ABALOPARATIDE

Products Affected

- TYMLOS

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT HAS RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ANY PARATHYROID HORMONE THERAPY.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS

PA Criteria	Criteria Details
Other Criteria	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), OR (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 ONE BISPHOSPHONATE.
Indications	All FDA-approved Indications.
Off Label Uses	

ABATACEPT

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	

ABEMACICLIB

Products Affected

- VERZENIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	THE PATIENT HAS NOT EXPERIENCED DISEASE PROGRESSION FOLLOWING PRIOR CDK INHIBITOR THERAPY.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ABIRATERONE SUBMICRONIZED

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	

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	

ADALIMUMAB

Products Affected

- HUMIRA PEN
- HUMIRA PEN CROHNS-UC-HS START
- HUMIRA PEN PSOR-UVEITS-ADOL HS
- HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML
- HUMIRA(CF)
- HUMIRA(CF) PEDI CROHNS STARTER
- HUMIRA(CF) PEN
- HUMIRA(CF) PEN CROHNS-UC-HS
- HUMIRA(CF) PEN PEDIATRIC UC
- HUMIRA(CF) PEN PSOR-UV-ADOL HS

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.
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. CROHNS 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. INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST 3 MONTHS OF TREATMENT WITH AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AN NSAID. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS,

PA Criteria	Criteria Details
	CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHNS DISEASE (CD) AND ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. RENEWAL FOR RA, PJIA, PSA, AS, PSO, HIDRADENITIS SUPPURATIVA, OR UVEITIS: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

ADO-TRASTUZUMAB EMTANSINE

Products Affected

- KADCYLA

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	

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	

AGALSIDASE BETA

Products Affected

- FABRAZYME

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	FABRY DISEASE INITIAL: THE PATIENT IS NOT CONCURRENTLY USING AN ALPHA-GAL A PHARMACOLOGICAL CHAPERONE (I.E. GALAFOLD (MIGALASTAT)). THE PATIENT IS SYMPTOMATIC OR HAS EVIDENCE OF INJURY FROM GL-3 TO THE KIDNEY, HEART, OR CENTRAL NERVOUS SYSTEM RECOGNIZED BY LABORATORY, HISTOLOGICAL, OR IMAGING FINDINGS.
Age Restrictions	8 YEARS OF AGE OR OLDER
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH NEPHROLOGIST, CARDIOLOGIST, OR SPECIALIST IN GENETICS OR INHERITED METABOLIC DISORDERS.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 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	

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	

ALEMTUZUMAB - LEMTRADA

Products Affected

- LEMTRADA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS.
Other Criteria	RENEWAL: AT LEAST 12 MONTHS HAVE ELAPSED SINCE THE PATIENT RECEIVED THE MOST RECENT COURSE OF LEMTRADA.
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	INITIAL: HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): 1) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, OR 2) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR 3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
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
  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 GRASS POLLEN-INDUCED ALLERGIC RHINITIS WITH OR WITHOUT CONJUNCTVITIS. 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	

ALPELISIB-VIJOICE

Products Affected

- VIJOICE

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	

AMIVANTAMAB-VMJW

Products Affected

- RYBREVANT

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	

ANAKINRA

Products Affected

- KINERET

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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ANIFROLUMAB-FNIA

Products Affected

- SAPHNELO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): PRESCRIBED BY OR IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: SLE: 6 MONTHS. RENEWAL: SLE: 12 MONTHS.
Other Criteria	RENEWAL: SLE: CLINICAL IMPROVEMENT WHILE ON THERAPY.
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	18 YEARS OR OLDER
Prescriber Restrictions	PARKINSONS DISEASE (PD): PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

APOMORPHINE HCL

Products Affected

- APOKYN
- *apomorphine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL:FOR BRAND OR GENERIC REQUESTS: PHYSICIAN ATTESTATION OF PATIENT IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PHYSICIAN ATTESTATION OF OPTIMIZATION OF DRUG THERAPY FOR PARKINSONS DISEASE.
Indications	All FDA-approved Indications.
Off Label Uses	

APREMILAST

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 BEHCETS DISEASE INITIAL: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. BEHCETS DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: BEHCETS DISEASE: 1) PATIENT HAS ORAL ULCERS OR A HISTORY OF RECURRENT ORAL ULCERS BASED ON CLINICAL SYMPTOMS AND 2) TRIAL OF OR CONTRAINDICATION TO COLCHICINE. RENEWAL: PSA, PSO, BEHCETS DISEASE: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

ARANESP

Products Affected

- ARANESP (IN POLYSORBATE)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: CHRONIC KIDNEY DISEASE (CKD) OR CANCER CHEMOTHERAPY: A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. RENEWAL: CKD DIAGNOSIS REQUIRES ONE OF THE FOLLOWING: 1) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO EFFECTS OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY REQUIRES A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL OR THAT THE HEMOGLOBIN LEVEL DOES NOT EXCEED A LEVEL NEEDED TO AVOID RBC TRANSFUSION.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: CKD: PATIENT IS NOT RECEIVING DIALYSIS TREATMENT. 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 FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

ARMODAFINIL

Products Affected

- *armodafinil oral tablet 150 mg, 200 mg, 250 mg, 50 mg*
- 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	

ASCIMINIB

Products Affected

- SCEMBLIX

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	

ASFOTASE

Products Affected

- STRENSIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION, SERUM ALKALINE PHOSPHATASE (ALP) LEVEL, SERUM PYRIDOXAL-5-PHOSPHATE (PLP) LEVELS, URINE PHOSPHOETHANOLAMINE (PEA) LEVEL, RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP)
Age Restrictions	PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP): 6 MONTHS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET. JUVENILE-ONSET HYPOPHOSPHATASIA (HPP): 18 YEARS OF AGE OR YOUNGER AT HYPOPHOSPHATASIA (HPP) ONSET.
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, A GENETICIST, OR A METABOLIC SPECIALIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: FOR PATIENTS WITH PERINATAL/INFANTILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5-PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.) URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.) RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.) PRESENCE OF TWO OR MORE OF THE FOLLOWING: RACHITIC CHEST DEFORMITY, CRANIOSYNOSTOSIS (PREMATURE CLOSURE OF SKULL BONES), DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, HISTORY OF VITAMIN B6 DEPENDENT SEIZURES, NEPHROCALCINOSIS, OR HISTORY OF ELEVATED SERUM CALCIUM. HISTORY OR PRESENCE OF NON-TRAUMATIC POSTNATAL FRACTURE AND DELAYED FRACTURE HEALING. FOR PATIENTS WITH JUVENILE-ONSET HYPOPHOSPHATASIA (HPP), ALL OF THE FOLLOWING CRITERIA MUST BE MET: POSITIVE FOR A TISSUE NON-SPECIFIC ALKALINE PHOSPHATASE (TNSALP) (ALPL) GENE MUTATION AS CONFIRMED BY GENETIC TESTING OR MEETS AT LEAST TWO OF THE FOLLOWING CRITERIA: 1.) SERUM ALKALINE PHOSPHATASE (ALP) LEVEL BELOW THAT OF NORMAL RANGE FOR PATIENT AGE 2.) SERUM PYRIDOXAL-5-

PA Criteria	Criteria Details
	PHOSPHATE (PLP) LEVELS ELEVATED AND PATIENT HAS NOT RECEIVED VITAMIN B6 SUPPLEMENTATION IN THE PREVIOUS WEEK 3.)URINE PHOSPHOETHANOLAMINE (PEA) LEVEL ABOVE THAT OF NORMAL RANGE FOR PATIENT AGE 4.)RADIOGRAPHIC EVIDENCE OF HYPOPHOSPHATASIA (HPP) (E.G., FLARED AND FRAYED METAPHYSES, OSTEOPENIA, OSTEOMALACIA, WIDENED GROWTH PLATES, AREAS OF RADIOLUCENCY OR SCLEROSIS) 5.)PRESENCE OF TWO OR MORE OF THE FOLLOWING:RACHITIC DEFORMITIES (RACHITIC CHEST, BOWED LEGS, KNOCK-KNEES),PREMATURE LOSS OF PRIMARY TEETH PRIOR TO 5 YEARS OF AGE, DELAY IN SKELETAL GROWTH RESULTING IN DELAY OF MOTOR DEVELOPMENT, OR HISTORY OR PRESENCE OF NON-TRAUMATIC FRACTURES OR DELAYED FRACTURE HEALING. STRENSIQ WILL NOT BE APPROVED FOR THE FOLLOWING PATIENTS: PATIENTS CURRENTLY RECEIVING TREATMENT WITH A BISPHOSPHONATE [E.G., BONIVA (IBANDRONATE), FOSAMAX (ALENDRONATE), ACTONEL (RISEDRONATE)], PATIENTS WITH SERUM CALCIUM OR PHOSPHATE LEVELS BELOW THE NORMAL RANGE, PATIENTS WITH A TREATABLE FORM OF RICKETS. RENEWAL: PATIENT HAS EXPERIENCED AN IMPROVEMENT IN THE SKELETAL CHARACTERISTICS OF HYPOPHOSPHATASIA (HPP) (E.G., IMPROVEMENT OF THE IRREGULARITY OF THE PROVISIONAL ZONE OF CALCIFICATION, PHYSEAL WIDENING, METAPHYSEAL FLARING, RADIOLUCENCIES, PATCHY OSTEOSCLEROSIS, RATIO OF MID-DIAPHYSEAL CORTEX TO BONE THICKNESS, GRACILE BONES, BONE FORMATION AND FRACTURES.
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	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

ASPARAGINASE ERWINIA-RYWN

Products Affected

- RYLAZE

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	

ATOGEPANT

Products Affected

- QULIPTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	EPISODIC MIGRAINE PREVENTION: INITIAL: 1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREVENTATIVE MIGRAINE TREATMENTS: DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED AGENTS: EMGALITY, AIMOVIG, AJOVY, OR NURTEC ODT, UNLESS THE PATIENT HAS NEEDLE PHOBIA, DEXTERITY ISSUE, OR OTHER REASON THEY CANNOT USE AN INJECTABLE CGRP INHIBITOR. RENEWAL: 1) REDUCTION IN MIGRAINE OR HEADACHE FREQUENCY OF AT LEAST 2 DAYS PER MONTH, OR 2) REDUCTION IN MIGRAINE SEVERITY OR MIGRAINE DURATION.
Indications	All FDA-approved Indications.
Off Label Uses	

AVACOPAN

Products Affected

- TAVNEOS

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	

AVALGLUCOSIDASE ALFA-NGPT

Products Affected

- NEXVIAZYME

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	LIFETIME
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	

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	CHRONIC LIVER DISEASE (CLD): PATIENT HAS A PLANNED PROCEDURE 10 TO 13 DAYS AFTER INITIATION OF DOPTELET. PATIENT IS NOT RECEIVING OTHER THROMBOPOIETIN RECEPTOR AGONISTS (E.G. ROMIPLOSTIM, ELTROMBOPAG, ETC.). CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): INITIAL: PREVIOUS TRIAL OF OR CONTRAINDICATION TO CORTICOSTEROIDS OR IMMUNOGLOBULINS OR INSUFFICIENT RESPONSE TO SPLENECTOMY, RENEWAL: PHYSICIAN ATTESTATION OF A CLINICAL RESPONSE.
Age Restrictions	
Prescriber Restrictions	CLD: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, GASTROENTEROLOGIST, HEPATOLOGIST, IMMUNOLOGIST, OR ENDOCRINOLOGIST. CHRONIC IMMUNE THROMBOCYTOPENIA (ITP): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	CLD: 1 MONTH. CHRONIC ITP: INITIAL: 2 MONTHS, RENEWAL: 12 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	

AXITINIB

Products Affected

- INLYTA ORAL TABLET 1 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	

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	

AZTREONAM LYSINE

Products Affected

- CAYSTON

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	AT LEAST 7 YEARS OLD
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	RHEUMATOID ARTHRITIS (RA): 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	
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	

BELIMUMAB

Products Affected

- BENLYSTA INTRAVENOUS
- BENLYSTA SUBCUTANEOUS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	LUPUS NEPHRITIS (LN): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): MEMBER IS CURRENTLY TAKING CORTICOSTEROIDS, ANTIMALARIALS, NSAIDS, OR IMMUNOSUPPRESSIVE AGENTS. RENEWAL: SLE: PHYSICIAN ATTESTATION OF IMPROVEMENT. LN: CLINICAL IMPROVEMENT IN RENAL RESPONSE COMPARED TO BASELINE OR CLINICAL PARAMETERS (E.G., FLUID RETENTION, USE OF RESCUE DRUGS, GLUCOCORTICOID DOSE).
Indications	All FDA-approved Indications.
Off Label Uses	

BELINOSTAT

Products Affected

- BELEODAQ

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	

BELUMOSUDIL MESYLATE

Products Affected

- REZUROCK

PA Criteria	Criteria Details
Exclusion Criteria	PA Criteria: Pending CMS Approval
Required Medical Information	PA Criteria: Pending CMS Approval
Age Restrictions	PA Criteria: Pending CMS Approval
Prescriber Restrictions	PA Criteria: Pending CMS Approval
Coverage Duration	PA Criteria: Pending CMS Approval
Other Criteria	PA Criteria: Pending CMS Approval
Indications	PA Criteria: Pending CMS Approval
Off Label Uses	PA Criteria: Pending CMS Approval

BELZUTIFAN

Products Affected

- WELIREG

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	

BEMPEDOIC ACID

Products Affected

- NEXLETOL

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	

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
- TREANDA

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	

BENRALIZUMAB

Products Affected

- FASENRA
- FASENRA PEN

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: CONCURRENT USE OF XOLAIR, DUPIXENT, OR OTHER ANTI-IL5 BIOLOGICS
Required Medical Information	INITIAL: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE, OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION AND 2) PATIENT HAS EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS). RENEWAL: PATIENT HAS SHOWN A CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR 4) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

BEROTRALSTAT

Products Affected

- ORLADEYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ALLERGIST, IMMUNOLOGIST, OR HEMATOLOGIST.
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: DIAGNOSIS OF HEREDITARY ANGIOEDEMA (HAE) CONFIRMED BY COMPLEMENT TESTING. NOT ON CONCURRENT TREATMENT WITH ALTERNATIVE PROPHYLACTIC AGENT FOR HAE. RENEWAL: IMPROVEMENT (I.E., REDUCTIONS IN ATTACK FREQUENCY OR ATTACK SEVERITY) COMPARED TO BASELINE IN HAE ATTACKS.
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	

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	

BEXAROTENE

Products Affected

- *bexarotene oral*
- *bexarotene topical*
- TARGRETIN ORAL
- TARGRETIN TOPICAL

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: RELAPSED OR REFRACTORY B-CELL: 3 MOS. MRD-POSITIVE B-CELL: 2 MOS. RENEWAL: 12 MOS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RELAPSED OR REFRACTORY B-CELL PRECURSOR ALL: APPROVAL IS FOR 2 CYCLES, MAY APPROVE FOR 1 ADDITIONAL CYCLE DUE TO TREATMENT INTERRUPTION FOR DOSE MODIFICATION. RENEWAL: FOR DIAGNOSIS OF RELAPSED OR REFRACTORY B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED COMPLETE REMISSION (CR) OR CR WITH PARTIAL HEMATOLOGICAL RECOVERY OF PERIPHERAL BLOOD COUNTS AFTER 2 CYCLES OF TREATMENT. RENEWAL IS NOT APPROVED FOR PATIENTS WHO RECEIVED AN ALLOGENEIC HEMATOPOIETIC STEM-CELL TRANSPLANT. FOR DIAGNOSIS OF MINIMAL RESIDUAL DISEASE (MRD)-POSITIVE B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL), RENEWAL IS APPROVED FOR PATIENTS WHO HAVE ACHIEVED UNDETECTABLE MINIMAL RESIDUAL DISEASE (MRD) WITHIN ONE CYCLE OF BLINCYTO TREATMENT AND IS RELAPSE-FREE (I.E., HEMATOLOGICAL OR EXTRAMEDULLARY RELAPSE, OR SECONDARY LEUKEMIA). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

BORTEZOMIB

Products Affected

- *bortezomib injection recon soln 1 mg, 2.5 mg*
- BORTEZOMIB INTRAVENOUS
- VELCADE

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	

BOSUTINIB

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CHRONIC, ACCELERATED, OR BLAST PHASE PHILADELPHIA CHROMOSOME-POSITIVE CHRONIC MYELOGENOUS LEUKEMIA: BCR-ABL MUTATIONAL ANALYSIS CONFIRMING THAT T315I, V299L, G250E, OR F317L MUTATIONS ARE NOT PRESENT.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
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: PLAQUE PSORIASIS: PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% OF BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PATIENT HAS BEEN COUNSELED ON AND EXPRESSES UNDERSTANDING OF THE RISK OF SUICIDAL IDEATION AND BEHAVIOR. RENEWAL: PSO: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION AND 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	

BUDESONIDE

Products Affected

- TARPEYO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PRIMARY IMMUNOGLOBULIN A NEPHROPATHY (IGAN): 1) DIAGNOSIS IS CONFIRMED BY A RENAL BIOPSY. 2) PROGRESSIVELY DECLINING GLOMERULAR FILTRATION RATE AND/OR WORSENING PROTEINURIA.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	9 MONTHS
Other Criteria	INITIAL: PRIMARY IGAN: CURRENTLY ON AN ACE INHIBITOR OR AN ARB AT MAXIMUM TOLERATED DOSE FOR AT LEAST THREE MONTHS OR HAS A CONTRAINDICATION TO BOTH. TRIAL OF OR CONTRAINDICATION TO ONE GENERIC SYSTEMIC CORTICOSTEROID THERAPY. RENEWAL: PRIMARY IGAN: ONE OF THE FOLLOWING: 1) IMPROVED OR STABLE KIDNEY FUNCTION COMPARED TO BASELINE, OR 2) REDUCTION IN PROTEINURIA.
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 SUBCUTANEOUS RECON SOLN 2,000 UNIT, 3,000 UNIT
- 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	

CALASPARGASE PEGOL-MKNL

Products Affected

- ASPARLAS

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	

CANAKINUMAB

Products Affected

- ILARIS (PF)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	CAPS - 4 YEARS OF AGE OR OLDER. SJIA - 2 YEARS OF AGE OR OLDER
Prescriber Restrictions	CRYOPYRIN-ASSOCIATED PERIODIC SYNDROMES (CAPS), SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA), AND ADULT-ONSET STILLS DISEASE (AOSD): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR AN IMMUNOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	ADULT-ONSET STILLS DISEASE (AOSD): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUGS).
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 oral capsule 10 mg, 2.5 mg, 5 mg*
- 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	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	12 MONTHS
Other Criteria	CABLIVI WAS PREVIOUSLY INITIATED AS PART OF THE FDA APPROVED TREATMENT REGIMEN IN COMBINATION WITH PLASMA EXCHANGE AND IMMUNOSUPPRESSIVE THERAPY WITHIN AN INPATIENT SETTING. THE PATIENT HAS NOT EXPERIENCED MORE THAN TWO RECURRENCES OF ATTP WHILE ON CABLIVI THERAPY (I.E., NEW DROP IN PLATELET COUNT REQUIRING REPEAT PLASMA EXCHANGE DURING 30 DAYS POST-PLASMA EXCHANGE THERAPY [PEX] AND UP TO 28 DAYS OF EXTENDED THERAPY).
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	

CASIMERSEN

Products Affected

- AMONDYS-45

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	

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	PRESCRIBED BY OR IN CONSULTATION WITH AN OPHTHALMOLOGIST.
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 AND 2) PHYSICIAN ATTESTATION THAT THE PATIENT HAS LOSS OF CORNEAL SENSITIVITY, CORNEAL EPITHELIUM CHANGES, OR LOSS OF TEAR PRODUCTION
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	

CERITINIB

Products Affected

- ZYKADIA 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	

CERTOLIZUMAB PEGOL

Products Affected

- CIMZIA
- CIMZIA POWDER FOR RECONST

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS/ANKYLOSING SPONDYLITIS/NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. CROHNS DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 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 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. FOR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS, PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION) OR PATIENTS CONDITION HAS STABILIZED. RENEWAL FOR RA, PSA, AS, PSO OR NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
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	
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	

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	
Indications	All FDA-approved Indications.
Off Label Uses	

CLOBAZAM PA

Products Affected

- *clobazam oral suspension*
- *clobazam oral tablet*
- ONFI ORAL SUSPENSION
- ONFI ORAL TABLET

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO 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	

COLCHICINE

Products Affected

- COLCRYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	PROPHYLAXIS OF GOUT FLARES: 16 YEARS AND OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO COLCHICINE CAPSULES (MITIGARE) WHERE INDICATIONS ALIGN.
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	

CORTICOTROPIN

Products Affected

- ACTHAR
- CORTROPHIN GEL

PA Criteria	Criteria Details
Exclusion Criteria	NOT APPROVED FOR DIAGNOSTIC PURPOSES.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS (MS): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, ALLERGIST/IMMUNOLOGIST, OPHTHALMOLOGIST, PULMONOLOGIST OR NEPHROLOGIST.
Coverage Duration	INFANTILE SPASMS AND MS: 28 DAYS. OTHER FDA APPROVED INDICATIONS: INITIAL AND RENEWAL: 28 DAYS
Other Criteria	RENEWAL: ALL FDA APPROVED INDICATIONS EXCEPT INFANTILE SPASMS AND MULTIPLE SCLEROSIS: DEMONSTRATED CLINICAL BENEFIT WHILE ON THERAPY AS INDICATED BY SYMPTOM RESOLUTION AND/OR NORMALIZATION OF LABORATORY TESTS.
Indications	All FDA-approved Indications.
Off Label Uses	

COSENTYX (S)

Products Affected

- COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML

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	

DACOMITINIB

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	

DALFAMPRIDINE

Products Affected

- AMPYRA
- *dalfampridine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	WALKING DISABILITY SUCH AS MILD TO MODERATE BILATERAL LOWER EXTREMITY WEAKNESS OR UNILATERAL WEAKNESS PLUS LOWER EXTREMITY OR TRUNCAL ATAXIA.
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST
Coverage Duration	INITIAL - 3 MONTHS. RENEWAL - 12 MONTHS
Other Criteria	RENEWAL: PHYSICIAN ATTESTATION OF IMPROVEMENT IN WALKING ABILITY.
Indications	All FDA-approved Indications.
Off Label Uses	

DARATUMUMAB-HYALURONIDASE-FIHJ

Products Affected

- DARZALEX FASPRO

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	

DARIDOREXANT

Products Affected

- QUVIVIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 6 MONTHS.
Other Criteria	INSOMNIA: INITIAL: 1) NOT CONCURRENTLY USING Z HYPNOTICS OR BENZODIAZEPINES FOR SLEEP, 2) DOES NOT HAVE NARCOLEPSY, AND 3) TRIAL OF OR CONTRAINDICATION TO BELSOMRA AND ONE OF THE FOLLOWING GENERIC INSOMNIA AGENTS: ESZOPICLONE, ZALEPLON, ZOLPIDEM IR. RENEWAL: 1) IMPROVEMENT OF INSOMNIA SYMPTOMS BUT CURRENTLY NOT A CANDIDATE FOR DISCONTINUATION, AND 2) NOT CONCURRENTLY USING Z HYPNOTICS OR BENZODIAZEPINES FOR SLEEP.
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	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: NON METASTATIC CASTRATION-RESISTANT PROSTATE CANCER (NMCRPC): THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS) AND MEETS ONE OF THE FOLLOWING: (1) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST OR (2) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY. RENEWAL: A DIAGNOSIS OF NMCRPC.
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 oral granules in packet*
- *deferasirox oral tablet 360 mg, 90 mg*
- *deferasirox oral tablet, dispersible*
- EXJADE
- JADENU
- 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 (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). NON-TRANSFUSION DEPENDENT THALASSEMIA (NTDT) INITIAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) AND LIVER IRON CONCENTRATION (LIC) OF 5 MG FE/G DRY WEIGHT OR GREATER. RENEWAL: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 300 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS) OR LIC OF 3 MG FE/G DRY WEIGHT OR GREATER. INITIAL FOR ALL INDICATIONS: FORMULARY VERSION OF DEFERASIROX SPRINKLE: TRIAL OF OR CONTRAINDICATION TO A GENERIC EQUIVALENT OF EITHER EXJADE TABLET FOR ORAL SUSPENSION OR A FORMULARY VERSION OF DEFERASIROX TABLET.

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

DEFERIPRONE

Products Affected

- *deferiprone oral tablet 500 mg*
- FERRIPROX ORAL SOLUTION
- FERRIPROX ORAL TABLET 500 MG

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

PA Criteria	Criteria Details
Other Criteria	INITIAL CRITERIA: TRANSFUSIONAL IRON OVERLOAD DUE TO THALASSEMIA SYNDROMES: (1) TRIAL OF OR CONTRAINDICATION TO A FORMULARY PREFERRED VERSION OF DEFERASIROX OR DEFEROXAMINE, AND (2) ONE OF THE FOLLOWING CRITERIA: A) PATIENT IS EXPERIENCING INTOLERABLE TOXICITIES OR CLINICALLY SIGNIFICANT ADVERSE EFFECTS OR HAS A CONTRAINDICATION TO THESE THERAPIES, OR B) INADEQUATE CHELATION DEFINED BY ONE OF THE FOLLOWING: I) SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 2500 MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS), OR II) EVIDENCE OF CARDIAC IRON ACCUMULATION (I.E., CARDIAC T2 STAR MRI LESS THAN 10 MILLISECONDS, IRON INDUCED CARDIOMYOPATHY, FALL IN LEFT VENTRICULAR EJECTION FRACTION, ARRHYTHMIA INDICATING INADEQUATE CHELATION). TRANSFUSIONAL IRON OVERLOAD DUE TO SICKLE CELL DISEASE OR OTHER ANEMIAS: TRIAL OF OR CONTRAINDICATION TO A FORMULARY PREFERRED VERSION OF DEFERASIROX OR DEFEROXAMINE. RENEWAL: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS).
Indications	All FDA-approved Indications.
Off Label Uses	

DEFEROXAMINE

Products Affected

- *deferoxamine*
- DESFERAL INJECTION RECON SOLN 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	CHRONIC IRON OVERLOAD: AT LEAST 3 YEARS OF AGE OR OLDER
Prescriber Restrictions	CHRONIC IRON OVERLOAD: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR HEMATOLOGIST/ONCOLOGIST
Coverage Duration	INITIAL: 6 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL: CHRONIC IRON OVERLOAD: SERUM FERRITIN LEVEL CONSISTENTLY ABOVE 1000MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). RENEWAL: CHRONIC IRON OVERLOAD: SERUM FERRITIN LEVELS MUST BE CONSISTENTLY ABOVE 500MCG/L (AT LEAST TWO LAB VALUES IN THE PREVIOUS THREE MONTHS). THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
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	PHYSICIAN ATTESTATION OF GENETIC TESTING CONFIRMING DMD DIAGNOSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 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

PA Criteria	Criteria Details
Other Criteria	ACUTE BACTERIAL SKIN OR SKIN STRUCTURE INFECTION (ABSSSI): ONE OF THE FOLLOWING: 1) PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST, OR 2) ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO ONE STANDARD OF CARE AGENT FOR ABSSSI (E.G., SULFAMETHOXAZOLE/TRIMETHOPRIM, LEVOFLOXACIN, CLINDAMYCIN, CEPHALEXIN, OR VANCOMYCIN), OR 3) IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PREFERRED FORMULARY AGENTS FOR ABSSSI: A PENICILLIN, A FLUOROQUINOLONE, A CEPHALOSPORIN, OR A GRAM POSITIVE TARGETING ANTIBIOTIC. COMMUNITY-ACQUIRED BACTERIAL PNEUMONIA (CABP): ONE OF THE FOLLOWING: 1) PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST, OR 2) ANTIMICROBIAL SUSCEPTIBILITY TESTING SHOWS SUSCEPTIBILITY TO DELAFLOXACIN AND RESISTANCE TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP (E.G., MACROLIDE, DOXYCYCLINE, LEVOFLOXACIN/MOXIFLOXACIN, BETA-LACTAM, LINEZOLID), OR 3) IF SENSITIVITY RESULTS ARE UNAVAILABLE: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO STANDARD OF CARE AGENTS FOR CABP (E.G., MACROLIDE, DOXYCYCLINE, LEVOFLOXACIN/MOXIFLOXACIN, BETA-LACTAM, LINEZOLID).
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	TARDIVE DYSKINESIA: PATIENT HAS A PRIOR HISTORY OF USING ANTIPSYCHOTIC MEDICATIONS OR METOCLOPRAMIDE PER PHYSICIAN ATTESTATION
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	

DIMETHYL FUMARATE

Products Affected

- *dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 120 mg (14)- 240 mg (46), 240 mg*
- 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	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

DINUTUXIMAB

Products Affected

- UNITUXIN

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	

DONEPEZIL

Products Affected

- ADLARITY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	DEMENTIA ASSOCIATED WITH ALZHEIMER'S DISEASE: 1) TRIAL OF OR CONTRAINDICATION TO ONE GENERIC ORAL ACETYLCHOLINESTERASE INHIBITOR, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE GENERIC ACETYLCHOLINESTERASE INHIBITOR PATCH.
Indications	All FDA-approved Indications.
Off Label Uses	

DOSTARLIMAB-GXLY

Products Affected

- JEMPERLI

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	

DRONABINOL 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	

DROXIDOPA

Products Affected

- *droxidopa*
- NORTHERA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	BLOOD PRESSURE READINGS WHILE THE PATIENT IS SITTING AND ALSO WITHIN 3 MINUTES OF STANDING FROM A SUPINE (LYING FACE UP) POSITION AT BASELINE AND RENEWAL.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR CARDIOLOGIST.
Coverage Duration	INITIAL: 3 MONTHS RENEWAL: 12 MONTHS
Other Criteria	INITIAL: DIAGNOSIS OF ORTHOSTATIC HYPOTENSION AS DOCUMENTED BY A DECREASE OF AT LEAST 20 MMHG IN SYSTOLIC BLOOD PRESSURE OR 10 MMHG DIASTOLIC BLOOD PRESSURE WITHIN THREE MINUTES AFTER STANDING FROM A SITTING POSITION. RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION
Indications	All FDA-approved Indications.
Off Label Uses	

DUPILUMAB

Products Affected

- DUPIXENT PEN
- DUPIXENT SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: ASTHMA: CONCURRENT USE OF XOLAIR OR ANTI-IL5 BIOLOGICS.
Required Medical Information	INITIAL APPROVAL FOR EOSINOPHILIC ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ATOPIC DERMATITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE. CHRONIC RHINOSINUSITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL: ATOPIC DERMATITIS, CRSWNP: 6 MOS, ASTHMA: 12 MOS. RENEWAL: 12 MOS (ALL INDICATIONS).

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 OR TOPICAL PDE4 INHIBITOR. 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) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY-TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION. 2) PATIENT HAS EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS). INITIAL APPROVAL FOR CHRONIC RHINOSINUSITIS WITH NASAL POLYPOSIS (CRSWNP) REQUIRES: 1) EVIDENCE OF NASAL POLYPS BY DIRECT EXAMINATION, ENDOSCOPY OR SINUS CT SCAN, 2) PATIENT HAS INADEQUATELY CONTROLLED DISEASE AS DETERMINED BY THE USE OF SYSTEMIC STEROIDS IN THE PAST 2 YEARS OR ENDOSCOPIC SINUS SURGERY. RENEWAL FOR ATOPIC DERMATITIS AND CHRONIC RHINOSINUSITIS: PATIENT IMPROVEMENT ON THERAPY. RENEWAL FOR ASTHMA: PATIENT HAS SHOWN A CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT
	BASELINE, OR 4) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS.
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
- RADICAVA ORS STARTER KIT SUSP

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	

EFGARTIGIMOD ALFA-FCAB

Products Affected

- VYVGART

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	
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 PREPARATION. INITIAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO NSAID AND PROGESTIN-CONTAINING PREPARATION. RENEWAL: MODERATE TO SEVERE PAIN ASSOCIATED WITH ENDOMETRIOSIS: IMPROVEMENT IN PAIN ASSOCIATED WITH ENDOMETRIOSIS.
Indications	All FDA-approved Indications.
Off Label Uses	

ELAGOLIX/ESTRADIOL/NORETHINDRONE

Products Affected

- ORIAHNN

PA Criteria	Criteria Details
Exclusion Criteria	HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS: HAS RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT WITH ORIAHNN.
Required Medical Information	
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS: PRESCRIBED BY OR IN CONSULTATION WITH AN OBSTETRICIAN/GYNECOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 18 MONTHS.
Other Criteria	RENEWAL: HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS: IMPROVEMENT OF HEAVY MENSTRUAL BLEEDING
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	INITIAL: ADENOSINE DEAMINASE SEVERE COMBINED IMMUNE DEFICIENCY (ADA-SCID): PRESCRIBED BY OR IN CONSULTATION WITH IMMUNOLOGIST, HEMATOLOGIST/ONCOLOGIST, OR PHYSICIAN SPECIALIZING IN INHERITED METABOLIC DISORDERS
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ADA-SCID: ADA-SCID AS MANIFESTED BY ONE OF THE FOLLOWING: 1) CONFIRMATORY GENETIC TEST OR 2) SUGGESTIVE LABORATORY FINDINGS (E.G., ELEVATED DEOXYADENOSINE NUCLEOTIDE [DAXP] LEVELS, LYMPHOPENIA) AND HALLMARK SIGNS/SYMPTOMS (E.G., RECURRENT INFECTIONS, FAILURE TO THRIVE, PERSISTENT DIARRHEA). RENEWAL: ADA-SCID: IMPROVEMENT OR MAINTENANCE OF IMMUNE FUNCTION FROM BASELINE AND THE PATIENT HAS NOT RECEIVED SUCCESSFUL HCT OR GENE THERAPY
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 WITHIN PAST 6 MONTHS. FOR GENOTYPE 1A -TESTING FOR NS5A RESISTANCE-ASSOCIATED POLYMORPHISMS.
Age Restrictions	
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	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. TRIAL OF A PREFERRED FORMULARY ALTERNATIVE INCLUDING HARVONI OR EPCLUSA WHEN THESE AGENTS ARE CONSIDERED ACCEPTABLE FOR TREATMENT OF THE SPECIFIC GENOTYPE PER AASLD/IDSA GUIDANCE. NO CONCURRENT USE WITH THE FOLLOWING AGENTS: PHENYTOIN, CARBAMAZEPINE, RIFAMPIN, EFAVIRENZ, ATAZANAVIR, DARUNAVIR, LOPINAVIR, SAQUINAVIR, TIPRANAVIR, CYCLOSPORINE, NAFCILLIN, KETOCONAZOLE, MODAFINIL, BOSENTAN, ETRAVIRINE, ELVITEGRAVIR/COBICISTAT/EMTRICITABINE/TENOFOVIR, ATORVASTATIN AT DOSES GREATER THAN 20MG PER DAY OR ROSUVASTATIN AT DOSES GREATER THAN 10MG PER DAY.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

ELEXACAFTOR/TEZACAFTOR/IVACAFT

Products Affected

- TRIKAFTA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME.
Other Criteria	RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	

ELOSULFASE ALFA

Products Affected

- VIMIZIM

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	ITP: PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST
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	

EMAPALUMAB-LZSG

Products Affected

- GAMIFANT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: HEMOPHAGOCYTIC LYMPHOHISTIOCYTOSIS (HLH): PATIENT HAS UNDERGONE A GENETIC TEST IDENTIFYING HLH-ASSOCIATED GENE MUTATION (E.G., PRF1, UNC13D) OR PATIENT HAS AT LEAST FIVE OF THE FOLLOWING EIGHT DIAGNOSTIC CRITERIA FOR HLH: 1) FEVER, 2) SPLENOMEGALY, 3) CYTOPENIAS (AFFECTING AT LEAST 2 OF 3 CELL LINEAGES), 4) HYPERTRIGLYCERIDEMIA OR HYPOFIBRINOGENEMIA, 5) HEMOPHAGOCYTOSIS IN BONE MARROW OR SPLEEN OR LYMPH NODES AND NO EVIDENCE OF MALIGNANCY, 6) LOW OR ABSENT NATURAL KILLER-CELL ACTIVITY, 7) FERRITIN LEVEL OF 500 MCG/L OR GREATER, 8) SOLUBLE CD25 LEVEL OF 2,400 U/ML OR GREATER.
Age Restrictions	
Prescriber Restrictions	HLH: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN IMMUNOLOGIST, HEMATOLOGIST, OR ONCOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 8 WEEKS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: HLH: 1) CONCURRENT THERAPY WITH DEXAMETHASONE AND 2) PATIENT EITHER HAS REFRACTORY, RECURRENT, OR PROGRESSIVE DISEASE, OR HAD A TRIAL OF OR INTOLERANCE TO CONVENTIONAL HLH THERAPY (I.E., CHEMOTHERAPY, STEROIDS, IMMUNOTHERAPY). RENEWAL: HLH: 1) PATIENT HAS NOT RECEIVED SUCCESSFUL HEMATOPOIETIC STEM CELL TRANSPLANTATION AND 2) PATIENT HAS DEMONSTRATED IMPROVED IMMUNE SYSTEM RESPONSE FROM BASELINE (E.G., RESOLUTION OF FEVER, DECREASED SPLENOMEGALY, IMPROVEMENT IN CNS SYMPTOMS, IMPROVED CBC, INCREASED FIBRINOGEN LEVELS, REDUCED D-DIMER, REDUCED FERRITIN, REDUCED SOLUBLE CD25 LEVELS.)
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	

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	

ENZALUTAMIDE

Products Affected

- XTANDI ORAL CAPSULE
- XTANDI ORAL TABLET 40 MG, 80 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: CASTRATION RESISTANT PROSTATE CANCER (CRPC) THAT IS NOT METASTATIC: THE PATIENT HAS HIGH RISK PROSTATE CANCER (I.E. RAPIDLY INCREASING PROSTATE SPECIFIC ANTIGEN [PSA] LEVELS). CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR METASTATIC CASTRATION-SENSITIVE PROSTATE CANCER (MCSPC): PATIENT MEETS ONE OF THE FOLLOWING: (1) CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) AGONIST OR ANTAGONIST OR (2) PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY. RENEWAL: A DIAGNOSIS OF CRPC (INCLUDES NON-METASTATIC AND METASTATIC) OR MCSPC.
Indications	All FDA-approved Indications.
Off Label Uses	

EPOETIN ALFA

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	RENEWAL: CKD: PATIENT IS NOT RECEIVING DIALYSIS TREATMENT. 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD W/O DIALYSIS/ZIDOVUDINE:12 MOS. SURGERY:1 MO.
Other Criteria	RENEWAL: CKD: PATIENT IS NOT RECEIVING DIALYSIS TREATMENT. 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 FDA-approved Indications.
Off Label Uses	

EPTINEZUMAB-JJMR

Products Affected

- VYEPTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
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. 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 VYEPTI THERAPY.
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	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL FOR MIGRAINE: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT. RENEWAL FOR MIGRAINE: 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.
Indications	All FDA-approved Indications.
Off Label Uses	

ERIBULIN

Products Affected

- HALAVEN

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	

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	RENEWAL: TREATMENT-RESISTANT DEPRESSION (TRD), MAJOR DEPRESSIVE DISORDER (MDD): PHYSICIAN ATTESTATION THAT THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT (IMPROVEMENT IN DEPRESSION) COMPARED TO BASELINE.
Age Restrictions	
Prescriber Restrictions	TRD, MDD: PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST.
Coverage Duration	INITIAL: 3 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: TRD: 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. MDD: 1) PATIENT HAS NON-PSYCHOTIC, UNIPOLAR DEPRESSION AND 2) PATIENT DOES NOT HAVE ACTIVE SUBSTANCE ABUSE.
Indications	All FDA-approved Indications.
Off Label Uses	

ETANERCEPT

Products Affected

- ENBREL
- ENBREL MINI
- ENBREL SURECLICK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PLAQUE PSORIASIS: MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING AT LEAST 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE OR GENITAL AREA.
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. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20 MG PER WEEK OR MAXIMALLY TOLERATED DOSE.IS REQUIRED. POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA), PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD. ANKYLOSING SPONDYLITIS (AS): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AN NSAID. PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. RENEWAL: RA, PJIA, PSA, AS, PSO: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
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
Coverage Duration	INITIAL: 24 WEEKS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL CRITERIA: PATIENT IS AMBULATORY AND IS CURRENTLY RECEIVING TREATMENT WITH OR HAS A CONTRAINDICATION TO CORTICOSTEROIDS. 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. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

EVEROLIMUS

Products Affected

- AFINITOR DISPERZ *suspension*
- AFINITOR ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG
- *everolimus (antineoplastic) oral tablet for*

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	

EVINACUMAB-DGNB

Products Affected

- EVKEEZA

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	

EVOLOCUMAB

Products Affected

- REPATHA PUSHTRONEX
- REPATHA SURECLICK
- REPATHA SYRINGE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: HOMOZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HOFH): 1) DEFINITE SIMON BROOME DIAGNOSTIC CRITERIA, OR 2) DUTCH LIPID NETWORK CRITERIA SCORE OF 8 OR GREATER, OR 3) 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.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
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	

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	

FEDRATINIB

Products Affected

- INREBIC

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION
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	

FILGRASTIM

Products Affected

- GRANIX
- NIVESTYM

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

FILGRASTIM-AYOW

Products Affected

- RELEUKO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A HEMATOLOGIST OR ONCOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO THE PREFERRED AGENT NIVESTYM, WHERE INDICATIONS ALIGN.
Indications	All FDA-approved Indications.
Off Label Uses	

FINGOLIMOD

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	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
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	

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 3)
- EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML, 300 MG/3 ML (100 MG/ML X

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: MIGRAINES: 6 MOS. CLUSTER HEADACHE: 3 MOS. RENEWAL (ALL INDICATIONS): 12 MONTHS.
Other Criteria	INITIAL FOR MIGRAINES: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, OR TIMOLOL. CLUSTER HEADACHE: NO STEP. RENEWAL FOR MIGRAINES: 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. RENEWAL FOR EPISODIC CLUSTER HEADACHE: IMPROVEMENT IN EPISODIC CLUSTER HEADACHE FREQUENCY AS COMPARED TO BASELINE.
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	

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	ACUTE HEPATIC PORPHYRIA (AHP): INITIAL: GENETIC CONFIRMATION OF MUTATION OR ELEVATED URINARY OR PLASMA PBG (PORPHOBILINOGEN) OR ALA (AMINOLEVULINIC ACID).
Age Restrictions	
Prescriber Restrictions	ACUTE HEPATIC PORPHYRIA (AHP): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GENETICIST, HEPATOLOGIST, HEMATOLOGIST, GASTROENTEROLOGIST, NEUROLOGIST, DERMATOLOGIST, OR A HEALTHCARE PROVIDER EXPERIENCED IN MANAGING AHP.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	AHP: INITIAL: HAS EXPERIENCED TWO OR MORE ACUTE HEPATIC PORPHYRIA (AHP) ATTACKS IN THE PAST 12 MONTHS. RENEWAL: 1) HAS ACHIEVED OR MAINTAINED CLINICAL BENEFIT COMPARED TO BASELINE, AND 2) HAS NOT RECEIVED A LIVER TRANSPLANT.
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	

GLATIRAMER ACETATE

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

GLECAPREVIR-PIBRENTASVIR

Products Affected

- MAVYRET ORAL PELLETS IN PACKET
- MAVYRET ORAL TABLET

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	

GLYCEROL PHENYLBUTYRATE

Products Affected

- RAVICTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: UREA CYCLE DISORDER (UCD): DIAGNOSIS IS CONFIRMED BY ENZYMATIC, BIOCHEMICAL OR GENETIC TESTING
Age Restrictions	2 MONTHS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: UREA CYCLE DISORDER (UCD): TRIAL OF OR CONTRAINDICATION TO SODIUM PHENYLBUTYRATE (BUPHENYL). RENEWAL: UCD: PATIENT HAS CLINICAL BENEFIT FROM BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

GOLIMUMAB

Products Affected

- SIMPONI

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. ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RENEWAL FOR ALL INDICATIONS: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

GOLIMUMAB IV

Products Affected

- SIMPONI ARIA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, POLYARTICULAR JUVENILE IDIOPATHIC 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: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RENEWAL: RA, PSA, AS, OR PJIA: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
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	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
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, FACE OR GENITAL AREA.
Age Restrictions	
Prescriber Restrictions	PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. PSORIATIC ARTHRITIS (PSA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA): TRIAL OF OR CONTRAINDICATION TO ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). RENEWAL: PSO, PSA: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
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*
- COMFORT PAC-CYCLOBENZAPRINE
- *cyclobenzaprine oral tablet 10 mg, 5 mg*
- *metaxalone*
- *methocarbamol oral*
- *orphenadrine citrate oral*
- 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 SYRINGE 25 MG/ML
- *meperidine (pf) injection solution 25 mg/ml*

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	

HYDROCODONE BITARTRATE

Products Affected

- ZOHYDRO ER

PA Criteria	Criteria Details
Exclusion Criteria	USE AS AN AS-NEEDED PAIN ANALGESIC
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	FOR STARTING DOSES OF ZYHYDRO ER GREATER THAN 10MG EVERY 12 HOURS OR HYSINGLA ER GREATER THAN 20MG EVERY 24 HOURS: PATIENT IS OPIOID TOLERANT (RECEIVING, FOR ONE WEEK OR LONGER, AT LEAST 60 MG ORAL MORPHINE PER DAY, 25 MCG TRANSDERMAL FENTANYL PER HOUR, 30 MG ORAL OXYCODONE PER DAY, 8 MG ORAL HYDROMORPHONE PER DAY, 25 MG ORAL OXYMORPHONE PER DAY, OR AN EQUIANALGESIC DOSE OF ANOTHER OPIOID)
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	

ICATIBANT

Products Affected

- FIRAZYR
- *icatibant*
- *sajazir*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ALLERGIST/IMMUNOLOGIST OR HEMATOLOGIST.
Coverage Duration	12 MONTHS
Other Criteria	DIAGNOSIS OF HEREDITARY ANGIOEDEMA CONFIRMED BY COMPLEMENT TESTING.
Indications	All FDA-approved Indications.
Off Label Uses	

IDELALISIB

Products Affected

- ZYDELIG

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	

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 MAY BE COVERED UNDER MEDICARE PART B OR D DEPENDING UPON THE CIRCUMSTANCES. INFORMATION MAY NEED TO BE SUBMITTED DESCRIBING THE USE AND SETTING OF THE DRUG TO MAKE THE DETERMINATION. 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 HAS SHOWN 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	

IMATINIB MESYLATE

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	PHILADELPHIA CHROMOSOME POSITIVE CHRONIC MYELOID LEUKEMIA: PREVIOUS TREATMENT WITH ANOTHER TYROSINE KINASE INHIBITOR.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	ALL DIAGNOSES: 12 MONTHS. ADJUVANT GIST TREATMENT (TWICE DAILY DOSE): 36 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

INCLISIRAN

Products Affected

- LEQVIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA (HEFH), ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD): LDL-CHOLESTEROL LEVEL GREATER THAN OR EQUAL TO 70 MG/DL AT INITIATION OF THERAPY.
Age Restrictions	
Prescriber Restrictions	INITIAL: HEFH, ASCVD: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST, ENDOCRINOLOGIST, OR LIPIDOLOGIST
Coverage Duration	INITIAL: HEFH, ASCVD: 12 MONTHS. RENEWAL: HEFH, ASCVD: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: HEFH, ASCVD: TRIAL OF OR CONTRAINDICATION TO EZETIMIBE. MEETS ONE OF THE FOLLOWING: (1) TAKING A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80 MG DAILY, ROSUVASTATIN 20-40 MG DAILY) FOR A DURATION OF AT LEAST 8 WEEKS AND PATIENT WILL CONTINUE STATIN TREATMENT IN COMBINATION WITH LEQVIO, (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 AND PATIENT WILL CONTINUE STATIN TREATMENT IN COMBINATION WITH LEQVIO, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY (E.G., ACTIVE DECOMPENSATED LIVER DISEASE, NURSING FEMALE, PREGNANCY OR PLANS TO BECOME PREGNANT, HYPERSENSITIVITY REACTION), OR (4) COMPLETE STATIN INTOLERANCE AS DEFINED BY SEVERE AND INTOLERABLE ADVERSE EFFECTS (E.G., CREATINE KINASE ELEVATION GREATER THAN OR EQUAL TO 10 TIMES THE UPPER LIMIT OF NORMAL, LIVER FUNCTION TEST ELEVATION GREATER THAN OR EQUAL TO 3 TIMES THE UPPER LIMIT OF NORMAL, RHABDOMYOLYSIS, SEVERE MUSCLE WEAKNESS LEADING TO TEMPORARY DISABILITY, FALL, OR INABILITY TO USE A MAJOR MUSCLE GROUP) THAT HAVE OCCURRED WITH TRIALS OF AT LEAST TWO SEPARATE STATINS AND HAVE IMPROVED WITH THE DISCONTINUATION OF EACH STATIN. RENEWAL: HEFH, ASCVD: MEETS ONE OF THE FOLLOWING: (1) CONTINUED CONCURRENT THERAPY WITH A HIGH-INTENSITY STATIN (I.E., ATORVASTATIN 40-80 MG DAILY, ROSUVASTATIN 20-40 MG DAILY), (2) CONTINUED CONCURRENT THERAPY WITH A MAXIMALLY TOLERATED DOSE OF ANY STATIN, (3) ABSOLUTE CONTRAINDICATION TO STATIN THERAPY, OR (4)
	COMPLETE STATIN INTOLERANCE. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
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	

INEBILIZUMAB-CDON

Products Affected

- UPLIZNA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD): DIAGNOSIS CONFIRMED BY A POSITIVE SEROLOGIC TEST FOR ANTI-AQUAPORIN-4 (AQP4) ANTIBODIES
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: NMOSD: PATIENT HAS AT LEAST ONE OF THE FOLLOWING CORE CLINICAL CHARACTERISTICS: 1) OPTIC NEURITIS, 2) ACUTE MYELITIS, 3) AREA POSTREMA SYNDROME, 4) ACUTE BRAINSTEM SYNDROME, 5) SYMPTOMATIC NARCOLEPSY OR ACUTE DIENCEPHALIC CLINICAL SYNDROME WITH NMOSD-TYPICAL DIENCEPHALIC MRI LESIONS, OR 6) SYMPTOMATIC CEREBRAL SYNDROME WITH NMOSD-TYPICAL BRAIN LESIONS. NO CONCURRENT USE WITH RITUXIMAB, SATRALIZUMAB, OR ECULIZUMAB. RENEWAL: NMOSD: PATIENT HAS SHOWN CLINICAL BENEFIT (E.G., REDUCTION IN RELAPSE FREQUENCY FROM BASELINE OR A DECREASE IN NMOSD-RELATED HOSPITALIZATIONS)
Indications	All FDA-approved Indications.
Off Label Uses	

INFIGRATINIB

Products Affected

- TRUSELTIQ

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	

INFLIXIMAB

Products Affected

- *infliximab*
- REMICADE

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. CROHNS DISEASE/ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 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	INITIAL: PLAQUE PSORIASIS: SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5% BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. RENEWAL FOR RHEUMATOID ARTHRITIS, PSORIATIC ARTHRITIS, ANKYLOSING SPONDYLITIS, OR PLAQUE PSORIASIS: PHYSICIAN ATTESTATION THAT THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
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	INITIAL: 6 MONTHS. RENEWAL: 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	

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	THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
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: 6 MONTHS. RENEWAL: 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	

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	
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). 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	

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	

INTERFERON ALFA-2B

Products Affected

- INTRON A INJECTION

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	HEPATITIS C: GASTROENTEROLOGIST, INFECTIOUS DISEASE SPECIALIST, PHYSICIAN SPECIALIZING IN THE TREATMENT OF HEPATITIS (E.G. HEPATOLOGIST).
Coverage Duration	6 MONTHS.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. LIMITED TO 1 YEAR OF THERAPY EXCEPT 18 MONTHS FOR FOLLICULAR LYMPHOMA AND 24 MONTHS FOR HEPATITIS C. HEPATITIS C GENOTYPE 1, 2, 3, 4, 5, OR 6: REQUIRES A TRIAL OF OR CONTRAINDICATION TO PEGINTERFERON ALFA-2A OR PEGINTERFERON ALFA-2B USED IN COMBINATION WITH RIBAVIRIN UNLESS CONTRAINDICATED.
Indications	All FDA-approved Indications.
Off Label Uses	

INTERFERON GAMMA-1B

Products Affected

- ACTIMMUNE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CHRONIC GRANULOMATOUS DISEASE (CGD): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST, INFECTIOUS DISEASE SPECIALIST, OR IMMUNOLOGIST. SEVERE MALIGNANT OSTEOPETROSIS (SMO): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: THE PATIENT HAS DEMONSTRATED CLINICAL BENEFIT COMPARED TO BASELINE AND HAS NOT RECEIVED HEMATOPOIETIC CELL TRANSPLANTATION.
Indications	All FDA-approved Indications.
Off Label Uses	

INTERFERONS FOR MULTIPLE SCLEROSIS

Products Affected

- AVONEX INTRAMUSCULAR PEN INJECTOR KIT
- AVONEX INTRAMUSCULAR SYRINGE KIT
- BETASERON SUBCUTANEOUS KIT
- EXTAVIA SUBCUTANEOUS KIT
- PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML, 63 MCG/0.5 ML- 94 MCG/0.5 ML
- REBIF (WITH ALBUMIN)
- REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML, 8.8MCG/0.2ML-22 MCG/0.5ML (6)
- 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	

IPILIMUMAB

Products Affected

- YERVOY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: UNRESECT/MET MEL: 4MO, RCC/CRC/HCC: 3MO, ALL OTHERS: 12MO. INITIAL/RENEWAL: CUTAN MEL: 6MO
Other Criteria	RENEWAL FOR ADJUVANT CUTANEOUS MELANOMA: NO EVIDENCE OF DISEASE RECURRENCE (DEFINED AS THE APPEARANCE OF ONE OR MORE NEW MELANOMA LESIONS: LOCAL, REGIONAL OR DISTANT METASTASIS)
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	

ISTRADEFYLLINE

Products Affected

- NOURIANZ

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	

IVACAFTOR

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	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR CYSTIC FIBROSIS EXPERT
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS
Other Criteria	RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
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	INITIAL: PLAQUE PSORIASIS (PSO): MODERATE TO SEVERE PLAQUE PSORIASIS INVOLVING GREATER THAN OR EQUAL TO 5 PERCENT BODY SURFACE AREA OR PSORIATIC LESIONS AFFECTING THE HANDS, FEET, FACE, OR GENITAL AREA. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
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 AND NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RENEWAL: PSO, PSA, AS OR NR-AXSPA: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
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	RENEWAL REQUIRES PHYSICIAN ATTESTATION OF IMPROVEMENT.
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	

LANREOTIDE ACETATE

Products Affected

- *lanreotide* ML
- SOMATULINE DEPOT SUBCUTANEOUS SYRINGE 120 MG/0.5 ML, 60 MG/0.2 ML, 90 MG/0.3

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	

LAPATINIB DITOSYLATE

Products Affected

- *lapatinib*
- TYKERB

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	

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	

LASMIDITAN

Products Affected

- REYVOW

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO FORMULARY TRIPTANS. RENEWAL: THE PATIENT HAS EXPERIENCED AN IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE OR THE PATIENT HAS EXPERIENCED CLINICAL IMPROVEMENT WITH DOCUMENTED PHYSICIAN ATTESTATION
Indications	All FDA-approved Indications.
Off Label Uses	

LEDIPASVIR-SOFOSBUVIR

Products Affected

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

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	HCV RNA LEVEL WITHIN PAST 6 MONTHS.
Age Restrictions	
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 PER FDA DOSING SEE OTHER CRITERIA FOR MORE INFO. CRITERIA APPLIED USING AASLD/IDSA GUIDANCE
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT AASLD/IDSA GUIDANCE. PATIENT IS NOT CONCURRENTLY TAKING ANY OF THE FOLLOWING: CARBAMAZEPINE, PHENYTOIN, PHENOBARBITAL, OXCARBAZEPINE, RIFAMPIN, RIFABUTIN, RIFAPENTINE, ROSUVASTATIN, SOFOSBUVIR (AS A SINGLE AGENT), OR TIPRANAVIR/RITONAVIR.
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	

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	

LEVAMLODIPINE

Products Affected

- CONJUPRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	HYPERTENSION: 1) TRIAL OF OR CONTRAINDICATION TO ONE GENERIC DIHYDROPYRIDINE CALCIUM CHANNEL BLOCKER, AND 2) TRIAL OF OR CONTRAINDICATION TO ONE OTHER ANTIHYPERTENSIVE AGENT IN ANOTHER CLASS (E.G., THIAZIDES, ACE INHIBITOR, ARB)
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	RENEWAL: PHYSICIAN ATTESTATION OF PATIENT IMPROVEMENT WITH MOTOR FLUCTUATIONS DURING OFF EPISODES WITH THE USE OF INBRIJA.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 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	

LEVOKETOCONAZOLE

Products Affected

- RECORLEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CUSHINGS SYNDROME (CS): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	CS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	CS: RENEWAL: PATIENT 1) CONTINUES TO BENEFIT FROM THE MEDICATION, AND 2) MAINTAINS TOLERABILITY TO RECORLEV.
Indications	All FDA-approved Indications.
Off Label Uses	

L-GLUTAMINE

Products Affected

- ENDARI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST
Coverage Duration	INITIAL: 12 MONTHS. RENEWAL: LIFETIME.
Other Criteria	INITIAL CRITERIA FOR ADULTS (18 YEARS OR OLDER): PHYSICIAN ATTESTATION OF ONE OF THE FOLLOWING: (1) AT LEAST 2 SICKLE CELL CRISES IN THE PAST YEAR OR (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 5-17 WILL BE APPROVED WITHOUT REQUIRING ADDITIONAL CRITERIA. RENEWAL FOR ALL PATIENTS: PHYSICIAN ATTESTATION PATIENT HAS MAINTAINED OR EXPERIENCED REDUCTION IN ACUTE COMPLICATIONS OF SICKLE CELL 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	

LONAFARNIB

Products Affected

- ZOKINVY

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	

LONAPEGSOMATROPIN-TCGD

Products Affected

- SKYTROFA

PA Criteria	Criteria Details
Exclusion Criteria	PEDIATRIC GROWTH HORMONE DEFICIENCY (GHD): INITIAL AND RENEWAL: ATHLETIC ENHANCEMENT, ANTI-AGING PURPOSES.
Required Medical Information	PEDIATRIC GHD: INITIAL: HEIGHT GREATER THAN OR EQUAL TO 2 STANDARD DEVIATIONS (SD) BELOW THE MEAN HEIGHT FOR NORMAL CHILDREN OF THE SAME AGE AND GENDER.
Age Restrictions	
Prescriber Restrictions	PEDIATRIC GHD: INITIAL AND RENEWAL: PRESCRIBED BY OR IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	PEDIATRIC GHD: INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	PEDIATRIC GHD: INITIAL: DIAGNOSED WITH OPEN EPIPHYSES. RENEWAL: 1) CONTINUED DIAGNOSIS OF OPEN EPIPHYSES OR PATIENT HAS NOT COMPLETED PREPUBERTAL GROWTH, AND 2) IMPROVEMENT ON THERAPY (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY).
Indications	All FDA-approved Indications.
Off Label Uses	

LONCASTUXIMAB TESIRINE-LPYL

Products Affected

- ZYNLONTA

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	

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	

LOTEPREDNOL

Products Affected

- EYSUVIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	2 WEEKS
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

LUMACAFTOR-IVACAFTOR

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	

LUMASIRAN

Products Affected

- OXLUMO

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	

MARALIXIBAT

Products Affected

- LIVMARLI

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	

MARGETUXIMAB-CMKB

Products Affected

- MARGENZA

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	

MARIBAVIR

Products Affected

- LIVTENCITY

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	

MELPHALAN FLUFENAMIDE

Products Affected

- PEPAXTO

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	

MEPOLIZUMAB

Products Affected

- NUCALA SUBCUTANEOUS AUTO-INJECTOR
- NUCALA SUBCUTANEOUS RECON SOLN
- NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML, 40 MG/0.4 ML

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: ASTHMA: CONCURRENT USE OF XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS.
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN PULMONARY OR ALLERGY MEDICINE.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL: ASTHMA: PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION. THE PATIENT HAS EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION IN THE PAST 12 MONTHS (DEFINED AS ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING 3 OR MORE DAYS). RENEWAL: ASTHMA: PATIENT HAS SHOWN A CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE , 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR 4) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE.
Indications	All FDA-approved Indications.

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

METHYLNALTREXONE ORAL

Products Affected

- RELISTOR ORAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
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	

METOCLOPRAMIDE

Products Affected

- GIMOTI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	3 MONTHS
Other Criteria	TRIAL OF OR CONTRAINDICATION TO TWO GENERIC METOCLOPRAMIDE PRODUCTS
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	

MIGLUSTAT

Products Affected

- ZAVESCA

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	

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	INITIAL: CHRONIC KIDNEY DISEASE (CKD): A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. RENEWAL: CKD DIAGNOSIS REQUIRES ONE OF THE FOLLOWING: 1) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND DOSE REDUCTION/ INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RENEWAL: CKD: PATIENT IS NOT RECEIVING DIALYSIS TREATMENT. 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 FDA-approved Indications.
Off Label Uses	

MOBOCERTINIB

Products Affected

- EXKIVITY

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	

MODAFINIL

Products Affected

- *modafinil oral tablet 100 mg, 200 mg*
- PROVIGIL ORAL TABLET 100 MG, 200 MG

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	

MONOMETHYL FUMARATE

Products Affected

- BAFIERTAM

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	

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	

NATALIZUMAB

Products Affected

- TYSABRI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHNS DISEASE: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	12 MONTHS MULTIPLE SCLEROSIS: 12 MOS. CROHNS DISEASE: INITIAL:6 MOS. RENEWAL: 12 MOS.
Other Criteria	PATIENT AND PHYSICIAN ARE REGISTERED IN THE TOUCH PRESCRIBING PROGRAM. CROHNS DISEASE RENEWAL CRITERIA: PATIENT HAS RECEIVED AT LEAST 12 MONTHS OF THERAPY WITH TYSABRI WITH PHYSICIAN ATTESTATION THAT THE PATIENT HAS NOT REQUIRED MORE THAN 3 MONTHS OF CORTICOSTEROID USE WITHIN THE PAST 12 MONTHS TO CONTROL THEIR CROHNS DISEASE WHILE ON TYSABRI, OR PATIENT HAS ONLY RECEIVED 6 MONTHS OF THERAPY WITH TYSABRI WITH PHYSICIAN ATTESTATION THAT THE PATIENT HAS TAPERED OFF CORTICOSTEROIDS DURING THE FIRST 24 WEEKS OF TYSABRI THERAPY. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

NAXITAMAB-GQGK

Products Affected

- DANYELZA

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	

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	

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	

NINTEDANIB

Products Affected

- OFEV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: IPF: 1) 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, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE. SSC-ILD: AT LEAST 10% FIBROSIS ON A CHEST HRCT AND BASELINE FVC AT LEAST 40% OF PREDICTED VALUE. PF-ILD: AT LEAST 10% FIBROSIS ON A CHEST HRCT AND BASELINE FVC AT LEAST 45% OF PREDICTED VALUE.
Age Restrictions	
Prescriber Restrictions	INITIAL: IPF: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST. SSC-ILD, PF-ILD: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST OR RHEUMATOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL: PF-ILD: LUNG FUNCTION AND RESPIRATORY SYMPTOMS OR CHEST IMAGING HAVE WORSENED/PROGRESSED DESPITE TREATMENT WITH MEDICATIONS USED IN CLINICAL PRACTICE FOR ILD (NOT ATTRIBUTABLE TO COMORBIDITIES SUCH AS INFECTION, HEART FAILURE). RENEWAL: IPF, SSC ILD, PF-ILD: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
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	NSCLC IN COMBINATION WITH YERVOY (IPILIMUMAB): PATIENT HAS RECEIVED A TOTAL OF 24 MONTHS CUMULATIVE TREATMENT.
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	

NIVOLUMAB-RELATLIMAB-RMBW

Products Affected

- OPDUALAG

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	

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 CONTINUES TO BENEFIT FROM THE MEDICATION
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 (MS): THE PATIENT HAD A PREVIOUS TRIAL OF TWO AGENTS INDICATED FOR TREATMENT OF MS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

OCTREOTIDE ORAL

Products Affected

- MYCAPSSA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ACROMEGALY: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	ACROMEGALY INITIAL: 3 MONTHS: RENEWAL: 12 MONTHS
Other Criteria	ACROMEGALY: INITIAL: RESPONDED TO AND IS CURRENTLY STABLE ON AN INJECTABLE SOMATOSTATIN ANALOG THERAPY. RENEWAL: 1) REDUCTION, NORMALIZATION, OR MAINTENANCE OF IGF-1 LEVELS BASED ON AGE AND GENDER, AND 2) IMPROVEMENT OR SUSTAINED REMISSION OF CLINICAL SYMPTOMS OF ACROMEGALY.
Indications	All FDA-approved Indications.
Off Label Uses	

OFATUMUMAB

Products Affected

- ARZERRA

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	

OFATUMUMAB-SQ

Products Affected

- KESIMPTA PEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	(1) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING PLATFORM THERAPIES: AUBAGIO, AVONEX, PLEGRIDY, REBIF, TECFIDERA, GLATIRAMER/COPAXONE/GLATOPA, VUMERITY. IF PATIENT SHOWS SIGNS OF HIGH-SEVERITY DISEASE, TRIAL OF PLATFORM THERAPY IS NOT REQUIRED. (2) TRIAL OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING HIGH EFFICACY DISEASE MODIFYING THERAPIES (DMTS): GILENYA, MAVENCLAD, MAYZENT.
Indications	All FDA-approved Indications.
Off Label Uses	

OLANZAPINE/SAMIDORPHAN

Products Affected

- LYBALVI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SCHIZOPHRENIA/BIPOLAR I: PRESCRIBED BY OR IN CONSULTATION WITH A PSYCHIATRIST
Coverage Duration	12 MONTHS
Other Criteria	SCHIZOPHRENIA/BIPOLAR I: (1) PATIENT IS AT HIGH RISK OF WEIGHT GAIN AND (2) TRIAL/FAILURE OF OR CONTRAINDICATION TO ONE OF THE FOLLOWING FORMULARY ORAL ANTIPSYCHOTICS: RISPERIDONE, CLOZAPINE TABLET, OLANZAPINE, IMMEDIATE RELEASE QUETIAPINE FUMARATE, ZIPRASIDONE, ARIPIPRAZOLE
Indications	All FDA-approved Indications.
Off Label Uses	

OLAPARIB

Products Affected

- LYNPARZA

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	

OMACETAXINE

Products Affected

- SYNRIBO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INDUCTION: 3 MONTHS. POST INDUCTION/RENEWAL: 3 TO 12 MONTHS.
Other Criteria	CML INDUCTION THERAPY: TRIAL OF OR CONTRAINDICATION TO AT LEAST TWO OF THE FOLLOWING AGENTS: GLEEVEC, SPRYCEL, TASIGNA, BOSULIF, OR ICLUSIG. APPROVAL FOR POST-INDUCTION THERAPY DURATION WILL DEPEND ON THE PATIENTS HEMATOLOGIC RESPONSE, DEFINED AS (1) AN ABSOLUTE NEUTROPHIL COUNT (ANC) GREATER THAN OR EQUAL TO 1.5 X 10^9/L AND PLATELETS GREATER THAN OR EQUAL TO 100 X 10^9/L WITHOUT BLOOD BLASTS OR (2) THE PATIENT HAS BONE MARROW BLASTS AT LESS THAN 5 PERCENT. APPROVAL IS FOR 12 MONTHS IF HEMATOLOGIC RESPONSE IS MET. IF NOT MET, APPROVAL IS FOR 3 MONTHS.
Indications	All FDA-approved Indications.
Off Label Uses	

OMALIZUMAB

Products Affected

- XOLAIR

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: ASTHMA: CONCURRENT USE OF DUPIXENT OR ANTI-IL5 BIOLOGIC
Required Medical Information	INITIAL APPROVAL FOR ASTHMA: POSITIVE SKIN PRICK OR RAST TEST TO A PERENNIAL AEROALLERGEN AND A BASELINE IGE SERUM LEVEL GREATER THAN OR EQUAL TO 30 IU/ML.
Age Restrictions	
Prescriber Restrictions	INITIAL: CHRONIC IDIOPATHIC URTICARIA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE, DERMATOLOGY OR IMMUNOLOGY. NASAL POLYPS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN OTOLARYNGOLOGIST, ALLERGIST OR IMMUNOLOGIST. ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE
Coverage Duration	INITIAL: ASTHMA: 12 MOS. CHRONIC IDIOPATHIC URTICARIA, NASAL POLYPS: 6 MOS. ALL RENEWAL: 12 MOS.

PA Criteria	Criteria Details
Other Criteria	INITIAL APPROVAL FOR CHRONIC IDIOPATHIC URTICARIA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO A MAXIMALLY TOLERATED DOSE OF AN H1 ANTI-HISTAMINE AND PATIENT STILL EXPERIENCES HIVES ON MOST DAYS OF THE WEEK. INITIAL APPROVAL FOR NASAL POLYPS: PREVIOUS 90 DAY TRIAL OF ONE TOPICAL NASAL CORTICOSTEROID. INITIAL APPROVAL FOR ASTHMA: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION. 2) PATIENT HAS EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT, OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS). 3) XOLAIR WILL BE USED AS ADD-ON MAINTENANCE TREATMENT. RENEWAL FOR ASTHMA: PATIENT HAS SHOWN A CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE , 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR 4) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE. RENEWAL FOR NASAL POLYPS: CLINICAL BENEFIT COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

OPICAPONE

Products Affected

- ONGENTYS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OF AGE OR OLDER
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	
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	CUSHINGS DISEASE (CD): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RENEWAL: CD: PATIENT CONTINUES TO HAVE IMPROVEMENT OF CD AND MAINTAINS TOLERABILITY TO ISTURISA.
Indications	All FDA-approved Indications.
Off Label Uses	

OSIMERTINIB

Products Affected

- TAGRISSO

PA Criteria	Criteria Details
Exclusion Criteria	CONCURRENT THERAPY WITH AN EGFR TYROSINE KINASE-INHIBITO
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	MULTIPLE SCLEROSIS: PREVIOUS TRIAL OF ONE SPHINGOSINE-1-PHOSPHATE RECEPTOR MODULATOR (E.G. GILENYA, MAYZENT) AND ANY ONE AGENT INDICATED FOR THE TREATMENT OF MULTIPLE SCLEROSIS. ULCERATIVE COLITIS (UC): TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, OR MESALAMINE
Indications	All FDA-approved Indications.
Off Label Uses	

PACRITINIB

Products Affected

- VONJO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	MYELOFIBROSIS: RENEWAL: CONTINUES TO BENEFIT FROM THE MEDICATION
Indications	All FDA-approved Indications.
Off Label Uses	

PALIVIZUMAB

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 PATIENTS 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 GESTATIONAL AGE
Age Restrictions	LESS THAN 24 MONTHS OF AGE.
Prescriber Restrictions	

PA Criteria	Criteria Details
Coverage Duration	1 MONTH TO 5 MONTHS. SEE OTHER CRITERIA FOR MORE INFORMATION.
Other Criteria	CRITERIA WILL BE APPLIED CONSISTENT WITH CURRENT RECOMMENDATIONS FROM THE AMERICAN ACADEMY OF PEDIATRICS FOR PALIVIZUMAB PROPHYLAXIS FOR RESPIRATORY SYNCYTIAL VIRUS INFECTIONS. INITIAL: APPROVAL WILL BE FOR AT LEAST 1 MONTH AND NO GREATER THAN 5 MONTHS DEPENDENT UPON REMAINING LENGTH OF RESPIRATORY SYNCYTIAL VIRUS (RSV) SEASON. RENEWAL: ADDITIONAL 1 MONTH OF TREATMENT FOR CARDIOPULMONARY BYPASS SURGERY DURING RSV PROPHYLAXIS SEASON.
Indications	All FDA-approved Indications.
Off Label Uses	

PANOBINOSTAT

Products Affected

- FARYDAK

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
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	

PARATHYROID HORMONE

Products Affected

- NATPARA

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	

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	

PAZOPANIB

Products Affected

- VOTRIENT

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	

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	

PEGFILGRASTIM

Products Affected

- FULPHILA
- NEULASTA
- NEULASTA ONPRO
- NYVEPRIA
- UDENYCA
- ZIEXTENZO

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

PEGVALIASE-PQPZ

Products Affected

- PALYNZIQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PEGVISOMANT

Products Affected

- SOMAVERT SUBCUTANEOUS RECON SOLN 10 MG, 15 MG, 20 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	

PEMBROLIZUMAB

Products Affected

- KEYTRUDA

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	

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	
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	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

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	

PIRFENIDONE

Products Affected

- ESBRIET ORAL CAPSULE
- ESBRIET ORAL TABLET 267 MG, 801 MG
- *pirfenidone oral tablet 267 mg, 801 mg*

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: IDIOPATHIC PULMONARY FIBROSIS (IPF): 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).
Required Medical Information	INITIAL: IPF: 1) 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, AND 2) BASELINE FORCED VITAL CAPACITY (FVC) AT LEAST 50% OF PREDICTED VALUE.
Age Restrictions	INITIAL: IPF: 18 YEARS OR OLDER
Prescriber Restrictions	INITIAL: IPF: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PULMONOLOGIST
Coverage Duration	INITIAL AND RENEWAL:12 MONTHS
Other Criteria	RENEWAL: IPF: CLINICAL MEANINGFUL IMPROVEMENT OR MAINTENANCE IN ANNUAL RATE OF DECLINE.
Indications	All FDA-approved Indications.
Off Label Uses	

PITOLISANT

Products Affected

- WAKIX

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: INITIAL: TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY VERSION OF SOLRIAMFETOL, ARMODAFINIL OR MODAFINIL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY. RENEWAL: PHYSICIAN ATTESTATION OF SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE.
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	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTH
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

PONATINIB

Products Affected

- ICLUSIG ORAL TABLET 10 MG, 15 MG, 30 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	

PONESIMOD

Products Affected

- PONVORY
- PONVORY 14-DAY STARTER PACK

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

PRALATREXATE

Products Affected

- FOLOTYN

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	

PRALSETINIB

Products Affected

- GAVRETO

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 FDA-approved 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	

PYRIMETHAMINE

Products Affected

- *pyrimethamine*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	TOXOPLASMOSIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN INFECTIOUS DISEASE SPECIALIST
Coverage Duration	TOXOPLASMOSIS: INITIAL: 8 WEEKS. RENEWAL: 6 MOS.
Other Criteria	RENEWAL: CONTINUED TREATMENT OF TOXOPLASMOSIS REQUIRES ONE OF THE FOLLOWING: 1) PERSISTENT CLINICAL DISEASE (HEADACHE, NEUROLOGICAL SYMPTOMS, OR FEVER) AND PERSISTENT RADIOGRAPHIC DISEASE (ONE OR MORE MASS LESIONS ON BRAIN IMAGING) OR 2) CD4 COUNT LESS THAN 200 CELLS/MM3 AND CURRENT ANTI-RETROVIRAL THERAPY IF HIV POSITIVE.
Indications	All FDA-approved Indications.
Off Label Uses	

QUININE SULFATE

Products Affected

- QUALAQUIN
- *quinine sulfate*

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	

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	

REGORAFENIB

Products Affected

- STIVARGA

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	

RELUGOLIX

Products Affected

- ORGOVYX

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	

RELUGOLIX-ESTRADIOL-NORETHINDRONE

Products Affected

- MYFEMBREE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	18 YEARS OR OLDER
Prescriber Restrictions	HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS: PRESCRIBED BY OR IN CONSULTATION WITH OBSTETRICIAN/GYNECOLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 18 MONTHS.
Other Criteria	INITIAL: HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS: TRIAL AND FAILURE OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING: ORAL TRANEXAMIC ACID, CONTRACEPTIVE PREPARATIONS. RENEWAL: HEAVY MENSTRUAL BLEEDING ASSOCIATED WITH UTERINE LEIOMYOMAS: IMPROVEMENT OF HEAVY MENSTRUAL BLEEDING.
Indications	All FDA-approved Indications.
Off Label Uses	

RESLIZUMAB

Products Affected

- CINQAIR

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL: ASTHMA: CONCURRENT USE OF XOLAIR, DUPIXENT OR OTHER ANTI-IL5 BIOLOGICS.
Required Medical Information	INITIAL: ASTHMA: BLOOD EOSINOPHIL LEVEL GREATER THAN OR EQUAL TO 150 CELLS/MCL WITHIN THE PAST 12
Age Restrictions	
Prescriber Restrictions	INITIAL: ASTHMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	12 MONTHS
Other Criteria	INITIAL FOR ASTHMA: 1) PRIOR THERAPY WITH A MEDIUM, HIGH-DOSE OR MAXIMALLY TOLERATED DOSE OF AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION. 2) PATIENT HAS EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION IN THE PAST 12 MONTHS (DEFINED AS AN ASTHMA-RELATED EVENT REQUIRING HOSPITALIZATION, EMERGENCY ROOM VISIT OR SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS). RENEWAL FOR ASTHMA: PATIENT HAS SHOWN A CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: 1) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, 2) DECREASED UTILIZATION OF RESCUE MEDICATIONS, 3) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS, OR 4) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE.
Indications	All FDA-approved Indications.

PA Criteria	Criteria Details
Off Label Uses	

RETACRIT

Products Affected

- RETACRIT 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: CHRONIC KIDNEY DISEASE (CKD), ANEMIA RELATED TO ZIDOVUDINE THERAPY, OR CANCER CHEMOTHERAPY: A HEMOGLOBIN LEVEL OF LESS THAN 10G/DL. ELECTIVE NON-CARDIAC OR NON-VASCULAR SURGERY: A HEMOGLOBIN LEVEL LESS THAN 13G/DL. RENEWAL: CKD DIAGNOSIS REQUIRES ONE OF THE FOLLOWING: 1) HEMOGLOBIN LEVEL IS LESS THAN 10G/DL OR 2) HEMOGLOBIN LEVEL HAS REACHED 10G/DL AND DOSE REDUCTION/INTERRUPTION IS REQUIRED TO REDUCE THE NEED FOR BLOOD TRANSFUSIONS. ANEMIA DUE TO ZIDOVUDINE THERAPY: A HEMOGLOBIN LEVEL BETWEEN 10G/DL AND 12G/DL. ANEMIA DUE TO EFFECT OF CONCOMITANTLY ADMINISTERED CANCER CHEMOTHERAPY: 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	
Coverage Duration	ANEMIA FROM MYELOSUPPRESSIVE CHEMO/CKD WITHOUT DIALYSIS/ZIDOVUDINE:12 MONTHS.SURGERY:1 MO.

PA Criteria	Criteria Details
Other Criteria	RENEWAL: CKD: PATIENT IS NOT RECEIVING DIALYSIS TREATMENT. 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 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 200 MG DAILY DOSE
- 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	

RIFAXIMIN

Products Affected

- XIFAXAN ORAL TABLET 200 MG, 550 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	TRAVELERS DIARRHEA/HE: 12 MOS. IBS-D: 12 WKS.
Other Criteria	FOR RIFAXIMIN 550 MG TABLETS ONLY: HEPATIC ENCEPHALOPATHY (HE): PREVIOUS TRIAL OF OR CONTRAINDICATION TO LACTULOSE OR CONCURRENT LACTULOSE THERAPY. IBS-D: NO ADDITONAL CRITERIA
Indications	All FDA-approved Indications.
Off Label Uses	

RIMEGEPANT

Products Affected

- NURTEC ODT

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: ACUTE MIGRAINE TREATMENT: TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY TRIPTANS. EPISODIC MIGRAINE PREVENTION: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE FORMULARY ALTERNATIVE FOR PREVENTIVE MIGRAINE TREATMENT SUCH AS DIVALPROEX SODIUM, TOPIRAMATE, PROPRANOLOL, TIMOLOL. RENEWAL: ALL INDICATIONS: THE PATIENT HAS EXPERIENCED AN IMPROVEMENT WITH TREATMENT
Indications	All FDA-approved Indications.
Off Label Uses	

RIOCIGUAT

Products Affected

- ADEMPAS

PA Criteria	Criteria Details
Exclusion Criteria	INITIAL FOR PAH: PATIENT IS NOT CONCURRENTLY TAKING NITRATES OR NITRIC OXIDE DONORS, PHOSPHODIESTERASE INHIBITORS, OR NON-SPECIFIC PDE INHIBITORS. INITIAL FOR CTEPH: PATIENT IS NOT CONCURRENTLY OR INTERMITTENTLY TAKING NITRATES, NITRIC OXIDE DONORS OR ANY PDE INHIBITORS.
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	INITIAL FOR PAH: 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 AND PREVIOUS TRIAL OF OR CONTRAINDICATION TO A FORMULARY PREFERRED PHOSPHODIESTERASE-5 (PDE-5) INHIBITOR. INITIAL FOR CTEPH: PATIENT IS NOT A CANDIDATE FOR SURGERY OR HAS INOPERABLE CTEPH OR HAS PERSISTENT OR RECURRENT DISEASE AFTER SURGICAL TREATMENT. RENEWAL FOR PAH AND CTEPH: 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.

PA Criteria	Criteria Details
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 PEN INJECTOR
- SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML
- 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	

RISDIPLAM

Products Affected

- EVRYSDI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	SMA: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROMUSCULAR SPECIALIST OR SPINAL MUSCULAR ATROPHY (SMA) SPECIALIST AT A SMA SPECIALTY CENTER
Coverage Duration	SMA: INITIAL/RENEWAL: 12 MONTHS
Other Criteria	SPINAL MUSCULAR ATROPHY (SMA): INITIAL: DOCUMENTATION OF GENE MUTATION ANALYSIS INDICATING MUTATIONS OR DELETIONS OF BOTH ALLELES OF THE SURVIVAL MOTOR NEURON 1 (SMN1) GENE. FOR PRESYMPTOMATIC PATIENTS: DOCUMENTATION OF UP TO THREE COPIES OF SURVIVAL MOTOR NEURON 2 (SMN2) BASED ON NEWBORN SCREENING. FOR SYMPTOMATIC PATIENTS: 1) ONSET OF SMA SYMPTOMS OCCURRED BEFORE 20 YEARS OF AGE, 2) DOCUMENTATION OF BASELINE MOTOR FUNCTION ASSESSMENT BY A NEUROMUSCULAR SPECIALIST OR SMA SPECIALIST, 3) IF PREVIOUSLY RECEIVED GENE THERAPY, THE PATIENT HAD LESS THAN EXPECTED CLINICAL BENEFIT. RENEWAL: IMPROVED, MAINTAINED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN MOTOR FUNCTION ASSESSMENTS COMPARED TO BASELINE, OR OTHER MUSCLE FUNCTION.

PA Criteria	Criteria Details
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

- RIABNI
- 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	

ROMIDEPSIN

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	

ROMIPLOSTIM

Products Affected

- NPLATE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A HEMATOLOGIST OR IMMUNOLOGIST.
Coverage Duration	INITIAL: 4 MONTHS. RENEWAL: 12 MONTHS.
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	

ROPEGINTERFERON ALFA-2B-NJFT

Products Affected

- BESREMI

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	

RUCAPARIB

Products Affected

- RUBRACA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	METASTATIC CASTRATION-RESISTANT PROSTATE CANCER: PREVIOUSLY RECEIVED A BILATERAL ORCHIECTOMY, OR CONCURRENT USE WITH A GONADOTROPIN RELEASING HORMONE (GNRH) ANALOG, OR SERUM TESTOSTERONE LEVEL LESS THAN 50 NG/DL.
Indications	All FDA-approved Indications.
Off Label Uses	

RUXOLITINIB

Products Affected

- JAKAFI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MYELOFIBROSIS RENEWAL: IMPROVEMENT OR MAINTENANCE OF SYMPTOM IMPROVEMENT SUCH AS A 50% OR GREATER REDUCTION IN TOTAL SYMPTOM SCORE ON THE MODIFIED MYELOFIBROSIS SYMPTOM ASSESSMENT FORM (MFSAF) V2.0 OR 50% OR GREATER REDUCTION IN PALPABLE SPLEEN LENGTH, OR REDUCTION OF 35% OR GREATER FROM BASELINE SPLEEN VOLUME AFTER 6 MONTHS OF THERAPY. ACUTE GRAFT-VERSUS-HOST DISEASE (GVHD): NO RENEWAL CRITERIA.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	MYELOFIBROSIS: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS. POLYCYTHEMIA VERA, GVHD: 12 MONTHS.
Other Criteria	
Indications	All FDA-approved Indications.
Off Label Uses	

RUXOLITINIB TOPICAL

Products Affected

- OPZELURA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 2 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	ATOPIC DERMATITIS: INITIAL: TRIAL OF OR CONTRAINDICATION TO: 1) HIGH POTENCY (GROUP 2 OR GROUP 3) OR SUPER-HIGH POTENCY (GROUP 1) TOPICAL CORTICOSTEROID, AND 2) TOPICAL CALCINEURIN INHIBITOR OR EUCRISA, RENEWAL: EXPERIENCED OR MAINTAINED IMPROVEMENT IN PRURITUS, RELAPSINGREMITTING DERMATITIS, AND/OR FACIAL/INTERDIGITAL INVOLVEMENT.
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	

SACITUZUMAB

Products Affected

- TRODELVY

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	

SATRALIZUMAB-MWGE

Products Affected

- ENSPRYNG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NMOSD: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST OR OPHTHALMOLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS
Other Criteria	NMOSD: INITIAL: A) MEETS ONE OF THE FOLLOWING CORE CLINICAL CHARACTERISTIC: OPTIC NEURITIS, ACUTE MYELITIS, AREA POSTREMA SYNDROME, ACUTE BRAINSTEM SYNDROME, SYMPTOMATIC NARCOLEPSY OR ACUTE DIENCEPHALIC CLINICAL SYNDROME WITH NMOSD-TYPICAL DIENCEPHALIC MRI LESIONS, OR SYMPTOMATIC CEREBRAL SYNDROME WITH NMOSD-TYPICAL BRAIN LESIONS, B) PATIENT WILL NOT USE RITUXIMAB, INEBILIZUMAB, OR ECULIZUMAB CONCURRENTLY. NMOSD: RENEWAL: REDUCTION IN RELAPSE FREQUENCY FROM BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

SEBELIPASE ALFA

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	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH AN ENDOCRINOLOGIST, HEPATOLOGIST, GASTROENTEROLOGIST, MEDICAL GENETICIST, LIPIDOLOGIST, OR A METABOLIC SPECIALIST.
Coverage Duration	12 MONTHS LAL INITIAL 6 OR 12 MONTHS, SEE OTHER CRITERIA. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY, AS CONFIRMED BY THE PRESENCE OF CLINICAL FEATURES (E.G., HEPATOMEGALY, ELEVATED SERUM TRANSAMINASES, DYSLIPIDEMIA, SPLENOMEGALY) PLUS ANY OF THE FOLLOWING: A BLOOD TEST INDICATING LOW OR ABSENT LEVELS OF LAL ENZYME ACTIVITY, A DRIED BLOOD SPOT TEST INDICATING LOW OR ABSENT LAL ENZYME ACTIVITY, OR A GENETIC TEST INDICATING THE BI-ALLELIC PRESENCE OF ALTERED LIPA GENE(S). RENEWAL:DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING AFTER THE FIRST 6 MONTHS OF LIFE AND NOT CONSIDERED RAPIDLY PROGRESSIVE REQUIRES DOCUMENTED IMPROVEMENT IN ANY ONE OF THE FOLLOWING CLINICAL PARAMETERS ASSOCIATED WITH LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY DURING THE PAST 6 MONTHS: A RELATIVE REDUCTION FROM BASELINE IN ANY ONE OF THE FOLLOWING LIPID LEVELS (LDL-C, NON-HDL-C, OR TRIGLYCERIDES), NORMALIZATION OF ASPARTATE AMINOTRANSFERASE (AST) BASED ON AGE- AND GENDER-SPECIFIC NORMAL RANGES, A DECREASE IN LIVER FAT CONTENT COMPARED TO BASELINE ASSESSED BY ABDOMINAL IMAGING (E.G., MULTI-ECHO GRADIENT ECHO [MEGE] MRI). DIAGNOSIS OF RAPIDLY PROGRESSIVE LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING WITHIN THE FIRST 6 MONTHS OF LIFE: 12 MONTHS. A DIAGNOSIS OF LYSOSOMAL ACID LIPASE (LAL) DEFICIENCY PRESENTING AFTER THE FIRST 6 MONTHS OF LIFE AND NOT CONSIDERED RAPIDLY PROGRESSIVE: INITIAL: 6 MONTHS
Indications	All FDA-approved Indications.
Off Label Uses	

SECUKINUMAB

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 AFFECTING THE HANDS, FEET, GENITAL AREA, OR FACE. NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): (1) C-REACTIVE PROTEIN (CRP) LEVELS ABOVE THE UPPER LIMIT OF NORMAL, OR (2) SACROILIITIS ON MAGNETIC RESONANCE IMAGING (MRI).
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 A DERMATOLOGIST. ANKYLOSING SPONDYLITIS (AS) AND NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS

PA Criteria	Criteria Details
Other Criteria	INITIAL: PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTI-RHEUMATIC DRUG). ANKYLOSING SPONDYLITIS (AS) AND NON-RADIOGRAPHIC AXIAL SPONDYLOARTHRITIS (NR-AXSPA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AN NSAID (NON-STEROIDAL ANTI-INFLAMMATORY DRUG). RENEWAL: PSO, PSA, AS, NR-AXSPA: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

SELEXIPAG

Products Affected

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

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	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	

SELINEXOR

Products Affected

- XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (20 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 40MG TWICE WEEK (80 MG/WEEK), 60 MG/WEEK (20 MG X 3), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (20 MG X 4), 80 MG/WEEK (40 MG X 2), 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	

SILTUXIMAB

Products Affected

- SYLVANT

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	

SIPONIMOD

Products Affected

- MAYZENT ORAL TABLET 0.25 MG, 1 MG, 2 MG
- MAYZENT STARTER(FOR 1MG MAINT)

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	ALL INDICATIONS: INITIAL: THE PATIENT IS NOT CURRENTLY BEING TREATED WITH SEDATIVE HYPNOTIC AGENTS. EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: THE PATIENT HAS TRIED OR HAS A CONTRAINDICATION TO THE FORMULARY VERSION OF MODAFINIL, ARMODAFINIL OR SOLRIAMFETOL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY. RENEWAL: SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

SODIUM/CALCIUM/MAG/POT OXYBATE

Products Affected

- XYWAV

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	INITIAL: CATAPLEXY OR EXCESSIVE DAYTIME SLEEPINESS (EDS) IN NARCOLEPSY: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST, PSYCHIATRIST, OR SPECIALIST IN SLEEP MEDICINE.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS
Other Criteria	INITIAL: CATAPLEXY OR EDS IN NARCOLEPSY: PATIENT IS NOT CURRENTLY BEING TREATED WITH SEDATIVE HYPNOTIC AGENTS.EDS IN NARCOLEPSY: FOR PATIENTS 18 YEARS OR OLDER: TRIAL OF OR CONTRAINDICATION TO THE FORMULARY VERSION OF MODAFINIL, ARMODAFINIL, PITOLISANT, OR SOLRIAMFETOL AND ONE OTHER GENERIC STIMULANT INDICATED FOR EDS IN NARCOLEPSY IN ADULTS. RENEWAL: CATAPLEXY OR EDS IN NARCOLEPSY: SUSTAINED IMPROVEMENT OF SYMPTOMS COMPARED TO BASELINE.
Indications	All FDA-approved Indications.
Off Label Uses	

SOFOSBUVIR

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	
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	

SOFOSBUVIR/VELPATASVIR

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.
Required Medical Information	HCV RNA LEVEL.
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.
Indications	All FDA-approved Indications.
Off Label Uses	

SOFOSBUVIR/VELPATASVIR/VOXILAPREVIR

Products Affected

- VOSEVI

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 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	

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).
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.
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 (E.G. MEGESTEROL ACETATE, APPETITE STIMULANTS, ANABOLIC STEROIDS). 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).
Required Medical Information	INITIAL: PEDIATRIC GHD, ISS, SGA, AND TS: 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, AND TS: IMPROVEMENT (I.E., INCREASED HEIGHT OR INCREASED GROWTH VELOCITY). PWS: IMPROVEMENT IN BODY COMPOSITION.
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).
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	

SONIDEGIB

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	

SORAFENIB TOSYLATE

Products Affected

- NEXAVAR
- *sorafenib*

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	

SOTORASIB

Products Affected

- LUMAKRAS

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	

STIRIPENTOL

Products Affected

- DIACOMIT ORAL CAPSULE 250 MG, 500 MG
- DIACOMIT ORAL POWDER IN PACKET 250 MG, 500 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	DRAVET SYNDROME: PRESCRIBED BY OR IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL AND RENEWAL: 12 MONTHS.
Other Criteria	RENEWAL: DRAVET SYNDROME: CURRENTLY TREATED WITH CLOBAZAM.
Indications	All FDA-approved Indications.
Off Label Uses	

SUNITINIB MALATE

Products Affected

- *sunitinib*
- 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	

SUTIMLIMAB-JOME

Products Affected

- ENJAYMO

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	

SYMLIN (S)

Products Affected

- SYMLINPEN 120
- SYMLINPEN 60

PA Criteria	Criteria Details
Exclusion Criteria	
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	

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	

TALAZOPARIB

Products Affected

- TALZENNA ORAL CAPSULE 0.25 MG, 0.5 MG, 0.75 MG, 1 MG

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT HAS BEEN TREATED WITH CHEMOTHERAPY IN THE NEOADJUVANT, ADJUVANT, OR METASTATIC SETTING. PATIENTS WITH HORMONE RECEPTOR (HR)-POSITIVE BREAST CANCER MUST HAVE ADDITIONAL PRIOR TREATMENT WITH ENDOCRINE THERAPY OR BE CONSIDERED INAPPROPRIATE FOR ENDOCRINE THERAPY.
Indications	All FDA-approved Indications.
Off Label Uses	

TALIMOGENE

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	12 MONTHS
Other Criteria	IMLYGIC TO BE INJECTED INTO CUTANEOUS, SUBCUTANEOUS, AND OR NODAL LESIONS THAT ARE VISIBLE, PALPABLE, OR DETECTABLE BY ULTRASOUND GUIDANCE. NO CONCURRENT USE WITH PEMBROLIZUMAB, NIVOLUMAB, IPILIMUMAB, DABRAFENIB, TRAMETINIB, VEMURAFENIB, INTERLEUKIN-2, INTERFERON, DACARBAZINE, TEMOZOLOMIDE, PACLITAXEL, CARBOPLATIN, IMATINIB, MELPHALAN, IMIQUIMOD, OR RADIATION THERAPY.
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	

TASIMELTEON

Products Affected

- HETLIOZ
- HETLIOZ LQ

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	NON-24 HOUR SLEEP-WAKE DISORDER: PATIENT IS LIGHT-INSENSITIVE OR HAS TOTAL BLINDNESS.
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	

TEBENTAFUSP-TEBN

Products Affected

- KIMMTRAK

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	

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	

TEDUGLUTIDE

Products Affected

- GATTEX 30-VIAL

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	PATIENT IS DEPENDENT ON INTRAVENOUS PARENTERAL NUTRITION DEFINED AS REQUIRING PARENTERAL NUTRITION AT LEAST THREE TIMES PER WEEK
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	

TENAPANOR

Products Affected

- IBSRELA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	IRRITABLE BOWEL SYNDROME-CONSTIPATION (IBS-C): TRIAL OF ONE OF THE FOLLOWING PREFERRED AGENTS WHERE INDICATIONS ALIGN: LUBIPROSTONE AND LINZESS. MEN ARE ONLY REQUIRED TO A TRIAL OF LINZESS.
Indications	All FDA-approved Indications.
Off Label Uses	

TEPOTINIB

Products Affected

- TEPMETKO

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	

TEPROTUMUMAB-TRBW

Products Affected

- TEPEZZA

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	

TERIFLUNOMIDE

Products Affected

- AUBAGIO

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

- FORTEO SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (600MCG/2.4ML)
- *teriparatide*

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS

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

TESAMORELIN ACETATE

Products Affected

- 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

- ANDRODERM
- ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP
- 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)
- AVEED
- NATESTO
- TESTIM
- *testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)*
- *testosterone enanthate*
- *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
- XYOSTED

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: MALE HYPOGONADISM: INITIAL: CONFIRMED BY EITHER: 1) AT LEAST TWO MORNING TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS WHILE IN A FASTED STATE OR 2) A FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 PG/ML.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	PRIMARY OR SECONDARY HYPOGONADISM: 12 MONTHS. ALL OTHER INDICATIONS: LIFETIME OF MEMBERSHIP IN PLAN.

PA Criteria	Criteria Details
Other Criteria	MALE HYPOGONADISM: INITIAL: NO TESTOSTERONE LEVELS ARE REQUIRED WHEN THERE IS A PREVIOUSLY APPROVED AUTHORIZATION FOR TESTOSTERONE OR PATIENT HAS RECEIVED ANY FORM OF TESTOSTERONE REPLACEMENT THERAPY PER PHYSICIAN ATTESTATION OR CLAIMS HISTORY. RENEWAL: PHYSICIAN ATTESTATION OF IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

TESTOSTERONE-TLANDO

Products Affected

- TLANDO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	MALE HYPOGONADISM: INITIAL: CONFIRMED BY: 1) AT LEAST TWO TOTAL SERUM TESTOSTERONE LEVELS OF LESS THAN 300 NG/DL TAKEN ON SEPARATE OCCASIONS, OR 2) FREE SERUM TESTOSTERONE LEVEL OF LESS THAN 5 PG/ML.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL/RENEWAL: 12 MONTHS
Other Criteria	MALE HYPOGONADISM: INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO LOWER COST TESTOSTERONE AGENTS (E.G., TESTOSTERONE 12.5/1.25G, TESTOSTERONE 20.25/1.25, TESTOSTERONE 50 MG (1%)). RENEWAL: IMPROVED SYMPTOMS COMPARED TO BASELINE AND TOLERANCE TO TREATMENT.
Indications	All FDA-approved Indications.
Off Label Uses	

TETRABENAZINE

Products Affected

- *tetrabenazine*
- XENAZINE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	NEUROLOGIST OR MOVEMENT DISORDER SPECIALIST
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	CONFIRMED MUTATION IN CFTR GENE ACCEPTABLE FOR THE TREATMENT OF CYSTIC FIBROSIS.
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: LIFETIME
Other Criteria	RENEWAL: MAINTAINED, IMPROVED, OR DEMONSTRATED LESS THAN EXPECTED DECLINE IN FEV1 OR BODY MASS INDEX (BMI), OR REDUCTION IN NUMBER OF PULMONARY EXACERBATIONS.
Indications	All FDA-approved Indications.
Off Label Uses	

TEZEPELUMAB-EKKO

Products Affected

- TEZSPIRE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	ASTHMA WITH AN EOSINOPHILIC PHENOTYPE: INITIAL: BLOOD EOSINOPHIL LEVEL OF AT LEAST150 CELLS/MCL WITHIN THE LAST 12 MONTHS.
Age Restrictions	
Prescriber Restrictions	ASTHMA: INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A PHYSICIAN SPECIALIZING IN ALLERGY OR PULMONARY MEDICINE.
Coverage Duration	ASTHMA: INITIAL: 4 MONTHS, RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	ASTHMA: INITIAL: 1) CONCURRENTLY TREATED WITH MEDIUM, HIGH-DOSE, OR MAXIMALLY TOLERATED INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION, 2) NOT CONCURRENTLY RECEIVING XOLAIR, DUPIXENT, OR ANTI-IL5 BIOLOGICS WHEN THESE ARE USED FOR THE TREATMENT OF ASTHMA, 3) ONE OF THE FOLLOWING: (A) PATIENT EXPERIENCED AT LEAST ONE ASTHMA EXACERBATION REQUIRING SYSTEMIC CORTICOSTEROID BURST LASTING AT LEAST 3 DAYS WITHIN THE PAST 12 MONTHS OR AT LEAST ONE SERIOUS EXACERBATION REQUIRING HOSPITALIZATION OR ER VISIT WITHIN THE PAST 12 MONTHS, OR (B) PATIENT HAS POOR SYMPTOM CONTROL DESPITE CURRENT THERAPY AS EVIDENCED BY AT LEAST THREE OF THE FOLLOWING WITHIN THE PAST 4 WEEKS: DAYTIME ASTHMA SYMPTOMS MORE THAN TWICE PER WEEK, ANY NIGHT WAKING DUE TO ASTHMA, SABA RELIEVER FOR SYMPTOMS MORE THAN TWICE PER WEEK, ANY ACTIVITY LIMITATION DUE TO ASTHMA, AND 4) ONE OF THE FOLLOWING: (A) ASTHMA WITH AN EOSINOPHILIC PHENOTYPE (B) ORAL CORTICOSTEROID-DEPENDENT ASTHMA (C) ALLERGIC ASTHMA. RENEWAL: 1) PATIENT CONTINUES TO USE AN INHALED CORTICOSTEROID AND AT LEAST ONE OTHER MAINTENANCE MEDICATION AND 2) CLINICAL RESPONSE AS EVIDENCED BY ONE OF THE FOLLOWING: (A) REDUCTION IN ASTHMA EXACERBATIONS FROM BASELINE, (B) DECREASED UTILIZATION OF RESCUE MEDICATIONS, (C) INCREASE IN PERCENT PREDICTED FEV1 FROM PRETREATMENT BASELINE, OR (D) REDUCTION IN SEVERITY OR FREQUENCY OF ASTHMA-RELATED SYMPTOMS. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
Indications	All FDA-approved Indications.
Off Label Uses	

THALIDOMIDE

Products Affected

- THALOMID

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	

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	

TISOTUMAB VEDOTIN-TFTV

Products Affected

- TIVDAK

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	

TIVOZANIB

Products Affected

- FOTIVDA

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	

TOCILIZUMAB IV

Products Affected

- ACTEMRA

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	MODERATE TO SEVERE RHEUMATOID ARTHRITIS (RA), AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: RA, PJIA, OR SJIA: 6 MONTHS. CRS: 1 MONTH. RENEWAL: 12 MONTHS FOR RA, PJIA, OR SJIA
Other Criteria	RENEWAL FOR RA, PJIA, OR SJIA: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

TOCILIZUMAB SQ

Products Affected

- ACTEMRA
- ACTEMRA ACTPEN

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS (RA), AND POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS (PJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (SJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST, DERMATOLOGIST, OR IMMUNOLOGIST.
Coverage Duration	INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	RA, PJIA, AND SJIA RENEWAL: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

TOFACITINIB

Products Affected

- XELJANZ ORAL SOLUTION
- XELJANZ ORAL TABLET
- XELJANZ XR

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	RHEUMATOID ARTHRITIS AND POLYARTICULAR COURSE JUVENILE IDIOPATHIC ARTHRITIS (PCJIA): PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR DERMATOLOGIST. ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: RA: 6 MOS. PSA: 4 MOS. UC. 6 MO pcJIA: 6 MOS. RENEWAL (ALL INDICATIONS): 12 MOS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: RHEUMATOID ARTHRITIS (RA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST 3 MONTHS TREATMENT WITH AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG) - IF A PATIENT TRIED METHOTREXATE, THEN TRIAL AT A DOSE GREATER THAN OR EQUAL TO 20MG PER WEEK OR MAXIMALLY TOLERATED DOSE IS REQUIRED. PSORIATIC ARTHRITIS (PSA) AND PCJIA: PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE DMARD. ULCERATIVE COLITIS (UC): PREVIOUS TRIAL OF OR CONTRAINDICATION TO ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE). RENEWAL FOR RA, PSA, PCJIA: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
Indications	All FDA-approved Indications.
Off Label Uses	

TOLVAPTAN

Products Affected

- JYNARQUE ORAL TABLET
- JYNARQUE ORAL TABLETS, SEQUENTIAL 15 MG (AM)/ 15 MG (PM), 30 MG (AM)/ 15 MG (PM), 45 MG (AM)/ 15 MG (PM), 60 MG (AM)/ 30 MG (PM), 90 MG (AM)/ 30 MG (PM)

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	RENEWAL: PHYSICIAN ATTESTATION THAT PATIENT HAS NOT PROGRESSED TO ESRD/DIALYSIS OR TRANSPLANT.
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR IN CONSULTATION WITH A NEPHROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: THE PATIENT MEETS ALL OF THE FOLLOWING: (1) CONFIRMED POLYCYSTIC KIDNEY DISEASE VIA CT, MRI IMAGING, OR ULTRASOUND (2) GENETIC TESTING FOR CAUSATIVE MUTATIONS OR FAMILY HISTORY OF CONFIRMED POLYCYSTIC KIDNEY DISEASE IN ONE OR BOTH PARENTS, AND (3) PATIENT DOES NOT HAVE ESRD (I.E., RECEIVING DIALYSIS OR HAS UNDERGONE RENAL TRANSPLANT).
Indications	All FDA-approved Indications.
Off Label Uses	

TOPICAL TRETINOIN

Products Affected

- ALTRENO
- *tretinoin topical cream 0.025 %, 0.05 %*
- *tretinoin topical gel*

PA Criteria	Criteria Details
Exclusion Criteria	COSMETIC INDICATIONS SUCH AS 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	BRAND TOPICAL TRETINOIN REQUIRES TRIAL OF OR CONTRAINDICATION TO A FORMULARY GENERIC TOPICAL TRETINOIN PRODUCT.
Indications	All FDA-approved Indications.
Off Label Uses	

TRALOKINUMAB-LDRM

Products Affected

- ADBRY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	ATOPIC DERMATITIS (AD): INITIAL: PRESCRIBED BY OR IN CONSULTATION WITH A DERMATOLOGIST, ALLERGIST, OR IMMUNOLOGIST
Coverage Duration	ATOPIC DERMATITIS: INITIAL: 4 MONTHS, RENEWAL: 12 MONTHS.
Other Criteria	ATOPIC DERMATITIS: INITIAL: TRIAL OF A HIGH OR SUPER-HIGH POTENCY TOPICAL CORTICOSTEROID (E.G., TRIAMCINOLONE ACETONIDE, FLUOCINONIDE, CLOBETASOL PROPIONATE, HALOBETASOL PROPIONATE) AND ONE NON-STEROIDAL TOPICAL IMMUNOMODULATING AGENT (E.G., EUCRISA, PIMECROLIMUS, TACROLIMUS) RENEWAL: EXPERIENCED OR MAINTAINED IMPROVEMENT IN AT LEAST TWO OF THE FOLLOWING: INTRACTABLE PRURITUS, CRACKING AND OOZING/BLEEDING OF AFFECTED SKIN, IMPAIRED ACTIVITIES OF DAILY LIVING.
Indications	All FDA-approved Indications.
Off Label Uses	

TRAMETINIB DIMETHYL SULFOXIDE

Products Affected

- MEKINIST ORAL TABLET 0.5 MG, 2 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	

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 HYALURONIDASE

Products Affected

- HERCEPTIN HYLECTA
- HERCEPTIN INTRAVENOUS RECON SOLN 150 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	

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 DIOLAMINE

Products Affected

- ORENITRAM

PA Criteria	Criteria Details
Exclusion Criteria	PATIENT HAS SEVERE HEPATIC IMPAIRMENT.
Required Medical Information	DIAGNOSIS OF PULMONARY ARTERIAL HYPERTENSION WHO GROUP I
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. TRIAL OF OR CONTRAINDICATION TO A FORMULARY PHOSPHODIESTERASE-5 INHIBITOR OR AN ENDOTHELIN RECEPTOR ANTAGONIST. TRIAL OF A FORMULARY PHOSPHODIESTERASE-5 INHIBITOR OR ENDOTHELIN RECEPTOR ANTAGONIST IS NOT REQUIRED IF THE PATIENT WAS PREVIOUSLY STABLE ON ORENITRAM. 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	

TREPROSTINIL DPI

Products Affected

- TYVASO DPI

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: PULMONARY ARTERIAL HYPERTENSION (PAH): 1) CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION: A) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, B) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) 15 MMHG OR LESS, AND C) PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER, AND 2) NYHA-WHO FUNCTIONAL CLASS (FC) III-IV SYMPTOMS. PULMONARY HYPERTENSION-INTERSTITIAL LUNG DISEASE (PH-ILD): CONFIRMATORY DIAGNOSIS BASED ON RIGHT HEART CATHETERIZATION: 1) MEAN PULMONARY ARTERY PRESSURE (PAP) GREATER THAN 20 MMHG, 2) PULMONARY VASCULAR RESISTANCE (PVR) 3 WOOD UNITS OR GREATER, AND 3) PULMONARY CAPILLARY WEDGE PRESSURE (PCWP) OF 15 MMHG OR LESS.
Age Restrictions	
Prescriber Restrictions	PAH, PH-ILD: PRESCRIBED BY OR IN CONSULTATION WITH A CARDIOLOGIST OR PULMONOLOGIST.
Coverage Duration	PAH: INITIAL AND RENEWAL: 12 MONTHS. PH-ILD: INITIAL: 6 MONTHS, RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PAH: WHO FC III SYMPTOMS: TRIAL OF OR CONTRAINDICATION TO TWO OF THE FOLLOWING AGENTS FROM DIFFERENT DRUG CLASSES: 1) FORMULARY VERSION OF AN ORAL ENDOTHELIAN RECEPTOR ANTAGONIST, 2) FORMULARY VERSION OF AN ORAL PHOSPHODIESTERASE TYPE-5 INHIBITOR, OR 3) FORMULARY VERSION OF AN ORAL CGMP INHIBITOR. WHO FC III SYMPTOMS AND EVIDENCE OF RAPID PROGRESSION OR POOR PROGNOSIS, WHO FC IV SYMPTOMS: TRIAL OF OR CONTRAINDICATION TO A FORMULARY VERSION OF AN IV/SQ PROSTACYCLIN. RENEWAL: PAH: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST OR REMAINED STABLE FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST AND WHO FC HAS IMPROVED OR REMAINED STABLE. PH-ILD: IMPROVEMENT FROM BASELINE IN THE 6-MINUTE WALK DISTANCE TEST OR A STABLE 6-MINUTE WALK DISTANCE TEST.
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	
Required Medical Information	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. THIS DRUG ALSO REQUIRES PAYMENT DETERMINATION AND MAY BE COVERED UNDER MEDICARE PART B OR D.
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	

TRIFLURIDINE/TIPIRACIL

Products Affected

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

TRILACICLIB

Products Affected

- COSELA

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	

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	

UBROGEPANT

Products Affected

- UBRELVY

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: TRIAL OF OR CONTRAINDICATION TO TWO FORMULARY TRIPTANS. RENEWAL: THE PATIENT HAS EXPERIENCED AN IMPROVEMENT FROM BASELINE IN A VALIDATED ACUTE TREATMENT PATIENT-REPORTED OUTCOME QUESTIONNAIRE OR THE PATIENT HAS EXPERIENCED CLINICAL IMPROVEMENT WITH DOCUMENTED PHYSICIAN ATTESTATION
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	

URSODIOL

Products Affected

- RELTONE

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	
Coverage Duration	12 MONTHS
Other Criteria	RADIOLUCENT NONCALCIFIED GALLBLADDER STONES: TRIAL OF OR UNABLE TO TAKE GENERIC URSODIOL.
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. CROHNS DISEASE: GASTROENTEROLOGIST. PSORIATIC ARTHRITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST OR RHEUMATOLOGIST. PLAQUE PSORIASIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A DERMATOLOGIST. CROHNS DISEASE AND ULCERATIVE COLITIS: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A GASTROENTEROLOGIST.
Coverage Duration	INITIAL: PSA, PSO, CD, UC: 6 MONTHS. RENEWAL: 12 MONTHS.

PA Criteria	Criteria Details
Other Criteria	INITIAL: PSORIATIC ARTHRITIS (PSA): PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE DMARD (DISEASE-MODIFYING ANTIRHEUMATIC DRUG). PLAQUE PSORIASIS (PSO): PREVIOUS TRIAL OF OR CONTRAINDICATION AT LEAST ONE CONVENTIONAL THERAPY SUCH AS A PUVA (PHOTOTHERAPY ULTRAVIOLET LIGHT A), UVB (ULTRAVIOLET LIGHT B), TOPICAL CORTICOSTEROIDS, CALCIPOTRIENE, ACITRETIN, METHOTREXATE, OR CYCLOSPORINE. CROHNS DISEASE (CD) AND ULCERATIVE COLITIS: PREVIOUS TRIAL OF OR CONTRAINDICATION TO AT LEAST ONE CONVENTIONAL THERAPY SUCH AS A CORTICOSTEROID (E.G., BUDESONIDE, METHYLPREDNISOLONE), AZATHIOPRINE, MERCAPTOPURINE, METHOTREXATE, OR MESALAMINE. RENEWAL: PSA, PSO: THE PATIENT CONTINUES TO BENEFIT FROM THE MEDICATION.
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	TARDIVE DYSKINESIA: PATIENT HAS A PRIOR HISTORY OF USING AGENTS THAT CAUSE TARDIVE DYSKINESIA
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	

VEDOLIZUMAB

Products Affected

- ENTYVIO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	CROHNS DISEASE (CD), ULCERATIVE COLITIS (UC): PRESCRIBED BY OR IN CONSULTATION WITH A GASTROENTEROLOGIST
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	

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 VJBK

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	
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	

VIGABATRIN

Products Affected

- SABRIL
- *vigabatrin oral tablet*
- *vigadrone*

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	REFRACTORY COMPLEX PARTIAL SEIZURES (CPS): PATIENT HAS RESPONDED INADEQUATELY TO AT LEAST 2 ANTIEPILEPTIC AGENTS. FOR CPS AND INFANTILE SPASMS: PHYSICIAN ATTESTATION THAT BENEFITS OUTWEIGH THE POTENTIAL FOR VISION LOSS.
Indications	All FDA-approved Indications.
Off Label Uses	

VILTOLARSEN

Products Affected

- VILTEPSO

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	INITIAL: DUCHENNE MUSCULAR DYSTROPHY (DMD): CONFIRMED MUTATION OF THE DMD GENE THAT IS AMENABLE TO EXON 51 SKIPPING.
Age Restrictions	
Prescriber Restrictions	INITIAL: DMD: PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A NEUROLOGIST.
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	INITIAL: DMD: PATIENT IS AMBULATORY AND IS CURRENTLY RECEIVING TREATMENT WITH OR HAS A CONTRAINDICATION TO CORTICOSTEROIDS. RENEWAL: DMD: PATIENT HAS MAINTAINED OR DEMONSTRATED A LESS THAN EXPECTED DECLINE IN AMBULATORY ABILITY IN MUSCLE FUNCTION ASSESSMENTS OR OTHER MUSCLE FUNCTION.
Indications	All FDA-approved Indications.
Off Label Uses	

VISMODEGIB

Products Affected

- ERIVEDGE

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	

VOCLOSPORIN

Products Affected

- LUPKYNIS

PA Criteria	Criteria Details
Exclusion Criteria	
Required Medical Information	
Age Restrictions	
Prescriber Restrictions	PRESCRIBED BY OR GIVEN IN CONSULTATION WITH A RHEUMATOLOGIST OR NEPHROLOGIST
Coverage Duration	INITIAL: 6 MONTHS. RENEWAL: 12 MONTHS.
Other Criteria	RENEWAL: LUPUS NEPHRITIS: IMPROVEMENT IN RENAL RESPONSE FROM BASELINE LABORATORY VALUES (I.E., EGFR OR PROTEINURIA) AND/OR CLINICAL PARAMETERS.
Indications	All FDA-approved Indications.
Off Label Uses	

VOSORITIDE

Products Affected

- VOXZOGO

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	

VOXELOTOR

Products Affected

- OXBRYTA ORAL TABLET
- OXBRYTA ORAL TABLET FOR SUSPENSION

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. 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	

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	

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	

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	

ZIV-AFLIBERCEPT

Products Affected

- ZALTRAP

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	

ZYTIGA (S)

Products Affected

- *abiraterone*
- ZYTIGA

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	

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