AAT DEFICIENCY

Products Affected

- Aralast NP
- Glassia
- Prolastin-C
- Zemaira

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of severe congenital A1-PI deficiency who have clinically evident emphysema, weight, A1-PI phenotype, A1-PI baseline level
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a pulmonologist
Coverage Duration	6 months for initiation, 1 year for continuation
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ADAPALENE

Products Affected

- adapalene topical cream
- adapalene topical gel
- adapalene topical swab

PA Criteria	Criteria Details
Exclusion Criteria	Not approved when used to treat photo aging.
Required Medical Information	Diagnosis, previous treatments, and response therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Must have failure, intolerance, or contraindication to tretinoin
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ADEMPAS

Products Affected

- Adempas

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Confirmation of diagnosis, documentation of response to any prior therapies
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by pulmonologist or cardiologist
Coverage Duration	3 months initial, 1 year continuation
Other Criteria	For WHO Group 1 diagnosis, patient must have a history of taking or contraindication to sildenafil (Revatio).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

AFINITOR

Products Affected

- Afinitor Disperz
- Afinitor oral tablet 10 mg
- everolimus (antineoplastic)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR THERAPIES, AND TREATMENT RESPONSE
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ONCOLOGIST OR NEUROLOGIST
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

AIMOVIG

Products Affected

- Aimovig Autoinjector

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried, and outcome. Member has been evaluated for and does not have medication overuse headache.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Must be prescribed by or in consultation with a neurologist or pain specialist
Coverage Duration	1 year
Other Criteria	Patient must have an inadequate response, contraindication, or intolerance to two different chronic migraine prevention drugs. The two prerequisite drugs must be from different classes such as anticonvulsants (topiramate/valproate), beta blockers (propranolol, metoprolol), and antidepressants (nortriptyline/venlafaxine).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ALK POSITIVE TYROSINE KINASE INHIBITORS

Products Affected

- Alecensa
- Xalkori
- Zykadia oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other treatments tried and outcome
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ALUNBRIG

Products Affected

- Alunbrig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC. Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with an FDA-approved test or Clinical Laboratory Improvement Amendments-approved facility. Trial and failure or intolerance to Xalkori (crizotinib).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	2 years
Other Criteria	Approve for continuation of prior therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

AMIFAMPRIDINE

Products Affected

- Firdapse
- Ruzurgi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Must have a documented diagnosis of Lamber-Eaton with electrodiagnostic studies including repetitive nerve stimulation and anti-P/Q-type voltage-gated calcium channel (VGCC) antibody testing to confirm the diagnosis.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a neurologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

AMPYRA

Products Affected

- Ampyra
- dalfampridine

PA Criteria	Criteria Details
Exclusion Criteria	NOT A COVERED BENEFIT IN PATIENTS WITH SEIZURE DISORDER OR A CREATININE CLEARANCE LESS THAN 50 ML/MIN
Required Medical Information	EXPANDED DISABILITY SCALE SCORE, BASELINE AND FOLLOW-UP 25 FOOT WALK TEST, CREATININE CLEARANCE
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY A NEUROLOGIST
Coverage Duration	3 MONTHS INITIAL, 1 YEAR CONTINUATION
Other Criteria	PATIENT MUST SHOW AN IMPROVEMENT IN WALKING SPEED TO CONTINUE TREATMENT
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ANTIDEPRESSANTS

Products Affected

- Drizalma Sprinkle
- Fetzima
- Trintellix
- Viibryd oral tablet
- Viibryd oral tablets,dose pack 10 mg (7)-20 mg (23)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR THERAPIES TRIED AND FAILED
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	MUST SEE CONTRAINDICATION TO OR FAILURE OF 2 DIFFERENT CLASSES OF GENERIC ANTIDEPRESSANTS INCLUDING SSRIS, SNRIS, TCAS, NOREPINEPHRINE-DOPAMINE REUPTAKE INHIBITORS, OR NORADRENERGIC AND SPECIFIC SEROTONERGIC ANTIDEPRESSANTS. EXAMPLES INCLUDE: SERTRALINE, CITALOPRAM, ESCITALOPRAM, FLUOXETINE, PAROXETINE, VENLAFAXINE, DULOXETINE, BUPROPION, AMITRIPTYLINE, DOXEPIN, ETC.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ANTIPSYCHOTICS

Products Affected

- Abilify Maintena
- Aristada
- Aristada Initio
- Caplyta
- chlorpromazine injection
- Fanapt
- Invega Sustenna
- Invega Trinza
- Latuda
- Rexulti
- Saphris
- Secuado
- Versacloz
- Vraylar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	FOR BIPOLAR DISORDER OR SCHIZOPHRENIA, DOCUMENTATION OF DIAGNOSIS, TREATMENT FAILURE WITH TWO ATYPICAL ANTIPSYCHOTICS (ZIPRASIDONE, RISPERIDONE, QUETIAPINE, OLANZAPINE, CLOZAPINE), OR RATIONALE AS TO WHY ALTERNATIVES ARE NOT SUITABLE
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

APOKYN

Products Affected

- APOKYN

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior treatments, and outcome
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by neurologist
Coverage Duration	1 year
Other Criteria	Treatment failure or inotlernace to ropinirole and pramipexole.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ARCALYST

Products Affected

- Arcalyst

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	12 YEARS AND OLDER
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR AT A TIME
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

AYVAKIT

Products Affected

- Ayvakit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to avapritinib.
Age Restrictions	Adults age 18 or older.
Prescriber Restrictions	Prescription must be written by an oncologist or gastroenterologist.
Coverage Duration	3 months for initial authorization, 12 months for continuation.
Other Criteria	Documentation of a PDGFRA exon 18 mutation or PDGFRA D842V mutation.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BALVERSA

Products Affected

- Balversa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior treatments, and outcome
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BENLYSTA

Products Affected

- Benlysta subcutaneous syringe

PA Criteria	Criteria Details
Exclusion Criteria	Severe active lupus nephritis, active central nervous, use in combination with other biologics
Required Medical Information	Diagnosis, autoantibody testing, prior treatments including response, and SLEDAI score.
Age Restrictions	must be 18 and older
Prescriber Restrictions	Prescription must be written by a rheumatologist
Coverage Duration	6 months
Other Criteria	Failed to demonstrate adequate response to TWO standard therapies at recommended doses: corticosteroids, antimalarials, NSAIDs, and/or immunosuppressants. SLEDAI score greater than 8.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BOSULIF

Products Affected

- Bosulif oral tablet 100 mg, 400 mg, 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to bosutinib. CBC and LFT lab test results are needed for continuation treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BRAFTOVI

Products Affected

- Braftovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

BRUKINSA

Products Affected

- Brukinsa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies, and result of prior therapy.
Age Restrictions	Adults age 18 or older.
Prescriber Restrictions	Prescription must be written by hematologist/oncologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CABOMETYX

Products Affected

- Cabometyx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of RCC. RCC is advanced. History of failure, contraindication, or intolerance to at least one prior anti-angiogenic therapy [e.g., Nexavar (sorafenib), Sutent (sunitinib)].
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CALQUENCE

Products Affected

- Calquence

PA Criteria	Criteria Details
Exclusion Criteria	NA
Required Medical Information	Documentation of diagnosis, previous treatments, and response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by oncology
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CAPRELSA

Products Affected

- Caprelsa oral tablet 100 mg, 300 mg

PA Criteria	Criteria Details
Exclusion Criteria	HISTORY OF CONGENITAL LONG QT SYNDROME
Required Medical Information	DIAGNOSIS, PRIOR THERAPIES, TREATMENT RESPONSE
Age Restrictions	18 YEARS AND OLDER
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ONCOLOGIST
Coverage Duration	2 years
Other Criteria	ECG, ELECTROLYTE(K,Mg,Ca), AND TSH MONITORING AT BASELINE, 2-4 WEEKS AND 8-12 WEEKS AFTER STARTING TREATMENT AND EVERY 3 MONTHS THEREAFTER
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CINQAIR

Products Affected

- Cinqair

PA Criteria	Criteria Details
Exclusion Criteria	Administration of reslizumab requires a specialized care setting and requires an experienced clinician prepared to manage anaphylaxis will not be approved for self-administration
Required Medical Information	Allergen test, baseline FEV1, FEV1 following bronchodilator, asthma medical history (including medications, emergency department visits, and hospitalizations), baseline eosinophil count
Age Restrictions	N/A
Prescriber Restrictions	Pulmonology or Immunologist
Coverage Duration	1 year
Other Criteria	Patient must be diagnosed with severe asthma, currently receiving inhaled and/or oral corticosteroid treatment, have a baseline eosinophil count of 400/mcL, have a contraindication, intolerance or failure of Nucala.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

COMETRIQ

Products Affected

- Cometriq

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

COPIKTRA

Products Affected

- Copiktra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or hematologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

CORLANOR

Products Affected

- Corlanor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For heart failure in adult patients, only: ejection fraction less than or equal to 35% AND heart rate greater than 70 beats per minute AND in sinus rhythm AND on maximally tolerated beta-blocker OR has contraindication to beta-blocker (i.e.. allergy, severe COPD limiting beta blocker usage).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a cardiologist.
Coverage Duration	12 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

COSENTYX

Products Affected

- Cosentyx (2 Syringes)
- Cosentyx Pen (2 Pens)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by a Rheumatologist or Dermatologist
Coverage Duration	3 months for initiation, 1 year for continuation
Other Criteria	For arthritis conditions, must have a trial of or contraindication to one non-biologic DMARD (including but not limited to methotrexate, hydroxychloroquine, sulfasalazine, azathioprine). For diagnosis of plaque psoriasis, must have a trial of or contraindication to cyclosporine or methotrexate
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

COTELLIC

Products Affected

- Cotellic

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and/or failed, and treatment response.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an oncologist.
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DALIRESP

Products Affected

- Daliresp

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Chronic Obstructive Pulmonary Disease (COPD), medications tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	COPD, approve in patients who meet all of the following conditions: Patients has severe COPD or very severe COPD, AND Patient has a history of exacerbations, AND Patient has tried a medication from two of the three following drug categories: long-acting beta2-agonist (LABA) [eg, salmeterol, indacaterol], long-acting muscarinic antagonist (LAMA) [eg, tiotropium], inhaled corticosteroid (eg, fluticasone).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DAURISMO

Products Affected

- Daurismo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies, and result of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or hematologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DEMSER

Products Affected

- Demser

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and whether the patient is a candidate for surgery
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DICLOFENAC GEL 3%

Products Affected

- diclofenac sodium topical gel 3 %

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and any prior treatments.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a Dermatologist
Coverage Duration	3 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DOPTELET

Products Affected

- Doptelet (10 tab pack)
- Doptelet (15 tab pack)
- Doptelet (30 tab pack)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and platelet count
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by a hematologist, oncologist, or gastroenterologist
Coverage Duration	1 month for chronic liver disease, 6 months for chronic immune thrombocytopenia
Other Criteria	For chronic liver disease-associated thrombocytpenia, the patient must be scheduled to undergo a pre planned medical or dental procedure with treatment beginning 10 to 13 days prior to the scheduled procedure. Patients should undergo their procedure 5 to 8 days after the last dose.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DRONABINOL

Products Affected

- dronabinol

PA Criteria	Criteria Details
Exclusion Criteria	Not covered for the treatment of pain
Required Medical Information	Diagnosis, previous treatments, and the outcome
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For cancer related weight loss must have a treatment failure or intolerance to megestrol.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DUPIXENT

Products Affected

- Dupixent Pen
- Dupixent Syringe subcutaneous syringe 200 mg/1.14 mL, 300 mg/2 mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used and result of prior therapy. If continuation, response to dupilumab with documented reduction in number of acute exacerbations.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribing limited to an allergist, pulmonologist, otolaryngologist or dermatologist.
Coverage Duration	1 year
Other Criteria	For atopic dermatitis: an adequate trial on at least one topical corticosteroid (fluticasone, fluocinonide, desonide) - and - one at least one topical immunomodulator (tacrolimus, pimecrolimus). For chronic rhinosinusitis with nasal polyps (CRS with NP), documentation of inflammatory persistence for 12 weeks or longer with and adequate trial of of a intranasal corticosteroid product (beclomethasone, fluticasone, mometasone) - and - an interleukine drug (montelukast, zafirlukast). For asthma, blood and/or tissue eosinophil testing with documentation of an adequate trial of an interleukine drug (montelukast, zafirlukast) - and - omalizumab.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EGRIFTA

Products Affected

- Egrifta subcutaneous recon soln 1 mg

PA Criteria	Criteria Details
Exclusion Criteria	ONLY APPROVED FOR PATIENTS WITH HIV ASSOCIATED LIPODYSTROPHY. NOT INDICATED FOR WEIGHT MANAGEMENT.
Required Medical Information	DIAGNOSIS, BASELINE WAIST CIRCUMFERENCE, BASELINE IGF-1 FASTING PLASMA GLUCOSE, AND BASELINE HGAIC. MONITORING EVERY 6 MONTHS OF PARAMETERS LISTED ABOVE. MUST NOT HAVE AN ACTIVE MALIGNANCY
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY AN INFECTIOUS DISEASE SPECIALIST OR ENDOCRINOLOGIST
Coverage Duration	3 MONTHS
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ENBREL

Products Affected

- Enbrel
- Enbrel SureClick

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with biologic therapy or targeted synthetic DMARD
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	RA/AS/JIA/JRA,prescribed by or in consult w/ rheumatologist. PsA, prescribed by or in consultation w/ rheumatologist or dermatologist. PP, prescribed by or in consult w/ dermatologist.GVHD,prescribed by or in consult w/ oncologist,hematologist,or physician affiliated w/ transplant center.Behcet's disease,prescribed by or in consult w/ rheumatologist,dermatologist,ophthalmologist,gastroenterologist,or neurologist. Uveitis, prescribed by or in consultation with an ophthalmologist.
Coverage Duration	FDA approved indications - 3 months initial, 3 years cont, others 12 months.
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to step back and try a conventional synthetic DMARD). JIA/JRA, approve if the pt has aggressive disease, as determined by the prescriber, or the pt has tried one other agent for this condition (eg, MTX, sulfasalazine, leflunomide, NSAID, biologic DMARD or the pt will be started on Enbrel concurrently with MTX, sulfasalazine, or leflunomide or the pt has an absolute contraindication to MTX (eg, pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias), sulfasalazine, or leflunomide.Plaque psoriasis (PP) initial approve if the patient meets one of the following conditions: 1) patient has tried at least one traditional systemic agent for at least 3 months for plaque psoriasis, unless intolerant (eg, MTX, cyclosporine, Soriatane, oral methoxsalen plus PUVA, (note: pts who have already tried a biologic for psoriasis are not required to step back and try a traditional agent first)

PA Criteria	Criteria Details
	OR 2) the patient has a contraindication to one oral agent for psoriasis such as MTX. GVHD. Tried or currently is receiving with etanercept 1 conventional GVHD tx (high-dose systemic corticosteroid, CSA, tacrolimus, MM, thalidomide, antithymocyte globulin, etc.). Behcet's. Has tried at least 1 conventional tx (eg, systemic corticosteroid, immunosuppressant, interferon alfa, MM, etc) or adalimumab or infliximab. Uveitis-tried one of the following: periocular, intraocular, or systemic coricosteroid, immunosuppressives, Humira or an infliximab product.RA/AS/JIA/PP/PsA Cont - must have a response to tx according to the prescriber. Behcet's, GVHD, Uveitis Cont-if the patient has had a response to tx according to the prescriber. Clinical criteria incorporated into the Enbrel 25 mg quantity limit edit, approve additional quantity (to allow for 50 mg twice weekly dosing) if one of the following is met: 1) Patient has plaque psoriasis, OR 2) Patient has RA/JIA/PsA/AS and is started and stabilized on 50 mg twice weekly dosing, OR 3) Patient has RA and the dose is being increased to 50 mg twice weekly and patient has taken MTX in combination with Enbrel 50 mg once weekly for at least 2 months, unless MTX is contraindicated or intolerant, OR 4) Patient has JIA/PsA/AS and the dose is being increased to 50 mg twice weekly after taking 50 mg once weekly for at least 2 months.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ENSPRYNG

Products Affected

- Enspryng

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to satralizumab-mwge.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Under CMS Review.
Coverage Duration	2 years
Other Criteria	Confirmed diagnosis of neuromyelitis optica spectrum disorder (NMOSD) with a positive serologic test for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMO-IgG antibodies. Documented treatment failure with immunosuppresvie therapy: corticosterioid therapy and mycophenolate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EPIDIOLEX

Products Affected

- Epidiolex

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by or in consultation with a neurologist
Coverage Duration	2 years
Other Criteria	For Lennox-Gastaut Syndrome: treatment failure or intolerance to valproate and lamotrigine. For Dravet Syndrome: treatment failure or intolerance to: valproate and topiramate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERIVEDGE

Products Affected

- Erivedge

PA Criteria	Criteria Details
Exclusion Criteria	PATIENTS WHO ARE CANDIDATES FOR SURGERY OR RADIATION
Required Medical Information	DIAGNOSIS, PRIOR TREATMENTS, RESPONSE TO THERAPY
Age Restrictions	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY A ONCOLOGIST OR DERMATOLOGIST
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERLEADA

Products Affected

- Erleada

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and outcome, fall risk assessment, and seizure history (if any)
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by an oncologist or urologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERYTHROPOIESIS STIMULATING AGENTS

Products Affected

- Aranesp (in polysorbate) injection solution 100 mcg/mL, 200 mcg/mL, 25 mcg/mL, 300 mcg/mL, 40 mcg/mL, 60 mcg/mL
- Aranesp (in polysorbate) injection syringe
- Epogen injection solution 2,000 unit/mL, 20,000 unit/2 mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL
- Procrit injection solution 10,000 unit/mL, 2,000 unit/mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL, 40,000 unit/mL

PA Criteria	Criteria Details
Exclusion Criteria	Uncontrolled hypertension. Pure red cell aplasia that begins after ESA treatment.
Required Medical Information	Pre-treatment hemoglobin level less than 10 g/dL AND Patient has adequate iron stores prior to initiation of therapy defined as ferritin more than 100 mcg/L or serum transferrin saturation greater than 20% AND other causes of anemia such as iron deficiency, folate deficiency or B12 deficiency, hemolysis, gastrointestinal bleeding, other active or occult bleeding, or underlying hematologic disease (such as sickle cell anemia, thalassemia, and porphyria) have been ruled out.
Age Restrictions	N/A
Prescriber Restrictions	CKD - prescribed by a nephrologist or hematologist. Non-myeloid malignancies - prescribed by an oncologist/hematologist. Surgery - Prescribed by a surgeon. HIV - Prescribed by an infectious disease specialist.
Coverage Duration	Initial: 3 months. Renewal: CKD-12 months, Non-myeloid cancers, HIV-4 months. Surgery-3 months
Other Criteria	For renewal of CKD, for dialysis patients: Hb less than 11 g/dL or physician will decrease or interrupt dose and for non-dialysis patients: Hb less than 10 g/dL or physician will decrease or interrupt dose. For renewal of non-myeloid malignancies: Concurrent myelosuppressive chemotherapy and Hb is 12g/dL or less and there is measurable response after eight weeks (defined as an increase in Hb 1 g/dL or more or a reduction in red blood cell transfusion requirements). For renewal of zidovudine-treated HIV, Hb is 12g/dL or less AND Zidovudine dose remains 4,200 mg/week or less and there is a measurable response after eight weeks (defined as an increase in Hb or a reduction in RBC transfusion requirements or documented dose

PA Criteria	Criteria Details
	escalation [up to max of 300 units/kg/dose])
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EXJADE

Products Affected

- deferasirox oral tablet, dispersible
- Exjade

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Serum ferritin, CrCl, serum transaminases and bilirubin, baseline auditory and ophthalmic examinations. For Non-Transfusion-Dependent Thalassemia Syndromes: liver iron concentration (LIC) by liver biopsy or by an FDA-cleared or approved method for identifying patients for treatment with deferasirox therapy. Dose verification
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	For chronic transfusional iron overload due to blood transfusion: serum ferritin consistently greater than 1000 mcg/L. For NON-transfusion dependent thalassemia syndrome and chronic iron overload a LIC (liver iron concentration) of at least 5 mg Fe/g dry weight and a serum ferritin greater than 300 mcg/L on at least 2 measurements 1 month apart. For patients continuation: current LIC is greater than 3 mg per gram of dry weight or Exjade (deferasirox) will be withheld until the LIC reaches above 5 mg per gram of dry weight.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FARYDAK

Products Affected

- Farydak

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and/or failed
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FASENRA

Products Affected

- Fasenra
- Fasenra Pen

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Allergen test, baseline FEV1, FEV1 following bronchodilator, asthma medical history (including medications, emergency department visits, and hospitalizations), baseline eosinophil count
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by a Pulmonologist or Immunologist or Allergist
Coverage Duration	Initiation: 3 months, continuation 1 year
Other Criteria	Patient must be diagnosed with severe asthma, currently receiving inhaled and/or oral corticosteroid treatment, AND have a baseline eosinophil count of 150 cells/mcL or greater within previous 12 months.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FERRIPROX

Products Affected

- deferiprone
- Ferriprox oral tablet 1,000 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, length of therapy, serum ferritin concentrations and dose/weight verification, & CBC
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Must have a contraindication to, an inadequate response, or has been intolerant to, or experienced clinically significant adverse effects to Exjade, such as evidence of cardiac iron overload or iron-induced cardiac dysfunction with Exjade. For continuation patient must have a 20% or greater reduction in serum ferritin with an adequate dose and duration of therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FINTEPLA

Products Affected

- Fintepla

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to fenfluramine.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by a neurologist.
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FULYZAQ

Products Affected

- Mytesi

PA Criteria	Criteria Details
Exclusion Criteria	Use when infectious diarrhea has not been ruled out
Required Medical Information	Diagnosis, use of antiretroviral therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months
Other Criteria	Infectious diarrhea needs to be ruled out prior to initiating treatment. Patient must have a history of using at least two prior treatments for diarrhea, including bismuth subsalicylate, kaolin, loperamide, or diphenoxylate/atropine.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FYCOMPA

Products Affected

- Fycompa oral suspension
- Fycompa oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried, response to prior therapy
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be prescribed by neurologist
Coverage Duration	2 years
Other Criteria	Monitor at initiation and after dose increases for serious psychiatric and/or behavioral reactions.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GALAFOLD

Products Affected

- Galafold

PA Criteria	Criteria Details
Exclusion Criteria	Not covered in combination with Fabrazyme
Required Medical Information	Confirmed diagnosis of Fabry disease and baseline renal function assessment
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a specialist in genetic disorders, or nephrologist
Coverage Duration	6 months for initiation, 1 year for continuation
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GATTEX

Products Affected

- Gattex 30-Vial

PA Criteria	Criteria Details
Exclusion Criteria	Therapy should be discontinued in cases of intestinal malignancy.
Required Medical Information	Diagnosis, other therapies tried and/or failed.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a gastroenterologist
Coverage Duration	3 months for initiation, 6 months for continuation
Other Criteria	A colonoscopy of the entire colon with removal of polyps must be done before initiating therapy, medical records documenting this procedure must be submitted.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GAUCHER'S DISEASE TREATMENT

Products Affected

- Cerdelga
- miglustat
- Zavesca

PA Criteria	Criteria Details
Exclusion Criteria	NOT APPROVED FOR TYPE II OR TYPE III GAUCHER'S DISEASE
Required Medical Information	DIAGNOSIS, WEIGHT. FOR MIGLUSTAT: RATIONALE AS TO WHY ERT IS NOT APPROPRIATE
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY GENETICIST, HEMOTOLOGIST, OR METABOLIC SPECIALIST
Coverage Duration	1 YEAR
Other Criteria	USE OF MIGLUSTAT IS RESERVED FOR THOSE WHOM ENZYME REPLACEMENT THERAPY IS NOT AN OPTION
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GAVRETO

Products Affected

- Gavreto

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to pralsetinib.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by an oncologist or pulmonologist.
Coverage Duration	2 years
Other Criteria	Diagnosis of non-small cell lung cancer (NSCLC) that is verified by an FDA-approved diagnostic test to have rearranged during transfection (RET) fusion mutations.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GILOTRIF

Products Affected

- Gilotrif

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous therapies tried and/or failed
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GLEEVEC

Products Affected

- imatinib

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR THERAPIES, AND TREATMENT RESPONSE
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ONCOLOGIST
Coverage Duration	2 years
Other Criteria	GENETIC, HEMATOLOGIC, AND CYTOGENIC TESTS ARE REQUIRED BASED ON THE SPECIFIC INDICATION TO ASSESS APPROPRIATE USE AND ADEQUATE RESPONSE TO THERAPY
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GRALISE

Products Affected

- Gralise

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous treatments including dosage, outcome of previous treatment
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Must have a documented intolerance, contraindication to, or failure of gabapentin titrated to maximum tolerated dosage or rationale as to why gabapentin cannot be used.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GROWTH HORMONE

Products Affected

- Norditropin FlexPro
- Nutropin AQ Nuspin

PA Criteria	Criteria Details
Exclusion Criteria	PRESENCE OF CONTRAINDICATIONS TO THERAPY
Required Medical Information	DIAGNOSIS, HEIGHT AND WEIGHT, HISTORY OF GROWTH MEASUREMENT. REPLACEMENT THERAPY IN PATIENTS WITH GROWTH HORMONE DEFICIENCY WITH DIAGNOSIS CONFIRMED BY APPROPRIATE GROWTH HORMONE STIMULATION TESTING
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ENDOCRINOLOGIST OR NEPHROLOGIST
Coverage Duration	3 MONTHS FOR INITIATION, 1 YEAR FOR CONTINUATION
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HEPATITIS B

Products Affected

- Baraclude oral solution
- entecavir

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	TREATMENT CONSIDERATION IS BASED ON HBEAG, HBV DNA QUANTITY, AND ALT LEVEL
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY A GASTROENTEROLOGIST, HEPATOLOGIST, OR INFECTIOUS DISEASE SPECIALIST
Coverage Duration	1 YEAR
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HEPATITIS C TREATMENT

Products Affected

- Mavyret
- Zepatier

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	PATIENT WEIGHT, GENOTYPE, HCV-RNA , LEVEL OF FIBROSIS, TREATMENT HISTORY
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY GASTROENTEROLOGIST, HEPATOLOGIST, OR INFECTIOUS DISEASE SPECIALIST
Coverage Duration	8 - 24 WEEKS. TREATMENT WILL BE APPROVED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HEREDITARY ANGIOEDEMA

Products Affected

- Cinryze
- Haegarda
- icatibant
- Takhzyro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, including the results immunologic laboratory testing that show low C4 and functional C1- inhibitor levels
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by Allergist or Immunologist
Coverage Duration	3 months initially, 12 months for continuation
Other Criteria	Prophylactic treatment with Cinryze is limited to patients who experience one or more severe attacks per month, on average.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HETLIOZ

Products Affected

- Hetlioz

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and/or failed
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months initial, 1 year continuation
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA

Products Affected

- Juxtapid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, results of prior therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months for initiation, 6 months for continuation
Other Criteria	Patient must have a diagnosis of homozygous familial hypercholesterolemia. Liver function tests required at baseline and at least monthly during the first year of treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HUMIRA

Products Affected

- Humira
- Humira Pen
- Humira Pen Crohns-UC-HS Start
- Humira Pen Psor-Uveits-Adol HS
- Humira(CF)
- Humira(CF) Pedi Crohns Starter
- Humira(CF) Pen Crohns-UC-HS
- Humira(CF) Pen Psor-Uv-Adol HS
- HUMIRA(CF) PEN SUBCUTANEOUS INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use with another biologic DMARD or targeted synthetic DMARD.
Required Medical Information	Diagnosis, concurrent medications, previous therapies tried
Age Restrictions	Crohn's disease (CD), 6 or older (initial therapy only). Ulcerative colitis (UC), adults.
Prescriber Restrictions	RA/JIA/JRA/Ankylosing spondylitis, prescribed by or in consultation with rheumatologist. Psoriatic arthritis (PsA), prescribed by or in consultation with a rheumatologist or dermatologist. Plaque psoriasis (PP), prescribed by or in consultation with a dermatologist. UC/ CD, prescribed by or in consultation with a gastroenterologist. HS - dermatologist.UV-ophthalmologist
Coverage Duration	initial 3 mo, cont tx 3 years.
Other Criteria	RA initial, patient has tried one conventional synthetic DMARD for at least 3 months (note: patients who have already had a 3-month trial of a biologic for RA are not required to 'step back' and try a conventional synthetic DMARD). JIA/JRA initial. Tried another agent (e.g MTX, sulfasalazine, leflunomide, NSAID, or biologic DMARD (eg, etanercept, abatacept, infliximab, anakinra, tocilizumab) or will be starting on adalimumab concurrently with MTX, sulfasalazine, or leflunomide. Approve without trying another agent if pt has absolute contraindication to MTX, sulfasalazine, or leflunomide or if pt has aggressive disease. PP initial-approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (eg, MTX, cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: pts who

PA Criteria	Criteria Details
	have already tried a biologic for psoriasis are not required to 'step back' and try a traditional agent first) OR 2) pt has a contraindication to MTX as determined by the prescribing physician. CD initial. Tried corticosteroids (CSs) or if CSs are contraindicated or if pt currently on CSs or patient has tried one other agent for CD (eg, azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR pt had ilecolonic resection OR enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC initial. Pt has tried a systemic therapy (eg, 6-mercaptopurine, azathioprine, CSA, tacrolimus, infliximab, golimumab SC, or a corticosteroid such as prednisone or methylprednisolone) for 2 months or was intolerant to one of these agents, or the pt has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. FDA approve indications cont tx - must respond to tx as determined by prescriber. HS - tried ONE other therapy (e.g., intralesional or oral corticosteroids, systemic antibiotics, isotretinoin). Clinical criteria incorporated into the Humira 40 mg quantity limit edit allow for approval of additional quantities to accommodate induction dosing. The allowable quantity is dependent upon the induction dosing regimen for the applicable FDA-labeled indications as outlined in product labeling.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

IBRANCE (S)

Products Affected

- Ibrance

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ICLUSIG

Products Affected

- Iclusig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or hematologist
Coverage Duration	2 years
Other Criteria	Liver function monitoring required at baseline and 3 months after initiation
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

IDHIFA

Products Affected

- Idhifa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous treatments, and outcome.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist/oncologist.
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

IMBRUVICA

Products Affected

- Imbruvica oral capsule 140 mg, 70 mg
- Imbruvica oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR TREATMENTS, RESPONSE TO THERAPY
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be prescribed by oncologist, hematologist, or transplant specialist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INBRIJA

Products Affected

- Inbrija inhalation capsule, w/inhalation device

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to LEVODOPA ORAL INHALATION.
Age Restrictions	Adult patients aged 18 years and older.
Prescriber Restrictions	Prescription must be written by a neurologist.
Coverage Duration	3 months for initial authorization, 12 months for continuation.
Other Criteria	Required trial and failure of: 1) both carbidopa/levodopa IR and ER and, 2) at least one other Parkinson's Disease drug: entacapone, pramipexole, ropinirole, selegiline, rasagiline, or amantadine. Intention to continue use of carbidopa/levodopa.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INCRELEX

Products Affected

- Increlex

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, HEIGHT AND WEIGHT MEASUREMENTS, GH LEVEL, IGF-1 LEVEL
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ENDOCRINOLOGIST
Coverage Duration	3 MONTHS INITIAL, 1 YEAR CONTINUATION
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INHALED TOBRAMYCIN

Products Affected

- Tobi Podhaler

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, therapies tried, and outcome
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by Infectious disease specialist or pulmonologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INLYTA

Products Affected

- Inlyta oral tablet 1 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR TREATMENTS, RESPONSE TO THERAPY
Age Restrictions	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY A ONCOLOGIST
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INQOVI

Products Affected

- Inqovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis. If treatment experienced: prior therapy used and result of prior therapy. If continuation, prior response to decitabine / cedazuridine.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by an oncologist or hematologist.
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INREBIC

Products Affected

- Inrebic

PA Criteria	Criteria Details
Exclusion Criteria	Evaluate baseline thiamine levels prior to treatment initiation, do not initiate fedratinib in patients with thiamine deficiency. Replete thiamine prior to fedratinib initiation and during treatment if thiamine levels are low.
Required Medical Information	Diagnosis, Other therapies tried with treatment response, baseline thiamine level, baseline platelet level
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by Hematologist / Oncologist
Coverage Duration	3 years
Other Criteria	Documented baseline platelet count of at least 50,000 per cubic milimeter.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INTERFERON ALPHA

Products Affected

- Intron A injection
- Pegasys
- Pegasys ProClick subcutaneous pen injector 180 mcg/0.5 mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	FOR HEPATITIS C: PATIENT WEIGHT, GENOTYPE, HCV-RNA QUANTITY AND DATE OF TEST, PRESENCE OF DIRRHOSIS (Y/N), TREATMENT HISTORY, HISTORY OF ANEMIA OR DEPRESSION. HEPATITIS B: HBEAG STATUS, HBV DNA QUANTITY, AND ALT LEVEL. OTHERS: DIAGNOSIS, OTHER THERAPIES TRIED AND FAILED, RESPONSE TO TREATMENT
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 YEARS FOR INDICATIONS OTHER THAN HEPATITIS C. HEPC APPROVALS FROM 12-48 WKS BASED ON DRUG REGIMEN
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

IRESSA

Products Affected

- Iressa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, response to prior therapy
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ONCOLOGIST
Coverage Duration	2 years
Other Criteria	GEFITINIB IS COVERED AS MONOTHERAPY
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

IVIG

Products Affected

- Bivigam
- Cuvitru subcutaneous solution 1 gram/5 mL (20 %), 2 gram/10 mL (20 %), 4 gram/20 mL (20 %), 8 gram/40 mL (20 %)
- Flebogamma DIF
- Gammagard Liquid
- Gammagard S-D (IgA < 1 mcg/mL)
- Gammaked
- Gammaplex
- Gammaplex (with sorbitol)
- Gamunex-C
- Hizentra subcutaneous solution
- HyQvia
- Octagam
- Privigen

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, OTHER THERAPIES TRIED AND FAILED, RESPONSE TO TREATMENT
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 MONTHS FOR INITIATION, 6 MONTHS FOR CONTINUATION
Other Criteria	DIAGNOSIS AND ADMINISTRATION INFORMATION WILL BE REVIEWED TO DETERMINE IF COVERAGE IS AVAILABLE AS A MEDICARE PART B OR PART D BENEFIT
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

JAKAFI

Products Affected

- Jakafi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, OTHER TREATMENTS TRIED AND FAILED, CBC AT BASELINE AND PERIODICALLY AFTER INITIATION, HISTORY OF RBC TRANSFUSIONS
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIBER MUST BE A HEMATOLOGIST OR ONCOLOGIST
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

JYNARQUE

Products Affected

- Jynarque oral tablets, sequential 45 mg (AM)/ 15 mg (PM), 60 mg (AM)/ 30 mg (PM), 90 mg (AM)/ 30 mg (PM)

PA Criteria	Criteria Details
Exclusion Criteria	History of signs or symptoms of significant liver impairment or injury
Required Medical Information	Documented diagnosis of polycystic kidney disease, ultrasound results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by endocrinology or nephrology
Coverage Duration	6 months initial, 1 year continuation
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KALYDECO

Products Affected

- Kalydeco

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and the presence of one or more specific gene mutations that the drug is FDA approved to treat.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months initially, 12 months for continuation
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KINERET

Products Affected

- Kineret

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and/or failed
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by rheumatologist or pediatrician
Coverage Duration	3 months initially, 6 months for continuation
Other Criteria	Coverage for gout is limited to patients who have tried a maximum tolerated dose of a xanthine oxidase inhibitor (i.e.: allopurinol)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KISQALI

Products Affected

- Kisqali
- Kisqali Femara Co-Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies previously tried, and the outcome.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KORLYM

Products Affected

- Korlym

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and outcome, HbA1c
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by endocrinologist
Coverage Duration	1 year
Other Criteria	Must have trial of ketoconazole or metyrapone therapy or have intolerance or contraindication to these medications. Must have failed surgery or not be a candidate for surgery. For continuation of therapy patient must show an improvement in HbA1c.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KUVAN

Products Affected

- Kuvan oral powder in packet 100 mg
- Kuvan oral tablet,soluble

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS AND BASELINE AND FOLLOW UP PHENYLALANINE LEVELS. FOR CONTINUATION, MUST SHOW A 30% REDUCTION IN PHE LEVELS FROM BASELINE
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 MONTHS FOR INITIATION, 1 YEAR FOR CONTINUATION
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LENVIMA

Products Affected

- Lenvima

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LEUKINE

Products Affected

- Leukine injection recon soln

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS
Age Restrictions	ACUTE MYELOID LEUKEMIA (AML): GREATER OR EQUAL TO 55 YEARS OLD.
Prescriber Restrictions	N/A
Coverage Duration	3 MONTHS AT A TIME
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LIBTAYO

Products Affected

- Libtayo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and/or failed, and response to prior therapy
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by or in consultation with an oncologist or hematologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LIDOCAINE TRANSDERMAL

Products Affected

- lidocaine topical adhesive patch,medicated 5 %
- lidocaine topical ointment

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LINZESS

Products Affected

- Linzess

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and previous treatments
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Must have a failure, contraindication or intolerance to Amitza
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LOKELMA

Products Affected

- Lokelma

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of hyperkalemia, confirmed with laboratory test within the past month.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months for initiation, 1 year for continuation
Other Criteria	For initiation, must have a failure, contraindication, or intolerance to sodium polystyrene sulfonate. For continuation, must show response to therapy as demonstrated by normal potassium levels and patient remains at high risk for recurrence of hyperkalemia.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LONSURF

Products Affected

- Lonsurf

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and/or failed, and treatment response
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LORBRENA

Products Affected

- Lorbrena

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LUMIGAN

Products Affected

- Lumigan ophthalmic (eye) drops 0.01 %

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an ophthalmologist.
Coverage Duration	1 year
Other Criteria	Documentation of an adequate trial on bimatoprost AND at least one other drug: travoprost or latanoprost.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LYNPARZA

Products Affected

- Lynparza oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR THERAPIES, GENETIC TESTING
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ONCOLOGIST
Coverage Duration	3 months initiation, 6 months continuation
Other Criteria	Patients must have failed greater than equal to 3 prior courses of chemotherapy and have BRCA-positive or suspected BRCA-positive advanced ovarian cancer
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MAVENCLAD

Products Affected

- Mavenclad (10 tablet pack)
- Mavenclad (4 tablet pack)
- Mavenclad (5 tablet pack)
- Mavenclad (6 tablet pack)
- Mavenclad (7 tablet pack)
- Mavenclad (8 tablet pack)
- Mavenclad (9 tablet pack)

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for patients with HIV, active chronic hepatitis, or tuberculosis.
Required Medical Information	For MS Diagnosis, EDSS score, relapse history, physical or cognitive disability, TB test
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a neurologist
Coverage Duration	1 year
Other Criteria	For MS-failure of at least two of the following: glatiramer or glatopa AND either Gilenya, Betaseron, or Avonex.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MAYZENT

Products Affected

- Mayzent

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, EDSS score, relapse history, and physical or cognitive disability
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a neurologist
Coverage Duration	1 year
Other Criteria	Failure of at least two of the following: glatiramer or glatopa AND either Gilenya, Betaseron, or Avonex.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MEDICALLY ACCEPTED USE

Products Affected

- Auryxia
- topiramate oral capsule, sprinkle
- topiramate oral tablet
- zonisamide

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MEKINIST

Products Affected

- Mekinist oral tablet 0.5 mg, 2 mg

PA Criteria	Criteria Details
Exclusion Criteria	Wild-type BRAF melanoma
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. Documentation of BRAF mutation, as detected using an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MEKTOVI

Products Affected

- Mektovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	Must be used in combination with encorafenib.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

METHAMPHETAMINE

Products Affected

- methamphetamine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies previously tried and failed, and response to treatment
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For the treatment of attention deficit disorder patient must have a trial of both methylphenidate and amphetamine/dextroamphetamine or rationale as to why these treatments are not suitable.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MIRVASO

Products Affected

- Mirvaso topical gel with pump

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis and other treatments tried and outcome.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For the treatment of acne rosacea: doxycycline (oral) and topical metronidazole.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MOVANTIK

Products Affected

- Movantik
- Symproic

PA Criteria	Criteria Details
Exclusion Criteria	Will not be approved for cancer related pain
Required Medical Information	Documented diagnosis of opiate induced constipation (non-cancer pain)
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Patient must have a trial of or contraindication to at least two different classes of laxative agents including bulk, osmotic, or stimulant laxatives.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MULPLETA

Products Affected

- Mulpleta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and platelet count
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by a hematologist, oncologist, or gastroenterologist
Coverage Duration	1 month
Other Criteria	Patient must be scheduled to undergo a pre-planned medical or dental procedure with treatment beginning 8 to 14 days prior to the scheduled procedure. Patients should undergo their procedure 2 to 8 days after the last dose.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MULTIPLE SCLEROSIS

Products Affected

- Aubagio
- Avonex intramuscular pen injector kit
- Avonex intramuscular syringe kit
- Betaseron subcutaneous kit
- dimethyl fumarate oral capsule,delayed release(DR/EC) 120 mg, 240 mg
- Gilenya oral capsule 0.5 mg
- glatiramer
- Glatopa
- Plegridy
- Tecfidera oral capsule,delayed release(DR/EC) 120 mg (14)- 240 mg (46)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, EDSS score, relapse history, and physical or cognitive disability
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a neurologist
Coverage Duration	2 years
Other Criteria	Patient must have a trial of or contraindication to glatiramer or glatopa prior to initiating the other drugs listed in this criteria.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MYALEPT

Products Affected

- Myalept

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months for initiation, 1 year for continuation
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NATPARA

Products Affected

- Natpara

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, BASELINE SERUM CALCIUM AND 25-HYDROXYVITAMIN D LEVELS
Age Restrictions	N/A
Prescriber Restrictions	MUST BE PRESCRIBED BY AN ENDOCRINOLOGIST
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NAYZILAM

Products Affected

- Nayzilam

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to midazolam.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a neurologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NERLYNX

Products Affected

- Nerlynx

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous treatments, and outcome.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	2 years
Other Criteria	Approve for continuation of prior therapy if treatment duration of Nerlynx has not exceeded a total of 12 months
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NEUPRO

Products Affected

- Neupro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and/or failed, frequency of symptoms
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Patient must have a trial of or contraindication to two of the following therapies prior to coverage of Neupro: pramipexole, ropinirole, or carbidopa/levodopa.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NEXAVAR

Products Affected

- Nexavar

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR THERAPIES, AND TREATMENT RESPONSE
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ONCOLOGIST
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NEXLETOL

Products Affected

- Nexletol
- Nexlizet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to bempedoic acid (with or without ezetimibe).
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by or given in consultation with a cardiologist, endocrinologist, or physician who focuses on CV risk management and or lipid disorders.
Coverage Duration	1 year
Other Criteria	Established diagnosis of heterozygous familial hypercholesterolemia (HeFH) OR atherosclerotic cardiovascular disease (ASCVD) with history of ONE of the following (for ASCVD): ii. Myocardial infarction (MI) -OR- iii. Acute Coronary Syndrome (ACS) -OR- iv. Stable or unstable angina -OR- v. Thromboembolic stroke -OR- vi. Transient ischemic attack (TIA) -OR- vii. Peripheral arterial disease (PAD) -OR- viii. Coronary or other arterial revascularization. Patient has had a previous trial of or has a contraindication to a high-intensity statin (i.e., atorvastatin 40-80 mg daily, rosuvastatin 20-40 mg daily) and LDL-C remains greater than 100 mg/dL with laboratory confirmation within the last 30 days. If patient cannot tolerate a high intensity statin, the patient is taking a maximally tolerated dose of any statin. If intolerate of all statins, patient has had an adequate trial of ezetimbe, unless contraindicated, and LDL-C remains greater than 100 mg/dL with laboratory confirmation within the last 30 days. Patient will continue taking the maximally tolerated statin (unless contraindicated) in combination with Nexletol or Nexlizet.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NINLARO

Products Affected

- Ninlaro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and/or failed, and treatment response. Used in combination with Revlimid (lenalidomide) and dexamethasone.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or hematologist
Coverage Duration	2 years
Other Criteria	Must have an intolerance or contraindication to Velcade
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NOXAFIL

Products Affected

- Noxafil oral suspension

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, therapies tried, and outcome
Age Restrictions	N/A
Prescriber Restrictions	Prescribed Infectious disease specialist
Coverage Duration	6 months
Other Criteria	For the treatment of aspergillosis patient must have failure of, intolerance or contraindication to vorconizole OR rationale as to why vorconizole is not suitable.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NUBEQA

Products Affected

- Nubeqa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to darolutamide.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or urologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NUCALA

Products Affected

- Nucala

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For patients with asthma: allergen test, baseline FEV1, FEV1 following bronchodilator, asthma medical history (including medications, emergency department visits, and hospitalizations), baseline eosinophil count. For patients with eosinophilic granulomatosis with polyangiitis: documentation of diagnosis, prior therapies, and the outcome.
Age Restrictions	N/A
Prescriber Restrictions	Pulmonologist, immunologist, allergist or rheumatologist.
Coverage Duration	3 months for initial, 1 year for continuation
Other Criteria	For patients with asthma: must be currently receiving inhaled and/or oral corticosteroid treatment, AND have a baseline eosinophil count of 300 cells/mcL or greater within previous 12 months or 150 cell/mcL within previous 6 weeks.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NUEDEXTA

Products Affected

- Nuedexta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NUPLAZID

Products Affected

- Nuplazid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Parkinson's disease psychosis: Diagnosis of Parkinson's disease. Patient has at least one of the following: hallucinations or delusions.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by or in consultation with a neurologist or psychiatrist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

NURTEC

Products Affected

- Nurtec ODT

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for migraine prevention.
Required Medical Information	N/A
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by a neurologist or pain management specialist.
Coverage Duration	1 year
Other Criteria	Unless contraindicated per the FDA label, a trial of at least one-month of two different triptans: one oral tablet and one other formulation, either nasal spray or injection.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OCALIVA

Products Affected

- Ocaliva

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and failed, and response to therapy, baseline alkaline phosphatase (ALP) level for initiation, and ALP levels after first 3 months of therapy and then yearly for continuation of therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months for initial and 1 year for continuation
Other Criteria	Use in combination with ursodiol in patients with an inadequate biochemical response to treatment (elevated ALP levels) with ursodiol dosed at 13-15 mg/kg/day for at least 1 year, may be used as monotherapy in patients unable to tolerate ursodiol. Must show improvement in ALP levels for continuation.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ODOMZO

Products Affected

- Odomzo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Patient has recurring disease following surgery or radiation OR patient is not a candidate for surgery or radiation therapy
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or dermatologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORENCIA

Products Affected

- Orencia
- Orencia ClickJect

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS AND OTHER THERAPIES TRIED AND FAILED, NEGATIVE TB TEST
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY A RHEUMATOLOGIST
Coverage Duration	3 MONTHS INITIAL, 2 YEARS CONTINUATION
Other Criteria	PATIENT MUST HAVE A DOCUMENTED FAILURE OR CONTRAINDICATION TO AT LEAST ONE NON-BIOLOGIC DMARD (including but not limited to methotrexate, hydroxychloroquine, sulfasalazine, azathioprine).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORFADIN

Products Affected

- nitisinone
- Orfadin oral capsule 20 mg
- Orfadin oral suspension

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS AND WEIGHT
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY AN ENDOCRINOLOGIST, GASTROENTEROLOGIST, HEMATOLOGIST, METABOLIC SPECIALIST, OR NEPHROLOGIST
Coverage Duration	3 MONTHS INITIAL, 1 YEAR CONTINUATION
Other Criteria	CLOSE MONITORING OF DISEASE MARKERS (ERYTHROCYTE PBG-SYNTHASE ACTIVITY, URINE 5-ALA, SUCCINYLACETONE) DURING THE FIRST 3 MONTHS OF TREATMENT TO ENSURE NORMALIZATION
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORKAMBI

Products Affected

- Orkambi oral granules in packet
- Orkambi oral tablet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Patient has a diagnosis of cystic fibrosis (CF) AND Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene AND The presence of the mutation was documented by an FDA-cleared cystic fibrosis mutation test.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	For renewal, Patient is benefiting from treatment (i.e., improvement in lung function [forced expiratory volume in one second [FEV1], decreased number of pulmonary exacerbations)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORLISSA

Products Affected

- Orilissa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies, and result of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Must have a failure, contraindication, or intolerance to a continuous hormonal contraceptive AND progestin therapy (e.g. medroxyprogesterone, norethindrone).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OTEZLA

Products Affected

- Otezla
- Otezla Starter oral tablets,dose pack 10 mg (4)-20 mg (4)-30 mg (47)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by a Rheumatologist or Dermatologist
Coverage Duration	3 months for initiation, 2 years for continuation
Other Criteria	For arthritis conditions, must have a trial of or contraindication to one non-biologic DMARD (including but not limited to methotrexate, hydroxychloroquine, sulfasalazine, azathioprine). For diagnosis of plaque psoriasis, must have a trial of or contraindication to cyclosporine or methotrexate
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OXERVATE

Products Affected

- Oxervate

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies, and result of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an ophthalmologist
Coverage Duration	8 weeks
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

OXYCONTIN

Products Affected

- oxycodone oral tablet,oral only,ext.rel.12 hr

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, OTHER THERAPIES TRIED AND FAILED, RESPONSE TO TREATMENT, OTHER OPIATES CURRENTLY BEING USED
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 MONTHS
Other Criteria	MONITOR FOR POTENIAL MISUSE INCLUDING EARLY REFILL HISTORY, MULTIPLE CONCURRENT LONG ACTING OPIATES OVER 3 MONTH PERIOD, AND MULTIPLE TREATING PHYSICIANS
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PALYNZIQ

Products Affected

- Palynziq

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior treatments, and outcome. Baseline and follow up phenylalanine (Phe) concentrations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months for initial, 1 year for continuation
Other Criteria	Must have phenylalanine (Phe) concentrations greater than 600 micromol/L on existing management, and a failure, contraindication, or intolerance to Kuvan.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PANRETIN

Products Affected

- Panretin

PA Criteria	Criteria Details
Exclusion Criteria	NOT INDICATED WHEN SYSTEMIC ANTI-KS THERAPY IS REQUIRED.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 MONTHS
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PEMAZYRE

Products Affected

- Pemazyre

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to pemigatinib.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by an oncologist or gastroenterologist.
Coverage Duration	2 years
Other Criteria	Documentation of a susceptable fibroblast growth factor receptor 2 fusion or other genetic rearrangement (as detected by an FDA-approved test).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PHOSPHODIESTERASE-5 INHIBITORS FOR PAH

Products Affected

- Alyq
- sildenafil (Pulmonary Arterial Hypertension) oral
- tadalafil (pulmonary arterial hypertension) oral tablet 20 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, right heart cath results
Age Restrictions	N/A
Prescriber Restrictions	For PAH, if prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	3 years
Other Criteria	Pulmonary arterial hypertension (PAH) WHO Group 1, are required to have had a right-heart catheterization to confirm diagnosis of PAH to ensure appropriate medical assessment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PIQRAY

Products Affected

- Piqray

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Breast Cancer. Approve if the patient meets the following criteria (A, B, C, D, and E): A) The patient is a postmenopausal female or a male AND B) The patient has advanced or metastatic hormone receptor (HR)-positive disease AND C) The patient has human epidermal growth factor receptor 2 (HER2)-negative disease AND D) The patient has PIK3CA-mutated breast cancer as detected by an approved test AND E) The patient has progressed on or after at least one prior endocrine-based regimen (e.g., anastrozole, letrozole, exemestane, Faslodex, tamoxifen, toremifene).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

POMALYST

Products Affected

- Pomalyst

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or hematologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PROLIA

Products Affected

- Prolia

PA Criteria	Criteria Details
Exclusion Criteria	Concomitant use with other medications for osteoporosis (eg, denosumab [Prolia], bisphosphonates, raloxifene, calcitonin nasal spray [Fortical], abaloparatide), except calcium and Vitamin D.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Treatment of postmenopausal osteoporosis/Treatment of osteoporosis in men (to increase bone mass) [a man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression], approve if the patient meets one of the following: 1. has had inadequate response after 12 months of therapy with an oral bisphosphonate, had osteoporotic fracture or fragility fracture while receiving an oral bisphosphonate, or intolerability to an oral bisphosphonate, OR 2. the patient cannot take an oral bisphosphonate because they cannot swallow or have difficulty swallowing, they cannot remain in an upright position, or they have a pre-existing GI medical condition, OR 3. pt has tried an IV bisphosphonate (ibandronate or zoledronic acid), OR 4. the patient has severe renal impairment (eg, creatinine clearance less than 35 mL/min) or chronic kidney disease, or if the patient has an osteoporotic fracture or fragility fracture. Treatment of bone loss in patient at high risk for fracture receiving ADT for nonmetastatic prostate cancer, approve if the patient has prostate cancer that is not metastatic to the bone and the patient is receiving ADT (eg, leuprolide, triptorelin, goserelin) or the patient has undergone a bilateral orchiectomy. Treatment of bone loss (to increase bone mass) in patients at high risk for fracture receiving adjuvant AI therapy for breast cancer,

PA Criteria	Criteria Details
	approve if the patient has breast cancer that is not metastatic to the bone and in receiving concurrent AI therapy (eg, anastrozole, letrozole, exemestane). Treatment of GIO, approve if pt tried one oral bisphosphonate OR pt cannot take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing or the patient cannot remain in an upright position post oral bisphosphonate administration or has a pre-existing GI medical condition (eg, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR pt has tried zoledronic acid (Reclast), OR pt has severe renal impairment (CrCL less than 35 mL/min) or has CKD or has had an osteoporotic fracture or fragility fracture.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PROMACTA

Products Affected

- Promacta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and/or failed, and platelet count
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	INITIAL FILL FOR 6 MONTHS, 1 YEAR THEREAFTER
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PULMONARY FIBROSIS

Products Affected

- Esbriet
- Ofev

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	liver function
Age Restrictions	N/A
Prescriber Restrictions	prescriber must be a pulmonologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PULMONARY HYPERTENSION

Products Affected

- ambrisentan
- bosentan
- Letairis
- Opsumit
- sildenafil (Pulmonary Arterial Hypertension) oral
- Tracleer
- Tyvaso
- Tyvaso Institutional Start Kit
- Tyvaso Refill Kit
- Tyvaso Starter Kit
- Ventavis

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	CONFIRMATION OF DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION (WHO GROUP 1), PRIOR THERAPIES USED, DOCUMENTATION OF RESPONSE TO THERAPY
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY PULMONOLOGIST OR CARDIOLOGIST
Coverage Duration	2 years
Other Criteria	Ventavis will also be reviewed for coverage under part B versus part D. Sildenafil must be tried prior to the use of the drugs included in this criteria, unless there is a contraindication to sildenafil.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PURIXAN

Products Affected

- Purixan

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR TREATMENTS, RESPONSE TO THERAPY
Age Restrictions	N/A
Prescriber Restrictions	prescriber must be a oncologist or hematologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

QINLOCK

Products Affected

- Qinlock

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to ripretinib.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by a oncologist or gastroenterologist.
Coverage Duration	2 years
Other Criteria	For initiation, documentation of prior treatment with three or more kinase inhibitors, including imatinib.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RELISTOR

Products Affected

- Relistor oral
- Relistor subcutaneous solution
- Relistor subcutaneous syringe

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and prior therapies tried and failed
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months for initiation, 1 year for continuation
Other Criteria	For the treatment of opioid-induced constipation associated with chronic noncancerous pain: prior trial of or contraindication to at least one class of laxative agents (including bulk, osmotic, or stimulant laxatives) AND Amitiza. For all other conditions: a trial of or contraindication to at least two different classes of laxative agents (including bulk, osmotic, or stimulant laxatives)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REPATHA

Products Affected

- Repatha
- Repatha Pushtronex
- Repatha SureClick

PA Criteria	Criteria Details
Exclusion Criteria	Concurrent use of Juxtapid or Praluent.
Required Medical Information	LDL-C and response to other agents, prior therapies tried, medication adverse event history, medical history
Age Restrictions	ASCVD/HeFH/Primary Hyperlipidemia - 18 yo and older, HoFH 13 yo and older.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders
Coverage Duration	Approve for 3 years for ASCVD/HeFH/HoFH. Approve for 1 year for primary hyperlipidemia.
Other Criteria	Hyperlipidemia with HeFH - approve if: 1) diagnosis of HeFH AND 2) tried ONE high intensity statin (i.e. atorvastatin greater than or equal to 40 mg daily or rosuvastatin greater than or equal to 20 mg daily) and LDL remains 70 mg/dL or higher unless pt is statin intolerant defined by experiencing statin related rhabdomyolysis or skeletal-related muscle symptoms while receiving separate trials of atorvastatin and rosuvastatin and during both trials the symptoms resolved upon discontinuation. Hyperlipidemia with ASCVD -approve if: 1) has one of the following conditions: prior MI, h/o ACS, diagnosis of angina, h/o CVA or TIA, PAD, undergone a coronary or other arterial revascularization procedure, AND 2) tried ONE high intensity statin (defined above) and LDL remains 70 mg/dL or higher unless pt is statin intolerant (defined above). HoFH - approve if: 1) has one of the following: a) genetic confirmation of two mutant alleles at the LDLR, APOB, PCSK9, or LDLRAP1 gene locus, OR b) untreated LDL greater than 500 mg/dL (prior to treatment), OR c) treated LDL greater than or equal to 300 mg/dL (after treatment but prior to agents such as Repatha or Juxtapid), OR d) has clinical manifestations of HoFH (e.g., cutaneous xanthomas, tendon xanthomas, arcus cornea, tuberous xanthomas or xanthelasma), AND 2) tried ONE high intensity statin

PA Criteria	Criteria Details
	(defined above) for 8 weeks or longer and LDL remains 70 mg/dL or higher unless statin intolerant (defined above). Primary hyperlipidemia (not associated with ASCVD, HeFH, or HoFH)-approve if tried one high-intensity statin therapy (defined above) and ezetimibe for 8 weeks or longer and LDL remains 100 mg/dL or higher unless statin intolerant (defined above).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RETEVMO

Products Affected

- Retevmo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to selpercatinib.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by a oncologist, pulmonologist or endocrinologist.
Coverage Duration	2 years
Other Criteria	For initiation, documentation of the presence of a RET gene fusion (with non-small cell lung cancer or thyroid cancer) or specific RET gene mutation (medullary thyroid cancer) in tumor specimens or plasma.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REVCOVI

Products Affected

- Revcovi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documented diagnosis of Adenosine deaminase (ADA) deficiency, IgA, IgM, and IgG levels, CBC, and presence of mutations in the ADA gene at 20q13.11
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by immunologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REVLIMID

Products Affected

- Revlimid

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and previous therapies or drug regimens tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	MCL-approve if the patient meets one of the following 1) Pt has tried two prior therapies or therapeutic regimens OR 2) Pt has tried one prior therapy or therapeutic regimen and cannot take Velcade according to the prescribing physician. MDS-approve if the patient meets one of the following: 1) Pt has symptomatic anemia, OR 2) Pt has transfusion-dependent anemia, OR 3) Pt has anemia that is not controlled with an erythroid stimulating agent (eg, Epogen, Procrit [epoetin alfa injection], Aranesp [darbepoetin alfa injection]). Diffuse, Large B Cell Lymphoma (Non-Hodgkin's Lymphoma)-approve if the pt has tried one other medication treatment regimen. Myelofibrosis-approve if the pt has tried one other therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REYVOW

Products Affected

- Reyvow

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for migraine prevention.
Required Medical Information	N/A
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by a neurologist or pain management specialist.
Coverage Duration	1 year
Other Criteria	Unless contraindicated per the FDA label, a trial of at least one-month of two different triptans: one oral tablet and one other formulation, either nasal spray or injection.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RINVOQ

Products Affected

- Rinvoq

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to UPADACITINIB.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a rheumatologist.
Coverage Duration	3 months for initial authorization, 12 months for continuation.
Other Criteria	Documented trial and failure of triple therapy with oral non-biologic DMARDs, a combination of methotrexate, hydroxychloroquine and sulfasalazine, for at least three months or a contraindication to triple therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ROZLYTREK

Products Affected

- Rozlytrek oral capsule 100 mg, 200 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to ENTRECTINIB.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RUBRACA

Products Affected

- Rubraca

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Ovarian cancer: Diagnosis of advanced ovarian cancer. Presence of deleterious BRCA mutation as detected by an FDA-approved diagnostic test (e.g., Foundation Focus CDxBRCA Assay). History of failure, contraindication, or intolerance to two or more chemotherapies (e.g., cisplatin, carboplatin).
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

RYDAPT

Products Affected

- Rydapt

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Acute Myeloid Leukemia (AML): Newly diagnosed acute myeloid leukemia (AML), FMS-like tyrosine kinase 3 (FLT3) mutation-positive as detected by a U.S. Food and Drug Administration (FDA)-approved test, used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. Aggressive Systemic Mastocytosis (ASM), Systemic Mastocytosis with Associated Hematological Neoplasm (SM-AHN), Mast Cell Leukemia (MCL): Diagnosis of one of the following: aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).
Age Restrictions	N/A
Prescriber Restrictions	All indications: Prescribed by or in consultation with a hematologist or oncologist.
Coverage Duration	2 years
Other Criteria	Approve for continuation of prior therapy
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SAMSCA

Products Affected

- Samsca oral tablet 15 mg
- tolvaptan oral tablet 30 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, patient has a serum sodium less than 125 mEq/L at baseline, OR member has less marked hyponatremia (serum sodium less than 135 mEq/L at baseline) AND is symptomatic (e.g. nausea, vomiting, headache, lethargy, confusion, and baseline LFTs)
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by endocrinology or nephrology
Coverage Duration	1 month
Other Criteria	Patient must have documented failure of two other therapies (e.g. fluid restriction, furosemide, demeclocycline).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SAVELLA

Products Affected

- Savella oral tablet
- Savella oral tablets,dose pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS OF FIBROMYALGIA, RESPONSE TO THERAPY
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	MUST HAVE TREATMENT FAILURE, INTOLERANCE, OR CONTRAINDICATION TO MAXIMALLY TOLERATED GABAPENTIN AND DULOXETINE.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SIGNIFOR

Products Affected

- Signifor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and other treatments tried and failed. Documentation: of surgery with response (if performed), or when surgery is not a treatment option.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an endocrinologist
Coverage Duration	3 months for initiation, 6 months for continuation.
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SIRTURO

Products Affected

- Sirturo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and/or failed. ECG and liver function tests are required at baseline and at intervals as specified in the FDA prescribing information to monitor for potentially severe adverse events.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a infectious disease specialist
Coverage Duration	24 weeks
Other Criteria	Drug therapy must be directly observed. Use of Sirturo is reserved for MDR-TB where other treatment options cannot be used for safety or efficacy reasons.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SKYRIZI

Products Affected

- Skyrizi subcutaneous syringe kit

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by a Dermatologist
Coverage Duration	2 years
Other Criteria	For diagnosis of plaque psoriasis, must have a trial of or contraindication to cyclosporine or methotrexate
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SPRITAM

Products Affected

- Spritam

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, therapies tried, and outcome
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by Neurologist
Coverage Duration	2 years
Other Criteria	Rationale as to why generic levetiracetam is not suitable.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SPRYCEL

Products Affected

- Sprycel

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ONCOLOGIST
Coverage Duration	2 years
Other Criteria	Must have a failure, intolerance or contraindication to imatinib.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

STELARA

Products Affected

- Stelara subcutaneous

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies, and result of prior therapy. TB test results
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by gastroenterologist, dermatologist or rheumatologist.
Coverage Duration	1 year
Other Criteria	For arthritis conditions, must have a trial of or contraindication to one non-biologic DMARD (including but not limited to methotrexate, hydroxychloroquine, sulfasalazine, azathioprine). For diagnosis of plaque psoriasis, must have a trial of or contraindication to cyclosporine or methotrexate. For Crohn's disease, must have trial of or contraindication to at least one non-biologic conventional therapy, including but not limited to sulfasalazine, mesalamine, azathioprine, or methotrexate.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

STIVARGA

Products Affected

- Stivarga

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to regorafenib. LFT lab test results are needed for continuation treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SUTENT

Products Affected

- Sutent

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR THERAPIES, AND TREATMENT RESPONSE. DOCUMENATION OF FAILURE OF IMATINIB FOR PATIENTS WITH GIST. DOCUMENTATION OF FAILURE OF VOTRIENT FOR PATIENTS WITH RENAL CELL CARCINOMA. IF NO PREVIOUS FAILURE, RATIONALE AS TO WHY PREFERRED AGENT CANNOT BE USED
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ONCOLOGIST
Coverage Duration	2 years
Other Criteria	GIST PATIENTS REQUIRE A FOLLOW-UP CT SCAN BETWEEN 8 AND 12 WEEKS.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYLATRON

Products Affected

- PegIntron subcutaneous kit 50 mcg/0.5 mL
- Sylatron subcutaneous kit 200 mcg, 300 mcg

PA Criteria	Criteria Details
Exclusion Criteria	HISTORY OF HEPATITIS OR HEPATIC DECOMPENSATION
Required Medical Information	DIAGNOSIS OF MALIGNANT MELANOMA WITH EVIDENCE OF NODAL INVOLVEMENT
Age Restrictions	18 YEARS AND OLDER
Prescriber Restrictions	PRESCRIBER MUST BE ONCOLOGIST OR DERMATOLOGIST
Coverage Duration	6 MONTHS
Other Criteria	MONITOR FOR NEUROPSYCHIATRIC DISORDERS, TOXICITY, AND NEW OR WORSENING RETINOPATHY
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYMDEKO

Products Affected

- Symdeko

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of CF AND homozygous for the F508del mutation or who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence. If the patients genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a CFTR mutation followed by verification with bi-directional sequencing when recommended by the mutation test instructions for use. FEV1 at baseline and continuation, baseline LFT and continuation, review for drug interactions CYP3A inducers
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by a pulmonologist or doctor specializing in cystic fibrosis
Coverage Duration	6 months initial, 1 year continuation
Other Criteria	For renewal, Patient is benefiting from treatment (i.e., improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYMLIN

Products Affected

- SymlinPen 120
- SymlinPen 60

PA Criteria	Criteria Details
Exclusion Criteria	GASTROPARESIS OR USE OF DRUGS TO STIMULATE GASTROINTESTINAL MOTILITY
Required Medical Information	HBA1C AND CURRENT DIABETES MEDICATIONS
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYMPAZAN

Products Affected

- Sympazan oral film 10 mg, 20 mg, 5 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	Must have failure, intolerance, or contraindication to generic clobazam
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SYNRIBO

Products Affected

- Synribo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or hematologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TABRECTA

Products Affected

- Tabrecta

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to capmatinib.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by an oncologist or pulmonologist.
Coverage Duration	2 years
Other Criteria	Documentation of a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping as detected by an FDA-approved test.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAFAMIDIS

Products Affected

- Vyndamax
- Vyndaqel

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Confirmation of diagnosis with appropriate testing.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a cardiologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAFINLAR

Products Affected

- Tafinlar

PA Criteria	Criteria Details
Exclusion Criteria	Wild-type BRAF melanoma
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. Documentation of BRAF mutation, as detected using an FDA-approved test.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAGRISSO

Products Affected

- Tagrisso

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis supported with an approved test for the detection of mutations named in FDA label found in tumor or plasma specimens. Other therapies tried and responses to treatments.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an oncologist.
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TALZENNA

Products Affected

- Talzenna

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TARCEVA

Products Affected

- erlotinib
- Tarceva

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR THERAPIES, AND TREATMENT RESPONSE
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ONCOLOGIST
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TASIGNA

Products Affected

- Tasigna oral capsule 150 mg, 200 mg, 50 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, OTHER THERAPIES TRIED AND FAILED, RESPONSE TO TREATMENT, POTENTIAL DRUG INTERACTIONS
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY AN ONCOLOGIST
Coverage Duration	2 years
Other Criteria	Must have a failure, intolerance or contraindication to imatinib and Sprycel.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAVALISSE

Products Affected

- Tavalisse

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried, outcome, and platelet count less than 50,000/microL for at least 3 months
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by a hematologist or oncologist
Coverage Duration	3 months
Other Criteria	Patient must have a failure, contraindication, or intolerance to at least two of the following therapies: corticosteroids, IVIG, Rituxan, or Promacta. For continuation of therapy the platelet counts must be to a level sufficient to avoid clinically important bleeding.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAZORAC

Products Affected

- tazarotene
- Tazorac topical cream 0.05 %
- Tazorac topical gel

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, OTHER THERAPIES TRIED AND FAILED.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAZVERIK

Products Affected

- Tazverik

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to tazemetostat.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribing limited to a hematologist/oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TEGSEDI

Products Affected

- Tegsedi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR). For continuation of therapy, demonstrated positive response to therapy (improved neurologic impairment, motor function, or slowing of disease progression)
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by a geneticist or neurologist
Coverage Duration	6 months for initiation, 1 year for continuation
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TEKTURNA

Products Affected

- Tekturna
- Tekturna HCT

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS AND OTHER THERAPIES TRIED AND FAILED.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 YEAR
Other Criteria	MUST SEE CONTRAINDICATION TO OR FAILURE OF 2 MEDICATIONS THAT BELONG TO DIFFERENT CLASSES OF ANTIHYPERTENSIVE MEDICATIONS. DIFFERENT CLASSES ALPHA BLOCKERS, BETA BLOCKERS, CALCIUM CHANNEL BLOCKERS, DIURETICS, ACE-INHIBITORS, ANGIOTENSIN-RECEPTOR BLOCKERS, OR VASODILATORS.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TESTOSTERONE

Products Affected

- testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)
- testosterone transdermal gel in packet

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of primary hypogonadism (congenital or acquired) in males. Diagnosis of secondary (hypogonadotropic) hypogonadism (congenital or acquired) in males. Hypogonadism (primary or secondary) in males, serum testosterone level. [Man is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Hypogonadism (primary or secondary) in males - initial therapy, approve if all of the following criteria are met: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) [eg, depressed mood, decreased energy, progressive decrease in muscle mass, osteoporosis, loss of libido, AND 2) patient has had two pre-treatment serum testosterone (total or available) measurements, each taken in the morning on two separate days, AND 3) the two serum testosterone levels are both low, as defined by the normal laboratory reference values. hypogonadism has been confirmed by a low for age serum testosterone (total or free) level defined by the normal laboratory reference values. Hypogonadism (primary or secondary) in males - continuing therapy, approve if the patient meets all of the following criteria: 1) patient has persistent signs and symptoms of androgen deficiency (pre-treatment) AND 2) patient had at least one pre-treatment serum testosterone level that was low. [Note: male is defined as an individual with the biological traits of a man, regardless of the individual's gender identity or gender expression.]

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TIBSOVO

Products Affected

- Tibsovo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRANSMUCOSAL IMMEDIATE RELEASE FENTANYL

Products Affected

- fentanyl citrate buccal lozenge on a handle

PA Criteria	Criteria Details
Exclusion Criteria	NOT APPROVED FOR PATIENTS WHO ARE NOT TOLERANT TO OPIOID THERAPY AND ARE NOT RECEIVING LONG ACTING OPIATE THERAPY
Required Medical Information	Diagnosis and trial of two formulary short-acting opioid analgesics such as oxycodone, morphine, or hydromorphone as immediate-release (IR) tablet formulations or oral solution.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 MONTHS AT A TIME
Other Criteria	DOCUMENTATION AS TO WHY A UNIQUE METHOD OF ADMINISTRATION IS NEEDED AND A TRADITIONAL SHORT ACTING ORAL OPIATE MEDICATION IS NOT SUITABLE. PRIOR TO COVERAGE, THE PLAN WILL DETERMINE WHETHER THE DIAGNOSIS MEETS PART D REQUIREMENTS FOR APPROVAL.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRELEGY

Products Affected

- Trelegy Ellipta inhalation blister with device 100-62.5-25 mcg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried, outcome, baseline FEV1, and history of ER visits/hospitalizations.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	Member is either currently on TRIPLE therapy with a LABA/LAMA/ICS and would benefit from once daily, single inhaler use for improved medication adherence OR failure of adequate treatment with LABA plus LAMA or ICS plus LABA. LABA = long acting beta agonist (ie: formoterol, salmeterol, vilanterol) LAMA = long acting muscarinic agonist (ie: tiotropium, glycopyrronium) ICS = inhaled corticosteroid (ie: fluticasone, budesonide, mometasone, beclometasone)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRELSTAR DEPOT, TRELSTAR LA

Products Affected

- Trelstar intramuscular suspension for reconstitution

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY AN ONCOLOGIST.
Coverage Duration	6 MONTHS AT A TIME
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRETINOIN

Products Affected

- Avita topical cream
- Avita topical gel
- tretinoin topical

PA Criteria	Criteria Details
Exclusion Criteria	Coverage is not provided for cosmetic use.
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRIENTINE

Products Affected

- Clovique
- trientine

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and the outcome, ferritin, LFTs baseline, serum iron, hemoglobin, and hematocrit
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a gastroenterologist
Coverage Duration	3 months for initiation, 6 months for continuation
Other Criteria	Must have a failure, contraindication, or intolerance to penicillamine.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TUKYSA

Products Affected

- Tukysa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to tucatinib.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by a oncologist.
Coverage Duration	2 years
Other Criteria	For initiation, documentation of human epidermal growth factor receptor 2 (HER2) testing. Documentation of one or more prior anti-HER2-based regimens in the metastatic setting.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TURALIO

Products Affected

- Turalio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis: symptomatic tenosynovial giant cell tumor associated with severe morbidity or functional limitations and not amenable to improvement with surgery in adults. Prior therapy used, result of prior therapy. If continuation, prior response to pexidartinib.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist.
Coverage Duration	3 months initiation and 1 year continuation
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TYKERB

Products Affected

- Tykerb

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR AND CURRENT THERAPIES, TREATMENT RESPONSE
Age Restrictions	18 YEARS AND OLDER
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ONCOLOGIST
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

UBRELVY

Products Affected

- Ubrelvy

PA Criteria	Criteria Details
Exclusion Criteria	Excluded for migraine prevention.
Required Medical Information	N/A
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by a neurologist or pain management specialist.
Coverage Duration	1 year
Other Criteria	Unless contraindicated per the FDA label, a trial of at least one-month of two different triptans: one oral tablet and one other formulation, either nasal spray or injection.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

UCERIS

Products Affected

- budesonide oral tablet,delayed and ext.release

PA Criteria	Criteria Details
Exclusion Criteria	Not approved for maintenance of remission or in patients with severe disease (UCDAI score = 10)
Required Medical Information	Diagnosis, other therapies tried and/or failed, including anti-inflammatory and immunosuppressant drugs
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a gastroenterology specialist
Coverage Duration	3 months
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

UPTRAVI

Products Affected

- Uptravi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Confirmation of diagnosis of PAH, other therapies tried, and documentation of response to therapy
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a cardiologist or pulmonologist
Coverage Duration	3 months for initial, 1 year for continuation
Other Criteria	Must have PAH WHO group 1 . Prior to receiving treatment with Uptravi, patient must have a contraindication, intolerance to, or history of taking a PDE5 inhibitor (sildenafil or Adcirca) AND an ERA (bosentan or ambrisentan)
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

UREA CYCLE DISORDER

Products Affected

- Ravicti
- sodium phenylbutyrate oral powder

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months for initiation, 1 year for continuation
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VALCHLOR

Products Affected

- Valchlor

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VALTOCO

Products Affected

- Valtoco

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to diazepam.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribing limited to a neurologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VASCEPA

Products Affected

- Vascepa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used and result of prior therapy. For continuation, response to Vascepa.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by, or in consultation with, a cardiologist, endocrinologist, or a physician who focuses in the treatment of CV risk management and/or lipid disorders.
Coverage Duration	1 year
Other Criteria	For indication of cardiovascular risk reduction with mild hypertriglyceridemia: must demonstrate either established cardiovascular disease OR type 2 diabetes mellitus with greater than 2 risk factors for cardiovascular disease AND elevated triglycerides greater than 150 mg/dL (within 30 days of request) and use of at least two statins titrated to maximally tolerated dose. For renewals, must demonstrate continued use of a statin and efficacy of Vascepa by repeat triglyceride level within 30 days. For indication of hypertriglyceridemia: must demonstrate severe elevated triglycerides greater than 500 mg/dL within 30 days of request and trial of omega-3 acid ethyl esters . For renewals, must demonstrate efficacy of Vascepa by repeat triglyceride level within 30 days.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VELTASSA

Products Affected

- Veltassa

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Evidence of episodes of moderate to severe hyperkalemia (serum potassium level = 5.1 mEq/L) requiring discontinuation or dose reduction of angiotensin-converting enzyme inhibitors, angiotensin receptor blockers, and/or aldosterone antagonists AND receives medication regimen that allows for practical administration of Veltassa 3 hours before or 3 hours after other oral medications
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VENCLEXTA

Products Affected

- Venclexta
- Venclexta Starting Pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis. Other treatments tried and response to therapies.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a hematologist or oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VERZENIO

Products Affected

- Verzenio

PA Criteria	Criteria Details
Exclusion Criteria	NA
Required Medical Information	Documentation of diagnosis, previous treatments, response to treatment, and LFTs.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by oncology
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VITRAKVI

Products Affected

- Vitrakvi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies, and result of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VIZIMPRO

Products Affected

- Vizimpro

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VOTRIENT

Products Affected

- Votrient

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, OTHER THERAPIES TRIED AND FAILED, RESPONSE TO TREATMENT
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY AN ONCOLOGIST
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

WAKIX

Products Affected

- Wakix

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to pitolisant.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescriber must be a neurologist or sleep specialist.
Coverage Duration	1 year
Other Criteria	Adequate trial (at least 2 months) on one analeptic drug (i.e., modafinil or armodafinil) AND one CNS stimulant drug (i.e., amphetamine, methylphenidate or amphetamine/dextroamphetamine), unless intolerant or contraindicated.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XATMEP

Products Affected

- Xatmep

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior treatments, response to therapy
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or rheumatologist
Coverage Duration	2 years
Other Criteria	Medical justification as to why member cannot use methotrexate tablets or injectable solution
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XCOPRI

Products Affected

- Xcopri
- Xcopri Maintenance Pack
- Xcopri Titration Pack

PA Criteria	Criteria Details
Exclusion Criteria	Not approved for patients with familial short QT syndrome.
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to cenobamate.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by a neurologist.
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XELJANZ

Products Affected

- Xeljanz
- Xeljanz XR oral tablet extended release 24 hr 11 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, response to prior therapy. Documentation of negative TB test.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY A SPECIALIST (INCLUDING BUT NOT LIMITED TO RHEUMATOLOGIST OR GASTROENTEROLOGIST)
Coverage Duration	3 months for initiation, 2 years for continuation
Other Criteria	Prior to receiving treatment with Xeljanz for arthritis related condition, patient must have trial of or contraindication to at least one non-biologic DMARD (including but not limited to methotrexate, hydroxychloroquine, sulfasalazine, azathioprine). Dose adjustments and laboratory monitoring parameters should be adhered to as specified in the FDA approved drug labeling.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XELJANZ22

Products Affected

- Xeljanz XR oral tablet extended release 24 hr 22 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, response to prior therapy. Documentation of negative TB test.
Age Restrictions	Adults age 18 or older.
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY A SPECIALIST (INCLUDING BUT NOT LIMITED TO RHEUMATOLOGIST OR GASTROENTEROLOGIST)
Coverage Duration	16 weeks
Other Criteria	Prior to receiving treatment with Xeljanz XR 22 mg for an ulcerative colitis condition, the patient must have an inadequate response or intolerance to tumor necrosis factor blockers. Dose adjustments and laboratory monitoring parameters should be adhered to as specified in the FDA approved drug labeling.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XENAZINE

Products Affected

- tetrabenazine

PA Criteria	Criteria Details
Exclusion Criteria	CONTRAINDICATED IN PATIENTS WITH HEPATIC DISEASE, THOSE TAKING MAOIS, OR WITH UNTREATED OR INADEQUATELY TREATED DEPRESSION
Required Medical Information	DIAGNOSIS OF HUNTINGTONS DISEASE
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY NEUROLOGIST
Coverage Duration	1 YEAR
Other Criteria	CYP2D6 GENOTYPING IS REQUIRED FOR PATIENTS WHO REQUIRE MORE THAN 50 MG PER DAY
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XERMELO

Products Affected

- Xermelo

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of carcinoid syndrome diarrhea AND diarrhea is inadequately controlled by a stable dose of somatostatin analog (SSA) therapy (e.g., octreotide, Somatuline Depot) for at least 3 months AND used in combination with SSA therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist
Coverage Duration	2 years
Other Criteria	For continuation of therapy-Documentation of a positive clinical response to Xermelo therapy AND Xermelo will continue to be used in combination with SSA therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XGEVA

Products Affected

- Xgeva

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and/or failed
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by oncologist
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XIFAXAN

Products Affected

- Xifaxan

PA Criteria	Criteria Details
Exclusion Criteria	Not covered for prophylaxis for travelers diarrhea or small bowel over-growth (SIBO).
Required Medical Information	Confirmation of diagnosis, documentation of response to any prior therapies
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months for travelers diarrhea (TD) and recurrent C. diff. 1 year for all other conditions
Other Criteria	For hepatic encephalopathy: treatment failure, intolerance, or contraindication to lactulose. For travelers diarrhea: treatment failure, intolerance, or contraindication to a fluoroquinolone (such as ciprofloxacin) and azithromycin. For IBS-D: treatment failure, intolerance, or contraindication to loperamide and dicyclomine. For recurrent C. difficile: treatment failure, intolerance, or contraindication to vancomycin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XIIDRA

Products Affected

- Xiidra

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and other therapies tried.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 12 months
Other Criteria	Failure, contraindication, or intolerance to Restasis at an optimal dose and frequency for at least 2 weeks
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Exclusion Criteria	weight above 330 lbs
Required Medical Information	For asthma: weight, IgE level at baseline, baseline FEV1, FEV1 following bronchodilator, medication history, ER visits, and hospitalizations. Evidence of a positive skin test or in-vitro reactivity to a perennial aeroallergen. For uticaria: documentation of persistence of hives associated with itching and prior treatments with outcome.
Age Restrictions	N/A
Prescriber Restrictions	pulmonologist, immunologist, allergist, or dermatologist
Coverage Duration	1 year
Other Criteria	For asthma: IgE serum concentration between 30-700 IU/ml-+for adults and and 30-1,300 IU/mL for children, concurrent therapy with inhaled corticosteroids and long-acting -+-agonists for =3 months duration, and evidence of oral steroids or ER visits/hospitalizations For uticaria: failure, intolerance, or contraindication to desloratadine and montelukast.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XOSPATA

Products Affected

- Xospata

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapies, and result of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or hematologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XPOVIO

Products Affected

- Xpovio

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and treatment responses.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or hematologist.
Coverage Duration	3 months for initial authorization, 12 months for continuation.
Other Criteria	For multiple myeloma (MM): must demonstrate treatment with at least 4 prior therapies and whose disease is refractory to at least 2 proteasome inhibitors, at least 2 immunomodulatory agents, and an anti-CD38 monoclonal antibody. Treatment plan to include selinexor given in combination with dexamethasone. For diffuse large B-cell lymphoma (DLBCL): must demonstrate prior treatment with at least 2 lines of systemic therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XTANDI

Products Affected

- Xtandi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to enzalutamide.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or urologist
Coverage Duration	2 years
Other Criteria	Patient must undergo evaluation of seizure risk. For metastatic castration resistant prostate cancer (CRPC), patient must have a failure, intolerance, or contraindication to Zytiga prior to initiation of therapy with Xtandi.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XURIDEN

Products Affected

- Xuriden

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	The starting dose will be approved for 60 mg/kg once daily. Higher doses will be approved (up to 120 mg/kg once daily) in the following situations: Levels of orotic acid in urine remain above normal or increase above the usual or expected range for the patient OR Laboratory values (e.g., red blood cell or white blood cell indices) affected by hereditary orotic aciduria show evidence of worsening OR Worsening of other signs or symptoms of the disease
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months initial, 1 year continuation
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XYREM

Products Affected

- Xyrem

PA Criteria	Criteria Details
Exclusion Criteria	Not to be used in patients concurrently using alcohol or sedative-hypnotic agents
Required Medical Information	Diagnosis, other therapies tried and failed
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a sleep medicine specialist or neurologist
Coverage Duration	3 months for initiation, 6 months for continuation
Other Criteria	Dosing approved up to 9 grams per day
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZEJULA

Products Affected

- Zejula

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Documentation of diagnosis, prior therapies, and response to therapy
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZELBORAF

Products Affected

- Zelboraf

PA Criteria	Criteria Details
Exclusion Criteria	PATIENTS WITH WILD-TYPE BRAF MELANOMA, PREGNANCY
Required Medical Information	FOR METASTATIC MELANOMA: DOCUMENTATION OF DIAGONSIS AND BRAF V600E MUTATION AS DETECTED USING AN FDA-APPROVED TEST. FOR ERDHEIM-CHESTER DISEASE: DOCUMENTATION OF DIAGNOSIS AND BRAF V600 MUTATION.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY AN ONCOLOGIST.
Coverage Duration	2 years
Other Criteria	PERFORM DERMATOLOGICAL EVALUATIONS PRIOR TO INITIATION OF THERAPY AND EVERY 2 MONTHS WHILE ON THERAPY TO MONITOR FOR NEW PRIMARY MELANOMAS. MONITOR LIVER FUNCTION TESTS PRIOR TO INITIATION OF THERAPY AND AS CLINICALLY INDICATED THEREAFTER. MONITOR ECGs PRIOR TO INITIATION OF THERAPY, AT DAY 15, THEN MONTHLY, AND EVERY 3 MONTHS THEREAFTER.MONITOR PATIENTS FOR OPHTHALMOLOGIC REACTIONS AS CLINICALLY INDICATED.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZYDELIG

Products Affected

- Zydelig

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR TREATMENTS, RESPONSE TO THERAPY. FOR PATIENTS WITH CLL OR SLL, DOCUMENTATION OF PRIOR TREATMENT WITH IMBRUVICA. IF NO PREVIOUS FAILURE, RATIONALE AS TO WHY PREFERRED AGENT CANNOT BE USED
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY ONCOLOGIST OR HEMATOLOGIST
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ZYTIGA

Products Affected

- abiraterone
- Zytiga oral tablet 500 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to abiraterone.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an oncologist or urologist
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PART B VERSUS PART D

Products Affected

- Abelcet
- acetylcysteine
- acyclovir sodium intravenous solution
- albuterol sulfate inhalation solution for nebulization
- AmBisome
- Aminosyn II 10 %
- Aminosyn II 15 %
- Aminosyn-PF 7 % (sulfite-free)
- amphotericin B
- Astagraf XL
- Azasan
- azathioprine
- Bethkis
- bleomycin
- Brovana
- budesonide inhalation
- Clinimix 5%/D15W Sulfite Free
- Clinimix 4.25%/D10W Sulf Free
- Clinimix 4.25%/D5W Sulfit Free
- Clinimix 5%-D20W(sulfite-free)
- Clinimix E 2.75%/D5W Sulf Free
- Clinimix E 4.25%/D10W Sul Free
- Clinimix E 4.25%/D5W Sulf Free
- Clinimix E 5%/D15W Sulfit Free
- Clinimix E 5%/D20W Sulfit Free
- Clinisol SF 15 %
- cromolyn inhalation
- cyclophosphamide oral capsule
- cyclosporine modified
- cyclosporine oral capsule
- dexamethasone oral elixir
- dexamethasone oral solution
- dexamethasone oral tablet
- dexamethasone sodium phos (PF) injection solution
- dexamethasone sodium phosphate injection
- Engerix-B (PF) intramuscular syringe
- Engerix-B Pediatric (PF) intramuscular syringe
- everolimus (immunosuppressive)
- Freamine HBC 6.9 %
- Gengraf oral capsule 100 mg, 25 mg
- Gengraf oral solution
- granisetron HCl oral
- Hepatamine 8%
- Imovax Rabies Vaccine (PF)
- Intralipid intravenous emulsion 30 %
- ipratropium bromide inhalation
- ipratropium-albuterol
- levalbuterol HCl
- methylprednisolone oral tablet
- Millipred oral tablet
- mycophenolate mofetil
- mycophenolate sodium
- Myfortic
- Neoral
- Nephramine 5.4 %
- ondansetron
- ondansetron HCl oral
- pentamidine inhalation
- Perforomist
- Plenamine
- prednisolone oral solution 15 mg/5 mL
- prednisolone sodium phosphate oral solution 10 mg/5 mL, 15 mg/5 mL (3 mg/mL), 20 mg/5 mL (4 mg/mL), 25 mg/5 mL (5 mg/mL), 5 mg base/5 mL (6.7 mg/5 mL)
- Prednisone Intensol
- prednisone oral solution
- prednisone oral tablet
- Premasol 10 %
- Procalamine 3%
- Prograf oral granules in packet
- Pulmozyme
- RabAvert (PF)
- Rapamune
- Recombivax HB (PF) intramuscular suspension 10 mcg/mL, 40 mcg/mL

- Recombivax HB (PF) intramuscular syringe
- Sandimmune oral
- sirolimus
- tacrolimus oral
- tobramycin in 0.225 % NaCl
- Travasol 10 %
- TrophAmine 10 %
- Xembify
- Yupelri
- Zortress oral tablet 1 mg

Details

This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

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