

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	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ACTINIC KERATOSIS

Products Affected

- diclofenac sodium topical gel 3 %

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	Prior use of 5% fluorouracil topical and 5% imiquimod topical, unless contraindicated.
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

ADBRY

Products Affected

- Adbry

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used and result of prior therapy. If continuation, response to tralokinumab 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, immunologist, pulmonologist, otolaryngologist or dermatologist.
Coverage Duration	Initial 24 weeks. 1 year if conditions are met
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).
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	1 year
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

ADLARITY

Products Affected

- Adlarity

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, previous treatments, and response therapy
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Must have a intolerance, contraindication, or medical reason the tablets are not acceptable.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

AFINITOR

Products Affected

- 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	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Must be prescribed by or in consultation with a headache specialist, pain management specialist or neurologist.
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

AJOVY

Products Affected

- Ajoovy Autoinjector
- Ajoovy Syringe

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	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Must be prescribed by or in consultation with a headache specialist, pain management specialist or neurologist.
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

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	Metastatic non-small cell lung cancer (NSCLC): must be ALK-positive, as detected by an approved test.
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

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

- dalfampridine

PA Criteria	Criteria Details
Exclusion Criteria	Not a covered benefit in patients with a 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	1 year
Other Criteria	Patient must show improvement in walking speed to continue treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ANALEPTIC

Products Affected

- armodafinil

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Excessive sleepiness due to SWSD defined as the patient is working at least 5 overnight shifts per month. As adjunctive/augmentation treatment for depression in the adult if the patient is concurrently receiving other medication therapy for depression.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ANTIDEPRESSANTS

Products Affected

- Drizalma Sprinkle oral capsule, delayed rel sprinkle 20 mg, 30 mg, 40 mg, 60 mg
- Fetzima
- Trintellix
- Viibryd oral tablets, dose pack 10 mg (7)-20 mg (23)
- vilazodone

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	For treatment of major depressive disorder (MDD), must have tried generic antidepressants from at least two different classes: 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. For treatment of diabetic peripheral neuropathy with Drizalma: must have tried gabapentin and duloxetine. For treatment of chronic musculo-skeletal pain with Drizalma: must have tried duloxetine AND one other pain drug such as a non-steroidal anti-inflammatory (e.g. meloxicam or similar) or gabapentin, unless intolerant or contraindicated.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ANTIPSYCHOTICS

Products Affected

- Abilify Maintena
- asenapine maleate
- Caplyta
- Fanapt
- Invega Hafyera
- Invega Sustenna
- Invega Trinza
- Latuda oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg
- Rexulti
- Secuado
- Versacloz
- Vraylar oral capsule
- Vraylar oral capsule, dose pack

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and treatment history.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	For BIPOLAR DISORDER or SCHIZOPHRENIA, documentation of diagnosis, and treatment failure with two atypical anti-psychotics: ZIPRASIDONE, RISPERIDONE, QUETIAPINE, OLANZAPINE, CLOZAPINE, ARIPIPRAZOLE) or rationale as to why alternatives are not suitable. For treatment of major depressive disorder (MDD), must have tried generic antidepressants from at least two different classes: SSRIs, SNRIs, TCAs, NOREPINEPHRINE-DOPAMINE REUPTAKE INHIBITORS, or NORADRENERGIC and SPECIFIC SEROTONERGIC ANTIDEPRESSANTS.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

APOKYN

Products Affected

- apomorphine

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 intolerance to Inbrija and carbidopa/levodopa ER
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

APREPITANT

Products Affected

- aprepitant

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For use with highly and moderately-emetogenic chemotherapy, provide the chemotherapy regimen including drug, dose, and frequency. Ondansetron is preferred for post-operative nausea/vomiting (PONV) prophylaxis. When aprepitant is used for PONV prophylaxis, provide rationale as to why ondansetron is not a suitable alternative.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	6 months
Other Criteria	Request will also be reviewed for coverage under part B versus part D.
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	Beneficiary is of appropriate age for use per FDA prescribing information.
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

AURYXIA

Products Affected

- Auryxia

PA Criteria	Criteria Details
Exclusion Criteria	Not approved for treatment of iron deficiency anemia in patients with ESRD on dialysis.
Required Medical Information	Diagnosis, CKD/ESRD Stage, prior therapy used and response to prior therapy. Required pre-treatment testing for hyperphosphatemia: serum calcium and phosphorus, serum creatinine and eGFR.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a nephrologist.
Coverage Duration	1 year
Other Criteria	For hyperphosphatemia, documentation of prior use of calcium acetate and one other drug: sevelamer or lanthanum.
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	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by an oncologist or gastroenterologist - or - an allergist or immunologist, as appropriate to the diagnosis.
Coverage Duration	2 years
Other Criteria	For GIST: documentation of a PDGFRA exon 18 mutation or PDGFRA D842V mutation. For AdvSM, documentation of platelet count greater than 50×10^9 /L.
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

BANZEL

Products Affected

- rufinamide

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by a specialist appropriate to the disease state such as a neurologist.
Coverage Duration	2 years
Other Criteria	For Lennox-Gastaut Syndrome: documentation of treatment with valproate and lamotrigine with outcomes (treatment failure or intolerance).
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	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by a rheumatologist or nephrologist.
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

BESREMI

Products Affected

- Besremi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior treatments, and outcome
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	N/A
Coverage Duration	3 years
Other Criteria	Must have an intolerance, contraindication, or treatment failure with hydroxyurea and Peginterferon alpha-2a.
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 oral capsule 75 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 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

BRIVIACT

Products Affected

- Briviact oral

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used and result of prior therapy. If continuation, response to brivaracetam.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by neurologist.
Coverage Duration	3 years
Other Criteria	Failure of treatment with levetiracetam and ONE additional Part D formulary anticonvulsant drug.
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	Beneficiary is of appropriate age for use per FDA prescribing information.
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	N/A
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
- Calquence (acalabrutinib mal)

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	Beneficiary is of appropriate age for use per FDA prescribing information.
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	Oncologist or hematologist
Coverage Duration	5 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
- Cosentyx (2 Syringes)
- Cosentyx Pen (2 Pens)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other treatments tried and reasons for failure. Regular monitoring for TB required, both at baseline and during treatment
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribing limited to a rheumatologist or dermatologist.
Coverage Duration	1 year
Other Criteria	For arthritis conditions, must have a trial of or contraindication to one non-biologic DMARD (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

CROFELEMER

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	1 year
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

CYSTADROP

Products Affected

- Cystadrops

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to cysteamine.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribing limited to ophthalmologist or corneal specialist.
Coverage Duration	1 year
Other Criteria	To start treatment, documentation of presence of corneal cystine crystal accumulation by slit lamp examination, baseline Corneal Cystine Crystal Score (CCCS) provided. For continuation: positive response to therapy (e.g., documentation showing improvement in vision with less pain and photophobia).
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	2 years
Other Criteria	For COPD, patients must meet all of the following conditions: diagnosis of severe or very severe COPD (defined as FEV-1 less than 50 based on GOLD), AND a recent history of exacerbations or ER treatments within the last 120 days, AND documented use of TWO different combinations of triple therapy (LAMA, LABA, ICS) using products such as GEQ Advair and Spiriva (or similar) and Trelegy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

DAURISMO

Products Affected

- Daurismo oral tablet 100 mg, 25 mg

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

DEMSEER

Products Affected

- metyrosine

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

DIACOMIT

Products Affected

- Diacomit

PA Criteria	Criteria Details
Exclusion Criteria	There is no clinical data to support the use of Diacomit alone to treat Dravet syndrome.
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to stiripentol.
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	Documentation must show co-administration of stiripentol with clobazam.
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	Prescribed by a specialist appropriate to the disease state such as 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 thrombocytopenia, 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 the 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 subcutaneous pen injector 200 mg/1.14 mL, 300 mg/2 mL
- Dupixent Syringe subcutaneous syringe 100 mg/0.67 mL, 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, immunologist, 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 and an adequate trial of of a intranasal corticosteroid product (beclomethasone, fluticasone, mometasone). For asthma: blood and/or tissue eosinophil testing with documentation of an adequate trial of an interleukine drug (montelukast, zafirlukast).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ENBREL

Products Affected

- Enbrel Mini
- Enbrel subcutaneous solution
- Enbrel subcutaneous syringe
- 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	1 year
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
	<p>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 corticosteroid, 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.</p>
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	Prescribed by a neurologist or ophthalmologist.
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 immunosuppressive therapy: corticosteroid 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, 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: documentation of use of valproate and lamotrigine and outcomes (treatment failure or intolerance). For Dravet Syndrome: documentation of use of valproate and topiramate and outcomes (treatment failure or intolerance). For refractory seizures: documentation of use of two different anti-convulsant drugs from different pharmacologic classes (valproate, topiramate, lamotrigine or similar) and outcomes (intolerance or treatment failure).
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EPRONTIA

Products Affected

- Eprontia

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior treatments, and outcome
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	N/A
Coverage Duration	5 Years
Other Criteria	Must have a intolerance, contraindication, or medical reason the tablet or capsule are not acceptable.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ERGOTAMINE DERIVATIVES

Products Affected

- dihydroergotamine nasal

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior treatments and responses.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by a headache specialist, pain management specialist or neurologist.
Coverage Duration	1 year
Other Criteria	For treatment of migraine, unless contraindicated, a trial and failure of two different triptans (covered on the formulary): one oral tablet and one other formulation, either nasal spray or injection.
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	Beneficiary is of appropriate age for use per FDA prescribing information.
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, 40 mcg/mL, 60 mcg/mL
- Epogen injection solution 2,000 unit/mL, 20,000 unit/2 mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL
- Aranesp (in polysorbate) injection syringe

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 escalation [up to max of 300 units/kg/dose])
Indications	All Medically-accepted Indications.

Prior Authorization Criteria
Health Alliance Plan 2022
Date Effective: 12/01/2022

PA Criteria	Criteria Details
Off-Label Uses	N/A

EVRYSDI

Products Affected

- Evrysdi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to risdiplam.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by a pulmonologist, neurologist, orthopedist or gastroenterologist.
Coverage Duration	1 year
Other Criteria	Genetic testing to determine if the SMN1 gene is missing or damaged is required to initiate SMA treatment.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

EXJADE

Products Affected

- deferasirox oral tablet
- deferasirox oral tablet, dispersible

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	2 year
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: 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 continuation: current LIC is greater than 3 mg per gram of dry weight or 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

EXKIVITY

Products Affected

- Exkivity

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior treatments, and treatment response. Evidence of EGFR exon 20 insertion mutation
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by an oncologist
Coverage Duration	5 years
Other Criteria	N/A
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	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

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	1 year
Other Criteria	Must have a contraindication to, or an inadequate response to, or have experienced clinically significant adverse effects to deferasirox.
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

FOTIVDA

Products Affected

- Fotivda

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, response to tivozanib.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by a specialist in hematology / oncology.
Coverage Duration	3 years
Other Criteria	Documentation of two prior lines of systemic drug therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

FYCOMPA

Products Affected

- Fycompa

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	1 year
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 treatment responses.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a gastroenterologist.
Coverage Duration	1 year
Other Criteria	For ADULT patients: A colonoscopy of the entire colon with removal of polyps must be done before initiating therapy, medical records documenting this procedure must be submitted. For PEDIATRIC patients: Perform fecal occult blood testing: if there is unexplained blood in the stool, perform colonoscopy / sigmoidoscopy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

GAUCHER'S DISEASE TREATMENT

Products Affected

- Cerdelga
- miglustat

PA Criteria	Criteria Details
Exclusion Criteria	NOT APPROVED FOR TYPE II OR TYPE III GAUCHER'S DISEASE
Required Medical Information	Diagnosis. For MIGLUSTAT: rationale as to why ERT is not appropriate.
Age Restrictions	N/A
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY GENETICIST, HEMATOLOGIST, 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 oral tablet 100 mg, 400 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR THERAPIES, AND TREATMENT RESPONSE
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by an oncologist, allergist or immunologist.
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 oral tablet extended release 24 hr

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis and previous treatments, including dosage and outcome of previous treatments.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
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 an an endocrinologist or nephrologist.
Coverage Duration	1 year
Other Criteria	Replacement therapy in patients with growth hormone deficiency with diagnosis confirmed by appropriate growth hormone stimulation testing.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HEMADY

Products Affected

- Hemady

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to dexamethasone.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribing limited to hematologist / oncologist.
Coverage Duration	2 years
Other Criteria	Clinical treatment plan to include combination therapy of dexamethasone with other anti-myeloma products. Dexamethasone dosing is to be in accordance with the Prescribing Information of the other anti-myeloma products used in the combination treatment.
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 oral tablet
- 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

- Haegarda
- icatibant
- Orladeyo
- Sajazir
- Takhzyro

PA Criteria	Criteria Details
Exclusion Criteria	Dual prescribing of injectable and oral formulations for HAE prophylaxis are not covered to prevent risk of double-dosing.
Required Medical Information	Diagnosis and the results of immunologic laboratory testing that show low C4 and functional C1- inhibitor levels (less than the lower limits of laboratory reference ranges).
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by an allergist or immunologist.
Coverage Duration	1 year
Other Criteria	For icatibant initiation: confirmed diagnosis of HAE. To continue icatibant in patients who have treated previous acute HAE attacks with icatibant: documentation demonstrating a favorable clinical response (e.g., decrease in the duration of HAE attacks, quick onset of symptom relief, complete resolution of symptoms, decrease in HAE acute attack frequency or severity). To initiate berotralstat (Orladeyo), C1 esterase inhibitor, (Haegrada) or lanadelumab-flyo (Takhzyro): documented use and effectiveness of on-demand treatment with icatibant (Firazyr) and that adding prophylaxis treatment is appropriate to the care plan. For C1 esterase inhibitor (Haegrada) and lanadelumab-flyo (Takhzyro), must show that an adequate trial of berotralstat (Orladeyo) has been tried with documentation of response.
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, prior therapies and responses.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by a sleep specialist.
Coverage Duration	1 year
Other Criteria	For a diagnosis of non-24-hour sleep-wake disorder, submit sleep log through a wrist activity monitor that supports diagnosis of non-24-hour sleep-wake disorder) AND sleep study has ruled out sleep apnea and periodic limb movement disorder. For continuation, positive clinical response demonstrated by: (1) increased total nighttime sleep and, (2) decreased daytime nap duration, as determined by treating physician. For nighttime sleep disturbances in Smith-Magenis Syndrome, documentation supporting the diagnosis.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA

Products Affected

- Juxtapid oral capsule 10 mg, 20 mg, 30 mg, 5 mg

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	1 year
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 Pen
- Humira Pen Crohns-UC-HS Start
- Humira Pen Psor-Uveits-Adol HS
- Humira subcutaneous syringe kit 40 mg/0.8 mL
- Humira(CF) Pedi Crohns Starter subcutaneous syringe kit 80 mg/0.8 mL, 80 mg/0.8 mL-40 mg/0.4 mL
- Humira(CF) Pen Crohns-UC-HS
- Humira(CF) Pen Pediatric UC
- Humira(CF) Pen Psor-Uv-Adol HS
- Humira(CF) Pen subcutaneous pen injector kit 40 mg/0.4 mL, 80 mg/0.8 mL
- Humira(CF) subcutaneous syringe kit 10 mg/0.1 mL, 20 mg/0.2 mL, 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	Beneficiary is of appropriate age for use per FDA prescribing information.
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	2 years
Other Criteria	RA: 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: patient has tried another a non-biologic DMARD (e.g., MTX, sulfasalazine, leflunomide, NSAID) - or - biologic DMARD (e.g., 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: approve if the patient meets one of the following criteria: 1) pt has tried at least one traditional systemic agent (e.g., MTX,

PA Criteria	Criteria Details
	<p>cyclosporine, acitretin, PUVA) for at least 3 months, unless intolerant (note: patients who have already tried a biologic for psoriasis are not required to 'step back' and try a traditional agent first) OR 2) patient has a contraindication to MTX as determined by the prescribing physician. CD: patient has tried corticosteroids (CSs), or if CSs are contraindicated, or if pt currently on CSs, or patient has tried one other agent for CD (e.g., azathioprine, 6-mercaptopurine, MTX, certolizumab, infliximab, ustekinumab, or vedolizumab) OR patient had ileocolonic resection or enterocutaneous (perianal or abdominal) or rectovaginal fistulas. UC: patient has tried a systemic therapy (e.g., 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 patient has pouchitis and has tried therapy with an antibiotic, probiotic, corticosteroid enema, or mesalamine (Rowasa) enema. HS: patient has 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. For all indications (excepting hidradenitis suppurativa), weekly dosing requires demonstration of treatment failure of every other week dosing.</p>
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
- Imbruvica oral suspension

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	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by a neurologist.
Coverage Duration	1 year
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 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INHALED TOBRAMYCIN

Products Affected

- Tobi Podhaler inhalation capsule,
w/inhalation device

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	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	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, prior therapy used, 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 a hematologist / oncologist.
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 millimeter.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

INTERFERON ALPHA

Products Affected

- Intron A injection recon soln 10 million unit (1 mL), 50 million unit (1 mL)
- Pegasys

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 DIRRHOISIS (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
- Flebogamma DIF
- Gammagard Liquid
- Gammagard S-D (IgA < 1 mcg/mL)
- Gammaked
- Gammaplex
- Gammaplex (with sorbitol)
- Gamunex-C
- Octagam
- Privigen

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other therapies tried and response to treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Diagnosis and administration information will be reviewed to determine if coverage is available as a Medicare Part B or Part D benefit. Part B before Part D Step Therapy: SCIG will be reserved for members who cannot use IVIG due to poor access (on going access site issues unresolved by traditional means) - or - SCIG will be reserved for patients who continue to experience infusion reactions despite documented infusion rate adjustments and adequate pre-treatment. For Idiopathic thrombocytopenia purpura (ITP): trial and failure of oral corticosteroids at therapeutic dose (standard dosage of prednisone is 1 mg/kg/day) required. For Chronic Inflammatory Demyelinating Polyneuropathy (CIDP): trial and failure of oral corticosteroids at therapeutic dose (standard dosage of prednisone is 1-1.5 mg/kg/day) required.
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	Prescribed by a hematologist, oncologist or transplant specialist.
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

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

KALYDECO

Products Affected

- Kalydeco oral granules in packet
- Kalydeco oral tablet

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 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

KERENDIA

Products Affected

- Kerendia

PA Criteria	Criteria Details
Exclusion Criteria	Not approved for serum potassium greater than 5.0 mEq/L.
Required Medical Information	Diagnosis, prior drug treatments and outcomes. Potassium level within 30 days.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by an endocrinologist, nephrologist or cardiologist.
Coverage Duration	1 year
Other Criteria	<p>INITIATION: Documented diagnosis of chronic kidney disease (CKD) associated with diabetes mellitus, Type 2 (T2D). Documentation in the medical record that the patient is currently receiving the following standard of care background therapy with the requested agent: (a) a maximally tolerated dose of angiotensin converting enzyme (ACE) inhibitor, angiotensin receptor blocker (ARB), or a combination medication containing an ACE inhibitor or ARB therapy - AND - (b) an antidiabetic agent (e.g., metformin or an agent containing metformin, SGLT2 inhibitor, GLP-1) - OR - (c) according to the prescriber, the patient has contraindications to both ACE and ARB drug therapy. At baseline (prior to initiation of finerenone), (a) an estimated glomerular filtration rate greater than or equal to 25 mL/min/1.73m² and less than 75 mL/min/1.73 m² - AND - (b) serum potassium level less than or equal to 5.0 mEq/L.</p> <p>CONTINUATION: Serum potassium within 30 days. Demonstrated response of GFR with finerenone therapy.</p>
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	1 year
Other Criteria	N/A
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

- sapropterin

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis. BASELINE and FOLLOW-UP phenylalanine levels.
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	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	N/A
Coverage Duration	3 months
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
- lidocaine topical ointment 5 %

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

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	1 year
Other Criteria	For initiation, must have a failure, contraindication, or intolerance to sodium polystyrene sulfonate (SPS). 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

LUMAKRAS

Products Affected

- Lumakras

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, diagnostic testing for mutations, prior drug treatments and outcomes.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by an oncologist.
Coverage Duration	2 years
Other Criteria	Diagnosis of KRAS G12C-mutated locally advanced or metastatic non-small cell lung cancer (NSCLC), as determined by an FDA-approved test, who have received at least one prior systemic therapy.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LYBALVI

Products Affected

- Lybalvi

PA Criteria	Criteria Details
Exclusion Criteria	Not approved for dementia-related psychosis. Not approved for patients using opioids. Not approved for patients undergoing acute opioid withdrawal.
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Psychiatrist or in consultation with psychiatrist.
Coverage Duration	3 years
Other Criteria	Demonstrated positive clinical response but with unacceptable weight gain while on single-agent olanzapine AND trial/failure of one other formulary atypical anti-psychotic (e.g., risperidone, aripiprazole, quetiapine, ziprasidone) titrated to maximum tolerated dose. Rationale for combination therapy in medical record. Patient does not have a known opioid use disorder nor is dependent on opioids for a chronic health condition. Prior to initiating LYBALVI when prescription history shows opioid fills within the last 30 days, prescriber attestation required to initiate olanzapine/samidorphine (LYBALVI): 7-day opioid-free interval from the last use of short-acting opioids, and at least a 14-day opioid-free interval from the last use of long-acting opioids to avoid precipitation of opioid withdrawal.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

LYNPARZA

Products Affected

- Lynparza

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 years
Other Criteria	<p>OVARIAN CANCER (epithelial ovarian, fallopian tube or primary peritoneal) - Initial - Approve if the patient meets the following criteria (i and ii): i. The patient has a germline BRCA-mutation as confirmed by an approved test AND, per product labeling, the patient has progressed on three or more prior lines of chemotherapy. Continuation - Approve if the patient has a BRCA mutation (germline) as confirmed by an approved test. Maintenance Therapy - Approve if the patient meets one of the following criteria (A or B): A) The patient meets both of the following criteria for first-line maintenance therapy (i and ii): i. The patient has a germline or somatic BRCA mutation-positive disease as confirmed by an approved test AND ii. The patient is in complete or partial response to first-line platinum-based chemotherapy regimen (e.g., carboplatin with paclitaxel, carboplatin with doxorubicin, docetaxel with carboplatin) OR B) The patient is in complete or partial response after at least two platinum-based chemotherapy regimens (e.g., carboplatin with gemcitabine, carboplatin with paclitaxel, cisplatin with gemcitabine). BREAST CANCER - Approve if the patient meets the following criteria (A, B, C, and D): A. The patient has metastatic, germline BRCA mutation-positive breast cancer AND B. The patient has human epidermal growth factor receptor 2 (HER2)-negative breast cancer AND C. The patient meets ONE of the following criteria (i or ii) - i. The patient meets BOTH of the following</p>

PA Criteria	Criteria Details
	<p>criteria (a and b) - a) The patient has hormone receptor positive (HR+) [i.e., estrogen receptor positive ER+ and/or progesterone receptor positive PR+] disease AND b) The patient meets ONE of the following criteria (1 or 2) - 1-The patient has been treated with prior endocrine therapy OR - 2 The patient is considered inappropriate for endocrine therapy OR ii. Patient has triple negative disease (i.e., ER-negative, PR-negative, and HER2-negative) AND D. The patient has been treated with chemotherapy in the neoadjuvant, adjuvant, or metastatic setting. PANCREATIC CANCER - Maintenance therapy - Approve if the patient has a germline BRCA mutation-positive metastatic disease and the disease has not progressed on at least 16 weeks of treatment with a first-line platinum-based chemotherapy regimen. PROSTATE CANCER: Approve if the patient has metastatic castration-resistant prostate cancer (mCRPC) WITH deleterious or suspected deleterious germline or somatic homologous recombination repair (HRR) gene-mutation based on a FDA approved test AND has progressed following prior treatment with enzalutamide or abiraterone.</p>
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MAVACAMTEN

Products Affected

- Camzyos

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	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by or in consultation with a cardiologist
Coverage Duration	1 year
Other Criteria	Diagnosis of Obstructive Hypertrophic Cardiomyopathy. New York Heart Association (NYHA) class II-III. Member has a left ventricular ejection fraction (LVEF) greater than or equal to 55%. Failure of TWO of the following at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated: Non-vasodilating beta-blocker (e.g., atenolol, metoprolol, bisoprolol, propranolol), Non-dihydropyridine calcium channel blocker (e.g., verapamil, diltiazem) OR Disopyramide.
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

MODAFINIL

Products Affected

- modafinil oral tablet 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 modafinil.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Excessive sleepiness associated with Shift Work Sleep Disorder (SWSD) - approve if patient is working at least 5 overnight shifts per month. Adjunctive/augmentation treatment for depression in adults - approve if the patient is concurrently receiving other medication therapy for depression. Excessive daytime sleepiness associated with obstructive sleep apnea/hypoapnea syndrome - approve. Excessive daytime sleepiness associated with narcolepsy - approve if narcolepsy has been confirmed with polysomnography and a multiple sleep latency test (MSLT).
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	Prescribed by a specialist appropriate to the disease state such as 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 the procedure 2 to 8 days after the last dose.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MULTIPLE SCLEROSIS - INJECTABLE

Products Affected

- Avonex intramuscular pen injector kit
- Avonex intramuscular syringe kit
- Betaseron subcutaneous kit
- glatiramer
- Glatopa
- Plegridy

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For MS diagnosis: EDSS score, relapse history, physical or cognitive disability, TB test.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by a specialist appropriate to the disease state such as a neurologist.
Coverage Duration	1 year
Other Criteria	To initiate interferon beta-1a (Avonex), peginterferon beta-1a (Plegridy) or interferon beta-1b (Betaseron): (unless contraindicated), must demonstrate an adequate trial of injectable glatopa or glatiramer with documented treatment failure.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MULTIPLE SCLEROSIS - ORAL

Products Affected

- Aubagio
- dimethyl fumarate
- fingolimod
- Gilenya oral capsule 0.5 mg
- 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)
- Mayzent
- Mayzent Starter(for 1mg maint)
- Mayzent Starter(for 2mg maint)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	For MS diagnosis: EDSS score, relapse history, physical or cognitive disability, TB test.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by a neurologist.
Coverage Duration	1 year
Other Criteria	To initiate fingolimod (Gilenya), terifunomide (Aubagio), cladribine (Mavenclad), and siponimod (Mayzent): (unless contraindicated), must demonstrate an adequate trial of oral dimethyl fumarate (Tecfidera) and documented treatment failure.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MU-OPIOID RECEPTOR ANTAGONIST.

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

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	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

MYFEMBREE

Products Affected

- Myfembree

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

NEXAVAR

Products Affected

- sorafenib

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): Myocardial infarction (MI) OR Acute Coronary Syndrome (ACS) OR Stable or unstable angina OR Thromboembolic stroke OR Transient ischemic attack (TIA) OR Peripheral arterial disease (PAD) OR 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 ezetimibe, 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
- posaconazole

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 voriconazole OR rationale as to why voriconazole 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	Prescribed by a: pulmonologist, immunologist, allergist, rheumatologist, hematologist or otolaryngologist.
Coverage Duration	3 years
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	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by or in consultation with a neurologist, psychiatrist or geriatrician.
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	N/A
Required Medical Information	N/A
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by a headache specialist, pain management specialist or neurologist.
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	6 months
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

ONUREG

Products Affected

- Onureg

PA Criteria	Criteria Details
Exclusion Criteria	Do not substitute ONUREG for intravenous or subcutaneous azacitidine.
Required Medical Information	N/A
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by an oncologist or hematologist oncologist.
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

ORENCIA

Products Affected

- Orenzia ClickJect
- Orenzia subcutaneous syringe 125 mg/mL, 50 mg/0.4 mL, 87.5 mg/0.7 mL

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, other treatments tried and reasons for failure. Regular monitoring for TB required, both at baseline and during treatment.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	PRESCRIPTION MUST BE WRITTEN BY A RHEUMATOLOGIST
Coverage Duration	1 year
Other Criteria	For arthritic conditions, an adequate trial at least one non-biologic DMARD (methotrexate, hydroxychloroquine, sulfasalazine, azathioprine) and documented reason for failure (or contraindication).
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	6 months
Other Criteria	CLOSE MONITORING OF DISEASE MARKERS (ERYTHROCYTE PBG-SYNTASE 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

ORGOVYX

Products Affected

- Orgovyx

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

ORKAMBI

Products Affected

- Orkambi oral granules in packet 100-125 mg, 150-188 mg
- 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	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
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

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	6 months
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	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	N/A
Coverage Duration	2 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

PDE-5 INHIBITORS FOR PAH

Products Affected

- Alyq
- sildenafil (Pulmonary Arterial Hypertension) oral suspension for reconstitution 10 mg/mL
- sildenafil (Pulmonary Arterial Hypertension) oral tablet 20 mg
- tadalafil (pulm. hypertension)

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, right heart cath results.
Age Restrictions	N/A
Prescriber Restrictions	For PAH: prescribed by, or in consultation with, a cardiologist or a pulmonologist.
Coverage Duration	2 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. Sildenafil must be tried prior to the use of the other drugs included in these criteria, unless using ambrisentan (Letairis) plus tadalafil for treatment-naive, WHO functional class II or III PAH.
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 susceptible 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

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	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	Prescribed or in consultation with Endocrinologist, Hematologist/Oncologist, Obstetrician/Gynecologist, Rheumatologist or Urologist
Coverage Duration	3 years
Other Criteria	For treatment of postmenopausal osteoporosis / treatment of osteoporosis in men [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 or (2) had osteoporotic fracture or fragility fracture while receiving an oral bisphosphonate or (3) the patient cannot take an oral bisphosphonate because (s)he cannot swallow or has difficulty swallowing, cannot remain in an upright position, or has a pre-existing GI medical condition - AND - the patient has tried an IV bisphosphonate (e.g., ibandronate or zoledronic acid). Part B before Part D Step Therapy. Approve if the patient has severe chronic kidney disease (e.g., creatinine clearance less than 35 mL/min). Approve for treatment of bone loss in patient at high risk for fracture receiving ADT for nonmetastatic prostate cancer or receiving adjuvant AI therapy for breast cancer. For treatment of glucocorticoid induced osteoporosis (GIO), approve if the patient has tried one oral bisphosphonate OR patient 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 (e.g., esophageal lesions,

Prior Authorization Criteria
Health Alliance Plan 2022
Date Effective: 12/01/2022

PA Criteria	Criteria Details
	esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia]), OR patient has tried zoledronic acid (Reclast), OR patient 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	For ITP, eltrombopag should only be used if the degree of thrombocytopenia and clinical condition increase the risk for bleeding. For chronic hepatitis C, eltrombopag should only be used if the degree of thrombocytopenia prevents initiation of or limits the ability to maintain interferon-based therapy. Eltrombopag is not indicated for the treatment of myelodysplastic syndromes.
Required Medical Information	Diagnosis, other therapies tried and outcome. Platelet count.
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

PULMONARY FIBROSIS

Products Affected

- Esbriet oral capsule
- Ofev
- pirfenidone oral tablet 267 mg, 801 mg

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
- Opsumit
- Orenitram
- Tracleer oral tablet for suspension
- 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 and responses to treatments.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by a pulmonologist or cardiologist.
Coverage Duration	2 years
Other Criteria	PAH (WHO Group 1) diagnosis confirmed by a right heart catheterization to ensure appropriate medical assessment. For new starts in the Treatment Naive patient: must initiate treatment with dual therapy with tadalafil and ambrisentan, unless intolerant or contraindicated. For these drugs: bosentan, iloprost, macitentan, treprostinil: must show documentation of prior drug treatment. Note: patients who are already established on any therapy and clinically responsive and stable, a step-back to dual therapy is not required.
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

PYRUKYND

Products Affected

- Pyrukynd

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by a hemoatologist or oncologist
Coverage Duration	3 months
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

RADICAVA

Products Affected

- Radicava ORS Starter Kit Susp

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy, if continuation, prior response to therapy
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by neurologist or prescriber with expertise with treating ALS
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

REGRANEX

Products Affected

- Regranex

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	1 year
Other Criteria	Prior use of collagenase (Santyl), unless contraindicated.
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	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	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 ezetimibe and ONE high intensity statin (e.g., 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 patient 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. For 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 ezetimibe and ONE high intensity statin (defined above) and LDL remains 70 mg/dL or higher, unless patient is statin intolerant (defined above). For 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 ezetimibe and ONE high

Prior Authorization Criteria
 Health Alliance Plan 2022
 Date Effective: 12/01/2022

PA Criteria	Criteria Details
	intensity statin (defined above) for 8 weeks or longer and LDL remains 70 mg/dL or higher unless statin intolerant (defined above). For primary hyperlipidemia with LDL of 190 or higher (not associated with ASCVD, HeFH, or HoFH), approve if tried one high-intensity statin therapy (defined above) and ezetimibe for at least 8 weeks 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 the presence of mutations in the ADA gene at 20q13.11
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by immunologist
Coverage Duration	3 year
Other Criteria	N/A
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

- lenalidomide oral capsule 2.5 mg, 20 mg
- Revlimid oral capsule 10 mg, 15 mg, 25 mg, 5 mg

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 headache specialist, pain management specialist or neurologist.
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, gastroenterologist, or dermatologist
Coverage Duration	1 year
Other Criteria	Prior to receiving treatment with Rinvoq for arthritis related conditions, the patient must have trial and failure of at least one non-biologic DMARDs, including but not limited to methotrexate, hydroxychloroquine and sulfasalazine, for at least three months or have a contraindication. 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 ulcerative colitis the patient must have an inadequate response or intolerance to tumor necrosis factor blockers (including but not limited to adalimumab).
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 (epithelial ovarian, fallopian tube or primary peritoneal): Diagnosis of advanced ovarian cancer. Presence of deleterious BRCA mutation as detected by an FDA-approved diagnostic test. History of failure, contraindication, or intolerance to two or more chemotherapies. Maintenance Therapy-Approve if the patient is in complete or partial response after at least two platinum-based chemotherapy regimens. PROSTATE CANCER: Diagnosis of advanced metastatic castration-resistant prostate cancer. Presence of deleterious BRCA mutation as detected by an FDA-approved diagnostic test. History of failure, contraindication, or intolerance to androgen receptor-directed therapy and a taxane-based chemotherapy.
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

- tolvaptan 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 a specialist appropriate to the disease state such as an endocrinologist or nephrologist.
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

SCSEMBLIX

Products Affected

- Scemblix oral tablet 20 mg, 40 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior treatments, evidence of T3151 mutation
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by oncologist
Coverage Duration	5 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SENSIPAR

Products Affected

- cinacalcet oral tablet 30 mg, 60 mg, 90 mg

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior treatments and responses.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	For secondary hyperparathyroidism associated with CKD undergoing dialysis, trial and failure with ONE phosphate binder (e.g. calcium acetate, sevelamer) - AND - ONE vitamin D analog (e.g. doxercalciferol, calcitriol, paricalcitol).
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	6 months
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 pen injector
- Skyrizi subcutaneous syringe 150 mg/mL
- Skyrizi subcutaneous syringe kit
- Skyrizi subcutaneous wearable injector

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, rheumatologist or a gastroenterologist.
Coverage Duration	2 years
Other Criteria	For diagnosis of plaque psoriasis, must have a trial of or contraindication to cyclosporine or methotrexate. For arthritis conditions, must have a trial of or contraindication to one non-biologic DMARD (methotrexate, hydroxychloroquine, sulfasalazine, azathioprine). For Crohn's disease, must have a trial 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

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 solution
- Stelara subcutaneous syringe 45 mg/0.5 mL, 90 mg/mL

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 psoriasis and psoriatic arthritis, 90 mg dosing requires demonstration of treatment failure of 45 mg for 16 weeks and patient weight greater than 100kg. For inflammatory bowel disease (CD and UC), 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

SUNOSI

Products Affected

- Sunosi

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior drug treatments and outcomes.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescription must be written by a pulmonologist or sleep specialist.
Coverage Duration	1 year
Other Criteria	INITIATION: 1) Demonstration that co-existing hypertension has been controlled before initiating treatment with solriamfetol. 2) A one-month trial of modafinil and armodafinil, both titrated to maximum tolerated dose.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

SUTENT

Products Affected

- sunitinib

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR THERAPIES, AND TREATMENT RESPONSE. DOCUMENTATION 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

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	1 year
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

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

TARGRETIN

Products Affected

- bexarotene topical

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, response to bexarotene.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribing limited to a specialist in hematology/oncology.
Coverage Duration	6 months
Other Criteria	Documentation that the patient has refractory or persistent cutaneous T-cell lymphoma (stage IA and IB) or who has not tolerated other therapies
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	1 year
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

TAVNEOS

Products Affected

- Tavneos

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 written hematologist, rheumatologist, neurologist, nephrologist, and immunologist
Coverage Duration	3 years
Other Criteria	Patient must have tried and failed two of the following: azathioprine, methotrexate, mycophenolate, rituximab, or cyclophosphamide
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAVNEOS

Products Affected

- Tavneos

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with a board-certified rheumatologist, nephrologist, hematologist or immunologist.
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TAZORAC

Products Affected

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

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

TEPMETKO

Products Affected

- Tepmetko

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to TEPOTINIB.
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	For NSCLC: confirmation of genertic alteration with biomarker testing for mesenchymal-epithelial transition (MET) exon 14 skipping alterations.
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.]

Prior Authorization Criteria
Health Alliance Plan 2022
Date Effective: 12/01/2022

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 drug treatment - AND - are NOT receiving long-acting opioids
Required Medical Information	Diagnosis and prior drug treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	1 year
Other Criteria	Documentation that shows prior use of two formulary short-acting opioid analgesics such as oxycodone, morphine, or hydromorphone as immediate-release (IR) tablet formulations or oral solution. Explanation of treatment failure or product intolerance must also explain why this unique method of administration is medically necessary and why a traditional short-acting oral opiate medication cannot be continued.
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	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRETINOIN

Products Affected

- Avita topical cream
- 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

- 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 or hepatatologist.
Coverage Duration	6 months
Other Criteria	Must have a failure, contraindication, or intolerance to penicillamine.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TRUSELTIQ

Products Affected

- Truseltiq oral capsule 100 mg/day (100 mg x 1), 125 mg/day(100 mg x1-25mg x1), 50 mg/day (25 mg x 2), 75 mg/day (25 mg x 3)

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	N/A
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 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

TYKERB

Products Affected

- lapatinib

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	DIAGNOSIS, PRIOR AND CURRENT THERAPIES, TREATMENT RESPONSE
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
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

TYMLOS

Products Affected

- Tymlos

PA Criteria	Criteria Details
Exclusion Criteria	Not approved for a cumulative lifetime duration of abaloparatide and any other parathyroid hormone therapy (eg, teriparatide) of more than 2 years. Not approved for combination therapy of a PTH/PTHrP analog in combination with other osteoporosis agents.
Required Medical Information	Diagnosis, fracture history, prior therapy used and response to prior therapy. Required pretreatment testing: DXA, if not performed in the past two years: serum calcium, phosphorus, creatinine, alkaline phosphatase, albumin, 25-hydroxyvitamin D (25[OH]D), and, 24-hour urine calcium, creatinine (or fasting specimen for calcium/creatinine ratio) to evaluate for baseline hypercalciuria.
Age Restrictions	N/A
Prescriber Restrictions	Prescription must be written by an endocrinologist.
Coverage Duration	2 years
Other Criteria	Documentation of an adequate trial on an oral bisphosphonate, or, if GI intolerant of oral bisphosphonates, use of a parenteral bisphosphonate - AND - an adequate trial on denosumab.
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, pain management specialist or headache 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 oral

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 years
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	6 months
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

- icosapent ethyl oral capsule 0.5 gram, 1 gram
- 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 icosapent ethyl.
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 hypertriglyceridemia: must demonstrate either established cardiovascular disease OR type 2 diabetes mellitus with at least 2 additional risk factors for cardiovascular disease AND elevated triglycerides of 150 mg/dL or higher (within 30 days of request) and use of at least two statins titrated to maximally tolerated dose. Waive the statin requirement for documented statin intolerant (e.g., zero tolerance). For renewals, must demonstrate continued use of a statin (unless documented as intolerant) and efficacy of icosapent ethyl 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 icosapent ethyl 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	Prior use of sodium polystyrene (SPS) and sodium zirconium cyclosilicate (Lokelma).
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

VONJO

Products Affected

- Vonjo

PA Criteria	Criteria Details
Exclusion Criteria	NA
Required Medical Information	Diagnosis, prior therapy used, result of prior therapy. If continuation, prior response to treatment.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by oncology or hematology
Coverage Duration	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VORICONAZOLE

Products Affected

- voriconazole intravenous

PA Criteria	Criteria Details
Exclusion Criteria	Not approved for topical use such as Foot Bath, Nasal Rinse, Mouthwash, etc. applications.
Required Medical Information	Medically accepted indication.
Age Restrictions	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	N/A
Coverage Duration	1 year
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

VOXZOGO

Products Affected

- Voxzogo

PA Criteria	Criteria Details
Exclusion Criteria	limb surgery
Required Medical Information	Documentation of achondroplasia confirmed by genetic testing for variants in the fibroblast growth factor receptor 3 (FGFR3) gene, members baseline annualized growth velocity, open epiphyses AND prescriber attests that there are no plans for the member to have limb-lengthening surgery and the member has not had limb-lengthening surgery.
Age Restrictions	5 years or older
Prescriber Restrictions	Prescribed by or in consultation with a board-certified geneticist, endocrinologist, neurologist, orthopedic surgeon, or specialist with experience in treating achondroplasia.
Coverage Duration	1 year
Other Criteria	Documentation of members positive clinical response as demonstrated by improvement in annualized growth velocity, open epiphyses AND prescriber attests that there are no plans for the member to have limb-lengthening surgery.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VUITY

Products Affected

- Vuity

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis
Age Restrictions	N/A
Prescriber Restrictions	Must be prescribed by an optometrist or ophthalmologist
Coverage Duration	3 years
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

VUITY

Products Affected

- Vuity

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	Diagnosis of presbyopia , Failure of corrective eyeglasses or contact lenses to resolve the presbyopia symptoms, unless contraindicated or clinically significant adverse effects are experienced
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with an optometrist or ophthalmologist
Coverage Duration	1 year
Other Criteria	Member does not have glaucoma or ocular hypertension
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	For narcolepsy without cataplexy: an 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

WEILREG

Products Affected

- Welireg

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	N/A
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 oral tablet
250mg/day(150 mg x1-100mg x1), 350
mg/day (200 mg x1-150mg x1)
- 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 oral solution
- Xeljanz oral tablet
- Xeljanz XR

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	Beneficiary is of appropriate age for use per FDA prescribing information.
Prescriber Restrictions	Prescribed by a specialist appropriate to the disease state, such as a rheumatologist or gastroenterologist.
Coverage Duration	1 year , Xelzanz XR 22 mg - 16 weeks
Other Criteria	Prior to receiving treatment with Xeljanz for ARTHRITIS-RELATED conditions, the 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. 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 (including but not limited to adalimumab). 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 oral tablet 200 mg, 550 mg

PA Criteria	Criteria Details
Exclusion Criteria	Not covered for small intestinal bacterial over-growth (SIBO). Not covered for PROPHYLAXIS of traveler's diarrhea. For TREATMENT of traveler's diarrhea, not covered for diarrhea due to pathogens other than E. coli, and, not covered for diarrhea complicated by fever or blood in the stool.
Required Medical Information	Confirmation of diagnosis, other treatments tried and documentation of response to prior therapies.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	3 months for all medically accepted indications, excepting 2 years for hepatic encephalopathy.
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 at least two of these drugs: loperamide, dicyclomine or diphenoxylate/atropine. For recurrent C. difficile: treatment failure, intolerance, or contraindication to vancomycin.
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XOLAIR

Products Affected

- Xolair

PA Criteria	Criteria Details
Exclusion Criteria	N/A
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 urticaria: documentation of persistence of hives associated with itching and prior treatments with outcome.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by a pulmonologist, immunologist, allergist, dermatologist or otolaryngologist.
Coverage Duration	1 year
Other Criteria	Moderate to severe persistent asthma approve if the patient meets criteria 1 and 2: 1) patient has received at least 3 months of combination therapy with an inhaled corticosteroid and at least one the following: long-acting beta-agonist (LABA), long-acting muscarinic antagonist (LAMA), leukotriene receptor antagonist, or theophylline, and 2) patient's asthma is uncontrolled or was uncontrolled prior to receiving any Xolair or anti-IL-4/13 therapy (Dupixent) therapy as defined by ONE of the following (a, b, c, d, or e): a) The patient experienced two or more asthma exacerbations requiring treatment with systemic corticosteroids in the previous year OR b) The patient experienced one or more asthma exacerbation requiring hospitalization or an Emergency Department (ED) visit in the previous year OR c) Patient has a forced expiratory volume in 1 second (FEV1) less than 80% predicted OR d) Patient has an FEV1/forced vital capacity (FVC) less than 0.80 OR e) The patient's asthma worsens upon tapering of oral corticosteroid therapy. NOTE: An exception to the requirement for a trial of one additional asthma controller/maintenance medication can be made if the patient has already received anti-IL-4/13 therapy (Dupixent) used concomitantly with an ICS for at least 3 consecutive months. For chronic idiopathic urticaria (CIU), approve if the patient has documented CIU for at

Prior Authorization Criteria
Health Alliance Plan 2022
Date Effective: 12/01/2022

PA Criteria	Criteria Details
	least 6 weeks AND failure, intolerance, or contraindication to cyclosporine and montelukast. For continuation of asthma treatment - The patient has responded to therapy as determined by the prescribing physician and continues to receive therapy with one inhaled corticosteroid or inhaled corticosteroid containing combination product. For continuation of CIU treatment - The patient must have responded to therapy as determined by the prescribing physician.
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 oral tablet 100 mg/week (50 mg x 2), 40 mg/week (40 mg x 1), 40mg twice week (40 mg x 2), 60 mg/week (60 mg x 1), 60mg twice week (120 mg/week), 80 mg/week (40 mg x 2), 80mg twice week (160 mg/week)

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	1 year
Other Criteria	N/A
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A

XTANDI

Products Affected

- Xtandi oral capsule
- Xtandi oral tablet

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) -- OR -- metastatic castration-sensitive prostate cancer (CSPC), patient must have a failure, intolerance, or contraindication to abiraterone (Zytiga) prior to initiation of therapy with enzalutamide (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	6 months
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	6 months
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 DIAGNOSIS 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 oral tablet 250 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 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 intravenous suspension 5 mg/mL
- acetylcysteine solution 100 mg/mL (10 %), 200 mg/mL (20 %)
- acyclovir sodium intravenous solution 50 mg/mL
- albuterol sulfate inhalation solution for nebulization 0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg/3 mL (0.083 %), 2.5 mg/0.5 mL, 5 mg/mL
- AmBisome intravenous suspension for reconstitution 50 mg
- amphotericin B injection recon soln 50 mg
- arformoterol inhalation solution for nebulization 15 mcg/2 mL
- Azasan oral tablet 100 mg, 75 mg
- azathioprine oral tablet 100 mg, 50 mg, 75 mg
- bleomycin injection recon soln 15 unit, 30 unit
- budesonide inhalation suspension for nebulization 0.25 mg/2 mL, 0.5 mg/2 mL, 1 mg/2 mL
- Clinimix 5%/D15W Sulfite Free intravenous parenteral solution 5 %
- Clinimix 4.25%/D10W Sulf Free intravenous parenteral solution 4.25 %
- Clinimix 4.25%/D5W Sulfit Free intravenous parenteral solution 4.25 %
- Clinimix 5%-D20W(sulfite-free) intravenous parenteral solution 5 %
- Clinimix E 2.75%/D5W Sulf Free intravenous parenteral solution 2.75 %
- Clinimix E 4.25%/D10W Sul Free intravenous parenteral solution 4.25 %
- Clinimix E 4.25%/D5W Sulf Free intravenous parenteral solution 4.25 %
- Clinimix E 5%/D15W Sulfit Free intravenous parenteral solution 5 %
- Clinimix E 5%/D20W Sulfit Free intravenous parenteral solution 5 %
- Clinisol SF 15 % intravenous parenteral solution 15 %
- cromolyn inhalation solution for nebulization 20 mg/2 mL
- cyclophosphamide oral capsule 25 mg, 50 mg
- cyclophosphamide oral tablet 25 mg, 50 mg
- cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg
- cyclosporine modified oral solution 100 mg/mL
- cyclosporine oral capsule 100 mg, 25 mg
- Engerix-B (PF) intramuscular syringe 20 mcg/mL
- Engerix-B Pediatric (PF) intramuscular syringe 10 mcg/0.5 mL
- everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg
- formoterol fumarate inhalation solution for nebulization 20 mcg/2 mL
- Gengraf oral capsule 100 mg, 25 mg
- Gengraf oral solution 100 mg/mL
- granisetron HCl oral tablet 1 mg
- Imovax Rabies Vaccine (PF) intramuscular recon soln 2.5 unit
- Intralipid intravenous emulsion 20 %
- Intralipid intravenous emulsion 30 %
- ipratropium bromide inhalation solution 0.02 %
- ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 mL
- levalbuterol HCl inhalation solution for nebulization 0.31 mg/3 mL, 0.63 mg/3 mL, 1.25 mg/0.5 mL, 1.25 mg/3 mL
- methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg
- Millipred oral tablet 5 mg
- mycophenolate mofetil oral capsule 250 mg

Prior Authorization Criteria
Health Alliance Plan 2022
Date Effective: 12/01/2022

- mycophenolate mofetil oral suspension for reconstitution 200 mg/mL
- mycophenolate mofetil oral tablet 500 mg
- mycophenolate sodium oral tablet, delayed release (DR/EC) 180 mg, 360 mg
- ondansetron HCl oral solution 4 mg/5 mL
- ondansetron HCl oral tablet 4 mg, 8 mg
- ondansetron oral tablet, disintegrating 4 mg, 8 mg
- pentamidine inhalation recon soln 300 mg
- Plenammine intravenous parenteral solution 15 %
- prednisolone oral solution 15 mg/5 mL
- prednisolone sodium phosphate oral solution 10 mg/5 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 oral concentrate 5 mg/mL
- prednisone oral solution 5 mg/5 mL
- prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg
- Premasol 10 % intravenous parenteral solution 10 %
- Prograf oral granules in packet 0.2 mg, 1 mg
- Prosol 20 % intravenous parenteral solution
- Pulmozyme inhalation solution 1 mg/mL
- RabAvert (PF) intramuscular suspension for reconstitution 2.5 unit
- Recombivax HB (PF) intramuscular suspension 10 mcg/mL, 40 mcg/mL
- Recombivax HB (PF) intramuscular syringe 10 mcg/mL, 5 mcg/0.5 mL
- sirolimus oral solution 1 mg/mL
- sirolimus oral tablet 0.5 mg, 1 mg, 2 mg
- tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg
- tobramycin in 0.225 % NaCl inhalation solution for nebulization 300 mg/5 mL
- tobramycin inhalation solution for nebulization 300 mg/4 mL
- Travasol 10 % intravenous parenteral solution 10 %
- TrophAmine 10 % intravenous parenteral solution 10 %
- Yupelri inhalation solution for nebulization 175 mcg/3 mL

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.

Index

A

Abelcet intravenous suspension 5 mg/mL	258
Abilify Maintena.....	16
abiraterone oral tablet 250 mg, 500 mg ..	257
acetylcysteine solution 100 mg/mL (10 %), 200 mg/mL (20 %).....	258
acyclovir sodium intravenous solution 50 mg/mL.....	258
adapalene topical cream.....	3
adapalene topical gel.....	3
adapalene topical swab	3
Adbry	4
Adempas	5
Adlarity	6
Aimovig Autoinjector	8
Ajovy Autoinjector	9
Ajovy Syringe	9
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 mL, 1.25 mg/3 mL, 2.5 mg /3 mL (0.083 %), 2.5 mg/0.5 mL, 5 mg/mL	258
Alecensa.....	10
Alunbrig.....	11
Alyq.....	151
AmBisome intravenous suspension for reconstitution 50 mg	258
ambrisentan	159
amphotericin B injection recon soln 50 mg	258
apomorphine	17
aprepitant.....	18
Aralast NP.....	1
Aranesp (in polysorbate) injection solution 100 mcg/mL, 200 mcg/mL, 25 mcg/mL, 40 mcg/mL, 60 mcg/mL	56, 57
Aranesp (in polysorbate) injection syringe	56, 57
Arcalyst.....	19
arformoterol inhalation solution for nebulization 15 mcg/2 mL	258
armodafinil.....	14

asenapine maleate	16
Aubagio.....	123
Auryxia	20
Avita topical cream.....	213
Avonex intramuscular pen injector kit....	122
Avonex intramuscular syringe kit.....	122
Ayvakit.....	21
Azasan oral tablet 100 mg, 75 mg	258
azathioprine oral tablet 100 mg, 50 mg, 75 mg	258

B

Balversa.....	22
Baraclude oral solution	76
Benlysta subcutaneous syringe	24
Besremi	25
Betaseron subcutaneous kit.....	122
bexarotene topical	199
Bivigam.....	95
bleomycin injection recon soln 15 unit, 30 unit	258
bosentan	159
Bosulif oral tablet 100 mg, 400 mg, 500 mg	26
Braftovi oral capsule 75 mg.....	27
Briviact oral	28
Brukina	29
budesonide inhalation suspension for nebulization 0.25 mg/2 mL, 0.5 mg/2 mL, 1 mg/2 mL.....	258
budesonide oral tablet, delayed and ext.release.....	221

C

Cabometyx	30
Calquence.....	31
Calquence (acalabrutinib mal)	31
Camzyos.....	115
Caplyta	16
Caprelsa oral tablet 100 mg, 300 mg	32
Cerdelga	69
cinacalcet oral tablet 30 mg, 60 mg, 90 mg	179
Cinqair.....	33

Clinimix 5%/D15W Sulfite Free intravenous parenteral solution 5 %....	258	deferiprone	63
Clinimix 4.25%/D10W Sulf Free intravenous parenteral solution 4.25 %	258	Diacomit.....	44
Clinimix 4.25%/D5W Sulfite Free intravenous parenteral solution 4.25 %	258	diclofenac sodium topical gel 3 %.....	2
Clinimix 5%-D20W(sulfite-free) intravenous parenteral solution 5 %....	258	dihydroergotamine nasal.....	53
Clinimix E 2.75%/D5W Sulf Free intravenous parenteral solution 2.75 %	258	dimethyl fumarate	123
Clinimix E 4.25%/D10W Sul Free intravenous parenteral solution 4.25 %	258	Doptelet (10 tab pack).....	45
Clinimix E 4.25%/D5W Sulf Free intravenous parenteral solution 4.25 %	258	Doptelet (15 tab pack).....	45
Clinimix E 5%/D15W Sulfite Free intravenous parenteral solution 5 %....	258	Doptelet (30 tab pack).....	45
Clinimix E 5%/D20W Sulfite Free intravenous parenteral solution 5 %....	258	Drizalma Sprinkle oral capsule, delayed rel sprinkle 20 mg, 30 mg, 40 mg, 60 mg ..	15
Clinisol SF 15 % intravenous parenteral solution 15 %	258	dronabinol	46
Cometriq	34	Dupixent Pen subcutaneous pen injector 200 mg/1.14 mL, 300 mg/2 mL	47
Copiktra.....	35	Dupixent Syringe subcutaneous syringe 100 mg/0.67 mL, 200 mg/1.14 mL, 300 mg/2 mL	47
Corlanor	36	E	
Cosentyx	37	Enbrel Mini	48, 49
Cosentyx (2 Syringes).....	37	Enbrel subcutaneous solution	48, 49
Cosentyx Pen (2 Pens)	37	Enbrel subcutaneous syringe.....	48, 49
Cotellic.....	38	Enbrel SureClick.....	48, 49
cromolyn inhalation solution for nebulization 20 mg/2 mL.....	258	Engerix-B (PF) intramuscular syringe 20 mcg/mL	258
cyclophosphamide oral capsule 25 mg, 50 mg	258	Engerix-B Pediatric (PF) intramuscular syringe 10 mcg/0.5 mL	258
cyclophosphamide oral tablet 25 mg, 50 mg	258	Enspryng	50
cyclosporine modified oral capsule 100 mg, 25 mg, 50 mg	258	entecavir	76
cyclosporine modified oral solution 100 mg/mL.....	258	Epidiolex.....	51
cyclosporine oral capsule 100 mg, 25 mg	258	Epogen injection solution 2,000 unit/mL, 20,000 unit/2 mL, 20,000 unit/mL, 3,000 unit/mL, 4,000 unit/mL.....	56, 57
Cystadrops.....	40	Eprontia.....	52
D		Erivedge	54
dalfampridine	13	Erleada	55
Daliresp.....	41	erlotinib	198
Daurismo oral tablet 100 mg, 25 mg	42	Esbriet oral capsule	158
deferasirox oral tablet	59	everolimus (antineoplastic).....	7
deferasirox oral tablet, dispersible	59	everolimus (immunosuppressive) oral tablet 0.25 mg, 0.5 mg, 0.75 mg, 1 mg	258
		Evrysdi	58
		Exkivity.....	60
		F	
		Fanapt.....	16
		Farydak	61
		Fasenra	62

Fasenra Pen	62
fentanyl citrate buccal lozenge on a handle	211
Fetzima.....	15
fingolimod.....	123
Fintepla	64
Firdapse.....	12
Flebogamma DIF	95
formoterol fumarate inhalation solution for nebulization 20 mcg/2 mL	258
Fotivda	65
Fycompa.....	66
G	
Galafold.....	67
Gammagard Liquid	95
Gammagard S-D (IgA < 1 mcg/mL).....	95
Gammaked	95
Gammaplex	95
Gammaplex (with sorbitol).....	95
Gamunex-C	95
Gattex 30-Vial.....	68
Gavreto.....	70
Gengraf oral capsule 100 mg, 25 mg.....	258
Gengraf oral solution 100 mg/mL.....	258
Gilenya oral capsule 0.5 mg.....	123
Gilotrif.....	71
Glassia.....	1
glatiramer	122
Glatopa.....	122
Gralise oral tablet extended release 24 hr.	73
granisetron HCl oral tablet 1 mg.....	258
H	
Haegarda	78
Hemady	75
Hetlioz.....	79
Humira Pen	81, 82
Humira Pen Crohns-UC-HS Start.....	81, 82
Humira Pen Psor-Uveits-Adol HS.....	81, 82
Humira subcutaneous syringe kit 40 mg/0.8 mL.....	81, 82
Humira(CF) Pedi Crohns Starter subcutaneous syringe kit 80 mg/0.8 mL, 80 mg/0.8 mL-40 mg/0.4 mL.....	81, 82
Humira(CF) Pen Crohns-UC-HS.....	81, 82
Humira(CF) Pen Pediatric UC	81, 82

Humira(CF) Pen Psor-Uv-Adol HS....	81, 82
Humira(CF) Pen subcutaneous pen injector kit 40 mg/0.4 mL, 80 mg/0.8 mL....	81, 82
Humira(CF) subcutaneous syringe kit 10 mg/0.1 mL, 20 mg/0.2 mL, 40 mg/0.4 mL	81, 82
I	
Ibrance.....	83
icatibant.....	78
Iclusig.....	84
icosapent ethyl oral capsule 0.5 gram, 1 gram	226
Idhifa	85
imatinib oral tablet 100 mg, 400 mg.....	72
Imbruvica oral capsule 140 mg, 70 mg.....	86
Imbruvica oral suspension	86
Imbruvica oral tablet.....	86
Imovax Rabies Vaccine (PF) intramuscular recon soln 2.5 unit.....	258
Inbrija inhalation capsule, w/inhalation device	87
Increlex	88
Inlyta oral tablet 1 mg, 5 mg.....	90
Inqovi	91
Inrebic	92
Intralipid intravenous emulsion 20 %.....	258
Intralipid intravenous emulsion 30 %.....	258
Intron A injection recon soln 10 million unit (1 mL), 50 million unit (1 mL)	93
Invega Hafyera.....	16
Invega Sustenna	16
Invega Trinza	16
ipratropium bromide inhalation solution 0.02 %	258
ipratropium-albuterol inhalation solution for nebulization 0.5 mg-3 mg(2.5 mg base)/3 mL.....	258
Iressa	94
J	
Jakafi.....	96
Juxtapid oral capsule 10 mg, 20 mg, 30 mg, 5 mg	80
Jynarque oral tablets, sequential	97
K	
Kalydeco oral granules in packet.....	98

Prior Authorization Criteria
 Health Alliance Plan 2022
 Date Effective: 12/01/2022

Kalydeco oral tablet	98
Kerendia	99
Kineret.....	100
Kisqali	101
Kisqali Femara Co-Pack	101
Korlym	102
L	
lapatinib.....	218
Latuda oral tablet 120 mg, 20 mg, 40 mg, 60 mg, 80 mg	16
lenalidomide oral capsule 2.5 mg, 20 mg	170
Lenvima	104
Leukine injection recon soln.....	105
levalbuterol HCl inhalation solution for nebulization 0.31 mg/3 mL, 0.63 mg/3 mL, 1.25 mg/0.5 mL, 1.25 mg/3 mL ..	258
Libtayo	106
lidocaine topical adhesive patch,medicated 5 %	107
lidocaine topical ointment.....	107
Lokelma	108
Lonsurf.....	109
Lorbrena	110
Lumakras.....	111
Lybalvi	112
Lynparza	113, 114
M	
Mavenclad (10 tablet pack).....	123
Mavenclad (4 tablet pack).....	123
Mavenclad (5 tablet pack).....	123
Mavenclad (6 tablet pack).....	123
Mavenclad (7 tablet pack).....	123
Mavenclad (8 tablet pack).....	123
Mavenclad (9 tablet pack).....	123
Mavyret oral tablet.....	77
Mayzent.....	123
Mayzent Starter(for 1mg maint)	123
Mayzent Starter(for 2mg maint)	123
Mekinist oral tablet 0.5 mg, 2 mg	116
Mektovi	117
methamphetamine	118
methylprednisolone oral tablet 16 mg, 32 mg, 4 mg, 8 mg	258
metyrosine.....	43
miglustat.....	69

Millipred oral tablet 5 mg	258
Mirvaso topical gel with pump	119
modafinil oral tablet 100 mg, 200 mg.....	120
Movantik.....	124
Mulpleta	121
Myalept	125
mycophenolate mofetil oral capsule 250 mg	258
mycophenolate mofetil oral suspension for reconstitution 200 mg/mL.....	259
mycophenolate mofetil oral tablet 500 mg	259
mycophenolate sodium oral tablet,delayed release (DR/EC) 180 mg, 360 mg.....	259
Myfembree.....	126
Mytesi	39
N	
Natpara.....	127
Nayzilam	128
Nerlynx	129
Nexletol.....	131
Nexlizet.....	131
Ninlaro	132
nitisinone.....	143
Norditropin FlexPro	74
Noxafil oral suspension.....	133
Nubeqa	134
Nucala	135
Nuedexta	136
Nuplazid.....	137
Nurtec ODT	138
Nutropin AQ Nuspin.....	74
O	
Ocaliva	139
Octagam	95
Odomzo.....	140
Ofev.....	158
ondansetron HCl oral solution 4 mg/5 mL	259
ondansetron HCl oral tablet 4 mg, 8 mg. 259	
ondansetron oral tablet,disintegrating 4 mg, 8 mg	259
Onureg.....	141
Opsumit.....	159
Orencia ClickJect.....	142

Orencia subcutaneous syringe 125 mg/mL, 50 mg/0.4 mL, 87.5 mg/0.7 mL.....	142	Prolia.....	155, 156
Orenitram.....	159	Promacta.....	157
Orfadin oral capsule 20 mg.....	143	Prosol 20 % intravenous parenteral solution	259
Orfadin oral suspension.....	143	Pulmozyme inhalation solution 1 mg/mL.....	259
Orgovyx.....	144	Purixan.....	160
Orilissa.....	146	Pyrukynd.....	161
Orkambi oral granules in packet 100-125 mg, 150-188 mg.....	145	Q	
Orkambi oral tablet.....	145	Qinlock.....	162
Orladeyo.....	78	R	
Otezla.....	147	RabAvert (PF) intramuscular suspension for reconstitution 2.5 unit.....	259
Otezla Starter oral tablets,dose pack 10 mg (4)-20 mg (4)-30 mg (47).....	147	Radicava ORS Starter Kit Susp.....	163
Oxervate.....	148	Ravicti.....	223
P		Recombivax HB (PF) intramuscular suspension 10 mcg/mL, 40 mcg/mL... ..	259
Palynziq.....	149	Recombivax HB (PF) intramuscular syringe 10 mcg/mL, 5 mcg/0.5 mL.....	259
Panretin.....	150	Regranex.....	164
Pegasys.....	93	Repatha.....	165, 166
Pemazyre.....	152	Repatha Pushtronex.....	165, 166
pentamidine inhalation recon soln 300 mg	259	Repatha SureClick.....	165, 166
Piqray.....	153	Retevmo.....	167
pirfenidone oral tablet 267 mg, 801 mg..	158	Revcovi.....	168, 169
Plegridy.....	122	Revlimid oral capsule 10 mg, 15 mg, 25 mg, 5 mg.....	170
Plenammine intravenous parenteral solution 15 %.....	259	Rexulti.....	16
Pomalyst.....	154	Reyvow.....	171
posaconazole.....	133	Rinvoq.....	172
prednisolone oral solution 15 mg/5 mL..	259	Rozlytrek oral capsule 100 mg, 200 mg .	173
prednisolone sodium phosphate oral solution 10 mg/5 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).....	259	Rubraca.....	174
Prednisone Intensol oral concentrate 5 mg/mL.....	259	rufinamide.....	23
prednisone oral solution 5 mg/5 mL.....	259	Rydapt.....	175
prednisone oral tablet 1 mg, 10 mg, 2.5 mg, 20 mg, 5 mg, 50 mg.....	259	S	
Premasol 10 % intravenous parenteral solution 10 %.....	259	Sajazir.....	78
Privigen.....	95	sapropterin.....	103
Prograf oral granules in packet 0.2 mg, 1 mg	259	Savella oral tablet.....	177
Prolastin-C.....	1	Savella oral tablets,dose pack.....	177
		Scemblix oral tablet 20 mg, 40 mg.....	178
		Secuado.....	16
		Signifor.....	180
		sildenafil (Pulmonary Arterial Hypertension) oral suspension for reconstitution 10 mg/mL.....	151

sildenafil (Pulmonary Arterial Hypertension) oral tablet 20 mg	151	testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %).....	208, 209
sirolimus oral solution 1 mg/mL.....	259	testosterone transdermal gel in packet ...	208, 209
sirolimus oral tablet 0.5 mg, 1 mg, 2 mg	259	tetrabenazine	243
Sirturo	181	Tibsovo	210
Skyrizi subcutaneous pen injector	182	Tobi Podhaler inhalation capsule, w/inhalation device	89
Skyrizi subcutaneous syringe 150 mg/mL	182	tobramycin in 0.225 % NaCl inhalation solution for nebulization 300 mg/5 mL	259
Skyrizi subcutaneous syringe kit	182	tobramycin inhalation solution for nebulization 300 mg/4 mL	259
Skyrizi subcutaneous wearable injector..	182	tolvaptan oral tablet 15 mg	176
sodium phenylbutyrate oral powder.....	223	tolvaptan oral tablet 30 mg	176
sorafenib.....	130	Tracleer oral tablet for suspension.....	159
Spritam.....	183	Travasol 10 % intravenous parenteral solution 10 %	259
Sprycel	184	Trelstar intramuscular suspension for reconstitution.....	212
Stelara subcutaneous solution.....	185	tretinoin topical	213
Stelara subcutaneous syringe 45 mg/0.5 mL, 90 mg/mL.....	185	trientine	214
Stivarga	186	Trintellix	15
sunitinib.....	188	TrophAmine 10 % intravenous parenteral solution 10 %	259
Sunosi.....	187	Truseltiq oral capsule 100 mg/day (100 mg x 1), 125 mg/day(100 mg x1-25mg x1), 50 mg/day (25 mg x 2), 75 mg/day (25 mg x 3).....	215
Symdeko	189	Tukysa.....	216
SymlinPen 120	190	Turalio.....	217
SymlinPen 60	190	Tymlos	219
Sympazan oral film 10 mg, 20 mg, 5 mg	191	U	
Symproic	124	Ubrelvy	220
Synribo.....	192	Uptravi oral	222
T		V	
Tabrecta.....	193	Valchlor.....	224
tacrolimus oral capsule 0.5 mg, 1 mg, 5 mg	259	Valtoco.....	225
tadalafil (pulm. hypertension).....	151	Vascepa.....	226
Tafinlar.....	195	Veltassa.....	227
Tagrisso.....	196	Venclexta	228
Takhzyro	78	Venclexta Starting Pack.....	228
Talzenna.....	197	Ventavis	159
Tasigna oral capsule 150 mg, 200 mg, 50 mg	200	Versacloz.....	16
Tavalisse	201		
Tavneos	202, 203		
tazarotene topical cream	204		
tazarotene topical gel	204		
Tazorac topical cream 0.05 %.....	204		
Tazverik	205		
Tegsedi.....	206		
Tepmetko	207		

Prior Authorization Criteria
 Health Alliance Plan 2022
 Date Effective: 12/01/2022

Verzenio.....	229	Xeljanz oral tablet.....	242
Viiibryd oral tablets,dose pack 10 mg (7)- 20 mg (23).....	15	Xeljanz XR.....	242
vilazodone.....	15	Xermelo.....	244
Vitrakvi.....	230	Xgeva.....	245
Vizimpro.....	231	Xifaxan oral tablet 200 mg, 550 mg.....	246
Vonjo.....	232	Xolair.....	247, 248
voriconazole intravenous.....	233	Xospata.....	249
Votrient.....	234	Xpovio oral tablet 100 mg/week (50 mg x 2), 40 mg/week (40 mg x 1), 40mg twice week (40 mg x 2), 60 mg/week (60 mg x 1), 60mg twice week (120 mg/week), 80 mg/week (40 mg x 2), 80mg twice week (160 mg/week).....	250
Voxzogo.....	235	Xtandi oral capsule.....	251
Vraylar oral capsule.....	16	Xtandi oral tablet.....	251
Vraylar oral capsule,dose pack.....	16	Xuriden.....	252
Vuity.....	236, 237	Xyrem.....	253
Vyndamax.....	194	Y	
Vyndaqel.....	194	Yupelri inhalation solution for nebulization 175 mcg/3 mL.....	259
W		Z	
Wakix.....	238	Zejula.....	254
Welireg.....	239	Zelboraf.....	255
X		Zemaira.....	1
Xalkori.....	10	Zepatier.....	77
Xatmep.....	240	Zydelig.....	256
Xcopri.....	241	Zykadia.....	10
Xcopri Maintenance Pack oral tablet 250mg/day(150 mg x1-100mg x1), 350 mg/day (200 mg x1-150mg x1).....	241		
Xcopri Titration Pack.....	241		
Xeljanz oral solution.....	242		