ABALOPARATIDE

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., FOSAMAX, ACTONEL, BONIVA).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

ABEMACICLIB

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ACALABRUTINIB

Products Affected

- CALQUENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ACTEMRA IV (S)

Products Affected

- ACTEMRA

PA Criteria	Criteria Details
Exclusion Criteria	ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS).
Required Medical Information	DIAGNOSIS OF ONE OF THE FOLLOWING: A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS FOR AT LEAST 3 CONSECUTIVE MONTHS, OR B) SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS AND PATIENT HAD INADEQUATE RESPONSE OR INTOLERANCE TO AT LEAST ONE ORAL SYSTEMIC AGENT (I.E. NSAID, CORTICOSTEROID) C) POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS AND PATIENT HAS HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS FOR AT LEAST 3 CONSECUTIVE MONTHS D) CYTOKINE RELEASE SYNDROME
Age Restrictions	RA - 18 YEARS OF AGE OR OLDER. SJIA, PJIA, AND CYTOKINE RELEASE SYNDROME - 2 YEARS OF AGE OR OLDER.
Prescriber Restrictions	
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED PER GUIDELINES. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED ON THERAPY (FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR SJIA, ABSENCE OF FEVER, REDUCTION IN NUMBER OF AFFECTED JOINTS, IMPROVEMENT IN FUNCTIONAL ABILITY. FOR PJIA, REDUCTION IN DISEASE FLARES, IMPROVEMENT IN ACR SCORING)
Indications	All FDA-approved Indications.
Off Label Uses	

ACTEMRA SC (S)

Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

PA Criteria	Criteria Details
Exclusion Criteria	ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS).
Required Medical Information	FOR THE DIAGNOSIS OF MODERATE TO SEVERE RHEUMATOID ARTHRITIS ONLY, THE PATIENT HAS HAD INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED PER GUIDELINES. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED ON THERAPY (FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING)
Indications	All FDA-approved Indications.
Off Label Uses	

ADALIMUMAB

Products Affected

- HUMIRA
- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PSOR-UV-ADOL HS
- HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. RENEWAL FOR RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, PLAQUE PSORIASIS, HIDRADENITIS SUPPURATIVA, OR UVEITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA), POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), AND PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHN'S DISEASE (CD) AND ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (I.E., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	

ADEMPAS (S)

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	CONCOMITANT ADMINISTRATION WITH NITRATES OR NITRIC OXIDE DONORS (SUCH AS AMYL NITRATE) IN ANY FORM. CONCOMITANT ADMINISTRATION WITH PHOSPHODIESTERASE INHIBITORS, INCLUDING SPECIFIC PDE-5 INHIBITORS (SUCH AS SILDENAFIL, TADALAFIL, OR VARDENAFIL) OR NON-SPECIFIC PDE INHIBITORS (SUCH AS DIPYRIDAMOLE OR THEOPHYLLINE). PREGNANCY.
Required Medical Information	DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I OR PATIENT HAS A DIAGNOSIS OF CHRONIC THROMBOEMBOLIC PULMONARY HYPERTENSION (CTEPH, WHO GROUP 4) AND PATIENT HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT (E.G., PULMONARY ENDARTERECTOMY) OR HAS CTEPH THAT IS INOPERABLE AND FEMALE PATIENTS ARE ENROLLED IN THE ADEMPAS REMS PROGRAM.
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	6 MONTHS - INITIAL. 12 MONTHS - RENEWAL
Other Criteria	FOR RENEWAL, MEDICATION WAS EFFECTIVE (I.E. IMPROVED 6 MINUTE WALK DISTANCE, OXYGEN SATURATION, ETC.)
Indications	All FDA-approved Indications.
Off Label Uses	

AFATINIB DIMALEATE

Products Affected

- GILOTRIF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AFINITOR (S)

Products Affected

- AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG
- *everolimus (antineoplastic)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	ADVANCED RENAL CELL CARCINOMA (RCC): TRIAL OF OR CONTRAINDICATION TO SUTENT OR NEXAVAR. POSTMENOPAUSAL WOMEN WITH ADVANCED HORMONE RECEPTOR-POSITIVE, HER2 NEGATIVE BREAST CANCER: USED IN COMBO WITH EXEMESTANE AFTER FAILURE OR TREATMENT WITH LETROZOLE OR ANASTROZOLE.
Indications	All FDA-approved Indications.
Off Label Uses	

AFINITOR DISPERZ (S)

Products Affected

- AFINITOR DISPERZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALDURAZYME (S)

Products Affected

- ALDURAZYME

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF HURLER OR HURLER-SCHEIE FORM OF MUCOPOLYSACCHARIDOSIS I (MPS I) OR DIAGNOSIS OF SCHEIE FORM OF MPS I WITH MODERATE TO SEVERE SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALECTINIB

Products Affected

- ALECENSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALIQOPA

Products Affected

- ALIQOPA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALIROCUMAB

Products Affected

- PRALUENT PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PATIENT MEETS ONE OF THE FOLLOWING: 1) CONTINUED CONCURRENT THERAPY WITH A MAXIMALLY TOLERATED DOSE OF A STATIN 2) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE 3) A CONTRAINDICATION TO STATIN THERAPY.
Age Restrictions	
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH): DIAGNOSIS DETERMINED BY (1) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA FOR HEFH OR (2) DUTCH LIPID NETWORK CRITERIA SCORE OF 6 OR GREATER. LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).
Indications	All FDA-approved Indications.
Off Label Uses	

ALLERGEN EXTRACT - TIMOTHY GRASS POLLEN

Products Affected

- GRASTEK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	POSITIVE SKIN PRICK TEST FOR TIMOTHY GRASS POLLEN, GRASS POLLEN OR POSITIVE TITER TO SPECIFIC IGE ANTIBODIES FOR TIMOTHY GRASS OR CROSS-REACTIVE GRASS POLLENS.
Age Restrictions	5 THROUGH 65 YEARS OF AGE.
Prescriber Restrictions	PRESCRIBED OR RECOMMENDED BY AN ALLERGIST, IMMUNOLOGIST, OR OTHER PHYSICIAN EXPERIENCED IN DIAGNOSIS AND TREATMENT OF ALLERGIC DISEASES.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ALLERGEN EXTRACT-HOUSE DUST MITE

Products Affected

- ODACTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR OTHER PHYSICIAN EXPERIENCED IN DIAGNOSIS AND TREATMENT OF ALLERGIC DISEASES.
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL CRITERIA: IMPROVEMENT IN SIGNS AND SYMPTOMS OF ALLERGIC RHINITIS FROM BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

ALLERGEN EXTRACT-MIXED GRASS POLLEN

Products Affected

- ORALAIR SUBLINGUAL TABLET 100 INDX REACTIVITY, 300 INDX REACTIVITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	POSITIVE SKIN PRICK TEST OR POSITIVE TITER TO SPECIFIC IGE ANTIBODIES FOR ANY OF THE FIVE GRASS SPECIES INCLUDED IN ORALAIR (SWEET VERNAL, ORCHARD, PERENNIAL RYE, TIMOTHY AND KENTUCKY BLUE GRASS).
Age Restrictions	
Prescriber Restrictions	PRESCRIBED OR RECOMMENDED BY AN ALLERGIST, IMMUNOLOGIST, OR OTHER PHYSICIAN EXPERIENCED IN DIAGNOSIS AND TREATMENT OF ALLERGIC DISEASES.
Coverage Duration	12 MONTHS
Other Criteria	DIAGNOSIS OF PERSISTENT AND MODERATE-TO-SEVERE SYMPTOMS OF ALLERGIC RHINITIS. PERSISTENT SYMPTOMS ARE DEFINED AS SYMPTOMS PRESENTING FOR AT LEAST 4 DAYS A WEEK OR FOR AT LEAST 4 WEEKS. MODERATE-TO-SEVERE SYMPTOMS INCLUDE ONE OR MORE OF THE FOLLOWING: TROUBLESOME SYMPTOMS, SLEEP DISTURBANCE, IMPAIRMENT OF DAILY ACTIVITIES, OR IMPAIRMENT OF SCHOOL OR WORK. CURRENT CLAIM OR PRESCRIPTION FOR AN AUTO-INJECTABLE EPINEPHRINE.
Indications	All FDA-approved Indications.
Off Label Uses	

ALPELISIB

Products Affected

- PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1), 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AMANTADINE ER

Products Affected

- GOCOVRI ORAL
  CAPSULE,EXTENDED RELEASE
  24HR 137 MG, 68.5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AMIFAMPRIDINE

Products Affected

- FIRDAPSE
- RUZURGI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT OR STABILIZATION IN MUSCLE WEAKNESS COMPARED TO BASELINE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST OR HEMATOLOGIST-ONCOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	DIAGNOSIS CONFIRMED BY 1) ELECTRODIAGNOSTIC STUDIES AND/OR VOLTAGE-GATED CALCIUM CHANNEL (VGCC) ANTIBODY TESTING, AND 2) CLINICAL TRIAD OF MUSCLE WEAKNESS, AUTONOMIC DYSFUNCTION, AND DECREASED TENDON REFLEXES.
Indications	All FDA-approved Indications.
Off Label Uses	

AMIKACIN LIPOSOMAL INH

Products Affected

- ARIKAYCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: NO POSITIVE MAC SPUTUM CULTURE AFTER CONSECUTIVE NEGATIVE CULTURES AND PHYSICIAN ATTESTATION OF IMPROVEMENT IN SYMPTOMS. ADDITIONALLY, FOR FIRST RENEWAL, APPROVAL REQUIRES AT LEAST ONE NEGATIVE SPUTUM CULTURE FOR MAC BY SIX MONTHS OF ARIKAYCE TREATMENT. FOR SECOND AND SUBSEQUENT RENEWALS, APPROVAL REQUIRES AT LEAST THREE NEGATIVE SPUTUM CULTURES FOR MAC BY 12 MONTHS OF ARIKAYCE TREATMENT.
Age Restrictions	
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	6 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AMPYRA (S)

Products Affected

- AMPYRA
- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	HISTORY OF SEIZURE. MODERATE OR SEVERE RENAL IMPAIRMENT (CREATININE CLEARANCE LESS THAN OR EQUAL TO 50 ML/MINUTE).
Required Medical Information	DIAGNOSIS OF MULTIPLE SCLEROSIS AND PATIENT IS AMBULATORY (ABLE TO WALK AT LEAST 25 FEET) AND PATIENT HAS WALKING IMPAIRMENT
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL - 3 MONTHS. RENEWAL - 12 MONTHS
Other Criteria	FOR RENEWAL, WALKING SPEED HAS IMPROVED FROM BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

APALUTAMIDE

Products Affected

- ERLEADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

APOMORPHINE - SL

Products Affected

- KYNMOBI SUBLINGUAL FILM 10 MG, 10-15-20-25-30 MG, 15 MG, 20 MG, 25 MG, 30 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ARANESP (S)

Products Affected

- ARANESP (IN POLYSORBATE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PRETREATMENT HEMOGLOBIN LEVEL IS LESS THAN 10 G/DL. RENEWAL: FOR ADULT PATIENTS WITH CKD NOT ON DIALYSIS OR CANCER PATIENTS, HEMOGLOBIN IS LESS THAN 10 G/DL. FOR ADULT PATIENTS WITH CKD ON DIALYSIS, HEMOGLOBIN IN LESS THAN 11 G/DL. FOR PEDIATRIC PATIENTS WITH CKD, HEMOGLOBIN IS LESS THAN 12 G/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
Indications	All FDA-approved Indications.
Off Label Uses	

ARIPIPRAZOLE SENSOR TABS

Products Affected

- ABILIFY MYCITE ORAL TABLET WITH SENSOR AND PATCH 10 MG, 15 MG, 2 MG, 20 MG, 30 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS A MEDICAL NECESSITY FOR TRACKING MEDICATION INGESTION
Indications	All FDA-approved Indications.
Off Label Uses	

ARMODAFINIL

Products Affected

- *armodafinil*
- NUVIGIL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

ARZERRA (S)

Products Affected

- ARZERRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF CHRONIC LYMPHOCYTIC LEUKEMIA (CLL) FOR TREATMENT NA?VE OR TREATMENT REFRACTORY TO FLUDARABINE AND ALEMTUZUMAB.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ASPARAGINASE

Products Affected

- ONCASPAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AUBAGIO (S)

Products Affected

- AUBAGIO

PA Criteria	Criteria Details
Exclusion Criteria	SEVERE HEPATIC IMPAIRMENT. CURRENT TREATMENT WITH LEFLUNOMIDE. PATIENTS WHO ARE PREGNANT OR WOMEN OF CHILDBEARING POTENTIAL NOT USING RELIABLE CONTRACEPTION.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AVAPRITINIB

Products Affected

- AYVAKIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AVATROMBOPAG

Products Affected

- DOPTELET (10 TAB PACK)
- DOPTELET (15 TAB PACK)
- DOPTELET (30 TAB PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AVELUMAB

Products Affected

- BAVENCIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AVONEX (S)

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

AZACITIDINE

Products Affected

- ONUREG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BARICITINIB

Products Affected

- OLUMIANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BECAPLERMIN

Products Affected

- REGRANEX

PA Criteria	Criteria Details
Exclusion Criteria	NON-DIABETIC ULCERS, NEOPLASM AT APPLICATION SITE, PRESSURE OR VENOUS STASIS ULCERS AND ULCERS THAT DO NOT EXTEND THROUGH THE DERMIS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	VASCULAR SURGEON, PODIATRIST, ENDOCRINOLOGIST, PHYSICIAN PRACTICING IN A SPECIALTY WOUND CLINIC OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BEDAQUILINE FUMARATE

Products Affected

- SIRTURO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OF AGE AND OLDER.
Prescriber Restrictions	
Coverage Duration	24 WEEKS
Other Criteria	SIRTURO USED IN COMBINATION WITH AT LEAST 3 OTHER ANTIBIOTICS FOR THE TREATMENT OF PULMONARY MULTI-DRUG RESISTANT TUBERCULOSIS.
Indications	All FDA-approved Indications.
Off Label Uses	

BELANTAMAB MAFODOTIN-BLMF

Products Affected

- BLENREP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BELEODAQ (S)

Products Affected

- BELEODAQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF PERIPHERAL T-CELL LYMPHOMA AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO AT LEAST ONE PRIOR THERAPY (E.G., CONVENTIONAL CHEMOTHERAPY)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BELIMUMAB

Products Affected

- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	AUTOANTIBODY POSITIVE LUPUS TEST.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. NO APPROVAL FOR DIAGNOSIS OF SEVERE ACTIVE LUPUS NEPHRITIS, SEVERE CENTRAL NERVOUS SYSTEM LUPUS OR CONCURRENT USE OF BIOLOGIC AGENTS OR INTRAVENOUS CYCLOPHOSPHAMIDE. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

BEMPEDOIC ACID/EZETIMIBE

Products Affected

- NEXLIZET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL FOR HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA: TRIAL OF OR CONTRAINDICATION TO EZETIMIBE. ALL INDICATIONS: INITIAL: MEETS ONE OF THE FOLLOWING: (1) TRIAL OF A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY), (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTION), (4) STATIN INTOLERANCE, OR (5) SKELETAL-MUSCLE EVENTS WHILE ON STATIN THERAPY. RENEWAL: MEETS ONE OF THE FOLLOWING: (1) LDL-C LOWERING AND CONTINUED THERAPY WITH A MAXIMALLY TOLERATED DOSE OF ANY STATIN, (2) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY, OR (3) COMPLETE STATIN INTOLERANCE.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

BENDAMUSTINE

Products Affected

- BENDEKA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BENLYSTA (S)

Products Affected

- BENLYSTA INTRAVENOUS

PA Criteria	Criteria Details
Exclusion Criteria	RECEIVING OTHER BIOLOGIC THERAPY OR INTRAVENOUS CYCLOPHOSPHAMIDE
Required Medical Information	DIAGNOSIS OF ACTIVE, AUTOANTIBODY-POSITIVE (ACCEPTABLE ASSAYS INCLUDE ANA, ANTI-DS-DNA, ANTI-SM, ETC.) SYSTEMIC LUPUS ERYTHEMATOSUS AND PATIENT IS CURRENTLY RECEIVING ONE OR MORE OF THE FOLLOWING STANDARD THERAPIES: CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, IMMUNOSUPPRESSANTS
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BESPONSA

Products Affected

- BESPONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BETASERON (S)

Products Affected

- BETASERON SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS OR DIAGNOSIS OF FIRST CLINICAL EPISODE AND MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR RENEWAL, PATIENT HAS EXPERIENCED AN OBJECTIVE RESPONSE TO THERAPY (I.E. NO OR SLOWED PROGRESSION OF DISEASE)
Indications	All FDA-approved Indications.
Off Label Uses	

BEVACIZUMAB

Products Affected

- AVASTIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BEVACIZUMAB-AWWB

Products Affected

- MVASI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BEVACIZUMAB-BVZR

Products Affected

- ZIRABEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BINIMETINIB

Products Affected

- MEKTOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BLINCYTO (S)

Products Affected

- BLINCYTO INTRAVENOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF PHILADELPHIA CHROMOSOME-NEGATIVE (PH-) B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA IN A PATIENT WHO HAS TRIED CHEMOTHERAPY AND IS THE PATIENT CLASSIFIED AS A RELAPSED OR REFRACTORY. INITIAL APPROVAL FOR 2 CYCLES . MAY APPROVE FOR 1 ADDITIONAL CYCLE IF THE PATIENT HAS NOT COMPLETED 2 CYCLES DUE TO INITIAL THERAPY INTERUPTION FOR DOSE MODIFICATION.RENEWAL APPROVAL FOR PATIENTS WHO HAVE ACHIEVED COMPLETE REMISSION (CR) OR CR WITH PARTIAL HAEMATOLOGICAL RECOVERY OF PERIPHERAL BLOOD COUNTS (CPH) AFTER 2 CYCLES. RENEWAL NOT APPROVED FOR PATIENTS WHO HAVE RECEIVED AN ALLOGENEIC HAEMATOPOIETIC STEM-CELL TRANSPLANTATION.
Indications	All FDA-approved Indications.
Off Label Uses	

BOSUTINIB

Products Affected

- BOSULIF ORAL TABLET 100 MG, 400 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CML: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT BOTH T315I AND V299L MUTATIONS ARE NOT PRESENT.
Indications	All FDA-approved Indications.
Off Label Uses	

BOTULINUM NEUROTOXIN

Products Affected

- XEOMIN

PA Criteria	Criteria Details
Exclusion Criteria	COSMETIC DIAGNOSIS SUCH AS WRINKLES.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MIGRAINE HEADACHE: TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

BRENTUXIMAB

Products Affected

- ADCETRIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRIGATINIB

Products Affected

- ALUNBRIG ORAL TABLET 180 MG, 30 MG, 90 MG
- ALUNBRIG ORAL TABLETS,DOSE PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

BRODALUMAB

Products Affected

- SILIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PATIENT HAS BEEN COUNSELED ON AND EXPRESSES UNDERSTANDING OF THE RISK OF SUICIDAL IDEATION AND BEHAVIOR. RENEWAL: PATIENT HAS NOT DEVELOPED OR REPORTED WORSENING DEPRESSIVE SYMPTOMS OR SUICIDAL IDEATION AND BEHAVIORS WHILE ON TREATMENT WITH SILIQ.
Indications	All FDA-approved Indications.
Off Label Uses	

BUROSUMAB

Products Affected

- CRYSVITA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

C1 ESTERASE INHIBITOR-CINRYZE, BERINERT

Products Affected

- BERINERT INTRAVENOUS KIT
- CINRYZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CINRYZE RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY) IN HAE ATTACKS WITH ROUTINE PROPHYLAXIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

C1 ESTERASE INHIBITOR-HAEGARDA, RUCONEST

Products Affected

- HAEGARDA
- RUCONEST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HAEGARDA RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY) IN HAE ATTACKS WITH ROUTINE PROPHYLAXIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR ALLERGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING.
Indications	All FDA-approved Indications.
Off Label Uses	

CABOZANTINIB

Products Affected

- COMETRIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CABOZANTINIB S-MALATE - CABOMETYX

Products Affected

- CABOMETYX ORAL TABLET 20 MG, 40 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CANNABIDIOL

Products Affected

- EPIDIOLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	LENNOX-GASTAUT SYNDROME (LGS): TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: CLOBAZAM, TOPIRAMATE, LAMOTRIGINE.
Indications	All FDA-approved Indications.
Off Label Uses	

CANNABINOIDS

Products Affected

- *dronabinol*
- MARINOL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO CONVENTIONAL ANTIEMETIC THERAPIES SUCH AS ONDANSETRON, STEROIDS INDICATED FOR EMESIS OR EMEND. NO ADDITIONAL REQUIREMENTS FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS.
Indications	All FDA-approved Indications.
Off Label Uses	

CAPLACIZUMAB

Products Affected

- CABLIVI INJECTION KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CAPMATINIB

Products Affected

- TABRECTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CARFILZOMIB

Products Affected

- KYPROLIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CEMIPLIMAB

Products Affected

- LIBTAYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CENEGERMIN-BKBJ

Products Affected

- OXERVATE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	8 WEEKS
Other Criteria	MEET ALL OF THE FOLLOWING: 1) PATIENT HAS A MEDICAL HISTORY SUPPORTIVE OF CAUSATIVE ETIOLOGY FOR TRIGEMINAL NERVE DAMAGE, 2) PHYSICIAN ATTESTATION THAT THE PATIENT HAS LOSS OF CORNEAL SENSITIVITY, CORNEAL EPITHELIUM CHANGES, OR LOSS OF TEAR PRODUCTION, AND 3) THE PATIENT IS REFRACTORY TO CONSERVATIVE MANAGEMENT (I.E. ARTIFICIAL TEARS, OCULAR LUBRICANTS, TOPICAL ANTIBIOTICS, THERAPEUTIC CONTACT LENSES).
Indications	All FDA-approved Indications.
Off Label Uses	

CENOBAMATE

Products Affected

- XCOPRI MAINTENANCE PACK
- XCOPRI ORAL TABLET 100 MG, 150 MG, 200 MG, 50 MG
- XCOPRI TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	TRIAL OF TWO GENERIC FORMULARY ANTICONVULSANT AGENTS INDICATED FOR PARTIAL-ONSET SEIZURES
Indications	All FDA-approved Indications.
Off Label Uses	

CERDELGA (S)

Products Affected

- CERDELGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CETUXIMAB

Products Affected

- ERBITUX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

CHENODIOL

Products Affected

- CHENODAL

PA Criteria	Criteria Details
Exclusion Criteria	RADIOLUCENT GALLSTONES: NO FAILED TREATMENT WITH URSODIOL
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO URSODIOL.
Indications	All FDA-approved Indications.
Off Label Uses	

CIALIS (S)

Products Affected

- CIALIS ORAL TABLET 2.5 MG, 5 MG
- *tadalafil oral tablet 2.5 mg, 5 mg*

PA Criteria	Criteria Details
Exclusion Criteria	ERECTILE DYSFUNCTION WITHOUT DIAGNOSIS OF BENIGN PROSTATIC HYPERPLASIA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF A FORMULARY ALPHA BLOCKER SUCH AS DOXAZOSIN, TERAZOSIN, OR TAMSULOSIN AND FINASTERIDE. APPLIES TO 2.5MG AND 5MG STRENGTHS ONLY.
Indications	All FDA-approved Indications.
Off Label Uses	

CIMZIA (S)

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Exclusion Criteria	ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)
Required Medical Information	DIAGNOSIS OF ONE OF THE FOLLOWING: A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS B) MODERATE TO SEVERE CROHN'S DISEASE AND PATIENT HAD AN INADEQUATE RESPONSE TO, IS INTOLERANT TO, OR IS CONTRAINDICATED TO CONVENTIONAL THERAPY WITH ONE OR MORE OF THE FOLLOWING: CORTICOSTEROIDS (I.E. PREDNISONE, METHYLPREDNISOLONE) OR NON-BIOLOGIC DMARDS (I.E. AZATHIOPRINE, METHOTREXATE, MERCAPTOPURINE, ETC.) C) PSORIATIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE TO, OR CONTRAINDICATION TO METHOTREXATE D) ANKYLOSING SPONDYLITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-STEROIDAL ANTI-INFLAMMATORY DRUGS E) MODERATE TO SEVERE PLAQUE PSORIASIS AND THE PATIENT HAS HAD A PREVIOUS TRIAL OF AT LEAST ONE OR MORE FORMS OF CONVENTIONAL THERAPY SUCH AS TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE.
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	16 WEEKS (CD), 12 WEEKS (OTHERS). RENEWAL 12 MONTHS.
Other Criteria	PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS OBTAINED A CLINICAL RESPONSE TO THERAPY (E.G., FOR CD, SYMPTOMATIC REMISSION. FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR PSA, IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, STIFFNESS. FOR AS, IMPROVEMENT IN AS SYMPTOMS, SUCH AS STIFFNESS AND BACK PAIN) OR PATIENT'S CONDITION HAS STABILIZED.
Indications	All FDA-approved Indications.
Off Label Uses	

CLADRIBINE

Products Affected

- MAVENCLAD (10 TABLET PACK)
- MAVENCLAD (4 TABLET PACK)
- MAVENCLAD (5 TABLET PACK)
- MAVENCLAD (6 TABLET PACK)
- MAVENCLAD (7 TABLET PACK)
- MAVENCLAD (8 TABLET PACK)
- MAVENCLAD (9 TABLET PACK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	48 WEEKS
Other Criteria	INITIAL: THE PATIENT MEETS ONE OF THE FOLLOWING: 1) TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS: AUBAGIO, AVONEX, FORMULARY VERSION OF FINGOLIMOD, PLEGRIDY, REBIF, TECFIDERA, OR GLATIRAMER ACETATE, OR 2) PHYSICIAN ATTESTATION THAT THE PATIENT SHOWS SIGNS OF SEVERE DISEASE REQUIRING HIGH EFFICACY DISEASE MODIFYING TREATMENT (DMT).
Indications	All FDA-approved Indications.
Off Label Uses	

CLOBAZAM PA

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- ONFI ORAL SUSPENSION
- ONFI ORAL TABLET 10 MG, 20 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	2 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF LAMOTRIGINE OR TOPIRAMATE. REQUESTS FOR ORAL SUSPENSION APPROVABLE IF PATIENT IS UNABLE TO SWALLOW OR IS UNDER THE AGE OF 5 YEARS.
Indications	All FDA-approved Indications.
Off Label Uses	

CLOBAZAM-SYMPAZAN

Products Affected

- SYMPAZAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PHYSICIAN ATTESTATION THAT THE PATIENT IS UNABLE TO TAKE TABLETS OR SUSPENSION. TRIAL OF OR CONTRAINDICATION TO A GENERIC CLOBAZAM AGENT.
Indications	All FDA-approved Indications.
Off Label Uses	

COLLAGENASE INJECTION

Products Affected

- XIAFLEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	COMPLETED XIAFLEX TRAINING
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

COPAXONE (S)

Products Affected

- COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML, 40 MG/ML
- *glatiramer subcutaneous syringe 20 mg/ml, 40 mg/ml*
- *glatopa subcutaneous syringe 20 mg/ml, 40 mg/ml*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF RELAPSING-REMITTING MULTIPLE SCLEROSIS OR DIAGNOSIS OF FIRST CLINICAL EPISODE WITH MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR RENEWAL, PATIENT HAS NO OR SLOWED DISEASE PROGRESSION.
Indications	All FDA-approved Indications.
Off Label Uses	

CORTICOTROPIN

Products Affected

- ACTHAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INFANTILE SPASMS AND MULTIPLE SCLEROSIS: 28 DAYS. OTHER FDA APPROVED INDICATIONS:12 MONTHS.
Other Criteria	NOT APPROVED FOR DIAGNOSTIC PURPOSES.
Indications	All FDA-approved Indications.
Off Label Uses	

COSENTYX (S)

Products Affected

- COSENTYX (2 SYRINGES)
- COSENTYX PEN (2 PENS)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECT THE HANDS, FEET, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	PSO: THERAPY PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST - PSA: RHEUMATOLOGIST OR DERMATOLOGIST - ANKYLOSING SPONDYLITIS: RHEUMATOLOGIST
Coverage Duration	INITIAL: 4 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL PSO: PREVIOUS TRIAL WITH ONE OF THE FOLLOWING CONVENTIONAL THERAPIES SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. INITIAL PSA: PREVIOUS TRIAL WITH AT LEAST ONE OF THE FOLLOWING DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) AGENTS SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.
Indications	All FDA-approved Indications.
Off Label Uses	

COTELLIC (S)

Products Affected

- COTELLIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

CRIZANLIZUMAB-TMCA

Products Affected

- ADAKVEO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SICKLE CELL DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME
Other Criteria	SICKLE CELL DISEASE: INITIAL CRITERIA FOR ADULTS (18 YEARS OR OLDER): PATIENT HAS ONE OF THE FOLLOWING: (1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR, (2) SICKLE-CELL ASSOCIATED SYMPTOMS WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING, OR (3) HISTORY OF OR HAS RECURRENT ACUTE CHEST SYNDROME (ACS). INITIAL REQUESTS FOR PATIENTS BETWEEN THE AGES OF 16 TO 17 YEARS WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA. RENEWAL FOR ALL PATIENTS: MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	

CYRAMZA (S)

Products Affected

- CYRAMZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DACOMATINIB

Products Affected

- VIZIMPRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DAROLUTAMIDE

Products Affected

- NUBEQA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DARZALEX (S)

Products Affected

- DARZALEX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DASATINIB

Products Affected

- SPRYCEL ORAL TABLET 100 MG, 140 MG, 20 MG, 50 MG, 70 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUSLY-TREATED CHRONIC MYELOID LEUKEMIA (CML) REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, V299L, T315A, F317L/V/I/C.
Indications	All FDA-approved Indications.
Off Label Uses	

DECITABINE/CEDAZURIDINE

Products Affected

- INQOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DEFERASIROX

Products Affected

- *deferasirox*
- EXJADE
- JADENU SPRINKLE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000 MCG/L. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L. NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT) INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L AND LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L OR LIC OF 3 MG FE/G DRY WEIGHT OR GREATER
Indications	All FDA-approved Indications.
Off Label Uses	

DEFERIPRONE

Products Affected

- FERRIPROX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL CRITERIA: REQUIRES TRIAL OF EXJADE, JADENU, OR GENERIC DEFEROXAMINE AND ONE OF THE FOLLOWING CRITERIA 1) PHYSICIAN ATTESTATION THAT PATIENT IS EXPERIENCING INTOLERABLE TOXICITIES, CLINICALLY SIGNIFICANT ADVERSE EFFECTS, OR CONTRAINDICATION TO THESE THERAPIES OR 2) INADEQUATE CHELATION DEFINED BY ONE OF THE FOLLOWING: A) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 2500 MCG/L OR B) EVIDENCE OF CARDIAC IRON ACCUMULATION. RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L
Indications	All FDA-approved Indications.
Off Label Uses	

DEFEROXAMINE

Products Affected

- *deferoxamine*
- DESFERAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	AT LEAST 3 YEARS OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000MCG/L RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L
Indications	All FDA-approved Indications.
Off Label Uses	

DEFLAZACORT

Products Affected

- EMFLAZA ORAL SUSPENSION
- EMFLAZA ORAL TABLET 18 MG, 30 MG, 36 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST SPECIALIZING IN THE TREATMENT OF DMD.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL CRITERIA: REQUIRE TRIAL OF PREDNISONE OR PREDNISOLONE AND PATIENT MEETS ONE OF THE FOLLOWING: 1) REQUEST DUE TO ADVERSE EFFECTS OF PREDNISONE OR PREDNISOLONE OR 2) REQUEST DUE TO LACK OF EFFICACY OF PREDNISONE OR PREDNISOLONE AND ALL OF THE FOLLOWING CRITERIA ARE MET: A) PATIENT IS NOT IN STAGE 1 (PRE-SYMPTOMATIC PHASE) B) STEROID MYOPATHY HAS BEEN RULED OUT C) PHYSICIAN ATTESTATION OF DETERIORATION IN AMBULATION, FUNCTIONAL STATUS, OR PULMONARY FUNCTION CONSISTENT WITH ADVANCING DISEASE. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION).
Indications	All FDA-approved Indications.
Off Label Uses	

DELAFLOXACIN

Products Affected

- BAXDELA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE MONTH
Other Criteria	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST OR ABSSSI ORGANISM ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO ONE PREFERRED FORMULARY STANDARD OF CARE AGENT OR IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED FORMULARY AGENTS: A PENICILLIN, A FLUOROQUINOLONE, A CEPHALOSPORIN, OR A GRAM POSITIVE TARGETING ANTIBIOTIC
Indications	All FDA-approved Indications.
Off Label Uses	

DENOSUMAB-XGEVA

Products Affected

- XGEVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DEUTETRABENAZINE

Products Affected

- AUSTEDO ORAL TABLET 12 MG, 6 MG, 9 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HUNTINGTON DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST. TARDIVE DYSKINESIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR MOVEMENT DISORDER SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DEXTROMETHORPHAN QUINIDINE

Products Affected

- NUEDEXTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

DICLOFENAC TOPICAL

Products Affected

- *diclofenac sodium topical gel 3 %*
- SOLARAZE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DIROXIMEL FUMARATE

Products Affected

- VUMERITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DROBABINOL ORAL SOLUTION

Products Affected

- SYNDROS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	B VS D COVERAGE CONSIDERATION. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF NAUSEA AND VOMITING ASSOCIATED WITH CANCER CHEMOTHERAPY REQUIRES A TRIAL OF OR CONTRAINDICATION TO FORMULARY DRONABINOL CAPSULES AND ONE CONVENTIONAL ANTIEMETIC THERAPY SUCH AS ONDANSETRON, STEROIDS INDICATED FOR EMESIS OR APREPITANT. PART D COVERAGE CONSIDERATION FOR A DIAGNOSIS OF ANOREXIA ASSOCIATED WITH WEIGHT LOSS IN PATIENTS WITH AIDS REQUIRES A TRIAL OF OR CONTRAINDICATION TO FORMULARY DRONABINOL CAPSULES.
Indications	All FDA-approved Indications.
Off Label Uses	

DUPILUMAB 2

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: ASTHMA: CONCURRENT USE OF XOLAIR OR ANTI-IL5 BIOLOGIC (E.G., NUCALA, CINQAIR, FASENRA).
Required Medical Information	INITIAL APPROVAL FOR ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 6 MONTHS (IF EOSINOPHILIC ASTHMA).
Age Restrictions	
Prescriber Restrictions	ATOPIC DERMATITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ALLERGIST OR PULMONOLOGIST.
Coverage Duration	INITIAL: ATOPIC DERMATITIS, CRSWNP: 6 MONTHS. ASTHMA: 12 MONTHS. RENEWAL ALL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL APPROVAL FOR ATOPIC DERMATITIS REQUIRES: 1) PREVIOUS TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: TOPICAL CORTICOSTEROIDS, TOPICAL CALCINEURIN INHIBITORS [E.G., ELIDEL (PIMECROLIMUS), GENERIC TACROLIMUS OINTMENT], OR TOPICAL PDE4 INHIBITOR [E.G., EUCRISA (CRISABOROLE)]. 2) ATOPIC DERMATITIS INVOLVING AT LEAST 10% OF BODY SURFACE AREA (BSA) OR ATOPIC DERMATITIS AFFECTING THE FACE, HEAD, NECK, HANDS, FEET, GROIN, OR INTERTRIGINOUS AREAS. 3) INTRACTABLE PRURITUS OR CRACKING/ OOZING/BLEEDING OF AFFECTED SKIN. INITIAL APPROVAL FOR ASTHMA: 1) PATIENT IS CURRENTLY ON A MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION (E.G., LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE). 2) PATIENT HAS EXPERIENCED AT LEAST 2 ASTHMA EXACERBATIONS IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST). RENEWAL FOR ATOPIC DERMATITIS, ASTHMA, AND CRSWNP: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

DURVALUMAB

Products Affected

- IMFINZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DUVELISIB

Products Affected

- COPIKTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

EDARAVONE

Products Affected

- RADICAVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELAGOLIX SODIUM

Products Affected

- ORILISSA ORAL TABLET 150 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PHYSICIAN ATTESTATION OF IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS.
Age Restrictions	18 YEARS OF AGE AND OLDER
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING CONTRACEPTIVE PREPARATION.
Indications	All FDA-approved Indications.
Off Label Uses	

ELAGOLIX/ESTRADIOL/NORETHINDRONE

Products Affected

- ORIAHNN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELAPEGADEMASE-LVLR

Products Affected

- REVCOVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELBASVIR/GRAZOPREVIR

Products Affected

- ZEPATIER

PA Criteria	Criteria Details
Exclusion Criteria	MODERATE TO SEVERE LIVER IMPAIRMENT (CHILD PUGH B OR C)
Required Medical Information	HCV RNA LEVEL. FOR GENOTYPE 1A - TESTING FOR NS5A RESISTANCE-ASSOCIATED POLYMORPHISMS.
Age Restrictions	18 YEARS OF AGE AND OLDER.
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	12 WEEKS OR 16 WEEKS, BASED ON FDA APPROVED INDICATIONS

PA Criteria	Criteria Details
Other Criteria	GUIDELINE CRITERIA ARE BASED ON AMERICAN ASSOCIATION FOR THE STUDY OF LIVER DISEASES AND INFECTIOUS DISEASE SOCIETY OF AMERICA (AASLD/IDSA) TREATMENT GUIDELINES AND BEST AVAILABLE EVIDENCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). APPROVAL REQUIRES PATIENT HAS EVIDENCE OF HEPATITIS C INFECTION (AT LEAST 2 DETECTABLE HCV RNA LEVELS) OVER THE PAST 6 MONTHS OR PATIENT HAS AT LEAST ONE DETECTABLE HCV RNA LEVEL OVER THE PAST 6 MONTHS AND HAS PREVIOUS EVIDENCE OF INFECTION (E.G., PREVIOUS PRESCRIPTION FOR TREATMENT OF HEPATITIS C). PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: PHENYTOIN, CARBAMAZEPINE, RIFAMPIN, EFAVIRENZ, ATAZANAVIR, DARUNAVIR, LOPINAVIR, SAQUINAVIR, TIPRANAVIR, CYCLOSPORINE, NAFCILLIN, KETOCONAZOLE, MODAFINIL, BOSENTAN, ETRAVIRINE, ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR, ATORVASTATIN AT DOSES ABOVE 20MG PER DAY OR ROSUVASTATIN AT DOSES GREATER THAN 10MG PER DAY. NO CONCURRENT USE WITH SOVALDI.
Indications	All FDA-approved Indications.
Off Label Uses	

ELEXACAFTOR/TEZACAFTOR/IVACAFT

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ELTROMBOPAG

Products Affected

- PROMACTA ORAL POWDER IN PACKET 12.5 MG, 25 MG
- PROMACTA ORAL TABLET 12.5 MG, 25 MG, 50 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ITP:INITIAL: 2MO.RENEW:12MO.HCV:12MO.SEVERE APLASTIC ANEMIA:12MO
Other Criteria	CHRONIC IMMUNE (IDIOPATHIC) THROMBOCYTOPENIA PURPURA (ITP): INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. ITP: RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
Indications	All FDA-approved Indications.
Off Label Uses	

EMPLICITI (S)

Products Affected

- EMPLICITI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENASIDENIB

Products Affected

- IDHIFA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENBREL (S)

Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)
Required Medical Information	DIAGNOSIS OF ONE OF THE FOLLOWING : A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS B) MODERATE TO SEVERE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) FOR AT C) PSORIATIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO METHOTREXATE D) ANKYLOSING SPONDYLITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NSAIDS E) MODERATE TO SEVERE CHRONIC PLAQUE PSORIASIS (AFFECTING MORE THAN 5% OF BODY SURFACE AREA OR AFFECTING CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE, OR GENITALS) AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO CONVENTIONAL THERAPY WITH AT LEAST ONE OF THE FOLLOWING: PHOTOTHERAPY (INCLUDING BUT NOT LIMITED TO ULTRAVIOLET A WITH A PSORALEN [PUVA] AND/OR RETINOIDS [REPUVA] OR ONE OR MORE ORAL SYSTEMIC TREATMENTS (I.E. METHOTREXATE, CYCLOSPORINE, ACITRETIN, SULFASALAZINE).

PA Criteria	Criteria Details
Age Restrictions	'2 YEARS OF AGE OR OLDER FOR JIA. 4 YEARS OF AGE OR OLDER FOR PLAQUE PSORIASIS. 18 YEARS OF AGE OR OLDER FOR ALL OTHER INDICATIONS
Prescriber Restrictions	
Coverage Duration	INITIAL 3 MONTHS (PLAQUE PSORIASIS), 12 MONTHS (OTHERS). RENEWAL 12 MONTHS.
Other Criteria	PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (E.G., FOR PJIA, REDUCTION IN DISEASE FLARES, IMPROVEMENT IN ACR SCORING. FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR PSA, IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, STIFFNESS. FOR AS, IMPROVEMENT IN AS SYMPTOMS, SUCH AS STIFFNESS AND BACK PAIN).
Indications	All FDA-approved Indications.
Off Label Uses	

ENCORAFENIB

Products Affected

- BRAFTOVI ORAL CAPSULE 50 MG, 75 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENDOTHELIN RECEPTOR ANTAGONISTS

Products Affected

- *ambrisentan*
- *bosentan*
- LETAIRIS
- OPSUMIT
- TRACLEER ORAL TABLET
- TRACLEER ORAL TABLET FOR SUSPENSION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. LETAIRIS (AMBRISENTAN): PATIENT DOES NOT HAVE IDIOPATHIC PULMONARY FIBROSIS (IPF). TRACLEER (BOSENTAN): PATIENT DOES NOT HAVE ELEVATED LIVER ENZYMES (ALT, AST) MORE THAN 3 TIMES UPPER LIMIT OF NORMAL (ULN) OR INCREASES IN BILIRUBIN BY 2 OR MORE TIMES ULN. PATIENT IS NOT CONCURRENTLY TAKING CYCLOSPORINE A OR GLYBURIDE. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

ENFORTUMAB

Products Affected

- PADCEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENTRECTINIB

Products Affected

- ROZLYTREK ORAL CAPSULE 100 MG, 200 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ENTYVIO (S)

Products Affected

- ENTYVIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY: CORTICOSTEROIDS, AMINOSALICYLATES, METHOTREXATE, AZATHIOPRINE, OR MERCAPTOPURINE.
Indications	All FDA-approved Indications.
Off Label Uses	

EPCLUSA

Products Affected

- EPCLUSA
- *sofosbuvir-velpatasvir*

PA Criteria	Criteria Details
Exclusion Criteria	NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, HIV REGIMEN THAT CONTAINS EFAVIRENZ, ROSUVASTATIN AT DOSES ABOVE 10MG, TIPRANAVIR/RITONAVIR OR TOPOTECAN. PATIENT MUST NOT HAVE SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS.
Required Medical Information	HCV RNA LEVEL.
Age Restrictions	18 YEARS OF AGE AND OLDER.
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

EPOETIN ALFA (S)

Products Affected

- EPOGEN INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML
- PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PRETREATMENT HEMOGLOBIN LEVEL IS LESS THAN 10 G/DL, RENEWAL: FOR ADULT PATIENTS WITH CKD NOT ON DIALYSIS OR CANCER PATIENTS, HEMOGLOBIN IS LESS THAN 10 G/DL. FOR ADULT PATIENTS WITH CKD ON DIALYSIS, HEMOGLOBIN IN LESS THAN 11 G/DL. FOR PEDIATRIC PATIENTS WITH CKD, HEMOGLOBIN IS LESS THAN 12 G/DL.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD W/O DIALYSIS/ZIDOVUDINE:12 MOS. SURGERY:1 MO.
Other Criteria	PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
Indications	All FDA-approved Indications.
Off Label Uses	

EPOETIN ALFA-EPBX

Products Affected

- RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC RENAL FAILURE (CRF) AND ANEMIA RELATED TO ZIDOVUDINE THERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ELECTIVE NON-CARDIAC OR NON-VASCULAR SURGERY REQUIRES A HEMOGLOBIN LEVEL LESS THAN 13G/DL RENEWAL: CHRONIC RENAL FAILURE REQUIRES THAT THE PATIENT MEETS ONE OF THE FOLLOWING: IF THE PATIENT IS CURRENTLY RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 11G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 11G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. IF THE PATIENT IS NOT RECEIVING DIALYSIS TREATMENT: 1) HEMOGLOBIN LEVEL OF LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL THAT HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10 G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE:12 MONTHS.SURGERY:1 MO.
Other Criteria	PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
Indications	All FDA-approved Indications.
Off Label Uses	

ERDAFITINIB

Products Affected

- BALVERSA ORAL TABLET 3 MG, 4 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ERENUMAB-AOOE

Products Affected

- AIMOVIG AUTOINJECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AIMOVIG THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING FORMULARY ALTERNATIVES FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL.
Indications	All FDA-approved Indications.
Off Label Uses	

ERIVEDGE (S)

Products Affected

- ERIVEDGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF METASTATIC BASAL CELL CARCINOMA OR DIAGNOSIS OF LOCALLY ADVANCED BASAL CELL CARCINOMA THAT HAS RECURRED FOLLOWING SURGERY OR WHEN THE PATIENT IS NOT A CANDIDATE FOR SURGERY AND RADIATION
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ESBRIET

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT WITH USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT. NOT APPROVED FOR PATIENTS WITH KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER). NOT APPROVED IF THE PATIENT HAS NOT OBTAINED LIVER FUNCTION TESTS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ESKETAMINE

Products Affected

- SPRAVATO NASAL SPRAY,NON-AEROSOL 56 MG (28 MG X 2), 84 MG (28 MG X 3)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.
Coverage Duration	12 MONTHS
Other Criteria	MEETS ALL OF THE FOLLOWING: 1) PATIENT HAS NON-PSYCHOTIC, UNIPOLAR DEPRESSION, 2) PATIENT DOES NOT HAVE ACTIVE SUBSTANCE ABUSE, AND 3) PHYSICIAN ATTESTATION OF ADEQUATE TRIAL (AT LEAST 4 WEEKS) OF AT LEAST TWO ANTIDEPRESSANT AGENTS FROM DIFFERENT CLASSES THAT ARE INDICATED FOR DEPRESSION.
Indications	All FDA-approved Indications.
Off Label Uses	

ETEPLIRSEN

Products Affected

- EXONDYS-51

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING THAT MUTATION IN DUCHENNE MUSCULAR DYSTROPHY (DMD) GENE IS AMENABLE TO EXON 51 SKIPPING.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST SPECIALIZING IN THE TREATMENT OF DMD AT A DMD TREATMENT CENTER.
Coverage Duration	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL CRITERIA: PATIENT IS AMBULATORY AND IS CONCURRENTLY RECEIVING TREATMENT WITH GLUCOCORTICOIDS. RENEWAL CRITERIA: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION (I.E. PULMONARY OR CARDIAC FUNCTION) DURING THE PAST 24 WEEKS.
Indications	All FDA-approved Indications.
Off Label Uses	

EVOLOCUMAB

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PATIENT MEETS ONE OF THE FOLLOWING: 1) CONTINUED CONCURRENT THERAPY WITH A MAXIMALLY TOLERATED DOSE OF A STATIN 2) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE 3) A CONTRAINDICATION TO STATIN THERAPY.
Age Restrictions	
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	PRIMARY HYPERLIPIDEMIA (E.G., HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH)): DIAGNOSIS DETERMINED BY (1) DEFINITE SIMON BROOME DIAGNOSTIC (SBD) CRITERIA FOR FH, OR (2) DUTCH LIPID NETWORK (DLN) CRITERIA SCORE OF 6 OR GREATER. HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): DIAGNOSIS DETERMINED BY (1) DEFINITE SBD CRITERIA, (2) DLN CRITERIA SCORE OF 8 OR GREATER, OR (3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).
Indications	All FDA-approved Indications.
Off Label Uses	

EXALGO (S)

Products Affected

- *hydromorphone oral tablet extended release 24 hr 12 mg, 16 mg, 32 mg, 8 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	OPIOID TOLERANCE (DEFINED AS THOSE WHO ARE TAKING, FOR ONE WEEK OR LONGER, AT LEAST 60 MG ORAL MORPHINE PER DAY, 25 MCG TRANSDERMAL FENTANYL/HOUR, 30 MG ORAL OXYCODONE/DAY, 25 MG ORAL OXYMORPHONE/DAY, 8 MG ORAL HYDROMORPHONE/DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID). REQUESTS FOR 32 MG STRENGTH REQUIRES PAIN SPECIALIST RECOMMENDATION. NO APPROVAL WHEN PRESCRIBED FOR AS NEEDED DOSAGE FREQUENCY.
Indications	All FDA-approved Indications.
Off Label Uses	

EXJADE (S)

Products Affected

- *deferasirox*
- JADENU

PA Criteria	Criteria Details
Exclusion Criteria	CREATININE CLEARANCE LESS THAN 40 ML/MINUTE. PLATELET COUNT LESS THAN 50 X 109/L. POOR PERFORMANCE STATUS. SEVERE (CHILD-PUGH CLASS C) HEPATIC IMPAIRMENT. HIGH-RISK MYELODYSPLASTIC SYNDROMES. ADVANCED MALIGNANCIES. GASTROINTESTINAL ULCERATION OR HEMORRHAGE.
Required Medical Information	PATIENT HAS A DIAGNOSIS OF ONE OF THE FOLLOWING: A) CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS AND PATIENT HAS A BASELINE FERRITIN LEVEL MORE THAN 1,000 MCG/L AND THE PATIENT HAS REQUIRED THE TRANSFUSION OF AT LEAST 100 ML/KG PACKED RED BLOOD CELLS OR B) CHRONIC IRON OVERLOAD DUE TO NON-TRANSFUSION-DEPENDENT THALASSEMIA (NTDT) AND LIVER IRON CONCENTRATION (LIC) IS 5 MG OF IRON PER GRAM OF LIVER DRY WEIGHT (MG FE/G DW) OR HIGHER AND SERUM FERRITIN LEVEL IS GREATER THAN 300 MCG/L
Age Restrictions	2 YEARS OF AGE OR OLDER FOR CHRONIC IRON OVERLOAD DUE TO TRANSFUSIONS. 10 YEARS OF AGE OR OLDER FOR CHRONIC IRON OVERLOAD DUE TO NTDT
Prescriber Restrictions	
Coverage Duration	NTDT - 6 MONTHS. TRANSFUSION-DEPENDENT ANEMIA, MDS - 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	FOR RENEWAL OF CHRONIC IRON OVERLOAD DUE TO BLOOD TRANSFUSIONS AND MDS, THE EXPERIENCED A REDUCTION IN SERUM FERRITIN LEVEL OR LIC. FOR RENEWAL OF CHRONIC IRON OVERLOAD DUE TO NTDT, PATIENT HAS LIC 3 MG FE/G DW OR HIGHER AND PATIENT EXPERIENCED A REDUCTION IN SERUM FERRITIN LEVEL OR LIC.
Indications	All FDA-approved Indications.
Off Label Uses	

EXTAVIA (S)

Products Affected

- EXTAVIA SUBCUTANEOUS KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS OR DIAGNOSIS OF FIRST CLINICAL EPISODE AND MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR RENEWAL, PATIENT HAS EXPERIENCED AN OBJECTIVE RESPONSE TO THERAPY (I.E. NO OR SLOWED PROGRESSION OF DISEASE)
Indications	All FDA-approved Indications.
Off Label Uses	

FAM-TRASTUZUMAB

Products Affected

- ENHERTU

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FARYDAK (S)

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL AND RENEWAL: 24 WEEKS EACH (48 WEEKS TOTAL)
Other Criteria	RENEWAL: PATIENT HAS TOLERATED THE FIRST 8 CYCLES OF THERAPY WITHOUT UNRESOLVED SEVERE OR MEDICALLY SIGNIFICANT TOXICITY.
Indications	All FDA-approved Indications.
Off Label Uses	

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FENFLURAMINE

Products Affected

- FINTEPLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: PATIENT HAS SHOWN CONTINUED CLINICAL BENEFIT (E.G. REDUCTION OF SEIZURES, REDUCED LENGTH OF SEIZURES, SEIZURE CONTROL MAINTAINED)
Indications	All FDA-approved Indications.
Off Label Uses	

FENTANYL NASAL SPRAY

Products Affected

- LAZANDA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER RELATED PAIN: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION. EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. TRIAL OR CONTRAINDICATION TO GENERIC FENTANYL CITRATE LOZENGE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

FENTANYL TRANSMUCOSAL AGENTS

Products Affected

- ACTIQ
- *fentanyl citrate buccal lozenge on a handle*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CANCER RELATED PAIN: CURRENTLY ON A MAINTENANCE DOSE OF CONTROLLED-RELEASE OPIOID PAIN MEDICATION. EITHER A TRIAL OR CONTRAINDICATION TO AT LEAST ONE IMMEDIATE-RELEASE ORAL OPIOID PAIN AGENT OR MEMBER HAS DIFFICULTY SWALLOWING TABLETS/CAPSULES. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

FERRIC CITRATE

Products Affected

- AURYXIA

PA Criteria	Criteria Details
Exclusion Criteria	IRON DEFICIENCY ANEMIA
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

FERRIPROX (S)

Products Affected

- FERRIPROX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF TRANSFUSIONAL IRON OVERLOAD DUE TO THALASSEMIA SYNDROMES AND PATIENT HAS FAILED PRIOR CHELATION THERAPY WITH DESFERAL OR EXJADE (FAILURE IS DEFINED AS A SERUM FERRITIN LEVEL GREATER THAN 2,500 MCG/L) OR PATIENT HAS A CONTRAINDICATION OR INTOLERANCE TO DESFERAL OR EXJADE AND PATIENT HAS AN ABSOLUTE NEUTROPHIL COUNT GREATER THAN 1.5 X 109/L.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR RENEWAL, PATIENT HAS EXPERIENCED AT LEAST A 20% REDUCTION IN SERUM FERRITIN LEVELS AND HAS AN ABSOLUTE NEUTROPHIL COUNT GREATER THAN 0.5 X 109/L
Indications	All FDA-approved Indications.
Off Label Uses	

FLECTOR (S)

Products Affected

- *diclofenac epolamine*
- FLECTOR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

FOLOTYN (S)

Products Affected

- FOLOTYN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF RELAPSED OR REFRACTORY PERIPHERAL T-CELL LYMPHOMA (PTCL)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FORTEO (S)

Products Affected

- FORTEO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS A DIAGNOSIS OF ONE OF THE FOLLOWING: A) OSTEOPOROSIS IN A POSTMENOPAUSAL FEMALE, B) PRIMARY OR HYPOGONADAL OSTEOPOROSIS IN A MALE, OR C) OSTEOPOROSIS ASSOCIATED WITH SUSTAINED SYSTEMIC GLUCOCORTICOID THERAPY AND PATIENT IS CONSIDERED TO BE AT HIGH-RISK FOR FRACTURE BY MEETING ONE OR MORE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC FRACTURE, B) MULTIPLE RISK FACTORS FOR FACTURE (INCLUDING OLDER AGE (POSTMENOPAUSAL WOMAN OR MAN GREATER THAN 50 YEARS OF AGE), FEMALE GENDER, LOW BODY MASS INDEX (LESS THAN 19 KG/M2), RHEUMATOID ARTHRITIS, SMOKER, ALCOHOL INTAKE MORE THAN 3 DRINKS/DAY, PARENTAL HISTORY OF HIP FRACTURE, ORAL GLUCOCORTICOID THERAPY OR PATIENT EVER TOOK PREDNISONE AT A DOSE OF 5 MG OR HIGHER), AND PATIENT HAS DOCUMENTED TRIAL AND FAILURE OF BISPHOSPHONATE OR DOCUMENTED CONTRAINDICATION OR INTOLERANCE TO BISPHOSPHONATE THERAPY. PATIENT HAS NOT RECEIVED MORE THAN 2 YEARS OF THERAPY WITH FORTEO.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

FOSTAMATINIB

Products Affected

- TAVALISSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, IMMUNOLOGIST, OR RHEUMATOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

FREMANEZUMAB-VFRM

Products Affected

- AJOVY AUTOINJECTOR
- AJOVY SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH AJOVY THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL.
Indications	All FDA-approved Indications.
Off Label Uses	

GALCANEZUMAB-GNLM

Products Affected

- EMGALITY PEN
- EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML
- EVENITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL FOR MIGRAINES ONLY: THE PATIENT HAS EXPERIENCED A REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH OR A REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION WITH EMGALITY THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MIGRAINE: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL. CLUSTER HEADACHE: TREATMENT REQUIRES PHYSICIAN DIAGNOSIS.
Indications	All FDA-approved Indications.
Off Label Uses	

GALCANEZUMAB-GNLM V2

Products Affected

- EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GATTEX (S)

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Exclusion Criteria	ACTIVE GASTROINTESTINAL MALIGNANCY (GASTROINTESTINAL TRACT, HEPATOBILIARY, PANCREATIC), COLORECTAL CANCER, OR SMALL BOWEL CANCER
Required Medical Information	DIAGNOSIS OF SHORT BOWEL SYNDROME AND PATIENT IS RECEIVING SPECIALIZED NUTRITIONAL SUPPORT (I.E. PARENTERAL NUTRITION)
Age Restrictions	1 YEAR OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GEMTUZUMAB OZOGAMICIN

Products Affected

- MYLOTARG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GILENYA (S)

Products Affected

- GILENYA

PA Criteria	Criteria Details
Exclusion Criteria	RECENT (WITHIN THE LAST 6 MONTHS) OCCURRENCE OF: MYOCARDIAL INFARCTION, UNSTABLE ANGINA, STROKE, TRANSIENT ISCHEMIC ATTACK, DECOMPENSATED HEART FAILURE REQUIRING HOSPITALIZATION, OR CLASS III/IV HEART FAILURE. HISTORY OR PRESENCE OF MOBITZ TYPE II 2ND DEGREE OR 3RD DEGREE AV BLOCK OR SICK SINUS SYNDROME, UNLESS PATIENT HAS A PACEMAKER. BASELINE QTC INTERVAL GREATER THAN OR EQUAL TO 500 MS. RECEIVING CONCURRENT TREATMENT WITH CLASS IA OR CLASS III ANTI-ARRHYTHMIC DRUGS (QUINIDINE, PROCAINAMIDE, AMIODARONE, SOTALOL).
Required Medical Information	DIAGNOSIS OF A RELAPSING FORM OF MULTIPLE SCLEROSIS AND PATIENT WILL BE OBSERVED FOR SIGNS AND SYMPTOMS OF BRADYCARDIA IN A CONTROLLED SETTING FOR AT LEAST 6 HOURS AFTER THE FIRST DOSE
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL - 6 MONTHS. RENEWAL - 12 MONTHS
Other Criteria	FOR RENEWAL, THE PATIENT HAS EXPERIENCED NO OR SLOWED DISEASE PROGRESSION.
Indications	All FDA-approved Indications.
Off Label Uses	

GILTERITINIB

Products Affected

- XOSPATA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GIVOSIRAN

Products Affected

- GIVLAARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GLASDEGIB

Products Affected

- DAURISMO ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GLECAPREVIR-PIBRENTASVIR

Products Affected

- MAVYRET

PA Criteria	Criteria Details
Exclusion Criteria	MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD PUGH B OR C)
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED OR CONTRAINDICATED BY THE MANUFACTURER: CARBAMAZEPINE, RIFAMPIN, ETHINYL ESTRADIOL-CONTAINING MEDICATION, ATAZANAVIR,DARUNAVIR, LOPINAVIR, RITONAVIR, EFAVIRENZ, ATORVASTATIN, LOVASTATIN, SIMVASTATIN, ROSUVASTATIN AT DOSES GREATER THAN 10MG, OR CYCLOSPORINE AT DOSES GREATER THAN 100MG PER DAY. PATIENT MUST NOT HAVE PRIOR FAILURE OF A DAA REGIMEN WITH NS5A INHIBITOR AND HCV PROTEASE INHIBITOR.
Indications	All FDA-approved Indications.
Off Label Uses	

GLEEVEC (S)

Products Affected

- GLEEVEC ORAL TABLET 100 MG, 400 MG
- *imatinib oral tablet 100 mg, 400 mg*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ALL DIAGNOSES: 12 MONTHS. ADJUVANT GIST TREATMENT (TWICE DAILY DOSE): 36 MONTHS.
Other Criteria	GASTROINTESTINAL STROMAL TUMOR (GIST) KIT (CD117) POSITIVE USE FOR GLEEVEC 400MG TWICE DAILY: TRIAL OF GLEEVEC 400MG ONCE DAILY OR GIST TUMOR EXPRESSING A KIT EXON 9 MUTATION. PREVIOUSLY TREATED CML REQUIRES MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS FOLLOWING BCR-ABL MUTATIONAL ANALYSIS - T315I, V299L, F317L/V/I/C, Y253H, E255K/V, F359V/C/I.
Indications	All FDA-approved Indications.
Off Label Uses	

GOLODIRSEN

Products Affected

- VYONDYS-53

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

GUSELKUMAB

Products Affected

- TREMFYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HALAVEN (S)

Products Affected

- HALAVEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF METASTATIC BREAST CANCER AND MEMBER HAS TRIED AND FAILED AN ANTHRACYCLINE AND A TAXANE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HARVONI (S)

Products Affected

- HARVONI ORAL PELLETS IN PACKET 33.75-150 MG, 45-200 MG
- HARVONI ORAL TABLET 45-200 MG, 90-400 MG
- *ledipasvir-sofosbuvir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL.
Age Restrictions	3 YEARS OF AGE AND OLDER.
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	DURATION BASED ON FDA APPROVED DOSING SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. NO APPROVAL FOR REQUESTS WHERE PROVIDER ATTESTS THAT PATIENT HAS LIFE EXPECTANCY LESS THAN 12 MONTHS DUE TO NON-LIVER RELATED COMORBID CONDITIONS (PER AASLD/IDSA TREATMENT GUIDELINE RECOMMENDATION). PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT).
Indications	All FDA-approved Indications.
Off Label Uses	

HERCEPTIN (S)

Products Affected

- HERCEPTIN HYLECTA
- HERCEPTIN INTRAVENOUS RECON SOLN 150 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BREAST CANCER, METASTATIC BREAST CANCER, GASTRIC CANCER: HER2 POSITIVE
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HETLIOZ (S)

Products Affected

- HETLIOZ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

HIGH RISK DRUGS IN THE ELDERLY - SKELETAL MUSCLE RELAXANTS

Products Affected

- *carisoprodol*
- *carisoprodol-aspirin*
- *carisoprodol-aspirin-codeine*
- *chlorzoxazone oral tablet 500 mg*
- *cyclobenzaprine oral tablet 10 mg, 5 mg*
- *metaxall*
- *metaxalone*
- *methocarbamol oral*
- *orphenadrine citrate*
- ROBAXIN-750
- SKELAXIN
- SOMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	APPROPRIATE HIGH RISK MEDICATION USE: 65 YEARS OF AGE OR OLDER. PA NOT REQUIRED FOR AGE 0-64 YEARS.
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER ACKNOWLEDGEMENT/AWARENESS DRUG IS LABELED AS HIGH RISK MEDICATION IN THE ELDERLY FOR PATIENTS 65 YEARS AND OLDER. HOSPICE PATIENTS WILL BE APPROVED WITHOUT PRESCRIBER ACKNOWLEDGEMENT REQUIREMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

HRM - ONCOLOGY

Products Affected

- *megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)*
- *megestrol oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION .
Age Restrictions	PA APPLIES TO PATIENTS 65 YEARS OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	APPLIES TO NEW STARTS ONLY.
Indications	All FDA-approved Indications.
Off Label Uses	

HRM MEPERIDINE

Products Affected

- DEMEROL (PF) INJECTION SOLUTION 100 MG/ML, 75 MG/1.5 ML
- DEMEROL (PF) INJECTION SYRINGE
- DEMEROL INJECTION
- DEMEROL ORAL TABLET 100 MG
- *meperidine (pf) injection solution 100 mg/ml, 25 mg/ml, 50 mg/ml*
- *meperidine injection cartridge*
- *meperidine oral solution*
- *meperidine oral tablet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	THE DRUG IS BEING PRESCRIBED FOR AN FDA-APPROVED INDICATION AND THE PRESCRIBING PHYSICIAN HAS BEEN MADE AWARE THAT THE REQUESTED DRUG IS CONSIDERED A HIGH RISK MEDICATION FOR ELDERLY PATIENTS (AGE 65 YEARS AND OLDER) AND WISHES TO PROCEED WITH THE ORIGINALLY PRESCRIBED MEDICATION.
Age Restrictions	PA APPLIES TO PATIENTS 65 YEARS OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	NOT COVERED FOR MEMBERS ENROLLED IN A MEDICARE APPROVED HOSPICE PROGRAM
Indications	All FDA-approved Indications.
Off Label Uses	

HYDROXYPROGESTERONE CAPROATE

Products Affected

- *hydroxyprogest(pf)(preg presv)*
- MAKENA INTRAMUSCULAR OIL
  250 MG/ML, 250 MG/ML (1 ML)

PA Criteria	Criteria Details
Exclusion Criteria	PREGNANCY WITH MULTIPLE GESTATIONS.
Required Medical Information	HISTORY OF DELIVERY AT LESS THAN 37 WEEKS OF GESTATION FOLLOWING SPONTANEOUS PRETERM LABOR OR PREMATURE RUPTURE OF MEMBRANES.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	UP TO 25 WEEKS.
Other Criteria	PREGNANCY AT LEAST 16 WEEKS BUT LESS THAN 37 WEEKS OF GESTATION WITH A SINGLE GESTATION.
Indications	All FDA-approved Indications.
Off Label Uses	

HYDROXYPROGESTERONE CAPROATE-DELALUTIN GENERIC

Products Affected

- *hydroxyprogesterone cap(ppres)*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

HYDROXYUREA

Products Affected

- SIKLOS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IBRANCE (S)

Products Affected

- IBRANCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IBRUTINIB

Products Affected

- IMBRUVICA ORAL CAPSULE 140 MG, 70 MG
- IMBRUVICA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ILARIS (S)

Products Affected

- ILARIS (PF) SUBCUTANEOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF CRYOPYRIN-ASSOCIATED PERIOD SYNDROMES (CAPS), INCLUDING FAMILIAL COLD AUTO-INFLAMMATORY SYNDROME (FCAS) AND/OR MUCKLE-WELLS SYNDROME (MWS) OR DIAGNOSIS OF ACTIVE SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA) AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, CONTRAINDICATION OR INTOLERANCE TO CORTICOSTEROIDS (E.G., PREDNISONE, METHYLPREDNISOLONE) OR METHOTREXATE
Age Restrictions	CAPS - 4 YEARS OF AGE OR OLDER. SJIA - 2 YEARS OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH OR RECOMMENDATION OF, AN IMMUNOLOGIST, ALLERGIST, DERMATOLOGIST, RHEUMATOLOGIST, NEUROLOGIST, OR OTHER MEDICAL SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	FOR RENEWAL, PATIENT EXPERIENCED DISEASE STABILITY OR IMPROVEMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

ILOPROST INHALED

Products Affected

- VENTAVIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	THIS DRUG MAYBE 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. NEBULIZER THERAPY IS COVERED UNDER PART B FOR PATIENTS WHO ARE USING THE MEDICATION VIA A NEBULIZER IN THEIR OWN HOME: THOSE WHO ARE NOT USING IT IN THEIR HOME WILL BE COVERED UNDER PART D. INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

IMIQUIMOD - ALDARA

Products Affected

- ALDARA
- *imiquimod topical cream in packet*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACTINIC KERATOSIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. SUPERFICIAL BASAL CELL CARCINOMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR AN ONCOLOGIST.
Coverage Duration	4 MONTHS
Other Criteria	EXTERNAL GENITAL WARTS: TRIAL OF PODOFILOX (CONDYLOX) 0.5% TOPICAL SOLUTION. ACTINIC KERATOSIS BRAND DRUG REQUEST: TRIAL OF GENERIC IMIQUIMOD 5% CREAM. SUPERFICIAL BASAL CELL CARCINOMA: LESS THAN 2CM IN SIZE AND NOT ON THE FACE.
Indications	All FDA-approved Indications.
Off Label Uses	

IMLYGIC - (S)

Products Affected

- IMLYGIC INJECTION SUSPENSION 10EXP6 (1 MILLION) PFU/ML, 10EXP8 (100 MILLION) PFU/ML

PA Criteria	Criteria Details
Exclusion Criteria	HISTORY OF PRIMARY OR ACQUIRED IMMUNODEFICIENT STATES, LEUKEMIA, LYMPHOMA, OR AIDS. PATIENT IS NOT CURRENTLY RECEIVING IMMUNOSUPPRESSIVE THERAPY.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	365 DAYS
Other Criteria	NO CONCURRENT USE WITH PEMBROLIZUMAB, NIVOLUMAB, IPILIMUMAB, DABRAFENIB, TRAMETINIB, VEMURAFENIB, DABRAFENIB, INTERLEUKIN-2, INTERFERON, DACARBAZINE, TEMOZOLOMIDE, PACLITAXEL, CARBOPLATIN, IMATINIB, MELPHALAN, IMIQUIMOD, OR RADIATION THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

INCRELEX (S)

Products Affected

- INCRELEX

PA Criteria	Criteria Details
Exclusion Criteria	CLOSED EPIPHYSES. ACTIVE OR SUSPECTED MALIGNANCY.
Required Medical Information	DIAGNOSIS OF GROWTH FAILURE IN A CHILD WITH SEVERE PRIMARY IGF-1 DEFICIENCY, DEFINED AS HEIGHT STANDARD DEVIATION SCORE (SDS) LESS THAN OR EQUAL TO -3.0 AND BASAL IGF-1 SDS LESS THAN OR EQUAL TO -3.0 AND NORMAL OR ELEVATED GROWTH HORMONE OR DIAGNOSIS OF GROWTH HORMONE GENE DELETION WITH DEVELOPMENT OF NEUTRALIZING ANTIBODIES TO GROWTH HORMONE AND OTHER CAUSES OF IGF-1 DEFICIENCY (E.G., HYPOTHYROIDISM, NUTRITIONAL DEFICIENCIES, PITUITARY DISORDERS, ETC.) HAVE BEEN RULED OUT OR CORRECTED PRIOR TO INITIATING THERAPY.
Age Restrictions	
Prescriber Restrictions	PEDIATRIC ENDOCRINOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INFLIXIMAB-ABDA

Products Affected

- RENFLEXIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	ALL INDICATIONS: 6 MO.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INFLIXIMAB-AXXQ

Products Affected

- AVSOLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

INFLIXIMAB-DYYB

Products Affected

- INFLECTRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHN'S DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: CD/UC: 8 MOS. RA: 6 MOS. PSA/AS/PSO: 4 MOS. RENEWAL FOR ALL INDICATIONS: 12 MOS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): CONCURRENT USE OF METHOTREXATE UNLESS CONTRAINDICATED: PLAQUE PSORIASIS (PSO): PREVIOUS TREATMENT WITH SYSTEMIC THERAPY SUCH AS PUVA, UVB, TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE: CROHN'S DISEASE (CD): TRIAL OF OR CONTRAINDICATION TO ONE OR MORE OF THE FOLLOWING CONVENTIONAL THERAPIES SUCH AS CORTICOSTEROIDS, AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

INHALED INSULIN

Products Affected

- AFREZZA INHALATION CARTRIDGE WITH INHALER 12 UNIT, 4 UNIT, 4 UNIT (90)/ 8 UNIT (90), 4 UNIT/8 UNIT/ 12 UNIT (60), 8 UNIT, 8 UNIT (90)/ 12 UNIT (90)

PA Criteria	Criteria Details
Exclusion Criteria	CHRONIC LUNG DISEASE (SUCH AS ASTHMA OR CHRONIC OBSTRUCTIVE PULMONARY DISEASE).
Required Medical Information	BASELINE SPIROMETRY TO MEASURE FEV1, FOLLOW UP SPIROMETRY AT 6 MONTHS AND ANNUALLY.
Age Restrictions	18 YEARS OF AGE OR OLDER.
Prescriber Restrictions	
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: 1 MONTH WITHOUT FEV1, 12 MONTHS WITH FEV1.

PA Criteria	Criteria Details
Other Criteria	INITIAL CRITERIA: FOR TYPE 1 DIABETES APPROVAL REQUIRES: 1) CONCURRENT USE OF LONG ACTING INSULIN (LANTUS) 2) TRIAL OF FORMULARY RAPID ACTING INSULIN (HUMALOG, NOVOLOG). FOR TYPE 2 DIABETES APPROVAL REQUIRES 1) TRIAL OF FORMULARY RAPID ACTING INSULIN OR PRESCRIBER HAS INDICATED THAT THE PATIENT IS PHYSICALLY UNABLE TO OR UNWILLING TO ADMINISTER INJECTABLE INSULIN 2) CONCURRENT USE OF ONE FORMULARY NON-INSULIN DIABETIC MEDICATION (JANUMET, JANUMET XR, JANUVIA, JENTADUETO, PRANDIMET, TRADJENTA, JARDIANCE, BYETTA, BYDUREON, CYCLOSET, METFORMIN, ACARBOSE, PIOGLITAZONE, PIOGLITAZONE-GLIMEPIRIDE, REPAGLINIDE, NATEGLINIDE). NOT APPROVED FOR PATIENTS WITH ONE OF THE FOLLOWING CRITERIA 1) LUNG CANCER 2) DIABETIC KETOACIDOSIS 3) PATIENT WHO SMOKES OR WHO HAS QUIT SMOKING WITHIN THE LAST 6 MONTHS. RENEWAL CRITERIA: APPROVE FOR 12 MONTHS IF PATIENT HAD FOLLOW UP SPIROMETRY AFTER 6 MONTHS OF TREATMENT AND ANNUALLY THEREAFTER, OTHERWISE APPROVE FOR 1 ADDITIONAL MONTH TO ALLOW FOR FOLLOW UP. NOT APPROVED FOR PATIENTS WITH A FEV1 DECLINE OF 20 PERCENT OR MORE FROM BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

INLYTA (S)

Products Affected

- INLYTA ORAL TABLET 1 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF ADVANCED RENAL CELL CARCINOMA AND PATIENT FAILED ONE OR MORE SYSTEMIC THERAPIES FOR RENAL CELL CARCINOMA (E.G., SUNITINIB-, BEVACIZUMAB-, TEMSIROLIMUS-, OR CYTOKINE-CONTAINING REGIMENS)
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INOTERSEN

Products Affected

- TEGSEDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS (HATTR) WITH POLYNEUROPATHY: PHYSICIAN ATTESTATION OF DIAGNOSIS OF HATTR AS CONFIRMED BY EITHER BIOPSY OF TISSUE/ORGAN TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TTR PROTEIN OR DNA GENETIC SEQUENCING TO CONFIRM HATTR MUTATION.
Age Restrictions	
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, CARDIOLOGIST, PHYSICIAN AT AN AMYLOIDOSIS TREATMENT CENTER, OR MEDICAL GENETICIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS STAGE 1 OR 2 POLYNEUROPATHY. RENEWAL: DIAGNOSIS OF HEREDITARY TTR AMYLOIDOSIS (HATTR) AND PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT PROGRESSED TO STAGE 3 POLYNEUROPATHY AS EVIDENCED BY FUNCTIONAL DECLINE (E.G., WHEELCHAIR-BOUND, BEDRIDDEN).
Indications	All FDA-approved Indications.
Off Label Uses	

INTRON A (S)

Products Affected

- INTRON A INJECTION

PA Criteria	Criteria Details
Exclusion Criteria	UNCONTROLLED DEPRESSION. SOLID ORGAN TRANSPLANT OTHER THAN LIVER. AUTOIMMUNE HEPATITIS OR OTHER AUTOIMMUNE CONDITION KNOWN TO BE EXACERBATED BY INTERFERON AND RIBAVIRIN.
Required Medical Information	DIAGNOSIS OF HAIRY CELL LEUKEMIA OR DIAGNOSIS OF CONDYLOMATA ACUMINATA OR DIAGNOSIS OF AIDS-RELATED KAPOSI'S SARCOMA OR CLINICALLY AGGRESSIVE FOLLICULAR LYMPHOMA AND THE MEDICATION WILL BE USED CONCURRENTLY WITH ANTHRACYCLINE-CONTAINING CHEMOTHERAPY OR IS NOT A CANDIDATE FOR ANTHRACYCLINE-CONTAINING CHEMOTHERAPY OR MALIGNANT MELANOMA AND THE REQUEST FOR COVERAGE IS WITHIN 56 DAYS OF SURGERY AND THE PATIENT IS AT HIGH RISK OF DISEASE RECURRENCE OR DIAGNOSIS OF CHRONIC HEPATITIS B WITH COMPENSATED LIVER DISEASE AND PATIENT HAS EVIDENCE OF HEPATITIS B VIRAL REPLICATION AND PATIENT HAS BEEN SERUM HEPATITIS B SURFACE ANTIGEN-POSITIVE FOR AT LEAST 6 MONTHS OR DIAGNOSIS OF CHRONIC HEPATITIS C WITH COMPENSATED LIVER DISEASE AND IS RECEIVING COMBINATION THERAPY WITH RIBAVIRIN, UNLESS RIBAVIRIN IS CONTRAINDICATED, AND THE MEDICATION WILL NOT BE USED AS PART OF TRIPLE THERAPY WITH A PROTEASE INHIBITOR AND PATIENT HAS A CLINICAL REASON FOR NOT USING PEGINTERFERON
Age Restrictions	1 YEAR OF AGE OR OLDER FOR HBV. 3 YEARS OF AGE OR OLDER FOR HCV. 18 YEARS OF AGE OR OLDER FOR OTHER INDICATIONS.

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	CONDYLOMATA: 3 MOS. HBV E ANTIGEN POS: 16 WKS, E ANTIGEN NEG: 48 WKS. KS: 16 WKS. OTHERS: 12 MOS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IRESSA (S)

Products Affected

- IRESSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ISATUXIMAB-IRFC

Products Affected

- SARCLISA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ISTODAX (S)

Products Affected

- ISTODAX
- *romidepsin*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF CUTANEOUS T-CELL LYMPHOMA (CTCL) AND THE PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO AT LEAST ONE PRIOR SYSTEMIC THERAPY (E.G., RETINOIDS, TARGRETIN, CORTICOSTEROIDS, RADIATION THERAPY) OR DIAGNOSIS OF PERIPHERAL T-CELL LYMPHOMA (PTCL) AND WHO HAVE TRIED AND HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO AT LEAST ONE PRIOR THERAPY (E.G., RETINOIDS, TARGRETIN, CORTICOSTEROIDS, RADIATION THERAPY).
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ISTRADEFYLLINE

Products Affected

- NOURIANZ ORAL TABLET 20 MG, 40 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IVOSIDENIB

Products Affected

- TIBSOVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

IXEKIZUMAB

Products Affected

- TALTZ AUTOINJECTOR
- TALTZ SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS (PSO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ANKYLOSING SPONDYLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	PLAQUE PSORIASIS (PSO): INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: COSENTYX OR OTEZLA. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF HUMIRA FOLLOWED BY ONE OF THE FOLLOWING PREFERRED AGENTS: CIMZIA, OTEZLA, OR COSENTYX.
Indications	All FDA-approved Indications.
Off Label Uses	

JAKAFI (S)

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) DIAGNOSIS OF MYELOFIBROSIS (PRIMARY, POST-POYCYTHEMIA VERA OR POST-ESSENTIAL THROMBOCYTHEMIA) AND PATIENT HAS TWO OR MORE OF THE FOLLOWING: AGE OLDER THAN 65 YEARS, WHITE BLOOD CELL COUNT GREATER THAN 25 X 109/L, HEMOGLOBIN LESS THAN 10 G/DL, PERIPHERAL BLASTS MORE THAN 1%, CONSTITUTIONAL SYMPTOMS (E.G., NIGHT SWEATS, FEVERS, UNINTENTIONAL WEIGHT LOSS, DEBILITATING FATIGUE) B) DIAGNOSIS OF ACUTE GRAFT-VERSUS-HOST DISEASE (GVHD) C) DIAGNOSIS OF POLYCYTHEMIA VERA
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS

PA Criteria	Criteria Details
Other Criteria	FOR MYELOFIBROISIS RENEWAL ONLY: THE PATIENT EXPERIENCED ONE OF THE FOLLOWING: AT LEAST 35% REDUCTION IN SPLEEN VOLUME FROM BASELINE AS MEASURED BY CT OR MRI OR A 50% REDUCTION IN SPLEEN SIZE FROM BASELINE BASED ON PALPATION OR 2 G/DL OR GREATER INCREASE IN HEMOGLOBIN LEVEL (IN TRANSFUSION-INDPENDENT) OR BECOMING TRANSFUSION INDEPENDENT (FOR TRANSFUSION DEPENDENT) OR IMPROVEMENT IN SYMPTOMS (I.E. ABDOMINAL DISCOMFORT, PAIN UNDER LEFT RIBS, EARLY SATIETY, NIGHT SWEATS, ITCHING, BONE OR MUSCLE PAIN) WITHOUR PROGRESSIVE SPLENOMEGALY OR WORSENING OF ANEMIA (I.E. NEWLY TRANSFUSION DEPENDENT OR HEMOGLOBIN REDUCTION BY 2 G/DL THAT PERSISTS FOR AT LEAST 12 WEEKS), THROMBOCYTOPENIA (MORE THAN 2-GRADE DECLINE BUT ABOVE 25,000 X 109/L) OR NEUTROPENIA (MORE THAN 2-GRADE DECLINE BUT ABOVE 0.5 X 109/L)
Indications	All FDA-approved Indications.
Off Label Uses	

KADCYLA (S)

Products Affected

- KADCYLA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS A DIAGNOSIS OF HER2-POSITIVE METASTATIC BREAST CANCER AND THE MEMBER HAS BEEN PREVIOUSLY TREATED WITH TRASTUZUMAB AND A TAXANE
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PRESCRIBER HAS ASSESSED THE PATIENT'S HEPATIC FUNCTION AND LEFT VENTRICULAR EJECTION FRACTION PRIOR TO INITIATION OF THERAPY. FEMALE PATIENTS OF CHILD-BEARING POTENTIAL HAD PREGNANCY STATUS VERIFIED PRIOR TO THE INITIATION OF KADCYLA AND HAVE BEEN ADVISED OF THE RISK OF EMBRYO-FETAL DEATHS AND BIRTH DEFECTS AND THE NEED FOR EFFECTIVE CONTRACEPTION.
Indications	All FDA-approved Indications.
Off Label Uses	

KALYDECO (S)

Products Affected

- KALYDECO

PA Criteria	Criteria Details
Exclusion Criteria	HOMOZYGOUS FOR F508DEL MUTATION IN CFTR GENE.
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS
Age Restrictions	6 MONTHS AND OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

KANUMA

Products Affected

- KANUMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BLOOD TEST OR DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT LYSOSOMAL ACID LIPASE DEFICIENCY (LAL) ENZYME ACTIVITY, OR A GENETIC TEST INDICATING THE PRESENCE OF ALTERED LIPA GENE(S)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

KEVEYIS

Products Affected

- KEVEYIS

PA Criteria	Criteria Details
Exclusion Criteria	HEPATIC INSUFFICIENCY, PULMONARY OBSTRUCTION, OR A HEALTH CONDITION THAT WARRANTS CONCURRENT USE OF HIGH-DOSE ASPIRIN
Required Medical Information	
Age Restrictions	18 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	INITIAL: 2 MONTHS RENEWAL: 12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

KEYTRUDA (S)

Products Affected

- KEYTRUDA INTRAVENOUS SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENTS WITH UNRESECTABLE OR METASTATIC MELANOMA: NO CONCURRENT REQUESTS FOR YERVOY, TAFINLAR, OR ZELBORAF
Indications	All FDA-approved Indications.
Off Label Uses	

KINERET (S)

Products Affected

- KINERET

PA Criteria	Criteria Details
Exclusion Criteria	ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)
Required Medical Information	DIAGNOSIS OF MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) OR DIAGNOSIS OF CRYOPYRIN-ASSOCIATED PERIODIC SYNDROME (CAPS) WITH NEONATAL-ONSET MULTISYSTEM INFLAMMATORY DISEASE (NOMID)
Age Restrictions	18 YEARS OF AGE OR OLDER FOR RHEUMATOID ARTHRITIS
Prescriber Restrictions	FOR CAPS, DIAGNOSED BY, OR UPON CONSULTATION WITH OR RECOMMENDATION OF, AN IMMUNOLOGIST, ALLERGIST, DERMATOLOGIST, RHEUMATOLOGIST, NEUROLOGIST OR OTHER MEDICAL SPECIALIST
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS BEEN TESTED FOR TB IN THE PAST YEAR AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED.
Indications	All FDA-approved Indications.
Off Label Uses	

LANADELUMAB

Products Affected

- TAKHZYRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY) IN HAE ATTACKS WITH ROUTINE PROPHYLAXIS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ALLERGIST/IMMUNOLOGIST OR HEMATOLOGIST.
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING.
Indications	All FDA-approved Indications.
Off Label Uses	

LAROTRECTINIB SULFATE

Products Affected

- VITRAKVI ORAL CAPSULE 100 MG, 25 MG
- VITRAKVI ORAL SOLUTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LEFAMULIN

Products Affected

- XENLETA ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE MONTH
Other Criteria	COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP): ONE OF THE FOLLOWING: 1) PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST, OR 2) CABP ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO XENLETA AND RESISTANCE TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP, OR 3) IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP.
Indications	All FDA-approved Indications.
Off Label Uses	

LEMTRADA (S)

Products Affected

- LEMTRADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 1 MONTH. RENEWAL: 12 MONTHS.
Other Criteria	TRIAL OF AT LEAST TWO FORMULARY AGENTS THAT HAVE BEEN FDA APPROVED FOR THE TREATMENT OF RELAPSING FORMS OF MULTIPLE SCLEROSIS. RENEWAL REQUESTS FOR ALEMTUZUMAB REQUIRE THAT AT LEAST 12 MONTHS HAVE ELAPSED SINCE RECEIVING THE FIRST COURSE OF LEMTRADA. PATIENTS ARE LIMITED TO TWO COURSES OF THERAPY WITH LEMTRADA WITHIN A LIFETIME.
Indications	All FDA-approved Indications.
Off Label Uses	

LENVIMA (S)

Products Affected

- LENVIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LETERMOVIR

Products Affected

- PREVYMIS INTRAVENOUS SOLUTION 240 MG/12 ML, 480 MG/24 ML
- PREVYMIS ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	4 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LEVODOPA

Products Affected

- INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: PATIENT IS NOT CURRENTLY TAKING MORE THAN 1600MG OF LEVODOPA PER DAY. PHYSICIAN ATTESTATION OF OPTIMIZATION OF DRUG THERAPY FOR PARKINSON'S DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	

LIDOCAINE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PATCH: 12 MONTHS. OINTMENT: 3 MONTHS.
Other Criteria	THIS DRUG REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

LIDOCAINE PRILOCAINE

Products Affected

- *lidocaine-prilocaine topical cream*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG MAY BE EITHER BUNDLED WITH AND COVERED UNDER END STAGE RENAL DISEASE DIALYSIS RELATED SERVICES OR COVERED UNDER MEDICARE D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

LISDEXAMFETAMINE DIMESYLATE

Products Affected

- VYVANSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	MODERATE TO SEVERE BINGE EATING DISORDER: 18 YEARS OF AGE AND OLDER
Prescriber Restrictions	MODERATE TO SEVERE BINGE EATING DISORDER: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PSYCHIATRIST
Coverage Duration	INITIAL 3 MOS FOR BINGE EATING. ADD/ADHD: 12 MOS. RENEWAL:12 MOS
Other Criteria	FOR MODERATE TO SEVERE BINGE EATING DISORDER: INITIAL CRITERIA: AT LEAST 3 EPISODES PER WEEK FOR AT LEAST 3 MONTHS, PATIENT DOES NOT HAVE CARDIOVASCULAR RISK FACTORS EXCEPT OBESITY AND SMOKING. RENEWAL CRITERIA: A REDUCTION IN THE NUMBER OF BINGE EATING EPISODES PER WEEK FROM THE PATIENT'S BASELINE
Indications	All FDA-approved Indications.
Off Label Uses	

LOMITAPIDE

Products Affected

- JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 40 MG, 5 MG, 60 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	LDL CHOLESTEROL LEVEL, LDL RECEPTOR STATUS.
Age Restrictions	
Prescriber Restrictions	CARDIOLOGIST, ENDOCRINOLOGIST OR LIPIDOLOGIST.
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	DIAGNOSIS DETERMINED BY (1) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, (2) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR (3) A CLINICAL DIAGNOSIS BASED ON A HISTORY OF AN UNTREATED LDL-C CONCENTRATION GREATER THAN 500 MG/DL TOGETHER WITH EITHER XANTHOMA BEFORE 10 YEARS OF AGE, OR EVIDENCE OF HEFH IN BOTH PARENTS. LDL-C LEVEL GREATER THAN OR EQUAL TO 70MG/DL WHILE ON MAXIMAL DRUG TREATMENT. PREVIOUS TRIAL OF EVOLOCUMAB UNLESS THE PATIENT HAS NON-FUNCTIONING LDL RECEPTORS. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80MG DAILY, ROSUVASTATIN 20-40MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS, (2) TAKING A MAXIMALLY TOLERATED DOSE OF ANY STATIN FOR A DURATION OF AT LEAST 8 WEEKS GIVEN THAT THE PATIENT CANNOT TOLERATE A HIGH-INTENSITY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTIONS), (4) PHYSICIAN ATTESTATION OF STATIN INTOLERANCE, OR (5) PATIENT HAS TRIED ROSUVASTATIN, ATORVASTATIN, OR STATIN THERAPY AT ANY DOSE AND HAS EXPERIENCED SKELETAL-MUSCLE RELATED SYMPTOMS (E.G., MYOPATHY).
Indications	All FDA-approved Indications.
Off Label Uses	

LONSURF

Products Affected

- LONSURF ORAL TABLET 15-6.14 MG, 20-8.19 MG

PA Criteria	Criteria Details
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 MONTHS
Other Criteria	N/A
Indications	All FDA-approved Indications.
Off Label Uses	

LORLATINIB

Products Affected

- LORBRENA ORAL TABLET 100 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LURBINECTEDIN

Products Affected

- ZEPZELCA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LUSPATERCEPT-AAMT

Products Affected

- REBLOZYL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LUSUTROMBOPAG

Products Affected

- MULPLETA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS A PLANNED PROCEDURE 8 TO 14 DAYS AFTER INITIATION OF MULPLETA. PATIENT IS NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G. AVATROMBOPAG, ROMIPLOSTIM, ELTROMBOPAG).
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, OR ENDOCRINOLOGIST.
Coverage Duration	3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MEKINIST (S)

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA AND MEDICATION IS USED AS A SINGLE AGENT AND PATIENT HAS A POSITIVE BRAF V600E OR V600K MUTATION AS DETECTED BY AN FDA-APPROVED TEST (THXID-BRAF KIT) OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)-APPROVED FACILITY, AND THE PATIENT HAS NOT RECEIVED PRIOR BRAF-INHIBITOR THERAPY OR MEDICATION WILL BE USED IN COMBINATION WITH TAFINLAR IN A PATIENT WITH BRAF V600E OR V600K MUTATIONS, AS DETECTED BY AN FDA-APPROVED TEST (THXID-BRAF KIT) OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)-APPROVED FACILITY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MEPOLIZUMAB

Products Affected

- NUCALA

PA Criteria	Criteria Details
Exclusion Criteria	CONCURRENT USE OF XOLAIR
Required Medical Information	BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE LAST 6 WEEKS OR GREATER THAN OR EQUAL TO 300 CELLS/MCL WITHIN THE LAST 12 MONTHS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE, AN ALLERGIST ,AN IMMUNOLOGIST, OR A RHEUMATOLOGIST.
Coverage Duration	INITIAL 24 WEEKS. RENEWAL 12 MONTHS
Other Criteria	INITIAL THERAPY: FOR ASTHMA: PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS AND AT LEAST ONE OTHER MAINTENANCE MEDICATION WHICH INCLUDES ANY OF THE FOLLOWING: LONG-ACTING INHALED BETA2-AGONIST, LONG-ACTING MUSCARINIC ANTAGONIST, A LEUKOTRIENE RECEPTOR ANTAGONIST, THEOPHYLLINE, OR ORAL CORTICOSTEROID: OR THE PATIENT HAS A DIAGNOSIS OF EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA). RENEWAL FOR ASTHMA REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED IMPROVEMENT IN ASTHMA EXACERBATIONS FROM BASELINE (PHYSICIAN ATTESTATION) AND A REDUCTION IN ORAL CORTICOSTEROID DOSE (IF THE PATIENT WAS ON A MAINTENANCE REGIMEN OF ORAL CORTICOSTEROIDS AT THE INITIATION OF TREATMENT).

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

METHAMPHETAMINE DVE

Products Affected

- DESOXYN
- *methamphetamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

METHYLNALTREXONE ORAL

Products Affected

- RELISTOR ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF OPIOID INDUCED CONSTIPATION
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS
Indications	All FDA-approved Indications.
Off Label Uses	

MIFEPRISTONE

Products Affected

- KORLYM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MIGALASTAT HCL

Products Affected

- GALAFOLD

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS.
Coverage Duration	12 MONTHS
Other Criteria	FABRY DISEASE RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED IMPROVEMENT OR STABILIZATION.
Indications	All FDA-approved Indications.
Off Label Uses	

MILTEFOSINE

Products Affected

- IMPAVIDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

MIRCERA

Products Affected

- MIRCERA INJECTION SYRINGE 100 MCG/0.3 ML, 200 MCG/0.3 ML, 50 MCG/0.3 ML, 75 MCG/0.3 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CHRONIC RENAL FAILURE: INITIAL: HEMOGLOBIN LEVELS LESS THAN 10 G/DL RENEWAL: HEMOGLOBIN LEVELS LESS THAN 10 G/DL IF NOT ON DIALYSIS AND LESS THAN 11 G/DL IF ON DIALYSIS OR HEMOGLOBIN HAS REACHED 11 G/DL IF ON DIALYSIS AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS OR HEMOGLOBIN HAS REACHED 10 G/DL IF NOT ON DIALYSIS AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PART D MEMBER RECEIVING DIALYSIS OR IDENTIFIED AS A PART D END STAGE RENAL DISEASE MEMBER: PAYS UNDER PART B.
Indications	All FDA-approved Indications.
Off Label Uses	

MODAFINIL

Products Affected

- *modafinil*
- PROVIGIL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

MOXETUMOMAB PASUDOTOX

Products Affected

- LUMOXITI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NATPARA (S)

Products Affected

- NATPARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NECITUMUMAB

Products Affected

- PORTRAZZA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NERATINIB

Products Affected

- NERLYNX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NEULASTA (S)

Products Affected

- NEULASTA SUBCUTANEOUS SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FOR USE AS PRIMARY PROPHYLAXIS OF FEBRILE NEUTROPENIA (FN) IN ONE OF THE FOLLOWING PATIENTS: A) PATIENT HAS A 20% OR HIGHER RISK OF FN BASED ON CHEMOTHERAPY REGIMEN OR B) PATIENT HAS 10% TO LESS THAN 20% RISK OF DEVELOPING FN BASED ON CHEMOTHERAPY REGIMEN AND AT LEAST ONE OF THE FOLLOWING RISK FACTORS ARE PRESENT: 65 YEARS OR OLDER, POOR PERFORMANCE STATUS, POOR NUTRITIONAL STATUS, PREVIOUS EPISODES OF FEBRILE NEUTROPENIA, EXTENSIVE PRIOR TREATMENT INCLUDING LARGE RADIATION PORTS, CYTOPENIAS DUE TO BONE MARROW INVOLVEMENT BY TUMOR, ADMINISTRATION OF COMBINED CHEMORADIOTHERAPY, PRESENCE OF OPEN WOUNDS OR ACTIVE INFECTIONS, OTHER SERIOUS COMORBIDITIES (INCLUDING RENAL OR LIVER DYSFUNCTION NOTABLY ELEVATED BILIRUBIN), OR C) PATIENT HAS LESS THAN 10% RISK OF DEVELOPING FN BASED ON CHEMOTHERAPY REGIMEN AND THE INTENT OF TREATMENT IS CURATIVE OR ADJUVANT AND PATIENT IS AT RISK FOR SERIOUS MEDICAL CONSEQUENCES OF FN, INCLUDING DEATH AND PATIENT IS RECEIVING MYELOSUPPRESSIVE CHEMOTHERAPY REGIMEN FOR A NON-MYELOID MALIGNANCY, OR D) FOR USE AS SECONDARY PROPHYLAXIS OF FN IN A PATIENT WHO HAD A NEUTROPENIC COMPLICATION FROM A PRIOR CYCLE OF CHEMOTHERAPY (FOR WHICH PRIMARY PROPHYLAXIS WAS NOT RECEIVED).
Age Restrictions	

PA Criteria	Criteria Details
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NEXAVAR (S)

Products Affected

- NEXAVAR

PA Criteria	Criteria Details
Exclusion Criteria	SQUAMOUS CELL LUNG CANCER BEING TREATED WITH CARBOPLATIN AND PACLITAXEL.
Required Medical Information	DIAGNOSIS OF ONE OF THE FOLLOWING: A) UNRESECTABLE HEPATOCELLULAR CARCINOMA, B) ADVANCED RENAL CELL CARCINOMA C) LOCALLY RECURRENT OR METASTATIC, PROGRESSIVE, DIFFERENTIATED THYROID CARCINOMA REFRACTORY TO RADIOACTIVE IODINE TREATMENT.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NILOTINIB

Products Affected

- TASIGNA ORAL CAPSULE 150 MG, 200 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUSLY TREATED CML REQUIRES BCR-ABL MUTATIONAL ANALYSIS NEGATIVE FOR THE FOLLOWING MUTATIONS: T315I, Y253H, E255K/V, AND F359V/C/I.
Indications	All FDA-approved Indications.
Off Label Uses	

NINLARO (S)

Products Affected

- NINLARO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NIRAPARIB

Products Affected

- ZEJULA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

NITISINONE

Products Affected

- *nitisinone*
- NITYR
- ORFADIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF HEREDITARY TYROSINEMIA TYPE 1 AS CONFIRMED BY ELEVATED URINARY OR PLASMA SUCCINYLACETONE LEVELS OR A MUTATION IN THE FUMARYLACETOACETATE HYDROLASE GENE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PRESCRIBER SPECIALIZING IN INHERITED METABOLIC DISEASES.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	ORFADIN SUSPENSION: TRIAL OF ORFADIN CAPSULES. RENEWAL: THE PATIENT'S URINARY OR PLASMA SUCCINYLACETONE LEVELS HAVE DECREASED FROM BASELINE WHILE ON TREATMENT WITH NITISINONE.
Indications	All FDA-approved Indications.
Off Label Uses	

NIVOLUMAB

Products Affected

- OPDIVO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	MELANOMA: OPDIVO IS NOT APPROVED FOR COMBINATION THERAPY WITH TAFINLAR, MEKINIST (TRAMETINIB), COTELLIC (COBIMETINIB), OR ZELBORAF.
Indications	All FDA-approved Indications.
Off Label Uses	

NORTHERA (S)

Products Affected

- NORTHERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OBETICHOLIC ACID

Products Affected

- OCALIVA

PA Criteria	Criteria Details
Exclusion Criteria	PATIENTS WITH COMPLETE BILIARY OBSTRUCTION.
Required Medical Information	DIAGNOSIS OF PRIMARY BILIARY CHOLANGITIS AS CONFIRMED BY AT LEAST TWO OF THE FOLLOWING CRITERIA: AN ALKALINE PHOSPHATASE LEVEL OF AT LEAST 1.5 TIMES THE UPPER LIMIT OF NORMAL (ULN), THE PRESENCE OF ANTIMITOCHONDRIAL ANTIBODIES AT A TITER OF 1:40 OR HIGHER, HISTOLOGIC EVIDENCE OF NON-SUPPURATIVE DESTRUCTIVE CHOLANGITIS AND DESTRUCTION OF INTERLOBULAR BILE DUCTS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST OR HEPATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: USED IN COMBINATION WITH URSODEOXYCHOLIC ACID (E.G., URSODIOL, URSO 250, URSO FORTE) IN ADULTS WITH AN INADEQUATE RESPONSE TO URSODEOXYCHOLIC ACID AT A DOSAGE OF 13-15 MG/KG/DAY FOR AT LEAST 1 YEAR, OR AS MONOTHERAPY IN ADULTS UNABLE TO TOLERATE URSODEOXYCHOLIC ACID. RENEWAL: PATIENT'S ALKALINE PHOSPHATASE LEVELS ARE LESS THAN 1.67-TIMES THE UPPER LIMIT OF NORMAL OR HAVE DECREASED BY AT LEAST 15% FROM BASELINE WHILE ON TREATMENT WITH OBETICHOLIC ACID.
Indications	All FDA-approved Indications.
Off Label Uses	

OBINUTUZUMAB

Products Affected

- GAZYVA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OCRELIZUMAB

Products Affected

- OCREVUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RELAPSING FORM OF MULTIPLE SCLEROSIS: TRIAL OF TWO OF THE FOLLOWING AGENTS FOR MULTIPLE SCLEROSIS: AUBAGIO, AVONEX, GILENYA, PLEGRIDY, REBIF, TECFIDERA, OR GLATIRAMER. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

ODOMZO

Products Affected

- ODOMZO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BASELINE SERUM CREATINE KINASE (CK) AND SERUM CREATININE LEVELS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OFEV (S)

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	NOT APPROVED FOR PATIENTS WITH OTHER KNOWN CAUSES OF INTERSTITIAL LUNG DISEASE (E.G., CONNECTIVE TISSUE DISEASE, DRUG TOXICITY, ASBESTOS OR BERYLLIUM EXPOSURE, HYPERSENSITIVITY PNEUMONITIS, SYSTEMIC SCLEROSIS, RHEUMATOID ARTHRITIS, RADIATION, SARCOIDOSIS, BRONCHIOLITIS OBLITERANS ORGANIZING PNEUMONIA, HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION, VIRAL HEPATITIS, AND CANCER. NOT APPROVED IF PATIENT HAS NOT OBTAINED LIVER FUNCTION TESTS
Required Medical Information	A USUAL INTERSTITIAL PNEUMONIA (UIP) PATTERN AS EVIDENCED BY HIGH-RESOLUTION COMPUTED TOMOGRAPHY (HRCT) ALONE OR VIA A COMBINATION OF SURGICAL LUNG BIOPSY AND HRCT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PULMONOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OLAPARIB

Products Affected

- LYNPARZA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ONMEL (S)

Products Affected

- ONMEL

PA Criteria	Criteria Details
Exclusion Criteria	VENTRICULAR DYSFUNCTION. CONGESTIVE HEART FAILURE (CHF). HISTORY OF CHF. CONCURRENT THERAPY WITH CERTAIN DRUGS METABOLIZED BY CYP3A4 (E.G., CISAPRIDE, LOVASTATIN, METHADONE, ETC.)
Required Medical Information	DIAGNOSIS OF ONYCHOMYCOSIS CONFIRMED BY ONE OF THE FOLLOWING: POSITIVE POTASSIUM HYDROXIDE (KOH) PREPARATION, CULTURE, OR HISTOLOGY AND THE PATIENT HAS EXTENSIVE NAIL INVOLVEMENT CAUSING SIGNIFICANT PAIN AND/OR DEBILITATION AND PATIENT HAS TRIED AND FAILED OR HAD A CONTRAINDICATION OR INTOLERANCE TO ORAL TERBINAFINE.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	FINGERNAILS - 1 MONTH. TOENAILS OR BOTH - 3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ORENCIA (S)

Products Affected

- ORENCIA
- ORENCIA (WITH MALTOSE)
- ORENCIA CLICKJECT

PA Criteria	Criteria Details
Exclusion Criteria	ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS).
Required Medical Information	DIAGNOSIS OF ONE OF THE FOLLOWING: A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) FOR AT B) MODERATE TO SEVERE POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DMARDS AND PATIENT HAD AN INADEQUATE RESPONSE TO ONE OR MORE TUMOR NECROSIS FACTOR INHIBITORS C) PSORIATIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DMARDS.
Age Restrictions	2 YEARS OF AGE OR OLDER FOR JIA. 18 YEARS OF AGE OR OLDER FOR RHEUMATOID ARTHRITIS AND PSORIATIC ARTHRITIS
Prescriber Restrictions	
Coverage Duration	12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (E.G., FOR PJIA, REDUCTION IN DISEASE FLARES, IMPROVEMENT IN ACR SCORING. FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING.)
Indications	All FDA-approved Indications.
Off Label Uses	

ORENITRAM (S)

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Exclusion Criteria	SEVERE HEPATIC IMPAIRMENT (CHILD PUGH CLASS C)
Required Medical Information	DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS - INITIAL. 12 MONTHS - RENEWAL
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ORKAMBI (S)

Products Affected

- ORKAMBI ORAL GRANULES IN PACKET
- ORKAMBI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS. BASELINE FEV1
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PLUMONOLOGIST OR CF EXPERT
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: MAINTAINED OR IMPROVEMENT IN FEV1 OR BODY MASS INDEX (BMI) OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	

OSILODROSTAT

Products Affected

- ISTURISA ORAL TABLET 1 MG, 10 MG, 5 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OTEZLA (S)

Products Affected

- OTEZLA
- OTEZLA STARTER

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) PATIENT HAS A DIAGNOSIS OF PSORIATIC ARTHRITIS AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, CONTRAINDICATION, OR INTOLERANCE TO METHOTREXATE OR B) THE PATIENT HAS A DIAGNOSIS OF MODERATE TO SEVERE PLAQUE PSORIASIS OR C) THE PATIENT HAS ORAL ULCERS ASSOCIATED WITH BEHCET'S DISEASE
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR PSORIATIC ARTHRITIS RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED ON THERAPY, SUCH AS IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, OR STIFFNESS.
Indications	All FDA-approved Indications.
Off Label Uses	

OXYMETHOLONE

Products Affected

- ANADROL-50

PA Criteria	Criteria Details
Exclusion Criteria	CARCINOMA OF THE PROSTATE OR BREAST IN MALE PATIENTS, CARCINOMA OF THE BREAST IN FEMALES WITH HYPERCALCEMIA, WOMEN WHO ARE OR MAY BECOME PREGNANT, NEPHROSIS OR THE NEPHROTIC PHASE OF NEPHRITIS, HYPERSENSITIVITY TO THE DRUG AND SEVERE HEPATIC DYSFUNCTION.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

OZANIMOD

Products Affected

- ZEPOSIA
- ZEPOSIA STARTER KIT
- ZEPOSIA STARTER PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF ONE SPHINGOSINE-1-PHOSPHATE RECEPTOR MODULATOR (E.G. GILENYA, MAYZENT) AND ANY ONE AGENT INDICATED FOR THE TREATMENT OF MULTIPLE SCLEROSIS
Indications	All FDA-approved Indications.
Off Label Uses	

PATISIRAN

Products Affected

- ONPATTRO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF HEREDITARY TRANSTHYRETIN-MEDIATED AMYLOIDOSIS (HATTR) WITH POLYNEUROPATHY: PHYSICIAN ATTESTATION OF DIAGNOSIS OF HATTR AS CONFIRMED BY EITHER BIOPSY OF TISSUE/ORGAN TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TTR PROTEIN OR DNA GENETIC SEQUENCING TO CONFIRM HATTR MUTATION.
Age Restrictions	
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, CARDIOLOGIST, SPECIALIST AT A HATTR TREATMENT CENTER, OR MEDICAL GENETICIST.
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS STAGE 1 OR 2 POLYNEUROPATHY. RENEWAL: DIAGNOSIS OF HEREDITARY TTR AMYLOIDOSIS (HATTR) AND PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT PROGRESSED TO STAGE 3 POLYNEUROPATHY AS EVIDENCED BY FUNCTIONAL DECLINE (E.G., WHEELCHAIR-BOUND, BEDRIDDEN). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION

Products Affected

- ADCIRCA
- *alyq*
- REVATIO ORAL TABLET
- *sildenafil (pulm.hypertension) oral tablet*
- *tadalafil (pulm. hypertension)*

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT IS NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS.
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/IMPROVED WHO FUNCTIONAL CLASS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION - IV

Products Affected

- REVATIO INTRAVENOUS
- *sildenafil (pulm.hypertension) intravenous*

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT IS NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS.
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.
Off Label Uses	

PDE5 INHIBITORS FOR PULMONARY ARTERIAL HYPERTENSION - ORAL SUSPENSION

Products Affected

- REVATIO ORAL SUSPENSION FOR RECONSTITUTION
- *sildenafil (pulm.hypertension) oral suspension for reconstitution*

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT IS NOT CONCURRENTLY OR INTERMITTENTLY TAKING ORAL ERECTILE DYSFUNCTION AGENTS (E.G. CIALIS, VIAGRA), ANY ORGANIC NITRATES IN ANY FORM, OR GUANYLATE CYCLASE STIMULATORS.
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER. PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS. PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. PATIENT IS UNABLE TO SWALLOW TABLETS. RENEWAL: PATIENT SHOWS IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

PEGVALIASE-PQPZ

Products Affected

- PALYNZIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PEMIGATINIB

Products Affected

- PEMAZYRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PENICILLAMINE

Products Affected

- CUPRIMINE
- DEPEN TITRATABS
- *penicillamine*
- THIOLA EC

PA Criteria	Criteria Details
Exclusion Criteria	RHEUMATOID ARTHRITIS: HISTORY OR OTHER EVIDENCE OF RENAL INSUFFICIENCY
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	WILSON'S DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST. CYSTINURIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEPHROLOGIST. RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	WILSON'S DISEASE: CONFIRMED DIAGNOSIS OF WILSON'S DISEASE. CYSTINURIA: DIAGNOSIS REQUIRES THE PRESENCE OF NEPHROLITHIASIS AND 1 OR MORE OF THE FOLLOWING: STONE ANALYSIS SHOWING PRESENCE OF CYSTEINE, IDENTIFICATION OF PATHOGNOMONIC HEXAGONAL CYSTINE CRYSTALS ON URINALYSIS, POSITIVE FAMILY HISTORY OF CYSTINURIA WITH POSITIVE CYANIDE-NITROPRUSSIDE SCREEN. REQUESTS FOR CUPRIMINE FOR THE TREATMENT OF WILSON'S DISEASE, CYSTINURIA, AND RHEUMATOID ARTHRITIS REQUIRE A PREVIOUS TRIAL OF OR CONTRAINDICATION TO DEPEN.
Indications	All FDA-approved Indications.
Off Label Uses	

PERTUZUMAB

Products Affected

- PERJETA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 5 MONTHS RENEWAL: 12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PERTUZUMAB-TRASTUZUMAB-HY-ZZXF

Products Affected

- PHESGO SUBCUTANEOUS SOLUTION 1,200 MG-600MG- 30000 UNIT/15ML, 600 MG-600 MG- 20000 UNIT/10ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PEXIDARTINIB HYDROCHLORIDE

Products Affected

- TURALIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PIMAVANSERIN

Products Affected

- NUPLAZID ORAL TABLET 10 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, GERIATRICIAN, OR A BEHAVIORAL HEALTH SPECIALIST (SUCH AS A PSYCHIATRIST).
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RENEWAL REQUIRES THAT THE PATIENT HAS EXPERIENCED AN IMPROVEMENT IN PSYCHOSIS SYMPTOMS FROM BASELINE AND DEMONSTRATES A CONTINUED NEED FOR TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

PLEGRIDY (S)

Products Affected

- PLEGRIDY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS OR DIAGNOSIS OF FIRST CLINICAL EPISODE AND MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR RENEWAL, DISEASE HAS NOT PROGRESSED AND HAS RESPONDED TO THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

POLATUZUMAB VEDOTIN

Products Affected

- POLIVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

POMALYST (S)

Products Affected

- POMALYST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS A DIAGNOSIS OF MULTIPLE MYELOMA AND THE PATIENT HAS RECEIVED TWO PRIOR THERAPIES, INCLUDING REVLIMID AND VELCADE UNLESS THE PATIENT HAS A CONTRAINDICATION OR INTOLERANCE TO REVLIMID OR VELCADE AND THE PATIENT HAS DEMONSTRATED DISEASE PROGRESSION ON OR WITHIN 60 DAYS OF COMPLETION OF LAST THERAPY AND THE PRESCRIBER IS REGISTERED, AND PATIENT IS ENROLLED IN THE POMALYST REMS PROGRAM
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTH
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PONATINIB

Products Affected

- ICLUSIG ORAL TABLET 15 MG, 45 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PROGESTERONE GEL DVE

Products Affected

- CRINONE VAGINAL GEL 4 %

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG REQUIRES PAYMENT DETERMINATION.
Indications	All Medically-accepted Indications.
Off Label Uses	

PULMOZYME (S)

Products Affected

- PULMOZYME

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF CYSTIC FIBROSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR RENEWAL, PATIENT IS BENEFITING FROM TREATMENT (I.E. IMPROVEMENT IN LUNG FUNCTION [FEV1], DECREASED NUMBER OF PULMONARY EXACERBATIONS). PART D IF PATIENT IN LONG TERM CARE (DEFINED BY CUSTOMER LOCATION CODE ON CLAIM) OTHERWISE PART B.
Indications	All FDA-approved Indications.
Off Label Uses	

QUININE SULFATE (S)

Products Affected

- QUALAQUIN
- *quinine sulfate*

PA Criteria	Criteria Details
Exclusion Criteria	PROLONGATION OF QT INTERVAL. GLUCOSE-6-PHOSPHATE DEHYDROGENASE DEFICIENCY. MYASTHENIA GRAVIS. KNOWN HYPERSENSITIVITY TO MEFLOQUINE OR QUINIDINE. OPTIC NEURITIS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ONE MONTH
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RAVICTI (S)

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	ACUTE HYPERAMMONEMIA. N-ACETYLGLUTAMATE SYNTHASE (NAGS) DEFICIENCY
Required Medical Information	DIAGNOSIS OF UREA CYCLE DISORDER INVOLVING DEFICIENCIES OF CARBAMOYL PHOSPHATE SYNTHETASE (CPS), ORNITHINE TRANSCARBAMYLASE (OTC), OR ARGININOSUCCINIC ACID SYNTHETASE (AAS) CONFIRMED VIA ENZYMATIC, BIOCHEMICAL, OR GENETIC TESTING AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, IS INTOLERANT, OR HAS A CONTRAINDICATION TO BUPHENYL
Age Restrictions	2 MONTHS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RAVULIZUMAB-CWVZ

Products Affected

- ULTOMIRIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH): PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	PNH: INITIAL: THE PATIENT MEETS BOTH OF THE FOLLOWING A) CONFIRMATION OF PNH DIAGNOSIS AS DEMONSTRATED BY ALL OF THE FOLLOWING VIA FLOW CYTOMETRY: 1) AT LEAST TWO DIFFERENT GPI PROTEIN DEFICIENCIES ON AT LEAST TWO CELL LINEAGES AND 2) PNH GRANULOCYTE CLONE SIZE OF 10 PERCENT OR HIGHER. B) THE PATIENT MEETS ONE OF THE FOLLOWING: 1) THE PATIENT IS TRANSITIONING FROM AN ALTERNATIVE COMPLEMENT INHIBITOR THERAPY OR 2) THE PATIENT HAS EVIDENCE OF INTRAVASCULAR HEMOLYSIS OR HISTORY OF MAJOR ADVERSE VASCULAR EVENT FROM THROMBOEMBOLISM. RENEWAL: PHYSICIAN ATTESTATION OF CLINICAL BENEFIT COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

REBIF (S)

Products Affected

- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE
- REBIF TITRATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RELISTOR (S)

Products Affected

- RELISTOR SUBCUTANEOUS SOLUTION
- RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML, 8 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ADVANCED ILLNESS: CONSTIPATION DUE TO OPIOIDS, CHRONIC NON-CANCER PAIN: HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	6 MONTHS FOR PATIENTS RECEIVING PALLATIVE CARE 12 MONTHS FOR CHRONIC NON-CANCER PAIN
Other Criteria	ADVANCED ILLNESS (OR TERMINAL ILLNESS): PATIENT IS RECEIVING PALLIATIVE CARE. CHRONIC NON-CANCER PAIN: HAS BEEN TAKING OPIOIDS FOR AT LEAST 4 WEEKS
Indications	All FDA-approved Indications.
Off Label Uses	

REMICADE (S)

Products Affected

- REMICADE

PA Criteria	Criteria Details
Exclusion Criteria	ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS). MODERATE TO SEVERE HEART FAILURE IN PATIENTS RECEIVING DOSES GREATER THAN 5 MG/KG.

PA Criteria	Criteria Details
Required Medical Information	DIAGNOSIS OF ONE OF THE FOLLOWING: A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)FOR AT LEAST 3 CONSECUTIVE MONTHS AND PATIENT WILL BE ON CONCOMITANT METHOTREXATE B) ANKYLOSING SPONDYLITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NSAIDS C) SEVERE CHRONIC PLAQUE PSORIASIS (AFFECTING MORE THAN 10% OF BODY SURFACE AREA OR AFFECTING CRUCIAL BODY AREAS SUCH AS THE HANDS, FEET, FACE, OR GENITALS) AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO CONVENTIONAL THERAPY WITH AT LEAST ONE OF THE FOLLOWING: PHOTOTHERAPY (INCLUDING BUT NOT LIMITED TO ULTRAVIOLET A WITH A PSORALEN [PUVA] AND/OR RETINOIDS [REPUVA] FOR AT LEAST ONE CONTINUOUS MONTH OR ONE OR MORE ORAL SYSTEMIC TREATMENTS FOR AT LEAST 3 CONSECUTIVE MONTHS D) MODERATE TO SEVERE CROHN'S DISEASE AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO CONVENTIONAL THERAPY WITH TWO OR MORE OF THE FOLLOWING: CORTICOSTEROIDS OR NON-BIOLOGIC DMARDS E) FISTULIZING CROHN'S DISEASE F) MODERATE TO SEVERE ULCERATIVE COLITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO CONVENTIONAL THERAPY WITH TWO OR MORE OF THE FOLLOWING: CORTICOSTEROIDS, 5-ASA (I.E. MESALAMINE, SULFASALAZINE, BALSALAZIDE, OLSALAZINE) OR NON-BIOLOGIC DMARDS G) PSORIATIC ARTHRITIS AND
	PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO METHOTREXATE.

PA Criteria	Criteria Details
Age Restrictions	6 YEARS OF AGE OR OLDER FOR UC OR CROHN'S DISEASE (NON-FISTULIZING). 18 YEARS OF AGE OR OLDER FOR ALL OTHER INDICATIONS, INCLUDING FISTULIZING CROHN'S DISEASE
Prescriber Restrictions	
Coverage Duration	INITIAL: 18 WEEKS (CD), 12 MONTHS (OTHERS). RENEWAL 12 MONTHS
Other Criteria	PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR PSA, IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, STIFFNESS. FOR AS, IMPROVEMENT IN AS SYMPTOMS, SUCH AS STIFFNESS AND BACK PAIN. FOR CD, SYMPTOMATIC REMISSION. FOR UC, CLINICAL REMISSION, REDUCTION IN STEROID USE.)
Indications	All FDA-approved Indications.
Off Label Uses	

RESLIZUMAB

Products Affected

- CINQAIR

PA Criteria	Criteria Details
Exclusion Criteria	CONCURRENT USE OF XOLAIR
Required Medical Information	BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 400 CELLS/MCL WITHIN THE LAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY MEDICINE
Coverage Duration	INITIAL 24 WEEKS. RENEWAL 12 MONTHS
Other Criteria	INITIAL THERAPY: PATIENT CURRENTLY TREATED WITH A MAXIMALLY TOLERATED DOSE OF INHALED CORTICOSTEROIDS. RENEWAL REQUIRES DOCUMENTATION THAT THE PATIENT HAS EXPERIENCED AT LEAST A 25 PERCENT REDUCTION IN ASTHMA EXACERBATIONS (FOR EXAMPLE: HOSPITALIZATIONS, URGENT OR EMERGENT CARE VISITS, USE OF RESCUE MEDICATIONS, ETC.) FROM BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

REVLIMID (S)

Products Affected

- REVLIMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RIBOCICLIB

Products Affected

- KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG, 400 MG/DAY(200 MG X 2)-2.5 MG, 600 MG/DAY(200 MG X 3)-2.5 MG
- KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1), 400 MG/DAY (200 MG X 2), 600 MG/DAY (200 MG X 3)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RIPRETINIB

Products Affected

- QINLOCK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RISANKIZUMAB

Products Affected

- SKYRIZI SUBCUTANEOUS SYRINGE KIT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY, SUCH AS PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE
Indications	All FDA-approved Indications.
Off Label Uses	

RITUXAN-HYALURONIDASE

Products Affected

- RITUXAN HYCELA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THE PATIENT HAS RECEIVED OR WILL RECEIVE AT LEAST ONE FULL DOSE OF A RITUXIMAB PRODUCT BY INTRAVENOUS INFUSION PRIOR TO INITIATION OF RITUXIMAB AND HYALURONIDASE.
Indications	All FDA-approved Indications.
Off Label Uses	

RITUXIMAB

Products Affected

- RITUXAN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL FOR RA: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. NHL, CLL: ONCOLOGIST.
Coverage Duration	RA: INITIAL: 6 MO, RENEWAL: 12 MONTHS. NHL, PV: 12 MONTHS. CLL: 6 MO. WG, MPA: 3 MONTHS.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

RITUXIMAB-ABBS

Products Affected

- TRUXIMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NHL, CLL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	NHL: 12 MONTHS. CLL: 6 MONTHS.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

RITUXIMAB-PVVR

Products Affected

- RUXIENCE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NHL, CLL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ONCOLOGIST.
Coverage Duration	NHL: 12 MONTHS. CLL: 6 MONTHS. WG, MPA: 3 MONTHS.
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

ROMIPLOSTIM

Products Affected

- NPLATE SUBCUTANEOUS RECON SOLN 125 MCG, 250 MCG, 500 MCG

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: ADEQUATE RESPONSE TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR SPLENECTOMY. RENEWAL: NO CLINICAL RESPONSE AS DEFINED BY AN INCREASE IN PLATELET COUNT OF GREATER THAN OR EQUAL TO 50 X10^9/L AT THE MAX DOSE OF 10 MCG/KG PER DAY FOR 4 WEEKS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	INITL: 2 MO., RENEW: IF NO RESPONSE AFTER INITIAL APPROVAL: 1 MO. AT MAX DOSE. IF RESPONSE: 12 MO.
Other Criteria	INITIAL: TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS, IMMUNOGLOBULINS, OR AN INSUFFICIENT RESPONSE TO SPLENECTOMY. RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
Indications	All FDA-approved Indications.
Off Label Uses	

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RYDAPT

Products Affected

- RYDAPT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SAFINAMIDE

Products Affected

- XADAGO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SARILUMAB

Products Affected

- KEVZARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PREVIOUS TRIAL OF AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC) DRUG SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE OR SULFASALAZINE.
Indications	All FDA-approved Indications.
Off Label Uses	

SELINEXOR

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 40 MG/WEEK (20 MG X 2), 40MG TWICE WEEK (80 MG/WEEK), 60 MG/WEEK (20 MG X 3), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (20 MG X 4), 80MG TWICE WEEK (160 MG/WEEK)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SELPERCATINIB

Products Affected

- RETEVMO ORAL CAPSULE 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SELUMETINIB

Products Affected

- KOSELUGO ORAL CAPSULE 10 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SIMPONI (S)

Products Affected

- SIMPONI

PA Criteria	Criteria Details
Exclusion Criteria	ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)
Required Medical Information	DIAGNOSIS OF ONE OF THE FOLLOWING: A) MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS) AND PATIENT WILL BE ON CONCOMITANT METHOTREXATE B) PSORIATIC ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO METHOTREXATE C) ANKYLOSING SPONDYLITIS AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE OR CONTRAINDICATION TO ONE OR MORE NSAIDS D) MODERATELY TO SEVERELY ACTIVE ULCERATIVE COLITIS AND PATIENT HAS HAD INADEQUATE RESPONSES TO, IS INTOLERANT TO, OR IS CONTRAINDICATED TO CONVENTIONAL THERAPY WITH TWO OR MORE OF THE FOLLOWING: CORTICOSTEROIDS (I.E. PREDNISONE, METHYLPREDNISOLONE), 5-ASAS (I.E. MESALAMINE, SULFASALAZINE, BALSALAZIDE, OLSALAZINE), OR NON-BIOLOGIC DMARDS (I.E. AZATHIOPRINE, METHOTREXATE, MERCAPTOPURINE)
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	RA /PSA/AS: 4 MONTHS. UC: 12 MONTHS RENEWAL: 12 MONTHS FOR ALL DIAGNOSES.

PA Criteria	Criteria Details
Other Criteria	PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (E.G., FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING. FOR PSA, IMPROVEMENT IN NUMBER OF SWOLLEN/TENDER JOINTS, PAIN, STIFFNESS. FOR AS, IMPROVEMENT IN AS SYMPTOMS, SUCH AS STIFFNESS AND BACK PAIN. FOR UC, CLINICAL REMISSION, REDUCTION IN STEROID USE.)
Indications	All FDA-approved Indications.
Off Label Uses	

SIMPONI ARIA (S)

Products Affected

- SIMPONI ARIA

PA Criteria	Criteria Details
Exclusion Criteria	ACTIVE SERIOUS INFECTION (INCLUDING TUBERCULOSIS)
Required Medical Information	DIAGNOSIS OF MODERATE TO SEVERE RHEUMATOID ARTHRITIS AND PATIENT HAD AN INADEQUATE RESPONSE TO, INTOLERANCE TO, OR CONTRAINDICATION TO ONE OR MORE NON-BIOLOGIC DISEASE MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)FOR AT LEAST 3 CONSECUTIVE MONTHS AND PATIENT WILL BE ON CONCOMITANT METHOTREXATE
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	PATIENT HAS BEEN TESTED FOR TB AND LATENT TB HAS BEEN RULED OUT OR IS BEING TREATED. FOR RENEWAL, PATIENT HAS STABLE DISEASE OR HAS IMPROVED WHILE ON THERAPY (E.G., FOR RA, IMPROVEMENT IN TENDER/SWOLLEN JOINT COUNT, IMPROVEMENT IN ACR SCORING.)
Indications	All FDA-approved Indications.
Off Label Uses	

SIMVASTATIN (S)

Products Affected

- VYTORIN 10-80
- ZOCOR ORAL TABLET 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	ACTIVE LIVER DISEASE. PREGNANCY. NURSING. PATIENT IS TAKING OR INITIATING THERAPY WITH ANY OF THE FOLLOWING: STRONG CYP3A4 INHIBITORS (I.E., ITRACONAZOLE, KETOCONAZOLE, POSACONAZOLE, PROTEASE INHIBITORS, ERYTHROMYCIN, CLARITHROMYCIN, TELITHROMYCIN, AND NEFAZODONE), GEMFIBROZIL, CYCLOSPORINE, AND DANAZOL.
Required Medical Information	PATIENT HAS BEEN TAKING SIMVASTATIN 80 MG CHRONICALLY (12 MONTHS OR MORE) WITHOUT EVIDENCE OF MUSCLE TOXICITY AND, IF PATIENT IS OF CHINESE DESCENT, THEY ARE NOT CONCURRENTLY RECEIVING LIPID-MODIFYING DOSES (AT LEAST 1 GRAM/DAY) OF NIACIN-CONTAINING PRODUCTS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SIPONIMOD

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 2 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO PRE TREATMENT BASELINE AND THE PATIENT DOES NOT HAVE LYMPHOPENIA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SODIUM OXYBATE

Products Affected

- XYREM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH ONE OF THE FOLLOWING SPECIALISTS: NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE
Coverage Duration	INITIAL 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: ALL INDICATIONS: THIS MEDICATION WILL NOT BE APPROVED FOR PATIENTS CURRENTLY BEING TREATED WITH SEDATIVE HYPNOTIC AGENTS. EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: THE PATIENT HAS TRIED THE FORMULARY VERSION OF MODAFINIL OR ARMODAFINIL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY. RENEWAL: PHYSICIAN ATTESTATION OF SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION.
Indications	All FDA-approved Indications.
Off Label Uses	

SOLRIAMFETOL

Products Affected

- SUNOSI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: THE PATIENT HAS TRIED THE FORMULARY VERSION OF MODAFINIL OR ARMODAFINIL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY. OBSTRUCTIVE SLEEP APNEA (OSA): THE PATIENT HAS TRIED THE FORMULARY VERSION OF MODAFINIL OR ARMODAFINIL. RENEWAL: SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

SOMATROPIN - GROWTH HORMONE

Products Affected

- HUMATROPE
- OMNITROPE
- SAIZEN
- SAIZEN SAIZENPREP
- ZOMACTON

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), AND SHOX DEFICIENCY.
Required Medical Information	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, AND SHOX DEFICIENCY: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	INITIAL AND RENEWAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. RENEWAL FOR PEDIATRIC GHD, ISS, SGA, TS, AND SHOX DEFICIENCY: IMPROVEMENT (I.E, INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). PWS: IMPROVEMENT IN BODY COMPOSITION.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

SOMATROPIN - SEROSTIM

Products Affected

- SEROSTIM SUBCUTANEOUS
  RECON SOLN 4 MG, 5 MG, 6 MG

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	INITIAL: HIV/WASTING: MEETS ONE OF THE FOLLOWING CRITERIA FOR WEIGHT LOSS: 10% UNINTENTIONAL WEIGHT LOSS OVER 12 MONTHS, OR 7.5% OVER 6 MONTHS, OR 5% BODY CELL MASS (BCM) LOSS WITHIN 6 MONTHS, OR A BCM LESS THAN 35% (MEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BCM LESS THAN 23% (WOMEN) OF TOTAL BODY WEIGHT AND A BODY MASS INDEX (BMI) LESS THAN 27 KG PER METER SQUARED, OR BMI LESS THAN 18.5 KG PER METER SQUARED.
Age Restrictions	
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST, NUTRITIONAL SUPPORT SPECIALIST, OR INFECTIOUS DISEASE SPECIALIST.
Coverage Duration	3 MONTHS
Other Criteria	INITIAL: HIV/WASTING: PATIENT HAS HAD INADEQUATE RESPONSE TO PREVIOUS THERAPY. RENEWAL: HIV/WASTING: PATIENT HAS SHOWN CLINICAL BENEFIT IN MUSCLE MASS AND WEIGHT. INITIAL AND RENEWAL: HIV/WASTING: CURRENTLY ON HIV ANTIRETROVIRAL THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

SOMATROPIN - ZORBTIVE

Products Affected

- ZORBTIVE

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST
Coverage Duration	SHORT BOWEL: 4 WEEKS ONCE.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SOMATROPIN-NORDITROPIN AND GENOTROPIN

Products Affected

- GENOTROPIN
- GENOTROPIN MINIQUICK
- NORDITROPIN FLEXPRO

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), SMALL FOR GESTATIONAL AGE (SGA), TURNER SYNDROME (TS), AND NOONAN SYNDROME.
Required Medical Information	INITIAL: PEDIATRIC GHD, ISS, SGA, TS, AND NOONAN SYNDROME: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. PRADER WILLI SYNDROME (PWS): CONFIRMED GENETIC DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	INITIAL AND RENEWAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. RENEWAL: PEDIATRIC GHD, ISS, SGA, TS, AND NOONAN SYNDROME: IMPROVEMENT (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). PWS: IMPROVEMENT IN BODY COMPOSITION.

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

SOMATROPIN-NUTROPIN AND NUTROPIN AQ

Products Affected

- NUTROPIN AQ NUSPIN

PA Criteria	Criteria Details
Exclusion Criteria	ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES. GROWTH FAILURE DUE TO CKD IF PATIENT HAS HAD A RENAL TRANSPLANT, OR GROWTH FAILURE WITH CLOSED EPIPHYSES FOR PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD), IDIOPATHIC SHORT STATURE (ISS), AND TURNER SYNDROME (TS).
Required Medical Information	INITIAL FOR PEDIATRIC GHD, ISS, AND TS: HEIGHT AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER. INITIAL FOR CKD: HEIGHT OR GROWTH VELOCITY AT LEAST 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER.
Age Restrictions	
Prescriber Restrictions	INITIAL AND RENEWAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST. FOR GROWTH HORMONE FAILURE DUE TO CKD: NEPHROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: ADULT GHD: GROWTH HORMONE DEFICIENCY ALONE OR ASSOCIATED WITH MULTIPLE HORMONE DEFICIENCIES (HYPOPITUITARISM), AS A RESULT OF PITUITARY DISEASES, HYPOTHALAMIC DISEASE, SURGERY, RADIATION THERAPY, TRAUMA, OR CONTINUATION OF THERAPY FROM CHILDHOOD ONSET GROWTH HORMONE DEFICIENCY. RENEWAL FOR ALL INDICATIONS EXCEPT ADULT GHD: IMPROVEMENT (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY).

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

SOVALDI (S)

Products Affected

- SOVALDI ORAL PELLETS IN PACKET 150 MG, 200 MG
- SOVALDI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT WITH END STAGE RENAL DISEASE OR REQUIRES DIALYSIS.
Required Medical Information	
Age Restrictions	12 YEARS OF AGE AND OLDER
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATIONS WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL
Coverage Duration	DURATION PER GENOTYPE DIAGNOSIS. SEE OTHER CRITERIA FIELD FOR MORE INFORMATION
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD-IDSA GUIDANCE.
Indications	All FDA-approved Indications.
Off Label Uses	

STIVARGA (S)

Products Affected

- STIVARGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF: A) METASTATIC COLON OR RECTAL CANCER AND PATIENT HAS PREVIOUSLY TREATED WITH FLUOROPYRIMIDINE-, OXALIPLATIN-, AND IRINOTECAN-BASED THERAPY, AN ANTI-VASCULAR ENDOTHELIAL GROWTH FACTOR (VEGF) THERAPY, AND, IF KRAS WILD TYPE, AN ANTI-EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) THERAPY OR B) GASTROINTESTINAL STROMAL TUMORS THAT IS LOCALLY ADVANCED, UNRESECTABLE OR METASTATIC AND PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, CONTRAINDICATION OR INTOLERANCE TO GLEEVEC OR SUTENT C) HEPATOCELLULAR CARCINOMA (HCC) WHO HAVE BEEN PREVIOUSLY TREATED WITH SORAFENIB.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	IF PATIENT HAS ELEVATED LIVER FUNCTION TESTS OF HEPATOCELLULAR NECROSIS, THERAPY WILL BE INTERRUPTED AND THEN REDUCED OR DISCONTINUED.
Indications	All FDA-approved Indications.
Off Label Uses	

STRENSIQ

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

SUNITINIB MALATE

Products Affected

- SUTENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	GASTROINTESTINAL STROMAL TUMORS (GIST): TRIAL OF OR CONTRAINDICATION TO GLEEVEC.
Indications	All FDA-approved Indications.
Off Label Uses	

SYLATRON (S)

Products Affected

- SYLATRON SUBCUTANEOUS KIT
  200 MCG, 300 MCG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	CRITERIA APPLIES TO NEW STARTS ONLY. DURATION LIMITATION OF 5 YEARS OF THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

SYLVANT (S)

Products Affected

- SYLVANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	PATIENT HAS A DIAGNOSIS OF MULTICENTRIC CASTLEMAN'S DISEASE AND PATIENT IS HIV NEGATIVE AND PATIENT IS HUMAN HERPES VIRUS-8 (HHV-8) NEGATIVE
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR RENEWAL, PATIENT HAS NOT EXPERIENCED TREATMENT FAILURE DEFINED AS DISEASE PROGRESSION BASED ON INCREASE IN SYMPTOMS, RADIOLOGIC PROGRESSION, OR DETERIORATION IN PERFORMANCE STATUS
Indications	All FDA-approved Indications.
Off Label Uses	

SYMLIN (S)

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Exclusion Criteria	CONFIRMED DIAGNOSIS OF GASTROPARESIS. CONCURRENT USE OF DRUGS THAT STIMULATE GASTROINTESTINAL MOTILITY. RECURRENT SEVERE HYPOGLYCEMIA REQUIRING ASSISTANCE DURING THE PAST 6 MONTHS. PRESENCE OF HYPOGLYCEMIA UNAWARENESS. POOR COMPLIANCE WITH CURRENT INSULIN REGIMEN. POOR COMPLIANCE WITH PRESCRIBED SELF-BLOOD GLUCOSE MONITORING. HEMOGLOBIN A1C LEVEL HIGHER THAN 9%.
Required Medical Information	DIAGNOSIS OF TYPE 1 OR TYPE 2 DIABETES MELLITUS AND PATIENT HAS FAILED TO ACHIEVE DESIRED GLUCOSE CONTROL DESPITE OPTIMAL INSULIN THERAPY AND PATIENT IS TAKING CONCURRENT MEALTIME INSULIN THERAPY (E.G., HUMULIN, HUMALOG, NOVOLIN, NOVOLOG)
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR RENEWAL, PATIENT HAS AN IMPROVEMENT IN HEMOGLOBIN A1C FROM BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

SYNAGIS (S)

Products Affected

- SYNAGIS

PA Criteria	Criteria Details
Exclusion Criteria	

PA Criteria	Criteria Details
Required Medical Information	PATIENT WILL USE PALIVIZUMAB FOR IMMUNOPROPHYLAXIS OF RESPIRATORY SYNCYTIAL VIRUS (RSV) DURING THE PEAK MONTHS OF INFECTION IN THE PATIENT'S GEOGRAPHIC REGION AND PATIENT MEETS ONE OF THE FOLLOWING CRITERIA: A) INFANTS BORN AT 28 WEEKS, SIX DAYS GESTATION OR EARLIER AND WHO ARE YOUNGER THAN 12 MONTHS OF AGE AT THE START OF THE RSV SEASON OR B) INFANTS BORN AT 29 TO 31 WEEKS, SIX DAYS GESTATION AND WHO ARE YOUNGER THAN SIX MONTHS OF AGE AT THE START OF THE RSV SEASON OR C) INFANTS BORN AT 32 TO 34 WEEKS, SIX DAYS GESTATION AND WHO ARE YOUNGER THAN THREE MONTHS OF AGE AT THE START OF RSV SEASON WITH AT LEAST ONE OF THE FOLLOWING RISK FACTORS MAY BE DOSED UNTIL 90 DAYS OF AGE: CHILD CARE ATTENDANCE OR SIBLING YOUNGER THAN FIVE YEARS OF AGE LIVING IN THE SAME HOUSEHOLD (WHO IS NOT A MULTIPLE BIRTH YOUNGER THAN ONE YEAR OF AGE) OR D) INFANTS AND CHILDREN YOUNGER THAN ONE YEAR OF AGE AT THE START OF RSV SEASON WITH EITHER CONGENITAL ABNORMALITIES OF THE AIRWAY OR NEUROMUSCULAR DISEASE THAT COMPROMISES HANDLING OF RESPIRATORY SECRETIONS OR E) INFANTS AND CHILDREN YOUNGER THAN TWO YEARS OF AGE WITH HEMODYNAMICALLY SIGNIFICANT CONGENITAL HEART DISEASE AND WHO HAVE AT LEAST ONE OF THE FOLLOWING CRITERIA: RECEIVING MEDICATION TO CONTROL CONGESTIVE HEART FAILURE, HAS MODERATE TO SEVERE PULMONARY HYPERTENSION, OR HAS CYANOTIC HEART DISEASE OR F) INFANTS AND CHILDREN YOUNGER THAN TWO YEARS OF AGE WHO HAVE RECEIVED MEDICAL THERAPY (OXYGEN, BRONCHODILATOR, DIURETIC, OR CORTICOSTEROID THERAPY) FOR
	CHRONIC LUNG DISEASE WITHIN SIX MONTHS OF THE START OF THE RSV SEASON
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	12 MONTHS
Other Criteria	APPROVE 5 DOSES BASED ON PATIENT BODY WEIGHT.
Indications	All FDA-approved Indications.
Off Label Uses	

SYNRIBO (S)

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF CHRONIC MYELOGENOUS LEUKEMIA AND PATIENT HAS TRIED AND FAILED OR HAS A CONTRAINDICATION OR INTOLERANCE TO 2 TYROSINE KINASE INHIBITORS
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TAFAMIDIS MEGLUMINE

Products Affected

- VYNDAMAX
- VYNDAQEL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT PROGRESSED TO NYHA CLASS IV HEART FAILURE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A CARDIOLOGIST, ATTR SPECIALIST, OR MEDICAL GENETICIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PATIENT HAS NEW YORK HEART ASSOCIATION (NYHA) CLASS I, II, OR III HEART FAILURE. DIAGNOSIS CONFIRMED BY ONE OF THE FOLLOWING: 1) BONE SCAN (SCINTIGRAPHY) STRONGLY POSITIVE FOR MYOCARDIAL UPTAKE OF 99MTCPYP/DPD, OR 2) BIOPSY OF TISSUE OF AFFECTED ORGAN(S) (CARDIAC AND POSSIBLY NON-CARDIAC SITES) TO CONFIRM AMYLOID PRESENCE AND CHEMICAL TYPING TO CONFIRM PRESENCE OF TRANSTHYRETIN (TTR) PROTEIN.
Indications	All FDA-approved Indications.
Off Label Uses	

TAFASITAMAB-CXIX

Products Affected

- MONJUVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TAFINLAR (S)

Products Affected

- TAFINLAR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF UNRESECTABLE OR METASTATIC MELANOMA AND MEDICATION WILL BE USED AS A 1)SINGLE AGENT IN A PATIENT WITH A POSITIVE BRAF V600E MUTATION AS DETECTED BY AN FDA-APPROVED TEST (THXID-BRAF KIT) OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)-APPROVED FACILITY OR 2)MEDICATION WILL BE USED IN COMBINATION WITH TRAMETINIB (MEKINIST) IN A PATIENT WITH BRAF V600E OR V600K MUTATION, AS DETECTED BY AN FDA-APPROVED TEST (THXID-BRAF KIT) OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)-APPROVED FACILITY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TAGRISSO (S)

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITOR
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TALAZOPARIB

Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 1 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TARCEVA (S)

Products Affected

- *erlotinib oral tablet 100 mg, 150 mg, 25 mg*
- TARCEVA ORAL TABLET 100 MG, 150 MG, 25 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF LOCALLY ADVANCED, UNRESECTABLE, OR METASTATIC PANCREATIC CANCER AND TARCEVA WILL BE USED IN COMBINATION WITH GEMCITABINE OR DIAGNOSIS OF LOCALLY ADVANCED OR METASTATIC (STAGE III OR IV) NON-SMALL CELL LUNG CANCER WITH ONE OF THE FOLLOWING: A) FAILURE WITH AT LEAST ONE PRIOR CHEMOTHERAPY REGIMEN AND TARCEVA WILL BE USED AS MONOTHERAPY, OR B) NO EVIDENCE OF DISEASE PROGRESSION AFTER FOUR CYCLES OF FIRST-LINE PLATINUM-BASED CHEMOTHERAPY AND TARCEVA WILL BE USED AS MAINTENANCE TREATMENT AND TARCEVA WILL BE USED AS MONOTHERAPY, OR C) PATIENT HAS KNOWN ACTIVE EPIDERMAL GROWTH FACTOR RECEPTOR (EGFR) EXON 19 DELETIONS OR EXON 21 (L858R) SUBSTITUTION MUTATION AS DETECTED BY AN FDA-APPROVED TEST OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS-APPROVED FACILITY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TARGRETIN (S)

Products Affected

- *bexarotene*
- TARGRETIN ORAL
- TARGRETIN TOPICAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF CUTANEOUS T-CELL LYMPHOMA (CTCL) AND PATIENT IS NOT A CANDIDATE FOR OR HAD AN INADEQUATE RESPONSE, IS INTOLERANT TO, OR HAS A CONTRAINDICATION TO AT LEAST ONE PRIOR SYSTEMIC THERAPY (E.G., CORTICOSTEROIDS) FOR CUTANEOUS MANIFESTATIONS OF CTCL
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FEMALE PATIENTS OF CHILD-BEARING POTENTIAL HAVE A DOCUMENTED NEGATIVE PREGNANCY TEST ONE WEEK PRIOR TO THE INITIATION OF THERAPY. FOR RENEWAL, PATIENT HAS NOT HAD DISEASE PROGRESSION WHILE ON THERAPY AND FEMALE PATIENTS OF CHILD-BEARING POTENTIAL ARE NOT PREGNANT AND ARE CONTINUING TO USE ADEQUATE BIRTH-CONTROL MEASURES DURING THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

TAZEMETOSTAT

Products Affected

- TAZVERIK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TECENTRIQ

Products Affected

- TECENTRIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TECFIDERA (S)

Products Affected

- TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG, 120 MG (14)- 240 MG (46), 240 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF RELAPSING FORMS OF MULTIPLE SCLEROSIS (RELAPSING-REMITTING MS OR PROGRESSIVE-RELAPSING MS, OR SECONDARY-PROGRESSIVE MS) OR PATIENT HAS EXPERIENCED A FIRST CLINICAL EPISODE AND HAS MRI FEATURES CONSISTENT WITH MULTIPLE SCLEROSIS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR RENEWAL, PATIENT HAD AN OBJECTIVE RESPONSE TO THERAPY (IE NO OR SLOWED PROGRESSION OF DISEASE)
Indications	All FDA-approved Indications.
Off Label Uses	

TELOTRISTAT

Products Affected

- XERMELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TERIPARATIDE

Products Affected

- *teriparatide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ONE OF THE FOLLOWING: (1) HIGH RISK FOR FRACTURES DEFINED AS ONE OF THE FOLLOWING: A) HISTORY OF OSTEOPOROTIC (I.E., FRAGILITY, LOW TRAUMA) FRACTURE(S). B) 2 OR MORE RISK FACTORS FOR FRACTURE (E.G., HISTORY OF MULTIPLE RECENT LOW TRAUMA FRACTURES, BMD T-SCORE LESS THAN OR EQUAL TO -2.5, CORTICOSTEROID USE, OR USE OF GNRH ANALOGS SUCH AS NAFARELIN, ETC.). C) NO PRIOR TREATMENT FOR OSTEOPOROSIS AND FRAX SCORE OF AT LEAST 20% FOR ANY MAJOR FRACTURE OR OF AT LEAST 3% FOR HIP FRACTURE. (2) UNABLE TO USE ORAL THERAPY (I.E., UPPER GASTROINTESTINAL PROBLEMS UNABLE TO TOLERATE ORAL MEDICATION, LOWER GASTROINTESTINAL PROBLEMS UNABLE TO ABSORB ORAL MEDICATIONS, TROUBLE REMEMBERING TO TAKE ORAL MEDICATIONS OR COORDINATING AN ORAL BISPHOSPHONATE WITH OTHER ORAL MEDICATIONS OR THEIR DAILY ROUTINE). (3) ADEQUATE TRIAL OF, INTOLERANCE TO, OR A CONTRAINDICATION TO BISPHOSPHONATES (E.G., ALENDRONATE, RISEDRONATE, IBANDRONATE).
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off Label Uses	

TESAMORELIN ACETATE

Products Affected

- EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG
- EGRIFTA SV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TESTOSTERONE

Products Affected

- AVEED
- NATESTO
- *testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)*
- *testosterone enanthate*
- XYOSTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LAB CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 300 NG/DL OR 2) A LOW TOTAL SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB RESULT WITH A REFERENCE RANGE OBTAINED WITHIN 90 DAYS, OR 3) A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 PG/ML. B) DIAGNOSIS OF BREAST CANCER IN FEMALE PATIENTS C) DIAGNOSIS OF DELAYED PUBERTY NOT SECONDARY TO A PATHOLOGICAL DISORDER IN MALE PATIENTS
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME OF MEMBERSHIP IN PLAN
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TESTOSTERONE (S)

Products Affected

- ANDRODERM
- ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)
- ANDROGEL TRANSDERMAL GEL IN PACKET 1 % (25 MG/2.5GRAM), 1 % (50 MG/5 GRAM), 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM)
- STRIANT
- TESTIM
- *testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 12.5 mg/ 1.25 gram (1 %), 20.25 mg/1.25 gram (1.62 %)*
- *testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram), 1.62 % (20.25 mg/1.25 gram), 1.62 % (40.5 mg/2.5 gram)*
- *testosterone transdermal solution in metered pump w/app*
- VOGELXO TRANSDERMAL GEL
- VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM CONFIRMED BY EITHER: 1) LAB CONFIRMED TOTAL SERUM TESTOSTERONE LEVEL OF LESS THAN 300NG/DL OR 2) A LOW TOTAL SERUM TESTOSTERONE LEVEL AS INDICATED BY A LAB RESULT WITH A REFERENCE RANGE OBTAINED WITHIN 90 DAYS, OR 3) A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 50 NG/L.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TEZACAFTOR IVACAFTOR

Products Affected

- SYMDEKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

THALOMID (S)

Products Affected

- THALOMID

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF MULTIPLE MYELOMA THAT IS NEWLY DIAGNOSED AND IS RECEIVING CONCURRENT DEXAMETHASONE OR DIAGNOSIS OF MODERATE TO SEVERE ERYTHEMA NODOSUM LEPROSUM WITH CUTANEOUS MANIFESTATIONS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBER IS REGISTERED AND THE MEMBER IS ENROLLED IN THE THALOMID REMS PROGRAM
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TILDRAKIZUMAB

Products Affected

- ILUMYA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TOFACITINIB

Products Affected

- XELJANZ
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	INITIAL: RA: 6 MOS. PSA: 4 MOS. UC. 6 MO RENEWAL (ALL INDICATIONS): 12 MOS.
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA) AND PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE.
Indications	All FDA-approved Indications.
Off Label Uses	

TOLVAPTAN

Products Affected

- JYNARQUE ORAL TABLET
- JYNARQUE ORAL TABLETS, SEQUENTIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TOPICAL RETINOIDS (S)

Products Affected

- ATRALIN
- *avita*
- RETIN-A
- RETIN-A MICRO
- RETIN-A MICRO PUMP TOPICAL GEL WITH PUMP 0.06 %, 0.08 %
- *tretinoin*
- *tretinoin microspheres topical gel*

PA Criteria	Criteria Details
Exclusion Criteria	WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	PA APPLIES TO PATIENTS OLDER THAN 26 YEARS OF AGE
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TOPICAL TRETINOIN LOTION

Products Affected

- ALTRENO

PA Criteria	Criteria Details
Exclusion Criteria	WRINKLES, PHOTOAGING, MELASMA.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO ANOTHER FORMULARY VERSION OF TOPICAL TRETINOIN
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB - DKST

Products Affected

- OGIVRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB-ANNS

Products Affected

- KANJINTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB-DTTB

Products Affected

- ONTRUZANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB-PKRB

Products Affected

- HERZUMA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TRASTUZUMAB-QYYP

Products Affected

- TRAZIMERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

TREPROSTINIL INHALED

Products Affected

- TYVASO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS III-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	THIS DRUG MAYBE 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. NEBULIZER THERAPY IS COVERED UNDER PART B FOR PATIENTS WHO ARE USING THE MEDICATION VIA A NEBULIZER IN THEIR OWN HOME. THOSE WHO ARE NOT USING IT IN THEIR HOME WILL BE COVERED UNDER PART D. INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

TREPROSTINIL IV SC

Products Affected

- REMODULIN
- *treprostinil sodium*

PA Criteria	Criteria Details
Exclusion Criteria	COVERED UNDER LOCAL COVERAGE POLICY OF APPLICABLE MEDICARE DMERC.
Required Medical Information	FORMULARY DRUG ADMINISTERED IN A LONG TERM CARE FACILITY TO A PATIENT WHOSE PART A COVERAGE HAS EXPIRED OR FORMULARY DRUG NOT ADMINISTERED VIA AN IMPLANTABLE PUMP OR AN EXTERNAL PUMP OR DRUG ADMINISTERED VIA AN IMPLANTABLE PUMP/AN EXTERNAL PUMP. DOCUMENTED CONFIRMATORY PULMONARY ARTERIAL HYPERTENSION (PAH) DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: MEAN PULMONARY ARTERY PRESSURE (PAP) OF AT LEAST 25 MMHG OR GREATER, PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS, PULMONARY VASCULAR RESISTANCE (PVR) GREATER THAN 3 WOOD UNITS. CONTINUATION OF CURRENT REMODULIN THERAPY: PATIENT MUST HAVE NYHA/WHO FC II-IV SYMPTOMS. NEW REQUESTS FOR REMODULIN THERAPY: PATIENT MUST HAVE NYHA/WHO FC III-IV SYMPTOMS. NEW REQUESTS FOR REMODULIN THERAPY FOR PATIENTS WITH NYHA/WHO FC II SYMPTOMS REQUIRES A TRIAL OF OR CONTRAINDICATION TO A PHOSPHODIESTERASE-5 INHIBITOR (PDE-5) (E.G., REVATIO, ADCIRCA) OR AN ENDOTHELIN RECEPTOR ANTAGONIST (ERA) (E.G., LETAIRIS, OPSUMIT, TRACLEER). RENEWAL: PATIENT SHOW IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE OR PATIENT HAS A STABLE 6-MINUTE WALK DISTANCE WITH A STABLE/ IMPROVED WHO FUNCTIONAL CLASS.
Indications	All FDA-approved Indications.
Off Label Uses	

TRIENTINE

Products Affected

- *clovique*
- SYPRINE
- *trientine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	KNOWN FAMILY HISTORY OF WILSON'S DISEASE OR PHYSICAL EXAMINATION CONSISTENT WITH WILSON'S DISEASE. PLASMA COPPER-PROTEIN CERULOPLASMIN LESS THAN 20 MG/DL. LIVER BIOPSY POSITIVE FOR AN ABNORMALLY HIGH CONCENTRATION OF COPPER (GREATER THAN 250 MCG/G DRY WEIGHT) OR THE PRESENCE OF KAYSER-FLEISCHER RINGS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEPATOLOGIST OR GASTROENTEROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO PENICILLAMINE (DEPEN).
Indications	All FDA-approved Indications.
Off Label Uses	

TUCATINIB

Products Affected

- TUKYSA ORAL TABLET 150 MG, 50 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

TYSABRI (S)

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Exclusion Criteria	HISTORY OF PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY.
Required Medical Information	DIAGNOSIS OF RELAPSING FORM OF MULTIPLE SCLEROSIS AND MEDICATION WILL BE USED AS MONOTHERAPY AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO ONE OF THE FOLLOWING: AN INTERFERON BETA PRODUCT, COPAXONE, GILENYA, AUBAGIO, OR TECFIDERA OR DIAGNOSIS OF MODERATE TO SEVERE ACTIVE CROHN'S DISEASE AND MEDICATION WILL NOT BE USED IN COMBINATION WITH IMMUNOSUPPRESSANTS OR INHIBITORS OF TUMOR NECROSIS FACTOR-ALFA AND PATIENT HAD AN INADEQUATE RESPONSE, INTOLERANCE, OR CONTRAINDICATION TO ANY OF THE FOLLOWING: HUMIRA, REMICADE, OR CIMZIA.
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT AND PHYSICIAN ARE REGISTERED IN THE TOUCH PRESCRIBING PROGRAM.
Indications	All FDA-approved Indications.
Off Label Uses	

UNITUXIN (S)

Products Affected

- UNITUXIN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	17 YEARS OF AGE OR YOUNGER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS RECEIVED AN AUTOLOGOUS STEM CELL TRANSPLANT. MUST BE USED IN COMBINATION WITH ISOTRETINOIN, LEUKINE, OR PROLEUKIN. PATIENT HAS ACHIEVED A PARTIAL RESPONSE TO CHEMOTHERAPY GIVEN PRIOR TO AUTOLOGOUS STEM CELL TRANSPLANT. PATIENT HAS NOT PREVIOUSLY UNDERGONE 5 CYCLES OF DINUTUXIMAB
Indications	All FDA-approved Indications.
Off Label Uses	

UPADACITINIB

Products Affected

- RINVOQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RHEUMATOID ARTHRITIS (RA): INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) SUCH AS METHOTREXATE, LEFLUNOMIDE, HYDROXYCHLOROQUINE, OR SULFASALAZINE. RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

UPTRAVI

Products Affected

- UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 200 MCG, 400 MCG, 600 MCG, 800 MCG PACK
- UPTRAVI ORAL TABLETS,DOSE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DOCUMENTED CONFIRMATORY PAH DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION. PATIENT HAS NYHA-WHO FUNCTIONAL CLASS II-IV SYMPTOMS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	PREVIOUS OR CURRENT TREATMENT WITH A PHOSPHODIESTERASE-5 INHIBITOR (E.G., REVATIO [SILDENAFIL] OR ADCIRCA [TADALAFIL]) AND AN ENDOTHELIN RECEPTOR ANTAGONIST (E.G.,TRACLEER [BOSENTAN], LETAIRIS [AMBRISENTAN], OR OPSUMIT [MACITENTAN]), OR A CONTRAINDICATION TO ALL OF THESE AGENTS.
Indications	All FDA-approved Indications.
Off Label Uses	

USTEKINUMAB

Products Affected

- STELARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, OR GENITAL AREA. RENEWAL FOR PSORIATIC ARTHRITIS OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION OF IMPROVEMENT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH: PSORIATIC ARTHRITIS: DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: DERMATOLOGIST. CROHN'S DISEASE: GASTROENTEROLOGIST.
Coverage Duration	INITIAL: PSA, PSO, CD: 4 MONTHS. CD WITH PREVIOUS DOSE IV: 2 MONTHS. RENEW ALL: 12 MO
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS (I.E. BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE.
Indications	All FDA-approved Indications.
Off Label Uses	

USTEKINUMAB IV

Products Affected

- STELARA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	2 MONTHS
Other Criteria	PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROIDS (I.E. BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

VALBENAZINE

Products Affected

- INGREZZA
- INGREZZA INITIATION PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST,MOVEMENT DISORDER SPECIALIST, OR PSYCHIATRIST
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VANDETANIB

Products Affected

- CAPRELSA ORAL TABLET 100 MG, 300 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VECTIBIX (S)

Products Affected

- VECTIBIX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VELCADE (S)

Products Affected

- BORTEZOMIB
- VELCADE

PA Criteria	Criteria Details
Exclusion Criteria	HYPERSENSITIVITY TO BORTEZOMIB, BORON, OR MANNITOL. MEDICATION WILL BE GIVEN INTRATHECALLY
Required Medical Information	PATIENT HAS A DIAGNOSIS OF: A) MULTIPLE MYELOMA, OR B) MANTLE CELL LYMPHOMA AND THE PATIENT HAS RECEIVED AT LEAST ONE PRIOR THERAPY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VEMURAFENIB

Products Affected

- ZELBORAF

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VENETOCLAX

Products Affected

- VENCLEXTA ORAL TABLET 10 MG, 100 MG, 50 MG
- VENCLEXTA STARTING PACK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VESTRONIDASE ALFA

Products Affected

- MEPSEVII

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT THE PATIENT HAS IMPROVED, MAINTAINED, OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY FROM BASELINE.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN GENETIC OR METABOLIC DISORDERS.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: THE PATIENT MEETS ALL OF THE FOLLOWING CRITERIA: 1) THE PATIENT HAS NOT UNDERGONE SUCCESSFUL BONE MARROW OR STEM CELL TREATMENT FOR MPS VII, 2) THE PATIENT HAS LIMITATION IN MOBILITY, BUT REMAINS SUFFICIENTLY AMBUATLORY, AND 3) DIAGNOSIS OF MPS VII CONFIRMED BY ALL OF THE FOLLOWING CRITERIA: A) PHYSICIAN ATTESTATION OF URINARY GAG (GLYCOSAMINOGLYCAN) LEVEL OF GREATER THAN THREE TIMES THE UPPER LEVEL OF NORMAL BASED ON THE LABORATORY ASSAY, B) PHYSICIAN ATTESTATION OF BETA-GLUCURONIDASE ENZYME ACTIVITY DEFICIENCY OR GENETIC TESTING, AND C) PHYSICIAN ATTESTATION THAT THE PATIENT HAS AT LEAST ONE OF THE FOLLOWING CLINICAL SIGNS OF MPS VII: ENLARGED LIVER AND SPLEEN, JOINT LIMITATIONS, AIRWAY OBSTRUCTIONS OR PULMONARY DYSFUNCTION. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

VIBERZI

Products Affected

- VIBERZI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VIEKIRA (S)

Products Affected

- VIEKIRA PAK

PA Criteria	Criteria Details
Exclusion Criteria	DECOMPENSATED CIRRHOSIS, SEVERE LIVER IMPAIRMENT (CHILD-PUGH C).
Required Medical Information	
Age Restrictions	18 YEARS OF AGE AND OLDER.
Prescriber Restrictions	GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	DURATION BASED ON FDA APPROVED DOSING SEE OTHER CRITERIA FIELD FOR MORE INFORMATION.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Indications	All FDA-approved Indications.
Off Label Uses	

VIMIZIM (S)

Products Affected

- VIMIZIM

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME OF MEMBERSHIP IN PLAN.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VOSEVI

Products Affected

- VOSEVI

PA Criteria	Criteria Details
Exclusion Criteria	SEVERE RENAL IMPAIRMENT, ESRD OR ON HEMODIALYSIS. MODERATE OR SEVERE HEPATIC IMPAIRMENT (CHILD-PUGH B OR C).
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (HEPATOLOGIST), OR A SPECIALLY TRAINED GROUP SUCH AS ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES) MODEL.
Coverage Duration	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. HCV RNA LEVEL WITHIN PAST 6 MONTHS. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING MEDICATIONS NOT RECOMMENDED BY THE MANUFACTURER: AMIODARONE, CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, CYCLOSPORINE, PITAVASTATIN, PRAVASTATIN (DOSES ABOVE 40MG), ROSUVASTATIN, METHOTREXATE, MITOXANTRONE, IMATINIB, IRINOTECAN, LAPATINIB, SULFASALAZINE, TOPOTECAN, OR HIV REGIMEN THAT CONTAINS EFAVIRENZ, ATAZANAVIR, LOPINAVIR OR TIPRANAVIR/RITONAVIR.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

VOTRIENT (S)

Products Affected

- VOTRIENT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF ADVANCED/METASTATIC RENAL CELL CARCINOMA OR DIAGNOSIS OF ADVANCED SOFT TISSUE SARCOMA AND PATIENT RECEIVED AT LEAST ONE PRIOR CHEMOTHERAPY (E.G., IFOSFAMIDE, DOXORUBICIN, CISPLATIN, DACARBAZINE, DOCETAXEL, OXALIPLATIN, ETC.)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

VOXELOTOR

Products Affected

- OXBRYTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HEMOGLOBIN LESS THAN 10.5 G/DL
Age Restrictions	
Prescriber Restrictions	SICKLE CELL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	SICKLE CELL: INITIAL: PATIENT HAS SYMPTOMS OF ANEMIA WHICH ARE INTERFERING WITH ACTIVITIES OF DAILY LIVING. RENEWAL: PATIENT HAS MAINTAINED AN IMPROVEMENT IN SYMPTOMS ASSOCIATED WITH ANEMIA.
Indications	All FDA-approved Indications.
Off Label Uses	

XALKORI (S)

Products Affected

- XALKORI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XIFAXAN (S)

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	TRAVELERS' DIARRHEA: 12 YEARS OR OLDER.
Prescriber Restrictions	
Coverage Duration	TRAVELERS' DIARRHEA: 1 FILL IN 1 MONTH. HEPATIC ENCEPHALOPATHY: 12 MO. IBS WITH DIARRHEA: 12 MO.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XOLAIR (S)

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL CRITERIA FOR ASTHMA: PATIENT MEETS THE CRITERIA OF MODERATE TO SEVERE ASTHMA, POSITIVE SKIN PRICK OR RAST TEST, FEV1 LESS THAN 80%, DEMONSTRATED INADEQUATELY CONTROLLED SYMPTOMS ON INHALED CORTICOSTEROIDS AND SECOND ASTHMA CONTROLLER, BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30IU/ML.
Age Restrictions	6 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	ASTHMA: 12 MONTHS CIU: 6 MONTHS
Other Criteria	FOR CIU: TRIAL OF A HIGH DOSE H1 ANTI-HISTAMINE (LEVOCETIRIZINE) FOR AT LEAST 2 WEEKS AND STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK OR PATIENT HAS AN INTOLERANCE OR CONTRAINDICATION TO H1 ANTI-HISTAMINES AS DOCUMENTED BY PHYSICIAN ATTESTATION
Indications	All FDA-approved Indications.
Off Label Uses	

XTANDI (S)

Products Affected

- XTANDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	A) DIAGNOSIS OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER AND PATIENT HAD PRIOR CHEMOTHERAPY THAT INCLUDED DOCETAXEL AND THE PATIENT HAS TRIED AND HAD AN INADEQUATE RESPONSE, CONTRAINDICATION OR INTOLERANCE TO ZYTIGA OR B) NON-METASTATIC CASTRATION-RESISTANT PROSTATE CANCER.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

XURIDEN

Products Affected

- XURIDEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: DIAGNOSIS CONFIRMED BY 1) GENETIC MUTATION OF URIDINE MONOPHOSPHATE SYNTHASE (UMPS) GENE AND 2) ELEVATED URINE OROTIC ACID PER AGE-SPECIFIC REFERENCE RANGE. RENEWAL: IMPROVEMENT FROM BASELINE OR STABILIZATION OF AGE DEPENDENT HEMATOLOGIC PARAMETERS (E.G., NEUTROPHIL COUNT, NEUTROPHIL PERCENT, WBC COUNT, MEAN CORPUSCULAR VOLUME)
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

YERVOY (S)

Products Affected

- YERVOY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

YONDELIS -(S)

Products Affected

- YONDELIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

YONSA

Products Affected

- YONSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ZAKADIA (S)

Products Affected

- ZYKADIA ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF METASTATIC NON-SMALL CELL LUNG CANCER AND PATIENT HAS ANAPLASTIC LYMPHOMA KINASE (ALK)-POSITIVE DISEASE AS DETECTED BY AN FDA-APPROVED OR CLINICAL LABORATORY IMPROVEMENT AMENDMENTS (CLIA)-APPROVED FACILITY
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ZALTRAP (S)

Products Affected

- ZALTRAP

PA Criteria	Criteria Details
Exclusion Criteria	SEVERE HEMORRHAGE, DEVELOPMENT OF GASTROINTESTINAL PERFORATION, COMPROMISED WOUND HEALING
Required Medical Information	DIAGNOSIS OF METASTATIC COLON OR RECTAL CANCER AND WILL BE USED IN COMBINATION WITH IRINOTECAN OR 5-FLUOROURACIL, LEUCOVORIN, AND IRINOTECAN (FOLFIRI) AND DISEASE IS RESISTANT TO OR HAS PROGRESSED FOLLOWING AN OXALIPLATIN-CONTAINING REGIMEN (E.G. 5-FLUOROURACIL, LEUCOVORIN, AND OXALIPLATIN [FOLFOX])
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT WILL BE MONITORED FOR SIGNS AND SYMPTOMS OF GASTROINTESTINAL BLEEDING AND OTHER SEVERE BLEEDING. THERAPY WILL BE SUSPENDED FOR AT LEAST 4 WEEKS PRIOR TO ELECTIVE SURGERY AND NOT RESUMED FOR AT LEAST 4 WEEKS FOLLOWING MAJOR SURGERY AND UNTIL THE WOUND IS FULLY HEALED.
Indications	All FDA-approved Indications.
Off Label Uses	

ZANUBRUTINIB

Products Affected

- BRUKINSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ZYDELIG (S)

Products Affected

- ZYDELIG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	THE PATIENT HAS ONE OF THE FOLLOWING DIAGNOSES: A) CHRONIC LYMPHOCYTIC LEUKEMIA AND THE MEDICATION WILL BE USED IN COMBINATION WITH RITUXIMAB AND THE PATIENT HAS RELAPSED ON AT LEAST ONE PRIOR THERAPY (E.G., PURINE ANALOGUES [FLUDARABINE, PENTOSTATIN, CLADRIBINE], ALKYLATING AGENTS [CHLORAMBUCIL, CYCLOPHOSPHAMIDE], OR MONOCLONAL ANTIBODIES [RITUXIMAB]) AND THE PATIENT DOES NOT HAVE ANY CO-MORBIDITIES THAT PREVENTS THE USE OF CYTOTOXIC CHEMOTHERAPY (I.E. SEVERE NEUTROPENIA OR THROMBOCYTOPENIA, CREATININE CLEARANCE LESS THAN 60 ML/MINUTE), B) FOLLICULAR LYMPHOMA AND THE PATIENT HAS RELAPSED ON AT LEAST TWO PRIOR SYSTEMIC THERAPIES (E.G., RITUXIMAB, ALKYLATING AGENTS [CYCLOPHOSPHAMIDE, CHLORAMBUCIL], ANTHRACYCLINES [DOXORUBICIN, DAUNORUBICIN], PURINE ANALOGS [FLUDARABINE]), OR C) SMALL LYMPHOCYTIC LYMPHOMA AND THE PATIENT HAS RELAPSED ON AT LEAST TWO PRIOR SYSTEMIC THERAPIES(E.G., RITUXIMAB, ALKYLATING AGENTS [CYCLOPHOSPHAMIDE, CHLORAMBUCIL], ANTHRACYCLINES [DOXORUBICIN, DAUNORUBICIN], PURINE ANALOGS [FLUDARABINE]).
Age Restrictions	
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ZYTIGA (S)

Products Affected

- *abiraterone*
- ZYTIGA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	DIAGNOSIS OF METASTATIC CASTRATION-RESISTANT PROSTATE CANCER OR METASTATIC HIGH-RISK CASTRATION-SENSITIVE PROSTATE CANCER AND ZYTIGA WILL BE USED IN COMBINATION WITH PREDNISONE
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

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