatment of secondary hyperparathyroidism in patients with chronic kidney disease (CKD) on dialysis. Treatment of hypercalcemia in patients with parathyroid carcinoma. Treatment of severe hypercalcemia in patients with primary hyperparathyroidism who are unable to undergo parathyroidectomy.
Age Restrictions	Patients 18 years of age and older.
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Cyclosporine, modified (Gengraf, Neoral)

Products Affected

- CYCLOSPORINE
- CYCLOSPORINE MODIFIED
- **GENGRAF**
- **SANDIMMUNE**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Treatment of Solid Organ Transplant, Rheumatoid arthritis, or Psoriasis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Deferasirox (Exjade)

Products Affected

- DEFERASIROX

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Patient has one of the following diagnoses: • Chronic iron overload due to blood transfusion. • Non-transfusion-dependent thalassemia syndromes. Patient has a creatinine clearance of greater than or equal to 40 mL/minute OR serum creatinine less than or equal to 2 times the age-appropriate level AND Patient has a serum ferritin levels consistently greater than 1,000 mcg/L (as demonstrated with at least two lab values within the previous two months) AND Patient has had a failure or contraindication to deferoxamine injection.
Age Restrictions	Patient is 2 years of age or older.
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Desmopressin (Stimate)

Products Affected

- DESMOPRESSIN ACETATE
- **STIMATE**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Nocturnal Enuresis
Required Medical Information	Injection and spray: Treatment of diabetes insipidus, maintenance of hemostasis and control of bleeding in hemophilia A with factor VIII coagulant activity levels greater than 5% and mild-to-moderate classic von Willebrand's disease (type 1) with factor VIII coagulant activity greater than 5%. Tablet: Central diabetes insipidus, temporary polyuria and polydipsia following pituitary surgery or head trauma. Sickle cell anemia, Diagnostic uses kidney function, Hemorrhage, Uremia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Dihydroergotamine (Migranal)

Products Affected

- DIHYDROERGOTAMINE MESYLATE

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Treatment of migraine headache with or without aura OR Treatment of cluster headaches (INJECTION ONLY) AND Patient has tried and failed or has a contraindication to a formulary serotonin 5-HT1B, 1D receptor agonist.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

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	Must be 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
- SOFOSBUVIR-VELPATASVIR
- **MAVYRET**

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 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). • Documentation if the prescribed regimen for the retreatment after failure of a DAA due to noncompliance or loss of follow-up AND

PA Criteria	Criteria Details
	the prescribed drug regimen is a recommended regimen based on the patient's genotype, age, treatment status (retreatment or treatment naïve) 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	

Donepezil Hydrochloride (Aricept)

Products Affected

- DONEPEZIL HCL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Treatment of mild, moderate, or severe dementia of the Alzheimer's type. Alzheimer's disease, Prophylaxis - Impaired cognition (Mild). Multi-infarct dementia.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Dronabinol (Marinol)

Products Affected

- DRONABINOL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Failure, contraindication, or intolerance to one 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). Failure, contraindication, or intolerance to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine). AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

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 percent 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	
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

- **EPOGEN**
- **PROCRIT**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
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.
Age Restrictions	

PA Criteria	Criteria Details
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**

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.

Erlotinib (Tarceva)

Products Affected

- ERLOTINIB HCL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Nonsmall cell lung cancer (NSCLC): First line treatment of metastatic NSCLC in patients with known EGFR exon 19 deletions or exon 21 (L858R) substitution mutations Treatment (as monotherapy) of locally advanced or metastatic NSCLC refractory to at least 1 prior chemotherapy regimen maintenance treatment of locally advanced or metastatic NCSLC which has not progressed after 4 cycles of first line platinum-based chemotherapy. Pancreatic cancer: First line treatment of locally advanced, unresectable or metastatic pancreatic cancer (combination with gemcitabine). Renal cell carcinoma: Relapsed or unresectable Stage IV disease with nonclear cell histology. Recurrent Chordoma.
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

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). 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. immunosuppressives, retinoic acid derivatives, and/or methotrexate; AND did not respond or non-candidate to a 3-month minimum trial of phototherapy PsA: Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) with the following: One or more non-steroidal anti-inflammatory drugs NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures); AND One or more non-biologic disease modifying anti-rheumatic drugs DMARDs (i.e., methotrexate, sulfasalazine, leflunomide, cyclosporine).

PA Criteria	Criteria Details
	RA: Moderate to severe rheumatoid arthritis diagnosis AND Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to one or more non-biologic- DMARDs (i.e., methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) for at least 3 consecutive months.
Age Restrictions	
Prescriber Restrictions	Ankylosing Spondylitis: Rheumatologist. Plaque Psoriasis: Dermatologist or Rheumatologist. Psoriatic Arthritis: Dermatologist or Rheumatologist. Rheumatoid Arthritis, Juvenile Idiopathic Arthritis: Rheumatologist.
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	Renewal Criteria: Documentation of continued effectiveness.

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) AND request meets criteria for treatment coverage specified in Guideline Note 12 of the prioritized list of health services, considering treatment of cancer with little or no benefit.
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.

Filgrastim (Neupogen)

Products Affected

- **NEUPOGEN**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Bone marrow/stem cell transplant (BMSCT): Prescribed for non-myeloid malignancies & undergoing myeloablative chemotherapy followed by autologous or allogeneic bone marrow transplant OR for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis OR for peripheral stem cell transplant patients who have received myeloablative chemotherapy. Acute myeloid leukemia (AML): Patients diagnosed with AML following induction or consolidation chemotherapy. Primary prophylaxis of chemotherapy-induced febrile neutropenia (CFN): Patients receiving chemotherapy associated with greater than 20% incidence of febrile neutropenia OR selected chemotherapy regimen associated with 10-20% incidence of febrile neutropenia AND one or more risk factors associated with chemotherapy-induced infection, febrile neutropenia, or neutropenia. Secondary prophylaxis of febrile neutropenia: Patient has a history of febrile neutropenia with previous chemotherapy AND is receiving myelosuppressive chemotherapy associated with neutropenia (ANC less than 500 cells/mm^3). Neutropenia associated with dose dense chemotherapy (NDDC): Patient is receiving National Cancer Institute's Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer OR patient is receiving a dose-dense chemotherapy regimen and the incidence of febrile neutropenia is unknown. Severe chronic neutropenia (SCN): Diagnosed with congenital, cyclic, and idiopathic neutropenia with chronic ANC less than or equal to 500 cells/mm^3.

PA Criteria	Criteria Details
	Febrile Neutropenia (FN): Patient receiving myelosuppressive chemotherapy associated with neutropenia (ANC less than or equal to 500 cells/mm^3) AND is at high risk for infection-associated complications. Acute radiation syndrome (ARS): Patient is/was acutely exposed to myelosuppressive doses of radiation.
Age Restrictions	
Prescriber Restrictions	Prescribed by hematologist or oncologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

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.

Fluorouracil, topical (Efudex, Fluoroplex)

Products Affected

- FLUOROURACIL CRE 5%
- FLUOROURACIL SOL 2%
- FLUOROURACIL SOL 5%

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Actinic keratosis
Required Medical Information	Diagnosis of superficial basal cell carcinoma with multiple lesions and/or difficult to treat areas.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 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	
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

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

Products Affected

- **BYDUREON BCISE**
- **BYETTA 10 MCG PEN**
- **BYETTA 5 MCG PEN**
- **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 dose of metformin.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months, Renewal: 12 months.
Other Criteria	

Golimumab (Simponi)

Products Affected

- **SIMPONI**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	AS: Clinically diagnosed active ankylosing spondylitis. Failed, contraindicated or intolerance to least 2 prescription strength NSAIDs with a minimum of a 12-week trial. RA: Diagnosis of moderate to severe active rheumatoid arthritis. Failed, contraindication or intolerance to a 12-week trial of one of the following DMARDs: Methotrexate, Leflunomide, Sulfasalazine, Hydroxychloroquine. PsA: Diagnosis of active psoriatic arthritis. Failed, contraindication or intolerance to a 12-week trial of one of the following DMARDs: Methotrexate, Leflunomide, Sulfasalazine, Hydroxychloroquine. UC: Diagnosis of moderate to severe active ulcerative colitis. Failure, contraindication or intolerance to a 12-week trial of one of the following: 6-mercaptopurine, Azathioprine, Corticosteroid (i.e., prednisone, methylprednisolone), Aminosalicylate (i.e., mesalamine products), Sulfasalazine.
Age Restrictions	
Prescriber Restrictions	AS, RA: Prescribed by a rheumatologist. PsA: Prescribed by a rheumatologist or dermatologist. UC: Prescribed by a gastroenterologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Grass Pollen Allergen Extract -Timothy Grass (Grastek)

Products Affected

- **GRASTEK**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of grass pollen-induced allergic rhinitis.
Age Restrictions	
Prescriber Restrictions	Prescribed by an Allergy or 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.

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.

Itraconazole (Sporanox)

Products Affected

- ITRACONAZOLE ORAL SOLUTION

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.

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	
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	
Prescriber Restrictions	

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

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	

Ketoconazole

Products Affected

- KETOCONAZOLE

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of tinea corporis, tinea cruris, tinea versicolor, cutaneous candidiasis, seborrheic dermatitis, or an above the line comorbid condition that may worsen if not treated AND Patient has diabetes OR Patient has peripheral vascular disease OR Patient is immunocompromised or has extensive or complicated infection.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months. Renewal: 3 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

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 AND disease is refractory to radioactive iodine therapy
Age Restrictions	Patient is 18 years of age or older
Prescriber Restrictions	Prescribed by oncologist
Coverage Duration	Initial: 3 months Renewal: 6 months
Other Criteria	Renewal Criteria: Documentation of continued need.

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.

Lisdexamfetamine (VYVANSE)

Products Affected

- **VYVANSE**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	ADHD: Clinical documentation of trial and failure (defined as at least 6 weeks of treatment) of generic Adderall XR, generic Concerta, and generic Focalin XR in the treatment of ADHD. In cases of concern of stimulant abuse, must provide clinical documentation of trial and failure of one long-acting formulary stimulant OR clinical justification as to why formulary long-acting stimulants are contraindicated for the member. BED: Clinical documentation confirming binge eating disorder diagnosis per DSM-5 criteria. Trial and failure of at least two therapeutic alternatives including SSRIs, topiramate, and/or methylphenidate.
Age Restrictions	BED: 18 years of age or older
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of positive clinical response to therapy.

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 CAPSULE EXTENDED RELEASE 12 HOUR 10 MG ORAL
- HYDROCODONE BITARTRATE ER CAPSULE EXTENDED RELEASE 12 HOUR 15 MG ORAL
- HYDROCODONE BITARTRATE ER CAPSULE EXTENDED RELEASE 12 HOUR 20 MG ORAL
- HYDROCODONE BITARTRATE ER CAPSULE EXTENDED RELEASE 12 HOUR 30 MG ORAL
- HYDROCODONE BITARTRATE ER CAPSULE EXTENDED RELEASE 12 HOUR 40 MG ORAL
- HYDROCODONE BITARTRATE ER CAPSULE EXTENDED RELEASE 12 HOUR 50 MG ORAL
- HYDROCODONE BITARTRATE ER ORAL TABLET ER 24 HOUR ABUSE-DETERRENT
- HYDROMORPHONE HCL ER
- METHADONE HCL ORAL TABLET
- 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	

PA Criteria	Criteria Details
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]. • 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	

Loratadine (Claritin)

Products Affected

- LORATADINE SOLUTION
- LORATADINE SYRUP

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of asthma or an above the line comorbid condition that may worsen if not treated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

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 Request meets criteria for treatment coverage specified in Guideline Note 12 of the prioritized list of health services, considering treatment of cancer with little or no benefit 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.

Mefloquine (Lariam)

Products Affected

- MEFLOQUINE HCL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Malaria treatment.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 1 month.
Other Criteria	Renewal Criteria: Documentation of continued need.

Memantine Hydrochloride (Namenda)

Products Affected

- MEMANTINE HCL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Treatment of moderate-to-severe dementia of the Alzheimer's type.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Mometasone, nasal (Nasonex)

Products Affected

- MOMETASONE FUROATE NASAL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of asthma or an above the line comorbid condition that may worsen if not treated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Mycophenolate (Cellcept, Myfortic)

Products Affected

- MYCOPHENOLATE MOFETIL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Prophylaxis of organ rejection concomitantly with cyclosporine and corticosteroids in patients receiving allogeneic renal (CellCept, Myfortic), cardiac (CellCept), or hepatic (CellCept) transplants.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Orkambi

Products Affected

- **ORKAMBI GRA 100-125**
- **ORKAMBI GRA 150-188**
- **ORKAMBI TAB 100-125**
- **ORKAMBI TAB 200-125**

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

- **Creon Capsules**
- **Pancreaze Capsules**

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

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 or 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 less 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.

Pramipexole Dihydrochloride (Mirapex)

Products Affected

- PRAMIPEXOLE DIHYDROCHLORIDE

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Restless Legs Syndrome is below the line on the HSC prioritized health service list.
Required Medical Information	For the treatment of Parkinson's Disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Pregabalin (Lyrica)

Products Affected

- PREGABALIN

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of diabetic neuropathy, post herpetic neuralgia, or neuropathic pain associated with spinal cord injury 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.

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	Patient must be 12 years or older.
Prescriber Restrictions	Prescribed by an oncologist or transplant specialist
Coverage Duration	Initial: 3 months. Renewal: 6 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

Rifaximin (Xifaxan)

Products Affected

- **XIFAXAN**

PA Criteria	Criteria Details
Covered Uses	Diagnosis of Hepatic Encephalopathy.
Exclusion Criteria	
Required Medical Information	Diagnosis of 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	Initial: 12 months. Renewal: 12 months.
Other Criteria	

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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	COPD Initial: 12 months. COPD Renewal: 12 months.
Other Criteria	Renewal Criteria COPD: Documentation of positive clinical response to Daliresp therapy.

Ropinirole Hydrochloride (Requip)

Products Affected

- ROPINIROLE HCL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	Restless Legs Syndrome is below the line on the HSC prioritized health service list.
Required Medical Information	For the treatment of Parkinson's Disease.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

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 INJ 250MCG**

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 a specialist.
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Scemblix (asciminib)

Products Affected

- **SCEMBLIX 20MG TABLETS**
- **SCEMBLIX 40MG TABLETS**

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 or older.
Prescriber Restrictions	Prescribed by a hematologist or oncologist
Coverage Duration	Initial: 3 months. Renewal: 6 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

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 20MG TAB

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 continued need.

Sirolimus (Rapamune)

Products Affected

- SIROLIMUS ORAL SOLUTION

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Lymphangioleiomyomatosis, Renal transplant rejection prophylaxis.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Sodium-Glucose Co-Transporter 2 (Sglt2) Inhibitors

Products Affected

- **FARXIGA TABLET 10 MG ORAL**
- **FARXIGA TABLET 5 MG ORAL**
- **INVOKANA TABLET 100 MG ORAL**
- **INVOKANA TABLET 300 MG ORAL**
- **JARDIANCE TABLET 10 MG ORAL**
- **JARDIANCE TABLET 25 MG ORAL**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	**T2DM:** Trial and failure of or contraindication to metformin AND trial and failure or reason why it is inappropriate to use a sulfonylurea or pioglitazone. **CKD (Farxiga)**: Concurrent therapy with an ACEi or ARB at maximum tolerated doses, or documented contraindication to both AND eGFR of 25 to 75 mL/min/1.73 m^2 or stage 2, 3, or 4 CKD AND no previous use of dialysis AND no history of polycystic kidney disease, type 1 diabetes, lupus nephritis, or antineutrophil cytoplasmic antibody-associate vasculitis. **HFrEF:** Patient must be stabilized and titrated to maximally tolerated or target dose of ACEi, ARB, or ARNI AND patient must be stabilized and titrated to maximally tolerated or target dose of either carvedilol, metoprolol succinate, or bisoprolol OR have a contraindication to beta blocker use AND NYHA class II-IV (EF≤40%) AND eGFR >30 mL/min/1.73$m^{2.}$ **HFpEF (Jardiance only)**: eGFR >30 mL/min/1.73^2
Age Restrictions	
Prescriber Restrictions	HFrEF & HFpEF: Cardiologist
Coverage Duration	Initial: Lifetime Approval. Renewal: Lifetime Approval
Other Criteria	

Somatropin, E-Coli Derived (Humatrope)

Products Affected

- **HUMATROPE**

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. Serum growth hormone concentration of less than 10ng/ml in two of any of the following stimulation tests. Insulin, L-arginine, Clonidine, L-dopa, Glucagon. 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. 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Sunitinib Malate (Sutent)

Products Affected

- SUNITINIB MALATE

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Treatment of gastrointestinal stromal tumor (GIST) intolerant to or with disease progression on imatinib. Treatment of advanced renal cell cancer (RCC). Treatment of advanced, metastatic or unresectable pancreatic neuroendocrine tumors (PNET).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

SUPREP Bowel Prep

Products Affected

- **SUPREP BOWEL PREP KIT**

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Bowel cleansing prior to GI examination. Prior use of formulary agent, golytely solution, must be tried and failed OR patient is having Bariatric surgery.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 1 treatment.
Other Criteria	

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	

Tacrolimus (Prograf)

Products Affected

- TACROLIMUS CAPS

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of any of the following: • prevention of organ rejection in a transplant recipient OR • immunosuppression after solid organ transplant for heart, liver, and kidney transplant recipient OR • Crohn's disease, fistulizing OR • Graft-versus-host disease OR • Rheumatoid arthritis, refractory OR • Myasthenia gravis OR • Lung transplant
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal PA criteria: Documented continued effectiveness.

Tacrolimus (Protopic)

Products Affected

- TACROLIMUS OINT

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Atopic Dermatitis: Clinically diagnosed moderate-to-severe atopic dermatitis: (10 percent BSA, hand, foot or mucous membrane involvement, or functional impairment). Trial and failure of topical steroids, UVB phototherapy, or reason why they would not be medically appropriate. Psoriasis: diagnosis of moderate to severe Psoriasis (10 percent BSA, hand, foot or mucous membrane involvement, or functional impairment). Trial and failure or contraindication to a high potency topical corticosteroid and/or UVB phototherapy.
Age Restrictions	
Prescriber Restrictions	Psoriasis: prescribed by or in consultation with a dermatologist.
Coverage Duration	Initial: 12 months. Renewal: 12 months
Other Criteria	Renewal criteria: Documentation of positive clinical response to therapy.

Tadalafil (Cialis)

Products Affected

- TADALAFIL (PAH) 20MG TAB

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 that are above the line** (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) Cream 1%

Products Affected

- TERBINAFINE CREAM

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Treatment of onychomycosis of the toenail or fingernail due to dermatophytes (tinea unguium) AND One of the following: Patient is experiencing pain which limits normal activity (i.e., unable to wear shoes, difficulty walking, etc.) OR Patient has diabetes OR Patient has peripheral vascular disease OR Patient is immunocompromised. Treatment of tinea corporis or tinea cruris in a patient who is immunocompromised or has extensive or complicated infection.
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	Patient is at least 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.

Tiagabine (Gabitril)

Products Affected

- TIAGABINE HCL TABLET 12 MG ORAL
- TIAGABINE HCL TABLET 16 MG ORAL

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	For the treatment of Partial seizures as adjunct therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

Tofacitinib (Xeljanz)

Products Affected

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

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	ALL: must have a negative tuberculin test (TB). PA: Patient has a documented diagnosis of psoriatic arthritis; AND 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 must be submitted demonstrating response previous therapies) with the following: One or more NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures); AND One or more non-biologic disease modifying anti-rheumatic drugs DMARDs (i.e. methotrexate, sulfasalazine, leflunomide, cyclosporine). RA: moderate to severe rheumatoid arthritis AND Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response to previous therapies) to one or more nonbiologic DMARDs (i.e. methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) for at least 3 consecutive months.
Age Restrictions	Must be 18 years or older
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

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	Pulmonary hypertension associated with interstitial lung disease (WHO Group 3)
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.

Triamcinolone Acetonide (Nasacort HFA, Nasacort AQ)

Products Affected

- TRIAMCINOLONE NASAL SPRAY

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Diagnosis of asthma or an above the line comorbid condition that may worsen if not treated.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.

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	
Exclusion Criteria	
Required Medical Information	ALL: must have a negative tuberculin test (TB). CD: Clinical documentation showing an inadequate response, intolerance, or contraindication to budesonide, mesalamine, or corticosteroids; or non-biologic DMARDs (i.e., azathioprine, methotrexate, mercaptopurine AND patient has had a trial and failure of Humira with clinical documentation. 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. immunosuppressives, retinoic acid derivatives, and/or methotrexate; AND did not respond or non-candidate to a 3-month minimum trial of phototherapy AND patient has had a trial and failure of Humira and Enbrel with clinical documentation. PA: Patient has a documented diagnosis of psoriatic arthritis; AND Patient has active psoriatic arthritis for at least 6 months defined as: > 3 swollen joints, AND > 3 tender joints, AND Patient has had an inadequate response, intolerance, or contraindication (clinical documentation must be submitted demonstrating response previous therapies) with the following: One or more NSAIDs (trial at maximum dose for at least 2-3 weeks before considering them as failures); AND One or more non-biologic disease modifying anti-rheumatic drugs DMARDs (i.e. methotrexate, sulfasalazine, leflunomide, cyclosporine); AND Patient has had a trial and failure of Humira OR Xeljanz OR Orencia within clinical documentation.
Age Restrictions	

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

Voriconazole (Vfend)

Products Affected

- VORICONAZOLE

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Approved for treatment of invasive aspergillosis and treatment of serious fungal infections in patients intolerant of, or refractory to other therapy.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 3 months. Renewal: 3 months.
Other Criteria	Renewal Criteria: Documentation of continued need.

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

PA Criteria	Criteria Details
	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) o Documented trial and failure of an H2 antihistamine (e.g. Famotidine, Cimetidine) o 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.

Zafirlukast (Accolate)

Products Affected

- ZAFIRLUKAST

PA Criteria	Criteria Details
Covered Uses	
Exclusion Criteria	
Required Medical Information	Patient has a diagnosis of asthma AND Patient has experienced suboptimal control with combined use of an inhaled steroid and beta agonist.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	Initial: 12 months. Renewal: 12 months.
Other Criteria	Renewal Criteria: Documentation of continued effectiveness.