

# ACTEMRA SC (S)

## Products Affected

- Actemra INJ 162MG/0.9ML
- Actemra Actpen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orenzia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib) or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Giant Cell Arteritis (GCA) (Initial): Diagnosis of GCA. TF/C/I to a glucocorticoid (eg, prednisone). Systemic Juvenile Idiopathic Arthritis (SJIA) (Initial): Diagnosis of active SJIA. TF/C/I to one of the following conventional therapies at maximally tolerated doses: minimum duration of a one month trial of a nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen), minimum duration of a 3-month trial of methotrexate, or minimum duration of a 2-week trial of a systemic glucocorticoid (eg, prednisone). Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of active PJIA. One of the following: a) TF/C/I to two of the following, or attestation demonstrating a trial may be inappropriate: Enbrel (etanercept), one formulary adalimumab product, Orenzia (abatacept), or Xeljanz (tofacitinib), OR b) for continuation of prior therapy. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (Initial): Diagnosis of SSc-ILD as documented by the following: a) Exclusion of other known causes of ILD AND b) One of the following: i) In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (eg, fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on high-resolution computed tomography (HRCT) revealing SSc-ILD or probable SSc-ILD, OR ii) In patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD.</p>
Age Restrictions	N/A

<b>Prescriber Restrictions</b>	RA, GC, SJIA, PJIA (initial): Prescribed by or in consultation with a rheumatologist. SSc-ILD (initial): Prescribed by or in consultation with a pulmonologist or rheumatologist.
<b>Coverage Duration</b>	RA, GC, SJIA, PJIA, SSc-ILD (initial): 6 months, (reauth): 12 months
<b>Other Criteria</b>	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. SJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in clinical features or symptoms (eg, pain, fever, inflammation, rash, lymphadenopathy, serositis) from baseline. GC, SSc-ILD (Reauth): Patient demonstrates positive clinical response to therapy.

# ACTIMMUNE (S)

---

## Products Affected

- Actimmune INJ 100MCG/0.5ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of one of the following: 1) Chronic granulomatous disease (CGD), or 2) severe malignant osteopetrosis (SMO).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ADBRY (S)

---

### Products Affected

- Adbry

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of moderate to severe atopic dermatitis. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing Atopic Dermatitis (SCORAD) index value of at least 25. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to at least two of the following: a) Medium or higher potency topical corticosteroid, b) Pimecrolimus cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment.
<b>Age Restrictions</b>	Initial: Patient is 12 years of age or older.
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist.
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline.

## ADCIRCA (S)

---

### Products Affected

- Alyq

- Tadalafil TABS 20MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH: Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

## ADEMPAS (S)

---

### Products Affected

- Adempas

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Chronic thromboembolic pulmonary hypertension (CTEPH) (Initial): One of the following: A) Both of the following: 1) Diagnosis of inoperable or persistent/recurrent CTEPH and 2) CTEPH is symptomatic OR B) Patient is currently on any therapy for the diagnosis of CTEPH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH, CTEPH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH, CTEPH: Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	PAH, CTEPH (Reauth): Patient demonstrates positive clinical response to therapy.

## AEMCOLO (S)

---

### Products Affected

- Aemcolo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Travelers' diarrhea (TD): Diagnosis of TD. Diarrhea is not accompanied by fever or bloody stool. One of the following: 1) Trial and failure to one of the following: Zithromax (azithromycin), Cipro (ciprofloxacin), Levaquin (levofloxacin), or ofloxacin OR 2) Resistance, contraindication, or intolerance to all of the following antibiotics: Zithromax (azithromycin), Cipro (ciprofloxacin), Levaquin (levofloxacin), or ofloxacin.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	N/A

# AFINITOR (S)

## Products Affected

- Afinitor TABS 10MG

- Everolimus TABS 10MG, 2.5MG, 5MG, 7.5MG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention. Renal cell carcinoma: Diagnosis of advanced renal cell carcinoma AND trial and failure, contraindication, or intolerance to SUTENT (sunitinib) or NEXAVAR (sorafenib). Neuroendocrine tumors of pancreatic origin (pNET): Diagnosis of progressive pNET that are unresectable, locally advanced, or metastatic. Renal angiomyolipoma: Diagnosis of renal angiomyolipoma and TSC. Breast Cancer: Diagnosis of advanced hormone receptor-positive, HER2-negative breast cancer AND trial and failure, contraindication, or intolerance to FEMARA (letrozole) or ARIMIDEX (anastrozole). Neuroendocrine tumors of gastrointestinal (GI) or lung origin: Diagnosis of progressive, well-differentiated, non-functional NET of GI or lung origin AND patient has unresectable, locally advanced or metastatic disease.
Age Restrictions	SEGA associated with TSC: Patient is 1 year of age or older.
Prescriber Restrictions	N/A
Coverage Duration	All uses: 12 months
Other Criteria	All Indications: Approve for continuation of prior therapy.



## AFINITOR DISPERZ (S)

---

### Products Affected

- Afinitor Disperz

- Everolimus TBSO

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Subependymal Giant Cell Astrocytoma (SEGA) associated with tuberous sclerosis complex (TSC): Diagnosis of SEGA associated with TSC that requires therapeutic intervention. TSC-associated partial-onset seizures: Diagnosis of TSC-associated partial-onset seizures.
<b>Age Restrictions</b>	SEGA associated with TSC: Patient is 1 year of age or older. TSC-associated partial-onset seizures: Patient is 2 years of age or older.
<b>Prescriber Restrictions</b>	TSC-associated partial-onset seizures: Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## AFREZZA (S)

---

### Products Affected

- Afrezza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: One of the following: 1) Diagnosis of type 1 diabetes mellitus and used in combination with a long-acting insulin (eg, Lantus, Levemir) OR 2) Diagnosis of type 2 diabetes mellitus. Patient has a documented FEV1. Will NOT be approved in patients with chronic lung disease [e.g., asthma, chronic obstructive pulmonary disease (COPD)]. Trial and failure or intolerance to Humalog and Novolog.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months
<b>Other Criteria</b>	Reauth: Repeat pulmonary function test confirms that the patient has NOT experienced a decline of 20% or more in FEV1 from baseline. Patient demonstrates positive clinical response to therapy. Patient does not have chronic lung disease (e.g., asthma, COPD).

## AGAMREE (S)

---

### Products Affected

- Agamree

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of Duchenne muscular dystrophy (DMD). Patient has received genetic testing for a mutation of the dystrophin gene. One of the following: A) Patient has a confirmed mutation of the dystrophin gene, or B) Muscle biopsy confirmed an absence of dystrophin protein. Trial and failure or intolerance to prednisone or prednisolone. Initial, Reauth: One of the following: A) For patients less than or equal to 50kg, dose will not exceed 6mg/kg of body weight once daily, or B) For patients greater than 50kg, dose will not exceed 300mg/day.
<b>Age Restrictions</b>	Initial: Patient is 2 years of age or older.
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a neurologist who has experience treating children.
<b>Coverage Duration</b>	Initial, Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient has experienced a benefit from therapy.

# AIMOVIG (S)

## Products Affected

- Aimovig

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Episodic Migraines (EM) (initial): Diagnosis of EM. Patient has greater than or equal to 4 migraine days per month. Chronic Migraines (CM) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Patient has greater than or equal to 8 migraine days per month. All Indications (initial): History of failure (after at least a two month trial), contraindication, or intolerance to two of the following preventive treatments for migraine from different classes: a) An antidepressant [i.e., Elavil (amitriptyline) or Effexor (venlafaxine)], OR b) An anticonvulsant [i.e., Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)], OR c) A beta blocker [i.e., atenolol, propranolol, nadolol, timolol, or metoprolol], OR d) Atacand (candesartan), OR e) Generic lisinopril. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
<b>Age Restrictions</b>	EM, CM (initial): 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	EM, CM (initial): 6 months. EM, CM (reauth): 12 months.
<b>Other Criteria</b>	EM, CM (reauth): Patient has experienced a positive response to therapy (e.g., a reduction in headache frequency and/or intensity, a reduction in the number of workdays missed due to migraines). Use of acute migraine medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDs] [e.g., ibuprofen, naproxen], triptans [e.g., eletriptan, rizatriptan, sumatriptan]) has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (reauth): Patient continues to be monitored for medication overuse headache.



# AJOVY (S)

## Products Affected

- Ajovy

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Episodic Migraines (EM) (initial): Diagnosis of EM. Patient has greater than or equal to 4 migraine days per month. Chronic Migraines (CM) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Patient has greater than or equal to 8 migraine days per month. All Indications (initial): Trial and failure, contraindication, or intolerance to Aimovig and Emgality. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.
<b>Age Restrictions</b>	EM, CM (initial): 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	EM, CM (initial): 6 months. EM, CM (reauth): 12 months.
<b>Other Criteria</b>	EM, CM (reauth): Patient has experienced a positive response to therapy (e.g., a reduction in headache frequency and/or intensity, a reduction in the number of workdays missed due to migraines). Use of acute migraine medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDs] [e.g., ibuprofen, naproxen], triptans [e.g., eletriptan, rizatriptan, sumatriptan]) has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (reauth): Patient continues to be monitored for medication overuse headache.

## AKEEGA (S)

---

### Products Affected

- Akeega

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of prostate cancer. Disease is all of the following: a) metastatic, b) castration-resistant, and c) deleterious or suspected deleterious BRCA-mutated (BRCAm). Used in combination with prednisone. One of the following: a) Used in combination with a gonadotropin-releasing hormone (GnRH) analog, or b) Patient has had a bilateral orchiectomy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## AKLIEF (S)

---

### Products Affected

- Akliief

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acne: Diagnosis of acne vulgaris (i.e., acne). Trial and failure, contraindication, or intolerance to two formulary topical retinoid products (e.g., generic tretinoin, generic adapalene).
<b>Age Restrictions</b>	PA applies to members 26 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A



## ALECENSA (S)

---

### Products Affected

- Alecensa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ALPHA-1 PROTEINASE INHIBITOR, NON-PREFERRED (S)

### Products Affected

- Aralast Np INJ 1000MG
- Glassia
- Zemaira INJ 1000MG

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Alpha-1 antitrypsin (AAT) deficiency (initial): Diagnosis of congenital AAT deficiency. Diagnosis of emphysema. Continued conventional treatment for emphysema (e.g., bronchodilators). One of the following: 1) PiZZ, PiZ(null), or Pi(null)(null) protein phenotypes (homozygous) OR 2) other rare AAT disease genotypes associated with pre-treatment serum AAT level less than 11 $\mu$ M/L [e.g., Pi(Malton, Malton), Pi(SZ)]. One of the following: Circulating pre-treatment serum AAT level less than 11 $\mu$ M/L (which corresponds to less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry) OR the patient has a concomitant diagnosis of necrotizing panniculitis. Trial and failure, or intolerance to Prolastin.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	AAT deficiency (initial, reauth): 12 months
<b>Other Criteria</b>	AAT deficiency (reauth): Patient demonstrates positive clinical response to therapy. Continued conventional treatment for emphysema (e.g., bronchodilators).

# ALPHA-1 PROTEINASE INHIBITOR, PROLASTIN (S)

## Products Affected

- Prolastin-c INJ 1000MG/20ML

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Alpha-1 antitrypsin (AAT) deficiency (initial): Diagnosis of congenital AAT deficiency. Diagnosis of emphysema. Continued conventional treatment for emphysema (e.g., bronchodilators). One of the following: 1) PiZZ, PiZ(null), or Pi(null)(null) protein phenotypes (homozygous) OR 2) other rare AAT disease genotypes associated with pre-treatment serum AAT level less than 11 µM/L [e.g., Pi(Malton, Malton), Pi(SZ)]. Circulating pre-treatment serum AAT level less than 11 µM/L (which corresponds to less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry), unless the patient has a concomitant diagnosis of necrotizing panniculitis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	AAT deficiency (initial, reauth): 12 months
<b>Other Criteria</b>	AAT deficiency (reauth): Patient demonstrates positive clinical response to therapy. Continued conventional treatment for emphysema (e.g., bronchodilators).

## ALTRENO (S)

---

### Products Affected

- Altreno

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acne: Diagnosis of acne vulgaris (i.e., acne). Trial and failure, contraindication, or intolerance to two formulary topical retinoid products (e.g., generic tretinoin, generic adapalene).
<b>Age Restrictions</b>	PA applies to members 26 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## ALUNBRIG (S)

---

### Products Affected

- Alunbrig

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ALVAIZ (S)

### Products Affected

- Alvaiz

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Immune thrombocytopenia (ITP) (initial): Diagnosis of one of the following: a) persistent ITP, b) chronic ITP, or c) relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL. Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding. Trial and failure, contraindication, or intolerance to one of the following: a) corticosteroids (e.g., prednisone, methylprednisolone), b) immunoglobulins [e.g., Gammagard, immune globulin (human)], or c) splenectomy. Severe aplastic anemia (SAA) (initial): Diagnosis of refractory SAA. Patient has a platelet count less than 30,000/mcL. Insufficient response to immunosuppressive therapy (e.g., horse antithymocyte globulin, cyclosporine). Chronic hepatitis C (Hep C)-associated thrombocytopenia (initial): Diagnosis of chronic Hep C-associated thrombocytopenia. One of the following: 1) Planning to initiate and maintain interferon-based treatment, or 2) Currently receiving interferon-based treatment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	ITP, SAA (initial): Prescribed by or in consultation with a hematologist/oncologist. Chronic Hep C-associated thrombocytopenia (initial): Prescribed by or in consultation with one of the following: hematologist/oncologist, gastroenterologist, hepatologist, infectious disease specialist, or HIV specialist certified through the American Academy of HIV Medicine.
<b>Coverage Duration</b>	ITP (init): 12 mo. SAA (init): 16 wk. Hep C (init): 3 mo. All uses (reauth): 12 mo.

<b>Other Criteria</b>	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding. SAA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count. Chronic Hep C-associated thrombocytopenia (reauth): One of the following criteria: 1) For patients that started treatment with Alvaiz prior to initiation of treatment with interferon, Alvaiz will be approved when both of the following criteria are met: a) Patient is currently on antiviral interferon therapy for treatment of chronic Hep C, and b) Documentation that the patient reached a threshold platelet count that allows initiation of antiviral interferon therapy with Alvaiz treatment by week 9, OR 2) For patients that started treatment with Alvaiz while on concomitant treatment with interferon, Alvaiz will be approved based on the following criterion: Currently on antiviral interferon therapy for treatment of chronic Hep C.
-----------------------	--

## AMPYRA (S)

---

### Products Affected

- Ampyra

- Dalfampridine Er

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Multiple Sclerosis (MS) (initial): Diagnosis of MS. Physician confirmation that patient has difficulty walking (eg, timed 25 foot walk test). One of the following: expanded disability status scale (EDSS) score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial): Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	MS (Initial): 6 months. (Reauth): 12 months.
<b>Other Criteria</b>	MS (Reauth): Physician confirmation that the patient's walking improved with therapy. One of the following: EDSS score less than or equal to 7, or not restricted to using a wheelchair (if EDSS is not measured).



## APOKYN (S)

---

### Products Affected

- Apokyn INJ 30MG/3ML
- Apomorphine Hydrochloride INJ

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	PD (Initial): Not used with any 5-HT3 antagonist (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron)
<b>Required Medical Information</b>	Parkinson's disease (PD) (Initial): Diagnosis of PD. Patient is experiencing acute intermittent hypomobility (defined as “off” episodes characterized by muscle stiffness, slow movements, or difficulty starting movements). Used in combination with other medications for the treatment of PD (e.g., carbidopa/levodopa, pramipexole, ropinirole, etc.).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PD (Initial): Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	PD (Initial, reauth): 12 months
<b>Other Criteria</b>	PD (Reauth): Patient demonstrates positive clinical response to therapy.

# ARANESP (S)

## Products Affected

- Aranesp Albumin Free INJ  
100MCG/0.5ML, 100MCG/ML,  
10MCG/0.4ML, 150MCG/0.3ML,  
200MCG/0.4ML, 200MCG/ML,  
25MCG/0.42ML, 25MCG/ML,  
300MCG/0.6ML, 40MCG/0.4ML,  
40MCG/ML, 500MCG/ML,  
60MCG/0.3ML, 60MCG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial): Other causes of anemia have been ruled out. Anemia by lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request. Cancer is a non-myeloid malignancy. Patient is receiving chemo. CKD (init, reauth), Chemo (init), MDS (init): Verify iron evaluation for adequate iron stores. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of MDS. Serum erythropoietin level is 500 mU/mL or less, or dx of transfusion-dependent MDS.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	CKD (Init): 6 mo. CKD (reauth): 12 mo. Chemo(init, reauth): 3 mo. MDS: (init) 3 mo,(reauth) 12 mo.

<b>Other Criteria</b>	Subject to ESRD review. CKD (Reauth): Dx of CKD. One of the following: 1) Most recent or average (avg) Hct over 3 mo is 33% or less (Hgb 11 g/dL or less) for patients on dialysis, without ESRD, 2) Most recent or avg Hct over 3 mo is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis, OR 3) Most recent or avg Hct over 3 mo is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Patient demonstrates positive clinical response to therapy from pre-treatment level. Chemo (Reauth): Anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Patient demonstrates a positive clinical response to therapy from pre-treatment level. Patient is receiving chemo. MDS (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates a positive clinical response to therapy from pre-treatment level. Off-label uses (except MDS, HCV): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%.
-----------------------	---

# ARCALYST (S)

## Products Affected

- Arcalyst

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cryopyrin-Associated Periodic Syndromes (CAPS) (Initial): Diagnosis of CAPS, including Familial Cold Auto-inflammatory Syndrome (FCAS) and/or Muckle-Wells Syndrome (MWS). The medication will not be used in combination with another biologic. Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Diagnosis of DIRA. Patient weighs at least 10 kg. Patient is currently in remission (e.g., no fever, skin rash, and bone pain/no radiological evidence of active bone lesions/C-reactive protein [CRP] less than 5 mg/L). Recurrent Pericarditis (Initial): Diagnosis of recurrent pericarditis as evidenced by at least 2 episodes that occur a minimum of 4 to 6 weeks apart. Trial and failure, contraindication, or intolerance (TF/C/I) to at least one of the following: nonsteroidal anti-inflammatory drugs (e.g., ibuprofen, naproxen), colchicine, or corticosteroids (e.g., prednisone).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	CAPS (initial): Prescribed by or in consultation with an immunologist, allergist, dermatologist, rheumatologist, neurologist, or specialist with expertise in the management of CAPS. Recurrent Pericarditis (initial): Prescribed by or in consultation with a cardiologist.
<b>Coverage Duration</b>	CAPS, Recurrent Pericarditis (initial, reauth): 12 months. DIRA: 12 months.
<b>Other Criteria</b>	CAPS (Reauth): Patient has experienced disease stability or improvement in clinical symptoms while on therapy as evidence by one of the following: A) improvement in rash, fever, joint pain, headache, conjunctivitis, B) decreased number of disease flare days, C) normalization of inflammatory markers (CRP, ESR, SAA), D) corticosteroid dose reduction, OR E) improvement in MD global score or active joint count. Recurrent Pericarditis (Reauth): Patient demonstrates positive clinical response to therapy.



## ARFORMOTEROL (S)

---

### Products Affected

- Arformoterol Tartrate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic Obstructive Pulmonary Disease (COPD): Diagnosis of COPD. Used for maintenance treatment of bronchoconstriction in patients with COPD, including chronic bronchitis and emphysema.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	COPD: 12 months.
<b>Other Criteria</b>	Subject to Part B vs. Part D review.

## ARIKAYCE (S)

---

### Products Affected

- Arikayce

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Mycobacterium avium complex (MAC) lung disease: Diagnosis of Mycobacterium avium complex (MAC) lung disease. Used as part of a combination antibacterial drug regimen. Used in patients who do not achieve at least two negative sputum cultures after a minimum of 6 consecutive months of a multidrug background regimen therapy (e.g., a macrolide, a rifamycin, ethambutol, etc).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an infectious disease specialist or pulmonologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## AUBAGIO (S)

---

### Products Affected

- Aubagio

- Teriflunomide

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
<b>Required Medical Information</b>	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	MS (initial, reauth): 12 months
<b>Other Criteria</b>	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).



## AUGTYRO (S)

---

### Products Affected

- Augtyro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) locally advanced, or b) metastatic. Patient has ROS1 rearrangement positive tumor(s).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## AURYXIA (S)

---

### Products Affected

- Auryxia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Exclude if used for iron deficiency anemia in chronic kidney disease (CKD) not on dialysis.
<b>Required Medical Information</b>	Hyperphosphatemia in chronic kidney disease: Diagnosis of hyperphosphatemia. Patient has chronic kidney disease (CKD). Patient is on dialysis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

# AUSTEDO (S)

## Products Affected

- Austedo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chorea associated with Huntington's disease (initial): Diagnosis of Chorea associated with Huntington's disease. Tardive dyskinesia (initial): Diagnosis of moderate to severe tardive dyskinesia. One of the following: 1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication or 2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Huntington's disease chorea (initial): Prescribed by a neurologist. Tardive dyskinesia (initial): Prescribed by or in consultation with a neurologist or psychiatrist.
<b>Coverage Duration</b>	Initial: 3 months. Reauth: 12 months
<b>Other Criteria</b>	All indications (Reauth): Patient demonstrates positive clinical response to therapy.

## AYVAKIT (S)

---

### Products Affected

- Ayvakit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Gastrointestinal stromal tumor (GIST): Diagnosis of GIST. Disease is one of the following: unresectable or metastatic. Presence of platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation, including PDGFRA D842V mutations. Advanced Systemic Mastocytosis (AdvSM): Diagnosis of AdvSM. Patient has one of the following: a) aggressive systemic mastocytosis (ASM), b) systemic mastocytosis with an associated hematological neoplasm (SM-AHN), or c) mast cell leukemia (MCL). Indolent Systemic Mastocytosis (ISM): Diagnosis of ISM. Platelet count is greater than $5 \times 10^9/L$ .
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## BAFIERTAM (S)

### Products Affected

- Bafiertam

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
<b>Required Medical Information</b>	MS (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	MS (initial, reauth): 12 months
<b>Other Criteria</b>	MS (reauth): Patient demonstrates clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).

## BALVERSA (S)

### Products Affected

- Balversa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Urothelial Carcinoma: Diagnosis of urothelial carcinoma (UC). Disease is one of the following: Locally advanced or Metastatic. Presence of susceptible fibroblast growth factor receptor (FGFR) 3 genetic alterations as detected by an U.S. Food and Drug Administration (FDA)-approved test (therascreen FGFR RGQ RT-PCR Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has progressed on or after at least one line of prior systemic therapy (e.g., chemotherapy). One of the following: 1) Patient had been treated with prior PD-1 inhibitor (e.g., Opdivo [nivolumab], Keytruda [pembrolizumab]) or PD-L1 inhibitor therapy (e.g., Bavencio [avelumab]) or 2) Patient is not a candidate for PD-1 or PD-L1 inhibitor therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# BENLYSTA (S)

## Products Affected

- Benlysta INJ 200MG/ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Systemic lupus erythematosus (SLE) (init): Diagnosis of active SLE. Autoantibody positive (ie, anti-nuclear antibody [ANA] titer greater than or equal to 1:80 or anti-dsDNA level greater than or equal to 30 IU/mL). Currently receiving at least one standard of care treatment for active SLE (eg, antimalarials [eg, Plaquenil (hydroxychloroquine)], corticosteroids [eg, prednisone], or immunosuppressants [eg, methotrexate, Imuran (azathioprine)]). Lupus Nephritis (init): Diagnosis of active lupus nephritis. Currently receiving standard of care treatment for active lupus nephritis (e.g., corticosteroids [e.g., prednisone] with mycophenolate or cyclophosphamide).
<b>Age Restrictions</b>	SLE, Lupus Nephritis (init): Benlysta IV (vial): Patient is 5 years of age or older. Benlysta SC (prefilled syringe): Patient is 18 years of age or older.
<b>Prescriber Restrictions</b>	SLE (init): Prescribed by or in consultation with a rheumatologist. Lupus Nephritis (init): Prescribed by or in consultation with a nephrologist or rheumatologist.
<b>Coverage Duration</b>	SLE, Lupus Nephritis (init, reauth): 6 months
<b>Other Criteria</b>	SLE, Lupus Nephritis (reauth): Patient demonstrates positive clinical response to therapy.

## BERINERT (S)

---

### Products Affected

- Berinert

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Treatment of hereditary angioedema (HAE) attacks: Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	HAE: Prescribed by or in consultation with an immunologist or an allergist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A



# BESREMI (S)

## Products Affected

- Besremi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of polycythemia vera as confirmed by all of the following: 1) One of the following: a) Hemoglobin greater than 16.5 g/dL for men or hemoglobin greater than 16.0 g/dL for women, b) Hematocrit greater than 49% for men or hematocrit greater than 48% for women, or c) Increased red cell mass, AND 2) Bone marrow biopsy showing hypercellularity for age with trilineage growth (panmyelosis) including prominent erythroid, granulocytic and megakaryocytic proliferation with pleomorphic, mature megakaryocytes, AND 3) One of the following: a) Presence of JAK2 or JAK2 exon 12 mutation or b) Subnormal serum erythropoietin level. For high-risk polycythemia vera only (patient greater than or equal to 60 years old and/or prior thrombosis history), trial and inadequate response, contraindication or intolerance to hydroxyurea.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## BIMZELX (S)

---

### Products Affected

- Bimzelx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Plaque Psoriasis (PsO) (initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure, contraindication, or intolerance to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), or Stelara (ustekinumab).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PsO (initial): Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	PsO (initial): 6 months. PsO (reauth): 12 months.
<b>Other Criteria</b>	PsO (Reauth): Patient demonstrates positive clinical response to therapy.

## BOSULIF (S)

---

### Products Affected

- Bosulif

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic myelogenous/myeloid leukemia (CML): Diagnosis of Philadelphia chromosome-positive (Ph+) CML.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# BRAFTOVI (S)

## Products Affected

- Braftovi CAPS 75MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAF V600E or V600K mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Mektovi (binimetinib). Colorectal Cancer: One of the following diagnoses: Colon Cancer or Rectal Cancer. One of the following: 1) Unresectable or advanced disease or 2) Metastatic disease. Patient has received prior therapy. Cancer is BRAF V600E mutant type as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Erbitux (cetuximab). Non-Small Cell Lung Cancer (NSCLC): Diagnosis of metastatic NSCLC. Cancer is BRAF V600E mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Mektovi (binimetinib).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy

## BRIVIACT (S)

---

### Products Affected

- Briviact ORAL SOLN
- Briviact TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Partial-onset seizures: Diagnosis of partial-onset seizures.
<b>Age Restrictions</b>	Patient is 1 month of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## BRONCHITOL (S)

---

### Products Affected

- Bronchitol

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cystic Fibrosis (CF) (initial): Diagnosis of CF. Patient has passed the Bronchitol Tolerance Test (BTT).
<b>Age Restrictions</b>	CF (initial): Patient is 18 years of age or older.
<b>Prescriber Restrictions</b>	CF (initial): Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center.
<b>Coverage Duration</b>	CF (initial): 6 months. CF (reauth): 12 months.
<b>Other Criteria</b>	CF (reauth): Patient demonstrates positive clinical response to therapy.

## BROVANA (S)

---

### Products Affected

- Brovana

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic Obstructive Pulmonary Disease (COPD): Diagnosis of COPD. Used for maintenance treatment of bronchoconstriction in patients with COPD, including chronic bronchitis and emphysema. Trial and failure, contraindication, or intolerance to Perforomist (formoterol fumarate).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	COPD: 12 months.
<b>Other Criteria</b>	Subject to Part B vs. Part D review.

# BRUKINSA (S)

## Products Affected

- Brukinsa

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Mantle Cell Lymphoma (MCL): Diagnosis of relapsed or refractory MCL. Patient has received at least one prior therapy for MCL (e.g., chemotherapy). Waldenstrom's Macroglobulinemia (WM)/Lymphoplasmacytic Lymphoma (LPL): Diagnosis of WM/LPL. Marginal Zone Lymphoma (MZL): Diagnosis of MZL. Disease is relapsed or refractory. Patient has received at least one prior anti-CD20-based regimen for MZL (e.g., rituximab, obinutuzumab). Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of ONE of the following: CLL or SLL. Follicular Lymphoma (FL): Diagnosis of FL. Disease is relapsed or refractory. Used in combination with Gazyva (obinutuzumab). Patient has received at least two prior lines of systemic therapy (e.g., chemotherapy).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months.
Other Criteria	Approve for continuation of prior therapy.



## BYLVAY (S)

### Products Affected

- Bylvay

- Bylvay (pellets)

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Progressive familial intrahepatic cholestasis (PFIC) (initial): Diagnosis of progressive familial intrahepatic cholestasis (PFIC) type 1, 2, or 3, confirmed by one of the following: 1) Diagnostic test (e.g., liver function test, liver ultrasound and biopsy, bile analysis) or 2) Genetic testing. Patient is experiencing moderate to severe pruritus. Patient has had an inadequate response to at least one of the following treatments used for the relief of pruritus: a) Ursodeoxycholic acid (e.g., Ursodiol), b) Antihistamines (e.g., diphenhydramine, hydroxyzine), c) Rifampin, or d) Bile acid sequestrants (e.g., Questran, Colestid, Welchol). Prescribed dose is consistent with FDA-approved package labeling and does not exceed a total daily dose of 6 mg. Alagille syndrome (ALGS) (initial): Both of the following: 1) Diagnosis of ALGS, and 2) Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene. Patient is experiencing both of the following: 1) Moderate to severe cholestatic pruritus, and 2) Patient has a serum bile acid concentration above the upper limit of the normal reference for the reporting laboratory. Patient has had an inadequate response to at least two of the following treatments used for the relief of pruritus: a) Ursodeoxycholic acid (e.g., Ursodiol), b) Antihistamines (e.g., diphenhydramine, hydroxyzine), c) Rifampin, or d) Bile acid sequestrants (e.g., Questran, Colestid, Welchol).</p>
<b>Age Restrictions</b>	PFIC (initial): Patient is 3 months of age or older. ALGS (initial): Patient is 12 months of age or older.
<b>Prescriber Restrictions</b>	PFIC, ALGS (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist
<b>Coverage Duration</b>	PFIC, ALGS (initial): 6 months. PFIC, ALGS (reauth): 12 months.

<b>Other Criteria</b>	PFIC (reauth): Patient demonstrates positive clinical response to therapy (e.g., reduced serum bile acids, improved pruritus). Prescribed dose is consistent with FDA-approved package labeling and does not exceed a total daily dose of 6 mg. ALGS (reauth): Patient demonstrates positive clinical response to therapy.
-----------------------	--

## CABLIVI (S)

---

### Products Affected

- Cablivi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acquired thrombotic thrombocytopenic purpura (aTTP): Diagnosis of aTTP. First dose was/will be administered by a healthcare provider as a bolus intravenous injection. Used in combination with immunosuppressive therapy (e.g. rituximab, glucocorticoids). One of the following: 1) Used in combination with plasma exchange or 2) both of the following: patient has completed plasma exchange and less than 59 days have or will have elapsed beyond the last plasma exchange.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hematologist or oncologist.
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	N/A

## CABOMETYX (S)

### Products Affected

- Cabometyx

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Renal cell carcinoma (RCC): Diagnosis of RCC. Hepatocellular Carcinoma (HCC): Diagnosis of HCC. One of the following: a) Trial and failure, contraindication, or intolerance to Nexavar (sorafenib tosylate), or b) Patient has metastatic disease, or c) Patient has extensive liver tumor burden, or d) Patient is inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only), or e) Disease is unresectable. Differentiated Thyroid Cancer (DTC): Diagnosis of DTC. Patient is 12 years of age or older. Disease has progressed following prior VEGFR-targeted therapy (e.g., Lenvima [lenvatinib], Nexavar [sorafenib]). Disease or patient is refractory to radioactive iodine treatment or ineligible.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

# CALQUENCE (S)

---

## Products Affected

- Calquence

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Mantle Cell Lymphoma: Diagnosis of mantle cell lymphoma (MCL) AND patient has received at least one prior therapy for MCL. Chronic Lymphocytic Leukemia (CLL) or Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## CAMZYOS (S)

### Products Affected

- Camzyos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of obstructive hypertrophic cardiomyopathy (HCM). Patient has New York Heart Association (NYHA) Class II or III symptoms (e.g., shortness of breath, chest pain). Patient has a left ventricular ejection fraction of greater than or equal to 55%. Patient has valsalva left ventricular outflow tract (LVOT) peak gradient greater than or equal to 50 mmHg at rest or with provocation. Trial and failure, contraindication, or intolerance to both of the following at a maximally tolerated dose: a) non-vasodilating beta blocker (e.g., bisoprolol, propranolol) and b) calcium channel blocker (e.g., verapamil, diltiazem).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a cardiologist.
<b>Coverage Duration</b>	Initial: 6 months, Reauth: 12 months
<b>Other Criteria</b>	Reauthorization: Patient demonstrates positive clinical response to therapy (e.g., improved symptom relief). Patient has a left ventricular ejection fraction of greater than or equal to 50%.

## CAPLYTA (S)

### Products Affected

- Caplyta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Schizophrenia: Diagnosis of schizophrenia. Trial and failure, contraindication, or intolerance to two of the following oral generic formulary atypical antipsychotic agents: asenapine, aripiprazole, olanzapine, paliperidone, quetiapine (IR or ER), risperidone, ziprasidone. Bipolar disorder: Diagnosis of bipolar I or II disorder (bipolar depression). Patient has depressive episodes associated with bipolar disorder. Used as monotherapy or as adjunctive therapy with lithium or valproate. Trial and failure, contraindication, or intolerance to quetiapine (IR or ER) or olanzapine.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy

## CAPRELSA (S)

---

### Products Affected

- Caprelsa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Thyroid Cancer: Diagnosis of one of the following: a) medullary thyroid cancer (MTC), or b) unresectable locally advanced MTC. Patient has symptomatic disease or progressive disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with oncologist or endocrinologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.



## CARISOPRODOL (S)

---

### Products Affected

- Carisoprodol TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	The drug is being prescribed for an FDA-approved indication. If the patient is 65 years of age or older, 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.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## CAYSTON (S)

---

### Products Affected

- Cayston

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cystic fibrosis (CF) (Initial, Reauth): Diagnosis of CF AND Patient has evidence of Pseudomonas aeruginosa in the lungs.
<b>Age Restrictions</b>	CF (Initial): 7 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CF (Initial, reauth): 12 months
<b>Other Criteria</b>	CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).

## CEQUA (S)

---

### Products Affected

- Cequa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Dry eye (Initial): Diagnosis of keratoconjunctivitis sicca (dry eye). Trial and failure, contraindication, or intolerance to one of the following: Restasis (cyclosporine 0.05%), Xiidra (lifitegrast), or Tyrvaya (varenicline solution).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial, reauth: 12 months
<b>Other Criteria</b>	Dry eye (Reauth): Patient demonstrates positive clinical response to therapy.

## CERDELGA (S)

---

### Products Affected

- Cerdelga

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Gaucher disease: Diagnosis of Gaucher disease type 1. Patient is an extensive metabolizer (EM), intermediate metabolizer (IM), or poor metabolizer (PM) of cytochrome P450 enzyme (CYP) 2D6 as detected by an FDA-cleared test.
<b>Age Restrictions</b>	Gaucher disease: Patient is 18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Gaucher disease: 12 months
<b>Other Criteria</b>	N/A

## CHENODAL (S)

---

### Products Affected

- Chenodal

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of radiolucent gallstones. Patient has a well-opacifying gallbladder visualized by oral cholecystography. Trial and failure, contraindication or intolerance to ursodiol. Patient is not a candidate for surgery. Stones are not calcified (radiopaque) or radiolucent bile pigment stones.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a gastroenterologist or provider who has specialized expertise in the management of gallstones
<b>Coverage Duration</b>	Initial, reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment as evidenced by oral cholecystograms or ultrasonograms.

## CHOLBAM (S)

### Products Affected

- Cholbam

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Bile acid synthesis disorders due to single enzyme defects (BAS) (initial): diagnosis of a bile acid synthesis disorder due to a single enzyme defect based on one of the following: a) an abnormal urinary bile acid analysis by mass spectrometry OR b) molecular genetic testing consistent with the diagnosis. Peroxisomal disorders (PD) (initial): All of the following: 1) diagnosis of a peroxisomal disorder based on one of the following: a) an abnormal urinary bile acid analysis by mass spectrometry OR b) molecular genetic testing consistent with the diagnosis, 2) patient exhibits at least one of the following: a) liver disease (eg, jaundice, elevated serum transaminases), OR b) steatorrhea, OR c) complications from decreased fat-soluble vitamin absorption (eg, poor growth), AND 3) will be used as an adjunctive treatment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses (initial): Prescribed by a hepatologist, medical geneticist, pediatric gastroenterologist, OR other specialist that treats inborn errors of metabolism.
<b>Coverage Duration</b>	All uses: 4 months (initial), 12 months (reauth).
<b>Other Criteria</b>	All uses (reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement in liver function.

## CIALIS (S)

---

### Products Affected

- Cialis TABS 2.5MG, 5MG
- Tadalafil TABS 2.5MG, 5MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Concurrent use of nitrates.
<b>Required Medical Information</b>	Diagnosis of benign prostatic hyperplasia (BPH). Trial and failure, contraindication, or intolerance to an alpha-blocker (e.g., doxazosin, prazosin, tamsulosin) or a 5-alpha reductase inhibitor (e.g., dutasteride, finasteride).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

# CIBINQO (S)

## Products Affected

- Cibinqo

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of moderate to severe atopic dermatitis. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing Atopic Dermatitis (SCORAD) index value of at least 25. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to at least one of the following: a) Medium or higher potency topical corticosteroid, b) Pimecrolimus cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment. One of the following: 1) Trial and failure of a minimum 12-week supply of at least one systemic drug product for the treatment of atopic dermatitis (examples include, but are not limited to, Adbry [tralokinumab-ldrm], Dupixent [dupilumab], etc.), OR 2) Patient has a contraindication, intolerance, or treatment is inadvisable with both of the following FDA-approved atopic dermatitis therapies: Adbry (tralokinumab-ldrm) and Dupixent (dupilumab). Not used in combination with other Janus kinase (JAK) inhibitors, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine).
<b>Age Restrictions</b>	(Initial): Patient is 12 years of age or older.
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist.
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates a positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. Not used in combination with other JAK inhibitors, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine).



## CICLOPIROX (S)

### Products Affected

- Ciclopirox Nail Lacquer

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	All of the following: 1) Patient does not have lunula (matrix) involvement, 2) one of the following: a) Diagnosis of onychomycosis of the toenails, OR b) Diagnosis of onychomycosis of the fingernails, 3) Diagnosis of onychomycosis has been confirmed by one of the following: a) positive potassium hydroxide (KOH) preparation, OR b) culture, OR c) histology, 4) If toenail onychomycosis, patient has mild to moderate disease involving at least 1 target toenail, AND 5) Trial and failure (of a minimum 12-week supply), contraindication, or intolerance to oral terbinafine.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	48 weeks.
<b>Other Criteria</b>	N/A

## CIMZIA (S)

### Products Affected

- Cimzia

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Rheumatoid Arthritis (RA, initial): Diagnosis (dx) of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib) or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Crohn's Disease (CD, initial): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CAI) greater than 220. TF/C/I to two of the following: one formulary adalimumab product, Rinvoq, Skyrizi (risankizumab-rzaa), or Stelara (ustekinumab), OR for continuation of prior therapy. Psoriatic Arthritis (PsA, initial): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: a) Either a TF/C/I to two of the following: Cosentyx (secukinumab), Enbrel, one formulary adalimumab product, Orencia, Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Rinvoq, or Xeljanz/XR, OR b) for continuation of prior therapy. Ankylosing Spondylitis (AS, initial): Dx of active AS. TF/C/I to two of the following: Enbrel, one formulary adalimumab product, Cosentyx, Rinvoq, Xeljanz/XR, OR for continuation of prior therapy. Plaque Psoriasis (PsO) (initial): Dx of moderate to severe PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. TF/C/I to two of the following: one formulary adalimumab product, Enbrel, Otezla, Skyrizi (risankizumab), Sotyktu (deucravacitinib), Stelara, Cosentyx, OR for continuation of prior therapy.</p>
Age Restrictions	N/A

<b>Prescriber Restrictions</b>	CD (init): Prescribed by or in consultation with a gastroenterologist. RA, AS, nr-axSpA (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	RA, PsA, AS, PsO, nr-axSpA (init): 6 mos, (reauth): 12 mos. CD (init): 16 wks. (reauth): 12 mos.
<b>Other Criteria</b>	<p>Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of nr-axSpA with objective signs of inflammation (eg, C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.). Minimum duration of a one-month TF/C/I to two non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, meloxicam, naproxen) at maximally tolerated doses. RA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy.</p>

## CINRYZE (S)

### Products Affected

- Cinryze

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prophylaxis of hereditary angioedema (HAE) attacks: Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
<b>Age Restrictions</b>	HAE (prophylaxis): Patient is 6 years of age or older
<b>Prescriber Restrictions</b>	HAE (prophylaxis): Prescribed by or in consultation with an immunologist or an allergist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## COMETRIQ (S)

---

### Products Affected

- Cometriq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Medullary thyroid cancer (MTC): Diagnosis of Metastatic MTC.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	All uses: 12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## COPIKTRA (S)

---

### Products Affected

- Copiktra

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of CLL or SLL. Disease is relapsed or refractory. Trial and failure, contraindication, or intolerance to at least two prior therapies for CLL/SLL (e.g., Leukeran [chlorambucil], Gazyva [obinutuzumab], Arzerra [ofatumumab], Bendeka [bendamustine], Imbruvica [ibrutinib], Rituxan [rituximab], etc.).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# CORLANOR (S)

## Products Affected

- Corlanor

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Chronic heart failure (CHF) (initial): Diagnosis of CHF. Patient has NYHA Class II, III, or IV symptoms. Patient has a left ventricular ejection fraction less than or equal to 35%. Patient is in sinus rhythm. Patient has a resting heart rate of greater than or equal to 70 beats per minute. Patient has been hospitalized for worsening HF in the previous 12 months. Trial and failure, contraindication, or intolerance to two of the following at a maximally tolerated dose: A) One of the following: 1) ACE inhibitor (e.g., captopril, enalapril, lisinopril), 2) ARB (e.g., candesartan, losartan, valsartan), or 3) ARNI (e.g., Entresto [sacubitril and valsartan]), B) One of the following: 1) bisoprolol, 2) carvedilol, or 3) metoprolol succinate extended release, C) Sodium-glucose co-transporter 2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin), Farxiga (dapagliflozin), Xigduo XR (dapagliflozin and metformin)], or D) Mineralocorticoid receptor antagonist (MRA) [e.g., eplerenone, spironolactone]. Dilated Cardiomyopathy (DCM) (initial): Diagnosis of heart failure due to DCM. Patient has NYHA Class II, III, or IV symptoms. Patient is in sinus rhythm. Patient has an elevated heart rate. Trial and failure, contraindication or intolerance to one of the following: 1) Beta blocker (e.g., bisoprolol, metoprolol succinate extended release), 2) Angiotensin-converting enzyme (ACE) inhibitor (e.g., captopril, enalapril), or 3) Diuretic Agent (e.g., spironolactone, furosemide).</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	CHF, DCM (initial): Prescribed by or in consultation with a cardiologist
<b>Coverage Duration</b>	CHF, DCM (initial, reauth): 12 months
<b>Other Criteria</b>	CHF, DCM (reauth): Patient demonstrates positive clinical response to therapy.





# CORTROPHIN (S)

## Products Affected

- Cortrophin

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Infantile Spasms (IS) (West Syndrome) [off-label]: Diagnosis of IS (West Syndrome). Multiple Sclerosis (MS): Diagnosis of acute exacerbation of MS. One of the following: 1) Both of the following: a) Patient is new to therapy with corticotropin AND b) Trial and failure, contraindication, or intolerance (TF/C/I) to treatment with two high dose corticosteroid treatments (e.g., prednisone, IV methylprednisolone) OR 2) All of the following: a) Patient's MS exacerbations have been treated in the past with corticotropin AND b) Patient has benefitted from treatment with corticotropin for acute exacerbations of MS AND c) Medication is being used to treat a new exacerbation of MS. Other FDA-Approved</p> <p>Indications: Diagnosis of one of the following: 1) Rheumatic disorders: As adjunctive therapy for short-term administration in: psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), ankylosing spondylitis, or acute gouty arthritis, OR 2) Collagen diseases: During an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematosus or systemic dermatomyositis (polymyositis), OR 3) Dermatologic diseases: Severe erythema multiforme, Stevens-Johnson syndrome, or severe psoriasis, OR 4) Allergic states: Serum sickness or atopic dermatitis, OR 5) Ophthalmic diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa, such as one of the following: keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation, or allergic conjunctivitis, OR 6) Respiratory diseases: Symptomatic sarcoidosis, OR 7) Edematous state: To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus. TF/C/I to treatment with two corticosteroids (e.g., prednisone, methylprednisolone).</p>
Age Restrictions	IS: less than 2 years old

<b>Prescriber Restrictions</b>	IS, MS: neurologist. Rheumatic disorder, collagen disease: rheumatologist. Dermatologic: dermatologist. Allergic state: allergist, immunologist. Ophthalmic disease: optometrist, ophthalmologist. Respiratory diseases: pulmonologist. Edematous state: nephrologist, rheumatologist.
<b>Coverage Duration</b>	IS: 4 weeks. MS: 3 weeks. Other FDA-Approved Indications: 3 months.
<b>Other Criteria</b>	IS: Dosing for IS (West Syndrome) is in accordance with the United States Food and Drug Administration (FDA) approved labeling: not to exceed 150U/m <sup>2</sup> daily. MS: Dosing for MS is in accordance with the United States FDA approved labeling: not to exceed 120 units once daily. Other FDA-Approved Indications: Dosing is in accordance with the United States FDA approved labeling: not to exceed 80 units per day.

# COSENTYX (S)

## Products Affected

- Cosentyx INJ 150MG/ML, 75MG/0.5ML
- Cosentyx Sensoready Pen

- Cosentyx Unoready

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of active nr-axSpA with objective signs of inflammation (eg, C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) Enthesitis-Related Arthritis (ERA) (Initial): Diagnosis of active ERA. nr-axSpA, ERA (Initial): Minimum duration of a one-month TF/C/I to two non-steroidal anti-inflammatory drugs (NSAIDs) (eg, ibuprofen, naproxen) at maximally tolerated doses. Hidradenitis suppurativa (HS) (Initial): Diagnosis of moderate to severe HS.</p>
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis, HS (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. AS, nr-axSpA, ERA (initial): Prescribed by or in consultation with a rheumatologist.

<b>Coverage Duration</b>	All uses (initial): 6 months. All uses (reauth): 12 months
<b>Other Criteria</b>	<p>PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Psoriasis (Reauth): Patient demonstrates positive clinical response to therapy. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. ERA (Reauth): Patient demonstrates a positive clinical response to therapy as evidenced by at least one of the following: Reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. HS (Reauth): Patient demonstrates positive clinical response to therapy.</p>

## COTELLIC (S)

---

### Products Affected

- Cotellic

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Melanoma: Diagnosis of unresectable or metastatic melanoma. Patient has a BRAF V600E or V600K mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., cobas 4800 BRAF V600 Mutation Test) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with vemurafenib. Histiocytic Neoplasm: Diagnosis of histiocytic neoplasm. Used as monotherapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## CRESEMBA ORAL (S)

---

### Products Affected

- Cresemba CAPS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Fungal infection: Diagnosis of invasive aspergillosis or invasive mucormycosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	6 months
<b>Other Criteria</b>	N/A

## CRINONE (S)

---

### Products Affected

- Crinone

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	All indications: Excluded if for fertility uses.
<b>Required Medical Information</b>	Secondary amenorrhea: Diagnosis of secondary amenorrhea (the absence of menses in women who have already started menstruation who are not pregnant, breastfeeding, or in menopause).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## CUPRIMINE (S)

### Products Affected

- Penicillamine CAPS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: One of the following: 1) Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration), 2) Diagnosis of cystinuria AND trial and failure, contraindication, or intolerance to Thiola (tiopronin), or 3) Diagnosis of severe active rheumatoid arthritis AND patient has been unresponsive to conventional therapy (e.g., traditional DMARDs [e.g., methotrexate, sulfasalazine], TNF inhibitor [e.g., Humira (adalimumab), Enbrel (etanercept)], Non-TNF biologic [e.g., Rinvoq (upadacitinib), Xeljanz (tofacitinib)]).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates a positive clinical response to therapy



## CUVPOSA (S)

---

### Products Affected

- Glycopyrrolate ORAL SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of chronic severe drooling (sialorrhea). Diagnosis of a neurologic condition (e.g., cerebral palsy) associated with chronic severe drooling (sialorrhea).
<b>Age Restrictions</b>	Initial: Patient is between 3 and 16 years of age.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial, Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates a positive clinical response to therapy (e.g., reduction in drooling severity compared to baseline).

## CUVRIOR (S)

---

### Products Affected

- Cuvrior

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration). Trial and failure, contraindication, or intolerance to a penicillamine product (e.g., Depen, Cuprimine)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy

## CYLTEZO (S)

### Products Affected

- Cyltezo INJ 10MG/0.2ML, 20MG/0.4ML, 40MG/0.8ML
- Cyltezo Starter Package For Crohns Disease/uc/hs INJ 40MG/0.8ML
- Cyltezo Starter Package For Psoriasis

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A

<b>Prescriber Restrictions</b>	RA, AS, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
<b>Coverage Duration</b>	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.

---

**Other Criteria**

Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine]. Hidradenitis suppurativa (HS) (Initial): Diagnosis of moderate to severe hidradenitis suppurativa (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS, Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Patient demonstrates clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

---

## DALIRESP (S)

---

### Products Affected

- Daliresp

- Roflumilast

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic Obstructive Pulmonary Disease (COPD) (initial): Diagnosis of COPD. History of COPD exacerbations which required the use of systemic corticosteroids, antibiotics, or hospital admission. Trial and failure, intolerance, or contraindication to two prior therapies for COPD (e.g., Combivent, Spiriva).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	COPD (init, reauth): 12 months
<b>Other Criteria</b>	COPD (reauth): Patient demonstrates positive clinical response to therapy.

## DARAPRIM (S)

### Products Affected

- Daraprim

- Pyrimethamine TABS

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Toxoplasmosis: 1) Patient is using pyrimethamine for the active treatment of toxoplasmosis (e.g., toxoplasmic encephalitis, ocular toxoplasmosis), secondary prophylaxis of toxoplasmosis, or treatment of congenital toxoplasmosis OR 2) Patient is using pyrimethamine for the primary prophylaxis of toxoplasmosis, patient has experienced intolerance to prior prophylaxis with trimethoprim-sulfamethoxazole (TMP-SMX), and one of the following: patient has been re-challenged with TMP-SMX using a desensitization protocol and is still unable to tolerate, or evidence of life-threatening reaction to TMP-SMX in the past (eg, toxic epidermal necrolysis, Stevens-Johnson syndrome). Malaria: Requests for coverage of any pyrimethamine products for the treatment and/or prophylaxis of malaria are not authorized and will not be approved. The use of pyrimethamine for the treatment and/or prophylaxis of malaria is not recommended by the Centers for Disease Control and Prevention (CDC).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Toxoplasmosis: Prescribed by or in consultation with an infectious disease specialist
<b>Coverage Duration</b>	Toxoplasmosis: 12 months
<b>Other Criteria</b>	N/A

## DAURISMO (S)

---

### Products Affected

- Daurismo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acute myeloid leukemia (AML): Diagnosis of newly-diagnosed acute myeloid leukemia (AML) AND Used in combination with low-dose cytarabine AND One of the following: 1) Patient is greater than or equal to 75 years old, or 2) Patient has comorbidities that preclude the use of intensive induction chemotherapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.



## DAYBUE (S)

### Products Affected

- Daybue

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of Rett syndrome. One of the following: 1) Presence of ALL of the following clinical signs and symptoms: a) A pattern of development, regression, then recovery or stabilization, b) Partial or complete loss of purposeful hand skills such as grasping with fingers, reaching for things, or touching things on purpose, c) Partial or complete loss of spoken language, d) Repetitive hand movements, such as wringing the hands, washing, squeezing, clapping, or rubbing, or e) Gait abnormalities, including walking on toes or with an unsteady, wide-based, stiff-legged gait, OR 2) Molecular genetic testing confirms mutations in the MECP2 gene.
<b>Age Restrictions</b>	Initial: Patient is 2 years of age or older.
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a geneticist or neurologist.
<b>Coverage Duration</b>	Initial: 3 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

## DAYVIGO (S)

---

### Products Affected

- Dayvigo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of insomnia. Trial and failure, contraindication, or intolerance to Belsonra (suvorexant). One of the following: a) Patient is 65 years of age or older OR b) Both of the following: Patient is less than 65 years of age AND trial and failure, contraindication, or intolerance to one of the following: eszopiclone, temazepam, zaleplon, zolpidem, zolpidem ER.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

## DEFERASIROX (S)

### Products Affected

- Deferasirox
- Exjade
- Jadenu Sprinkle

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic Iron Overload Due to Blood Transfusions (Initial): Diagnosis of chronic iron overload due to blood transfusions (transfusional hemosiderosis). Patient has a baseline ferritin level more than 1,000 mcg/L. Patient has required the transfusion of at least 100 mL/kg packed red blood cells. Myelodysplastic Syndrome (MDS) (Initial): Diagnosis of MDS. Patient has Low or Intermediate-1 disease or is a potential transplant patient. Patient has received more than 20 red blood cell transfusions. Chronic iron overload due to non-transfusion-dependent thalassemia (NTDT) (Initial): Diagnosis of chronic iron overload due to NTDT. Liver iron concentration (LIC) 5 milligrams of iron per gram of liver dry weight (mg Fe/g dw) or higher. Serum ferritin level greater than 300 mcg/L.
<b>Age Restrictions</b>	Iron Overload Due to Blood Transfusions (initial): 2 years of age or older. NTDT (initial): 10 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Iron Overload Due to Blood Transfusions, MDS (initial, reauth):12 mo. NTDT (initial, reauth): 6mo.
<b>Other Criteria</b>	Iron Overload Due to Blood Transfusions, MDS (Reauth): Patient experienced a reduction from baseline in serum ferritin level or LIC. NTDT (Reauth): Patient has LIC 3 mg Fe/g dw or higher. Patient experienced a reduction from baseline in serum ferritin level or LIC.

## DEMSEER (S)

### Products Affected

- Demser

- Metyrosine

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Preoperative preparation: Diagnosis of pheochromocytoma confirmed by one of the following biochemical testing: a) plasma free metanephrines OR b) urinary fractioned metanephrines. Medication is being used for preoperative preparation. Trial and failure, contraindication, or intolerance to both of the following: a) alpha-adrenergic blocker (e.g., phenoxybenzamine, doxazosin, terazosin) AND b) beta-adrenergic blocker (e.g., propranolol, metoprolol). Treatment of pheochromocytoma (initial): Diagnosis of pheochromocytoma confirmed by one of the following biochemical testing: a) plasma free metanephrines OR b) urinary fractioned metanephrines. Patient with hormonally active (catecholamine excess) pheochromocytoma. One of the following: a) patient is not a candidate for surgery OR b) chronic treatment due to malignant pheochromocytoma. Patient has not reached normotension after treatment with a selective alpha-1-adrenergic blocker (e.g., doxazosin, terazosin) and beta-adrenergic blocker (e.g., propranolol, metoprolol). Medication will not be used to control essential hypertension.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Preop prep: Prescribed by or in consultation with an endocrinologist OR Endocrine surgeon. Pheochromocytoma (initial): Prescribed by or in consultation with endocrinologist OR provider who specializes in the management of pheochromocytoma.
<b>Coverage Duration</b>	Preop prep: 4 wks. Treatment of pheo (initial): 6 months, (reauth): 12 months.
<b>Other Criteria</b>	Treatment of pheochromocytoma (reauth): Patient demonstrates positive clinical response to therapy (e.g., decreased frequency and severity of hypertensive attacks).

## DESOXYN (S)

---

### Products Affected

- Methamphetamine Hcl

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	One of the following: a) diagnosis of attention deficit hyperactivity disorder (ADHD), OR b) diagnosis of attention deficit disorder (ADD).
<b>Age Restrictions</b>	PA applies to members 19 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## DIACOMIT (S)

---

### Products Affected

- Diacomit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of seizures associated with Dravet syndrome (DS). Used in combination with clobazam. Patient weighs 7kg or more.
<b>Age Restrictions</b>	Patient is 6 months of age or older.
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## DIBENZYLINE (S)

---

### Products Affected

- Dibenzyline

- Phenoxybenzamine Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Preoperative preparation: Diagnosis of pheochromocytoma confirmed by one of the following biochemical testing: a) plasma free metanephrines OR b) urinary fractionated metanephrines. Medication is being used for preoperative preparation. Trial and failure, contraindication, or intolerance to one of the following: a) doxazosin, b) terazosin, c) prazosin.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Preop prep: prescribed by or in consultation with an endocrinologist or endocrine surgeon.
<b>Coverage Duration</b>	4 weeks
<b>Other Criteria</b>	N/A

## DOPTELET (S)

### Products Affected

- Doptelet

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Thrombocytopenia Prior to Planned Procedure (TPPP): Diagnosis (dx) of thrombocytopenia. Patient has chronic liver disease and is scheduled to undergo a procedure. Baseline platelet count is less than 50,000/mcL. Chronic Immune Thrombocytopenia (ITP) (initial): Diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) or relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL. Trial and failure, contraindication, or intolerance to at least one of the following: corticosteroids (e.g., prednisone, methylprednisolone), immunoglobulins [e.g., Gammagard, immune globulin (human)], or splenectomy. Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	ITP (initial): Prescribed by or in consultation with a hematologist/oncologist.
<b>Coverage Duration</b>	TPPP: 1 month. ITP (initial, reauth): 12 months
<b>Other Criteria</b>	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.



## DOXEPIN TOPICAL (S)

---

### Products Affected

- Doxepin Hydrochloride CREA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of moderate pruritus. Patient has atopic dermatitis or lichen simplex chronicus. Trial and failure, contraindication, or intolerance to at least one medium potency topical corticosteroid, or is not a candidate for topical corticosteroids (e.g., treatment is on face, axilla, or groin).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	N/A

## DULERA (S)

---

### Products Affected

- Dulera

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Asthma (initial): Diagnosis of asthma. Trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age), or intolerance to Breo Ellipta (fluticasone furoate and vilanterol trifenate).
<b>Age Restrictions</b>	Initial: Patient is 5 years or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial, reauth: 12 months
<b>Other Criteria</b>	Asthma (reauthorization): Patient demonstrates positive clinical response to therapy.

## DUOPA (S)

### Products Affected

- Duopa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Parkinson's disease (PD) (Initial): Diagnosis of PD. Patient is levodopa-responsive and experiences disabling "Off" periods for a minimum of 3 hours/day. Disabling "Off" periods occur despite therapy with both of the following: a) oral levodopa-carbidopa and b) one drug from a different class of anti-Parkinson's disease therapy (eg, COMT inhibitor [entacapone, tolcapone], MAO-B inhibitor [selegiline, rasagiline], dopamine agonist [pramipexole, ropinirole]).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PD (initial): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	PD (Initial, reauth): 12 months
<b>Other Criteria</b>	Subject to Part B vs. Part D review. PD (Reauth): Patient demonstrates positive clinical response to therapy.

# DUPIXENT (S)

## Products Affected

- Dupixent

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Eosinophilic Asthma (EA) (init): Dx of mod to severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-tx) peripheral blood eosinophil level greater than or equal to 150 cells/ml. One of the following: 1) Patient has had two or more asthma exacerbations requiring systemic corticosteroids (eg, prednisone) within the past 12 mo, 2) Prior asthma-related hospitalization within the past 12 mo. Corticosteroid Dependent Asthma (CDA) (init): Dx of mod to severe asthma. Patient is currently dependent on oral corticosteroids for the treatment of asthma.</p> <p>EA, CDA (init): One of the following: 1) Both of the following: a) Patient is 6 years of age or older but less than 12 years of age b) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Medium-dose inhaled corticosteroid (eg, greater than 100 – 200 mcg fluticasone propionate equivalent/day) and Additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]) or ii) One medium dosed combination ICS/LABA product (eg, Advair Diskus [fluticasone propionate 100mcg/ salmeterol 50mcg], Symbicort [budesonide 80mcg/ formoterol 4.5mcg] Breo Ellipta [fluticasone furoate 50 mcg/ vilanterol 25 mcg]) OR 2) Patient is 12 years of age or older and Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) High-dose ICS [eg, greater than 500 mcg fluticasone propionate equivalent/day] and ii) additional asthma controller medication [eg, LTRA [eg, montelukast], LABA [eg, salmeterol], LAMA [eg, tiotropium]), OR b) One maximally-dosed combination ICS/LABA product [eg, Advair (fluticasone propionate/salmeterol), Breo Ellipta (fluticasone/vilanterol)].</p>
Age Restrictions	AD (initial): Patient is 6 months or age or older. CRSwNP, PN: no age restriction. EoE (initial): Patient is at least 1 year of age.

<b>Prescriber Restrictions</b>	AD, Prurigo Nodularis (PN) (Initial): Prescribed by or in consultation with one of the following: dermatologist, allergist/immunologist. Asthma (initial, reauth): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CRSwNP (initial, reauth): Prescribed by or in consultation with an otolaryngologist, allergist/immunologist, or pulmonologist. EoE (initial): Prescribed by or in consultation with a gastroenterologist or allergist/immunologist.
<b>Coverage Duration</b>	CRSwNP, EoE (Init/Reauth): 12 months. Asthma, AD, PN (Init): 6 mo. Asthma, AD, PN (reauth): 12 mo.

---

**Other Criteria**

Chronic rhinosinusitis with nasal polyposis (CRSwNP) (init): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to 2 months of treatment with an intranasal corticosteroid (eg, fluticasone, mometasone). Used in combination with another agent for CRSwNP. Eosinophilic esophagitis (EoE) (initial): Dx of EoE. Patient has symptoms of esophageal dysfunction (eg, dysphagia, food impaction, gastroesophageal reflux disease [GERD]/heartburn symptoms, chest pain, abdominal pain). Patient has at least 15 intraepithelial eosinophils per high power field (HPF). Other causes of esophageal eosinophilia have been excluded. Patient weighs at least 15 kg. Trial and failure, contraindication, or intolerance to at least an 8-week trial of one of the following: proton pump inhibitors (eg, pantoprazole, omeprazole) or topical (esophageal) corticosteroids (eg, budesonide, fluticasone). PN (init): Diagnosis of PN. TF/C/I to one medium or higher potency topical corticosteroid. Atopic dermatitis (AD) (init): Diagnosis (dx) of mod to severe AD. One of the following: a) Involvement of at least 10% body surface area (BSA), or b) SCORing Atopic Dermatitis (SCORAD) index value of at least 25. Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication (eg, safety concerns, not indicated for patient's age/weight), or intolerance to at least one of the following: a) Medium or higher potency topical corticosteroid, b) Pimecrolimus cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment. AD (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. EA (reauth): Patient demonstrates positive clinical response to therapy. CDA, PN, CRSwNP (reauth): Patient demonstrates a positive clinical response to therapy. EA, CDA (reauth): Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] (e.g., montelukast), long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications. CRSwNP (reauth): Used in combination with another agent for CRSwNP. EoE (reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement of at least one of the following from baseline: symptoms (eg, dysphagia, food impaction, chest pain, heartburn), histologic measures (eg, esophageal intraepithelial eosinophil count), or endoscopic measures (eg, edema, furrows, exudates, rings, strictures).

---

## EGRIFTA (S)

### Products Affected

- Egrifta Sv

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	HIV-associated lipodystrophy (initial): All of the following: 1) diagnosis of HIV-associated lipodystrophy, 2) one of the following: a) waist-circumference of greater than or equal to 95 cm (37.4 inches) in men, OR b) waist-circumference of greater than or equal to 94 cm (37 inches) for women, 3) one of the following: a) Waist-to-hip ratio of greater than or equal to 0.94 for men, OR b) waist-to-hip ratio of greater than or equal to 0.88 for women, 4) body mass index (BMI) greater than 20 kg/m <sup>2</sup> , AND 5) fasting blood glucose (FBG) levels less than or equal to 150 mg/dL (8.33 mmol/L), AND 6) patient has been on a stable regimen of antiretrovirals (eg, NRTIs, NNRTI, Protease Inhibitors, Integrase Inhibitors) for at least 8 weeks.
Age Restrictions	Initial: 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, reauth: 6 months
Other Criteria	(reauth): Patient demonstrates clinical improvement (eg, improvement in visceral adipose tissue [VAT], decrease in waist circumference, belly appearance, etc) while on therapy.

## ELIGARD (S)

---

### Products Affected

- Eligard

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Trial and failure, contraindication, or intolerance to any brand Lupron formulation.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.



## ELYXYB (S)

---

### Products Affected

- Elyxyb

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of migraine with or without aura. Trial and failure, contraindication, or intolerance to two generic nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## EMFLAZA (S)

### Products Affected

- Deflazacort TABS

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Submission of medical records (e.g., chart notes, laboratory values) documenting diagnosis of Duchenne muscular dystrophy (DMD). Patient has received genetic testing for a mutation of the dystrophin gene. Submission of medical records (e.g., chart notes, laboratory values) documenting one of the following: A) Documentation of a confirmed mutation of the dystrophin gene or B) Muscle biopsy confirmed an absence of dystrophin protein. Patient has had a trial and failure or intolerance to prednisone or prednisolone. Dose will not exceed 0.9 milligrams per kilogram of body weight once daily.
<b>Age Restrictions</b>	Initial: Patient is 2 years of age or older
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a neurologist who has experience treating children
<b>Coverage Duration</b>	Initial, Reauth: 12 months
<b>Other Criteria</b>	Reauth: Patient has experienced a benefit from therapy (e.g., improvement or preservation of muscle strength). Dose will not exceed 0.9 milligrams per kilogram of body weight once daily.

# EMGALITY (S)

## Products Affected

- Emgality

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Episodic Migraines (EM) (120 mg/mL strength only) (initial): Diagnosis of EM. Patient has greater than or equal to 4 migraine days per month.</p> <p>Chronic Migraines (CM) (120 mg strength/mL only) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Patient has greater than or equal to 8 migraine days per month.</p> <p>Episodic Cluster Headache (ECH) (100 mg/mL strength only) (initial): Diagnosis of episodic cluster headache. Patient has experienced at least 2 cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least three months. Medication will not be used in combination with another injectable CGRP inhibitor.</p> <p>EM, CM (120 mg/mL strength only) (initial): History of failure (after at least a two month trial), contraindication, or intolerance to two of the following preventive treatments for migraine from different classes: a) An antidepressant [i.e., Elavil (amitriptyline) or Effexor (venlafaxine)], OR b) An anticonvulsant [i.e., Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)], OR c) A beta blocker [i.e., atenolol, propranolol, nadolol, timolol, or metoprolol], OR d) Atacand (candesartan), OR e) Generic lisinopril. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.</p>
<b>Age Restrictions</b>	EM, CM, ECH (initial): 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	EM, CM (initial): 6 months. ECH (initial): 3 months. EM, CM, ECH (reauth): 12 months.

<b>Other Criteria</b>	EM, CM (120 mg/mL strength only) (reauth): Patient has experienced a positive response to therapy (e.g., a reduction in headache frequency and/or intensity, a reduction in the number of workdays missed due to migraines). Use of acute migraine medications (e.g., non-steroidal anti-inflammatory drugs [NSAIDs] [e.g., ibuprofen, naproxen], triptans [e.g., eletriptan, rizatriptan, sumatriptan]) has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (120 mg/mL strength only) (reauth): Patient continues to be monitored for medication overuse headache. ECH (100 mg/mL strength only) (reauth): Patient has experienced a positive response to therapy, demonstrated by a reduction in headache frequency and/or intensity. Medication will not be used in combination with another injectable CGRP inhibitor.
-----------------------	--

## ENBREL (S)

### Products Affected

- Enbrel INJ 25MG/0.5ML, 50MG/ML
- Enbrel Mini
- Enbrel Sureclick

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (Initial): Diagnosis of moderate to severe chronic plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month trial and failure, contraindication, or intolerance to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA (initial), PJIA (initial), AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	All uses (initial): 6 months. All uses (reauth): 12 months

<b>Other Criteria</b>	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count.
-----------------------	---

## ENDARI (S)

---

### Products Affected

- Endari

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Sickle cell disease (initial): Diagnosis of sickle cell disease. Used to reduce acute complications of sickle cell disease. Patient has had 2 or more painful sickle cell crises within the past 12 months.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Sickle cell disease (initial): Prescribed by or in consultation with a hematologist/oncologist
<b>Coverage Duration</b>	Sickle cell disease (initial, reauth): 12 months
<b>Other Criteria</b>	Sickle cell disease (reauth): Patient demonstrates positive clinical response to therapy.

## ENSPRYNG (S)

---

### Products Affected

- Enspryng

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Neuromyelitis Optica Spectrum Disorder (NMOSD) (initial): Diagnosis of NMOSD. Patient is anti-aquaporin-4 (AQP4) antibody positive.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	NMOSD (initial): Prescribed by or in consultation with a neurologist or ophthalmologist.
<b>Coverage Duration</b>	NMOSD (initial, reauth): 12 months
<b>Other Criteria</b>	NMOSD (reauth): Patient demonstrates positive clinical response to therapy.



## ENTYVIO (S)

### Products Affected

- Entyvio INJ 108MG/0.68ML

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Ulcerative Colitis (UC) (init): Diagnosis (Dx) of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: a) Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Humira (adalimumab), Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz/XR (tofacitinib/ER), OR b) for continuation of prior therapy. Crohn's Disease (CD) (init): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to two of the following: Humira, Skyrizi (risankizumab-rzaa), or Stelara, OR for continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	UC, CD (init): Prescribed by or in consultation with a gastroenterologist
<b>Coverage Duration</b>	UC, CD (init): 14 weeks. UC, CD (reauth): 12 months.
<b>Other Criteria</b>	UC, CD (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.

## EPCLUSA NON-PREFERRED (S)

---

### Products Affected

- Epclusa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guideline. Diagnosis of chronic hepatitis C. One of the following: 1) Trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age/weight), or intolerance to Mavyret (except patients with decompensated cirrhosis) AND sofosbuvir/velpatasvir, OR 2) For continuation of prior therapy. Not used in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)].
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
<b>Coverage Duration</b>	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
<b>Other Criteria</b>	N/A

## EPCLUSA PREFERRED (S)

---

### Products Affected

- Sofosbuvir/velpatasvir

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guideline. Diagnosis of chronic hepatitis C. Not used in combination with another HCV direct acting antiviral agent [e.g., Sovaldi (sofosbuvir)].
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
<b>Coverage Duration</b>	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
<b>Other Criteria</b>	N/A

## EPIDIOLEX (S)

---

### Products Affected

- Epidiolex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Lennox-Gastaut syndrome (LGS): Diagnosis of seizures associated with LGS. Trial of, contraindication, or intolerance to two formulary anticonvulsants (e.g., topiramate, lamotrigine, valproate). Dravet syndrome (DS): Diagnosis of seizures associated with DS. Tuberous sclerosis complex (TSC): Diagnosis of seizures associated with TSC.
<b>Age Restrictions</b>	LGS, DS, TSC: Patient is 1 year of age or older.
<b>Prescriber Restrictions</b>	LGS, DS, TSC: Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## EPOETIN ALFA (S)

### Products Affected

- Epogen INJ 10000UNIT/ML, 20000UNIT/ML, 2000UNIT/ML, 3000UNIT/ML, 4000UNIT/ML
- Procrit

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial): Other causes of anemia have been ruled out. Anemia by lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request. Cancer is a non-myeloid malignancy. Patient is receiving chemo.</p> <p>Preoperative for reduction of allogeneic blood transfusion: Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery. Hgb is greater than 10 to less than or equal to 13 g/dL. Patient is at high risk for perioperative transfusions. Patient is unwilling or unable to donate autologous blood pre-operatively. Anemia in hepatitis C virus (HCV)-infected pts due to ribavirin in combination with interferon/peg-interferon (Initial): Dx of HCV infection. Anemia by labs (Hct less than 36% or Hgb less than 12 g/dL) collected within 30 days of request. Patient is receiving ribavirin and one of the following: interferon alfa or peginterferon alfa.</p> <p>Anemia with HIV (Initial): Anemia by lab values (Hgb less than 12 g/dL or Hct less than 36%) collected within 30 days of request. Serum erythropoietin level less than or equal to 500 mU/mL. Receiving zidovudine therapy or dx of HIV. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of MDS. Serum erythropoietin level is 500 mU/mL or less, or dx of transfusion-dependent MDS.</p>
<b>Age Restrictions</b>	N/A

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CKD,HIV(Init):6mo. CKD,HIV(reauth):12mo. Chemo,HCV(all):3mo. MDS:(init) 3mo,(reauth)12mo. Preop:1mo.
<b>Other Criteria</b>	<p>Subject to ESRD review. CKD (Reauth): Dx of CKD. One of the following: 1) Most recent or average (avg) Hct over 3 months is 33% or less (Hgb is 11 g/dL or less) for patients on dialysis, without ESRD, 2) Most recent or avg Hct over 3 mo is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis, OR 3) Most recent or avg Hct over 3 mo is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Patient demonstrates positive clinical response to therapy from pre-treatment level. HIV (Reauth): Most recent or avg Hct over 3 months is below 36% or most recent or avg Hgb over 3 months is below 12 g/dl. Patient demonstrates positive clinical response to therapy from pre-treatment level. Chemo (Reauth): Anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Patient demonstrates positive clinical response to therapy from pre-treatment level. Patient is receiving chemo. HCV (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates positive clinical response to therapy from pre-treatment level. If patient has demonstrated response to therapy, authorization will be issued for the full course of ribavirin therapy. MDS (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates a positive clinical response to therapy from pre-treatment level. Off-label uses (except MDS, HCV): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%. CKD (init, reauth), HIV (init), Chemo (init), Preop, MDS (init), HCV (init): Verify iron evaluation for adequate iron stores.</p>

## ERIVEDGE (S)

---

### Products Affected

- Erivedge

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Basal cell carcinoma: One of the following: A) Diagnosis of metastatic basal cell carcinoma OR B) Both of the following: 1) Diagnosis of locally advanced basal cell carcinoma AND 2) One of the following: a) Disease recurred following surgery or b) Patient is not a candidate for surgery and radiation.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ERLEADA (S)

---

### Products Affected

- Erleada

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of prostate cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.



## ESBRIET (S)

### Products Affected

- Esbriet

- Pirfenidone

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity), AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	IPF (initial): Prescribed by or in consultation with a pulmonologist
<b>Coverage Duration</b>	initial, reauth: 12 months
<b>Other Criteria</b>	IPF (reauth): Patient demonstrates positive clinical response to therapy.

## EUCRISA (S)

---

### Products Affected

- Eucrisa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Atopic dermatitis (initial): Diagnosis of mild to moderate atopic dermatitis. Trial and failure, contraindication, or intolerance to one prescription strength topical corticosteroid (e.g., triamcinolone acetonide, fluocinolone acetonide), unless the affected area is sensitive (i.e., face, axillae, groin).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates a positive clinical response to therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity).

## EVENTITY (S)

### Products Affected

- Evenity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Diagnosis of postmenopausal osteoporosis. One of the following: Set I) Both of the following: A) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) trial and failure, contraindication, or intolerance (TF/C/I) to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]), or Set II) Both of the following: A) BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) both of the following: i) TF/C/I to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) and ii) one of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities: a) major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions. Trial of, contraindication, or intolerance to one of the following: Forteo (teriparatide) or Tymlos (abaloparatide). Treatment duration of Evenity (romosozumab-aqqg) has not exceeded a total of 12 months during the patient's lifetime.</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months (max 12 months of therapy per lifetime)
Other Criteria	N/A

# EVRYSDI (S)

## Products Affected

- Evrysdi

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Spinal muscular atrophy (SMA) (initial): Diagnosis of spinal muscular atrophy (SMA) type I, II, or III. Both of the following: a) The mutation or deletion of genes in chromosome 5q resulting in one of the following: 1) Homozygous gene deletion or mutation (e.g., homozygous deletion of exon 7 at locus 5q13) or 2) Compound heterozygous mutation (e.g., deletion of SMN1 exon 7 [allele 1] and mutation of SMN1 [allele 2]) AND b) Patient has at least 2 copies of SMN2. Patient is not dependent on both of the following: 1) Invasive ventilation or tracheostomy and 2) Use of non-invasive ventilation beyond use for naps and nighttime sleep. At least one of the following exams (based on patient age and motor ability) has been conducted to establish baseline motor ability: Hammersmith Infant Neurological Exam Part 2 (HINE-2) (infant to early childhood), Hammersmith Functional Motor Scale Expanded (HFMSE), Revised Upper Limb Module (RULM) Test (Non ambulatory), Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND), Motor Function Measure 32 (MFM-32) Scale, or Item 22 of the Bayley Scales of Infant and Toddler Development Third Edition (BSID-III). Patient is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza). One of the following: a) patient has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) patient has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	SMA (Initial, Reauth): Prescribed by or in consultation with a neurologist with expertise in the diagnosis and treatment of SMA

<b>Coverage Duration</b>	Initial, Reauth: 12 months
<b>Other Criteria</b>	SMA (Reauth): Patient demonstrates positive clinical response to therapy. Pt is not to receive concomitant chronic survival motor neuron (SMN) modifying therapy for the treatment of SMA (e.g., Spinraza). One of the following: a) pt has not previously received gene replacement therapy for the treatment of SMA (e.g., Zolgensma) or b) pt has previously received gene therapy for the treatment of SMA (e.g., Zolgensma) AND submission of medical records (e.g., chart notes) documenting that there has been an inadequate response to gene therapy (e.g., sustained decrease in at least one motor test score over a period of 6 months).

## EYSUVIS (S)

---

### Products Affected

- Eysuvis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Dry Eye Disease (DED) (initial): Diagnosis of dry eye disease. Trial and failure for a minimum 14 days duration of therapy, contraindication, or intolerance to 0.5% loteprednol suspension.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with an ophthalmologist or optometrist
<b>Coverage Duration</b>	Initial, Reauth: 14 days
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

## FABHALTA (S)

---

### Products Affected

- Fabhalta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH). Hemoglobin level of less than 10 g/dL.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a hematologist/oncologist.
<b>Coverage Duration</b>	Initial, Reauth: 12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

## FASENRA (S)

### Products Affected

- Fasenra INJ 30MG/ML

- Fasenra Pen

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Asthma (initial): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by a baseline (pre-treatment) peripheral blood eosinophil level greater than or equal to 150 cells per microliter. One of the following: 1) Patient has had two or more asthma exacerbations requiring systemic corticosteroids (e.g., prednisone) within the past 12 months, OR 2) Prior asthma-related hospitalization within the past 12 months. One of the following: 1) Both of the following: a) Patient is 6 years of age or older but less than 12 years of age b) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Medium-dose inhaled corticosteroid (e.g., greater than 100 – 200 mcg fluticasone propionate equivalent/day) and Additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) or ii) One medium dosed combination ICS/LABA product (e.g., Advair Diskus [fluticasone propionate 100mcg/ salmeterol 50mcg], Symbicort [budesonide 80mcg/ formoterol 4.5mcg] Breo Ellipta [fluticasone furoate 50 mcg/ vilanterol 25 mcg]) OR 2) Patient is 12 years of age or older and Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) High-dose inhaled corticosteroid (ICS) (e.g., greater than 500 mcg fluticasone propionate equivalent/day) and ii) additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]), OR b) One maximally-dosed combination ICS/LABA product [e.g., Advair (fluticasone propionate/salmeterol), Breo Ellipta (fluticasone/vilanterol)].</p>
Age Restrictions	N/A



<b>Prescriber Restrictions</b>	Asthma (Initial/Reauth): Prescribed by or in consultation with a pulmonologist or allergist/immunologist
<b>Coverage Duration</b>	Asthma (init): 6 months. Asthma (reauth): 12 months
<b>Other Criteria</b>	Asthma (Reauth): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications.

## FENTANYL (S)

### Products Affected

- Fentanyl Citrate Oral Transmucosal

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	For the management of breakthrough cancer pain. Patient is currently taking a long-acting opioid around the clock for cancer pain. Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids: Morphine sulfate at doses of greater than or equal to 60 mg/day, Fentanyl transdermal patch at doses greater than or equal to 25 µg/hr, Oxycodone at a dose of greater than or equal to 30 mg/day, Oral hydromorphone at a dose of greater than or equal to 8 mg/day, Oral oxymorphone at a dose of greater than or equal to 25 mg/day, or an alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with one of the following: Pain specialist, Oncologist, Hematologist, Hospice care specialist, or Palliative care specialist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

# FERRIPROX (S)

## Products Affected

- Deferiprone

- Ferriprox Twice-a-day

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Transfusional iron overload (Initial): Diagnosis of transfusional iron overload due to one of the following: thalassemia syndromes, sickle cell disease, or other transfusion-dependent anemias. Patient has Absolute Neutrophil Count (ANC) greater than $1.5 \times 10^9/L$ . One of the following: A) Trial and failure to one chelation therapy (e.g., generic deferasirox) OR B) History of contraindication or intolerance to one chelation therapy (e.g., generic deferasirox).
<b>Age Restrictions</b>	Patient is 8 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	All uses (reauth): Patient demonstrates positive clinical response to therapy. ANC greater than $1.5 \times 10^9/L$ .

## FILSPARI (S)

### Products Affected

- Filspari

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of primary immunoglobulin A nephropathy (IgAN). Patient is at risk of rapid disease progression. Used to reduce proteinuria. Patient has an estimated glomerular filtration rate (eGFR) of greater than or equal to 30 mL/min/1.73 m <sup>2</sup> . Patient has been on a minimum 90-day trial of a maximally tolerated dose of one of the following: a) An angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril), OR b) An angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan). Medication will not be used in combination with any of the following: a) Angiotensin receptor blockers, b) Endothelin receptor antagonists (ERAs) [e.g., Letairis (ambrisentan), Tracleer (bosentan), Opsumit (macitentan)], and c) Tekturna (aliskiren).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a nephrologist.
<b>Coverage Duration</b>	Initial, Reauth: 12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates a positive clinical response to therapy. Medication is not taken in combination with any of the following: a) Angiotensin receptor blockers, b) Endothelin receptor antagonists (ERAs) [e.g., Letairis (ambrisentan), Tracleer (bosentan), Opsumit (macitentan)], and c) Tekturna (aliskiren).

# FILSUVEZ (S)

## Products Affected

- Filsuvez

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of one of the following: 1) dystrophic epidermolysis bullosa (DEB), or 2) junctional epidermolysis bullosa (JEB). Disease is confirmed by one of the following: 1) Genetic testing confirms mutation in one of the following genes: a) For DEB, collagen type VII (COL7A1), or b) For JEB, one of the following: i) ITGA6, ii) ITGB4, iii) collagen type XVII (COL17A1), iv) LAMA3, v) LAMB3, vi) LAMC2, vii) ITGA3, or viii) LAMA3A, OR 2) Skin biopsy. Medication is being used for the treatment of wounds. Target wound(s) meets all of the following: a) Present for at least 21 days, b) No signs of infection, and c) No evidence or history of basal or squamous cell carcinoma. Patient does not have history of stem cell transplant. Medication is not being used concurrently with other FDA approved therapies (e.g., Vyjuvek) on the same target wound for the treatment of epidermolysis bullosa.
<b>Age Restrictions</b>	Initial: Patient is 6 months of age or older.
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a specialist with expertise in wound care.
<b>Coverage Duration</b>	Initial: 3 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy. Wound(s) being treated continues to meet both of the following: a) No signs of infection, and b) No evidence or history of basal or squamous cell carcinoma.

## FINTEPLA (S)

---

### Products Affected

- Fintepla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Dravet Syndrome: Diagnosis of seizures associated with Dravet syndrome. Lennox-Gastaut Syndrome: Diagnosis of seizures associated with Lennox-Gastaut syndrome.
<b>Age Restrictions</b>	All Indications: Patient is 2 years of age or older.
<b>Prescriber Restrictions</b>	All Indications: Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	All Indications: 12 months
<b>Other Criteria</b>	All Indications: Approve for continuation of prior therapy.

## FIRAZYR (S)

---

### Products Affected

- Firazyr
- Icatibant Acetate
- Sajazir

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Treatment of hereditary angioedema (HAE) attacks: Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
<b>Age Restrictions</b>	Patient is 18 years of age or older
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with an immunologist or an allergist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## FIRDAPSE (S)

---

### Products Affected

- Firdapse

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Lambert-Eaton Myasthenic Syndrome (LEMS) (initial): Diagnosis of LEMS.
<b>Age Restrictions</b>	LEMS (initial): Patient is 6 years of age or older.
<b>Prescriber Restrictions</b>	LEMS (initial): Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	LEMS (initial): 3 months. LEMS (reauth): 12 months.
<b>Other Criteria</b>	LEMS (reauth): Patient demonstrates positive clinical response to therapy (e.g., improvement in dynamometry, Timed 25-Foot Walk Test, Timed Up and Go Test).



## FIRMAGON (S)

---

### Products Affected

- Firmagon INJ 120MG/VIAL, 80MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of advanced or metastatic prostate cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## FLECTOR (S)

### Products Affected

- Diclofenac Epolamine

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	History of severe allergic-type reactions after taking aspirin or other non-steroidal anti-inflammatory (NSAIDs), including urticaria and asthma (aspirin-sensitive asthma).
<b>Required Medical Information</b>	Pain: Diagnosis of acute, localized pain due to minor strains, sprains and contusions. Patient meets one of the following: 1) Treatment failure with at least two prescription strength topical or oral non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, meloxicam, naproxen). OR 2) History of peptic ulcer disease/gastrointestinal bleed. OR 3) Patient is older than 65 years of age with one additional risk factor for gastrointestinal adverse events (e.g. use of anticoagulants, chronic corticosteroids).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	N/A

## FLUTICASONE HFA (S)

---

### Products Affected

- Fluticasone Propionate Hfa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	One of the following: 1) use of the Brand product within the previous 365 days or 2) trial and failure, contraindication, or intolerance to Arnuity Ellipta or Qvar Redihaler.
<b>Age Restrictions</b>	PA applies to patients 6 years of age or older. Patients under age 6 years old do not need to undergo prior authorization review.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## FLUTICASONE-VILANTEROL (S)

---

### Products Affected

- Fluticasone Furoate/vilanterol Ellipta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	At least 3 months use of the Brand product within the previous 365 days (document drug, duration, dose and date of use). Both of the following: 1) Documentation provided stating the Brand product has not been effective and 2) Justification provided for why the target drug is expected to provide benefit when the Brand product has not been shown to be effective.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## FOTIVDA (S)

---

### Products Affected

- Fotivda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of renal cell carcinoma. Disease is one of the following: relapsed or refractory. Patient has received two or more prior systemic therapies (e.g., cabozantinib + nivolumab, lenvatinib + pembrolizumab, etc.).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## FRUZAQLA (S)

---

### Products Affected

- Fruzaqla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of metastatic colorectal cancer. Patient has been previously treated with both of the following: A) Fluoropyrimidine-, oxaliplatin-, irinotecan-based chemotherapy, and B) Anti-VEGF biological therapy (e.g., bevacizumab, ramucirumab). One of the following: A) Patient does not have RAS wild type tumors, OR B) Both of the following: a) Patient has RAS wild type tumors, AND b) Trial and failure, contraindication, or intolerance to both of the following: 1) An anti-EGFR biological therapy (e.g., panitumumab, cetuximab), and 2) One of the following: i) Trifluridine/tipiracil or ii) Regorafenib.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## FULPHILA (S)

### Products Affected

- Fulphila

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute’s Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. Acute radiation syndrome (ARS) (off-label): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses: Prescribed by or in consultation with a hematologist/oncologist
<b>Coverage Duration</b>	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
<b>Other Criteria</b>	All Indications (except for ARS): Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca/Udenyca Onbody. ARS: Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca.





## FUROSCIX (S)

---

### Products Affected

- Furoscix

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of chronic heart failure. Patient has New York Heart Association (NYHA) Class II or III. Patient is currently on maintenance oral diuretic therapy (e.g., bumetanide, furosemide, torsemide). Provider attests that patient will be closely monitored for fluid, electrolyte, and metabolic abnormalities throughout therapy (e.g., hypokalemia, hypovolemia, hyponatremia).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	3 months
<b>Other Criteria</b>	N/A

# FYLNETRA (S)

## Products Affected

- Fynetra

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute’s Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. Acute radiation syndrome (ARS) (off-label): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses: Prescribed by or in consultation with a hematologist/oncologist
<b>Coverage Duration</b>	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
<b>Other Criteria</b>	All Indications (except for ARS): Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca/Udenyca Onbody. ARS: Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca.



## GALAFOLD (S)

### Products Affected

- Galafold

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Fabry Disease (FD) (initial): Diagnosis of FD. One of the following: a) detection of pathogenic mutations in the GLA gene by molecular genetic testing, b) deficiency in $\alpha$ -galactosidase A ( $\alpha$ -Gal A) enzyme activity in plasma, isolated leukocytes, or dried blood spots (DBS), or c) significant clinical manifestations (e.g., neuropathic pain, cardiomyopathy, renal insufficiency, angiokeratomas, cornea verticillata). Patient has an amenable galactosidase alpha gene (GLA) variant based on in vitro assay data. FD (initial, reauthorization): Will not be used in combination with Fabrazyme (agalsidase beta).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	FD (initial, reauth): 12 months.
Other Criteria	FD (reauthorization): Patient demonstrates positive clinical response to therapy.

## GATTEX (S)

---

### Products Affected

- Gattex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Short Bowel Syndrome (SBS) (Initial): Diagnosis of SBS. Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient is dependent on parenteral nutrition/intravenous (PN/IV) support for at least 12 months.
<b>Age Restrictions</b>	SBS (initial): Patient is 1 year of age or older.
<b>Prescriber Restrictions</b>	SBS (Init, reauth): Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	SBS (Init): 6 months. SBS (Reauth): 12 months.
<b>Other Criteria</b>	SBS (Reauth): Submission of medical records (e.g., chart notes, laboratory values) documenting that the patient has had a reduction in weekly parenteral nutrition/intravenous (PN/IV) support from baseline while on therapy.

## GAVRETO (S)

---

### Products Affected

- Gavreto

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Presence of metastatic rearranged during transfection (RET) gene fusion-positive tumor(s) as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Thyroid Cancer: Diagnosis of thyroid cancer. Disease is one of the following: advanced or metastatic. Disease has presence of rearranged during transfection (RET) gene fusion-positive tumor(s). Disease requires treatment with systemic therapy. One of the following: patient is radioactive iodine-refractory or radioactive iodine therapy is not appropriate.
<b>Age Restrictions</b>	Thyroid Cancer: Patient is 12 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy

# GILENYA (S)

---

## Products Affected

- Fingolimod Hydrochloride

- Gilenya

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
<b>Required Medical Information</b>	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	MS (initial, reauth): 12 months
<b>Other Criteria</b>	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).

## GILOTRIF (S)

### Products Affected

- Gilotrif

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): A) Diagnosis of advanced or metastatic (stage IIIB or IV) NSCLC AND B) One of the following: 1) Both of the following: a) Tumors have non-resistant epidermal growth factor (EGFR) mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND b) GILOTRIF will be used as first-line treatment, OR 2) All of the following: a) disease progressed after platinum-based chemotherapy (e.g., cisplatin, carboplatin) and b) squamous NSCLC.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.



## GLATIRAMER ACETATE (S)

### Products Affected

- Copaxone INJ 20MG/ML, 40MG/ML
- Glatiramer Acetate
- Glatopa

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
<b>Required Medical Information</b>	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	MS (initial, reauth): 12 months
<b>Other Criteria</b>	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).

## GLEEVEC (S)

### Products Affected

- Imatinib Mesylate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	One of the following: A) Diagnosis of Philadelphia chromosome positive (Ph+)/BCR ABL-positive chronic myelogenous leukemia (CML) OR B) Ph+/BCR ABL+ acute lymphoblastic leukemia (ALL) OR C) Gastrointestinal stromal tumor (GIST) OR D) Dermatofibrosarcoma protuberans that is unresectable, recurrent, or metastatic OR E) Hypereosinophilic syndrome or chronic eosinophilic leukemia OR F) Myelodysplastic syndrome (MDS) or myeloproliferative disease associated with platelet-derived growth factor receptor gene re-arrangements OR G) Aggressive systemic mastocytosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	All uses: 12 months
<b>Other Criteria</b>	All uses: Approve for continuation of prior therapy.

## GLP (NON-PREFERRED) (S)

### Products Affected

- Victoza

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test). Trial and failure of a minimum 90-day supply or intolerance to two of the following preferred brands: a) Bydureon/Bydureon BCise, b) Byetta, c) Ozempic, d) Trulicity, e) Rybelsus, or f) Mounjaro.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

## GLP1 (PREFERRED) (S)

### Products Affected

- Bydureon Bcise
- Byetta
- Mounjaro
- Ozempic INJ 2MG/3ML, 4MG/3ML, 8MG/3ML
- Rybelsus
- Trulicity

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Initial: One of the following: a) For patients requiring ongoing treatment for type 2 diabetes mellitus (T2DM), submission of medical records (e.g., chart notes) confirming diagnosis of T2DM, OR b) Submission of medical records (e.g., chart notes) confirming diagnosis of T2DM as evidenced by one of the following laboratory values: i) A1c greater than or equal to 6.5%, ii) fasting plasma glucose (FPG) greater than or equal to 126 mg/dL, or iii) 2-hour plasma glucose (PG) greater than or equal to 200 mg/dL during OGTT (oral glucose tolerance test).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Reauth: Patient demonstrates positive clinical response to therapy.

## GLUMETZA (S)

### Products Affected

- Metformin Hydrochloride Er TB24  
1000MG, 500MG

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: One of the following: a) History of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR) AND documented history of an inadequate response to metformin extended-release (generic Glucophage XR) as evidenced by hemoglobin A1c level is above patient's goal OR b) Documented history of intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction). One of the following: a) History of greater than or equal to 12 week trial of metformin immediate-release AND documented history of an inadequate response to metformin immediate-release as evidenced by hemoglobin A1c level is above patient's goal OR b) documented history of intolerance to metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Reauth: Patient experienced an objective response to therapy demonstrated by an improvement in HbA1c from baseline

# GLYCOPYRROLATE TABLET (S)

## Products Affected

- Glycopyrrolate TABS

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of peptic ulcer. One of the following: 1) Patient is receiving concomitant treatment therapy with a proton-pump inhibitor (PPI) (e.g., lansoprazole, omeprazole), OR 2) Both of the following: a) Patient has a contraindication or intolerance to PPIs, and b) Patient is receiving concomitant treatment therapy with an H2-receptor antagonist (e.g., famotidine, nizatidine).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	Initial, Reauth: 3 months.
<b>Other Criteria</b>	Reauth: One of the following: 1) Patient's peptic ulcer has not healed, OR 2) Patient has a new peptic ulcer. One of the following: 1) Patient is receiving concomitant treatment therapy with a proton-pump inhibitor (PPI) (e.g., lansoprazole, omeprazole), OR 2) Both of the following: a) Patient has a contraindication or intolerance to PPIs, and b) Patient is receiving concomitant treatment therapy with an H2-receptor antagonist (e.g., famotidine, nizatidine). Patient experienced a reduction in peptic ulcer symptoms while on therapy.

# GOCOVRI (S)

## Products Affected

- Gocovri

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Dyskinesia in Parkinson's disease (PD) (initial): Diagnosis of Parkinson's disease, patient is experiencing dyskinesia, patient is receiving levodopa-based therapy. Trial and failure or intolerance to Osmolex ER. "Off" Episodes in Parkinson's disease (initial): Diagnosis of Parkinson's disease. Patient is experiencing "off" episodes. Used in combination with levodopa/carbidopa therapy. Trial and failure or intolerance to Osmolex ER.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All Indications (Initial): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	All Indications (initial, reauth): 12 months
<b>Other Criteria</b>	All Indications (reauthorization): Patient demonstrates positive clinical response to therapy.

## GRASTEK (S)

### Products Affected

- Grastek

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Allergic rhinitis (AR) (Initial): Diagnosis of grass pollen-induced allergic rhinitis. Patient has a positive skin test or in vitro test for the listed pollen-specific IgE antibody: timothy grass or cross-reactive grass pollens. Treatment will be initiated 3 months before the expected onset of the grass pollen season. Trial and failure, contraindication, or intolerance to an intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, flunisolide nasal spray) AND an antihistamine (e.g., cetirizine, loratadine, azelastine nasal spray, olapatadine nasal spray).
<b>Age Restrictions</b>	AR (Initial): 5 to 65 years of age
<b>Prescriber Restrictions</b>	AR (Initial): Prescribed by or in consultation with an allergist or immunologist
<b>Coverage Duration</b>	AR (initial, reauth): 12 months
<b>Other Criteria</b>	AR (Reauth): One of the following: A) Patient has experienced improvement in the symptoms of their allergic rhinitis, OR B) patient has experienced a decrease in the number of medications needed to control allergy symptoms.



## GROWTH HORMONE, NON-PREFERRED (S)

### Products Affected

- Humatrope INJ 12MG, 24MG, 6MG
- Norditropin Flexpro
- Omnitrope
- Zomacton

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>PGHD(initial):less than 4mo w/suspected GD based on clinical presentation (eg, persistent neonatal hypoglycemia, persistent/prolonged neonatal jaundice/elev bilirubin, male infant with microgenitalia, midline anatomical defects, failure to thrive),OR hx neonatal hypoglycemia assoc w/pituitary dz,or panhypopituitarism dx,or all of the following: PGHD dx [confrmd by ht (utilizing age and gender grwth charts related to ht) documented(doc) by ht more than 2.0SD below midparental ht or more than 2.25SD below population(pop) mean (below 1.2 percentile for age and gender),or grwth velocity more than 2SD below mean for age and gender, or delayed skeletal maturation more than 2SD below mean for age and gender (eg,delayed more than 2yrs compared w/chronological age)].</p> <p>PWS(reauth):evidence of positive response to tx(eg,incr in total LBM, decr in fat mass) and expctd adult ht not attained and doc of expctd adult ht goal. GFSGA(initial):SGA dx based on catchup grwth failure in 1st 24mo of life using 0-36mo grwth chart confrmd by birth wt or length below 3rd percentile for gestational age(more than 2SD below pop mean) and ht remains at or below 3rd percentile (more than 2SD below pop mean). TS,NS(initial):ped grwth failure dx assoc w/TS w/doc female w/bone age less than 14yrs, or NS and ht below 5th percentile on grwth charts for age and gender. SHOX(initial):ped grwth failure dx w/SHOX gene deficiency confirmed by genetic testing. GFCRI(initial): ped grwth failure dx assoc w/CRI. ISS(initial):ISS dx, diagnostic eval excluded other causes assoc w/short stature(eg GHD, chronic renal insufficiency), doc ht at or below -2.25SD score below corresponding mean ht for age and gender assoc with growth rates unlikely to permit attainment of adult height in the normal range. PGHD,NS,SHOX,GFCRI,ISS (initial): doc male w/bone age less than 16yrs or female w/bone age less than 14yrs. PGHD,GFSGA,TS/NS,SHOX,GFCRI,ISS(reauth):expctd adult ht not attained and doc of expctd adult ht goal.</p>

<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, TPAP, IGHDA, ISS: prescribed by or in consultation with an endocrinologist. GFCRI: prescribed by or in consultation with an endocrinologist or nephrologist
<b>Coverage Duration</b>	All uses (initial, reauth): 12 months
<b>Other Criteria</b>	<p>All uses (initial): Trial and failure or intolerance to Genotropin.</p> <p>AGHD(initial): dx of AGHD with clin records supporting dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg, damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and pt has 1 GH stim test (insulin tolerance test [ITT], glucagon, macimorelin) to confirm adult GHD w/peak GH values ([ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin]) or doc deficiency of 3 anterior pituitary hormones (prolactin, ACTH, TSH, FSH/LH) and IGF-1/somatomedinC below age and gender adjstd nrml range as provided by physicians lab.</p> <p>AGHD, IGHDA(reauth): monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. TransitionPhaseAdolescent Pts(TPAP)(initial): attained expctd adult ht or closed epiphyses on bone radiograph, and doc high risk of GHD d/t GHD in childhood (from embryopathic/congenital defects, genetic mutations, irreversible structural hypothalamic-pituitary dz, panhypopituitarism, or deficiency of 3 anterior pituitary hormones: ACTH, TSH, prolactin, FSH/LH), w/IGF-1/somatomedinC below age and gender adj nrml range as provided by physicians lab, or pt does not have low IGF-1/somatomedinC and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT, glucagon, macimorelin) after d/c of tx for at least 1mo w/peak GH value [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin], or at low risk of severe GHD(eg d/t isolated and/or idiopathic GHD) and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT, glucagon, macimorelin) after d/c of tx for at least 1mo w/corresponding peak GH value [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin]. TPAP(reauth): evidence of positive response to therapy (eg, incr in total lean body mass, exercise capacity or IGF-1 and IGFBP-3). IGHDA(initial): doc GHD after 2 GH stim tests(ITT, glucagon, macimorelin), w/ 2 corresponding peak GH values [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60, 90 mins after admin].</p>

## GROWTH HORMONE, PREFERRED (S)

### Products Affected

- Genotropin
- Genotropin Miniquick
- Nutropin Aq Nuspin 10
- Nutropin Aq Nuspin 20
- Nutropin Aq Nuspin 5

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>PGHD(initial):less than 4mo w/suspected GD based on clinical presentation (eg, persistent neonatal hypoglycemia, persistent/prolonged neonatal jaundice/elev bilirubin, male infant with microgenitalia, midline anatomical defects, failure to thrive),OR hx neonatal hypoglycemia assoc w/pituitary dz,or panhypopituitarism dx,or all of the following: PGHD dx [confrmd by ht (utilizing age and gender grwth charts related to ht) documented(doc) by ht more than 2.0SD below midparental ht or more than 2.25SD below population(pop) mean (below 1.2 percentile for age and gender),or grwth velocity more than 2SD below mean for age and gender, or delayed skeletal maturation more than 2SD below mean for age and gender (eg,delayed more than 2yrs compared w/chronological age)].</p> <p>PWS(reauth):evidence of positive response to tx(eg,incr in total LBM, decr in fat mass) and expctd adult ht not attained and doc of expctd adult ht goal. GFSGA(initial):SGA dx based on catchup grwth failure in 1st 24mo of life using 0-36mo grwth chart confrmd by birth wt or length below 3rd percentile for gestational age(more than 2SD below pop mean) and ht remains at or below 3rd percentile (more than 2SD below pop mean). TS,NS(initial):ped grwth failure dx assoc w/TS w/doc female w/bone age less than 14yrs, or NS and ht below 5th percentile on grwth charts for age and gender. SHOX(initial):ped grwth failure dx w/SHOX gene deficiency confirmed by genetic testing. GFCRI(initial): ped grwth failure dx assoc w/CRI. ISS(initial):ISS dx, diagnostic eval excluded other causes assoc w/short stature(eg GHD, chronic renal insufficiency), doc ht at or below -2.25SD score below corresponding mean ht for age and gender assoc with growth rates unlikely to permit attainment of adult height in the normal range. PGHD,NS,SHOX,GFCRI,ISS (initial): doc male w/bone age less than 16yrs or female w/bone age less than 14yrs. PGHD,GFSGA,TS/NS,SHOX,GFCRI,ISS(reauth):expctd adult ht not attained and doc of expctd adult ht goal.</p>

<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PGHD, PWS, GFSGA, TS/NS, SHOX, AGHD, TPAP, IGHDA, ISS: prescribed by or in consultation with an endocrinologist. GFCRI: prescribed by or in consultation with an endocrinologist or nephrologist
<b>Coverage Duration</b>	All uses (initial, reauth): 12 months
<b>Other Criteria</b>	<p>AGHD(initial):dx of AGHD with clin records supporting dx of childhood-onset GHD, or adult-onset GHD w/clin records doc hormone deficiency d/t hypothalamic-pituitary dz from organic or known causes (eg,damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage) and pt has 1GH stim test (insulin tolerance test [ITT],glucagon,macimorelin) to confirm adult GHD w/peak GH values ([ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin]) or doc deficiency of 3 anterior pituitary hormones (prolactin,ACTH,TSH,FSH/LH) and IGF-1/somatomedinC below age and gender adjstd nrml range as provided by physicians lab.</p> <p>AGHD,IGHDA(reauth):monitoring as demonstrated by doc w/in past 12mo of IGF-1/somatomedinC level. TransitionPhaseAdolescent Pts(TPAP)(initial): attained expctd adult ht or closed epiphyses on bone radiograph, and doc high risk of GHD d/t GHD in childhood (from embryopathic/congenital defects, genetic mutations, irreversible structural hypothalamic-pituitary dz, panhypopituitarism, or deficiency of 3 anterior pituitary hormones: ACTH,TSH,prolactin,FSH/LH), w/IGF-1/somatomedinC below age and gender adj nrml range as provided by physicians lab, or pt does not have low IGF-1/somatomedinC and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT,glucagon,macimorelin) after d/c of tx for at least 1mo w/peak GH value [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin], or at low risk of severe GHD(eg d/t isolated and/or idiopathic GHD) and d/c GH tx for at least 1mo, and pt has 1 GH stim test (ITT, glucagon, macimorelin) after d/c of tx for at least 1mo w/corresponding peak GH value [ITT at or below 5mcg/L], [glucagon at or below 3mcg/L], [macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after admin]. TPAP(reauth): evidence of positive response to therapy (eg,incr in total lean body mass, exercise capacity or IGF-1 and IGFBP-3). IGHDA(initial):doc GHD after 2 GH stim tests(ITT,glucagon,macimorelin), w/ 2 corresponding peak GH values [ITT at or below 5mcg/L],[glucagon at or below 3mcg/L],[macimorelin less than 2.8 ng/mL 30,45,60,90 mins after admin].</p>

# H.P. ACTHAR GEL (S)

## Products Affected

- Acthar

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Infantile Spasms (IS) (West Syndrome): Diagnosis of IS (West Syndrome). Multiple Sclerosis (MS): Diagnosis of acute exacerbation of MS. One of the following: 1) Both of the following: a) Patient is new to therapy with corticotropin AND b) Trial and failure, contraindication, or intolerance (TF/C/I) to treatment with two high dose corticosteroid treatments (e.g., prednisone, IV methylprednisolone) OR 2) All of the following: a) Patient's MS exacerbations have been treated in the past with corticotropin AND b) Patient has benefitted from treatment with corticotropin for acute exacerbations of MS AND c) Medication is being used to treat a new exacerbation of MS. Other FDA-Approved Indications: Diagnosis of one of the following: 1) Rheumatic disorders: As adjunctive therapy for short-term administration in: psoriatic arthritis, rheumatoid arthritis, juvenile rheumatoid arthritis (selected cases may require low-dose maintenance therapy), ankylosing spondylitis, or acute gouty arthritis, OR 2) Collagen diseases: During an exacerbation or as maintenance therapy in selected cases of: systemic lupus erythematosus, or systemic dermatomyositis (polymyositis), OR 3) Dermatologic diseases: Severe erythema multiforme, Stevens-Johnson syndrome, or severe psoriasis, OR 4) Allergic states: Serum sickness or atopic dermatitis, OR 5) Ophthalmic diseases: Severe acute and chronic allergic and inflammatory processes involving the eye and its adnexa, such as one of the following: keratitis, iritis, iridocyclitis, diffuse posterior uveitis and choroiditis, optic neuritis, chorioretinitis, anterior segment inflammation, or allergic conjunctivitis, OR 6) Respiratory diseases: Symptomatic sarcoidosis, OR 7) Edematous state: To induce a diuresis or a remission of proteinuria in the nephrotic syndrome without uremia of the idiopathic type or that due to lupus erythematosus. TF/C/I to treatment with two corticosteroids (e.g., prednisone, methylprednisolone).</p>
Age Restrictions	Infantile spasms: less than 2 years old

<b>Prescriber Restrictions</b>	Infantile Spasm, MS: neurologist. Rheumatic disorder, collagen disease: rheumatologist. Dermatologic: dermatologist. Allergic state: allergist, immunologist. Ophthalmic disease: optometrist, ophthalmologist. Respiratory diseases: pulmonologist. Edematous state: nephrologist, rheumatologist.
<b>Coverage Duration</b>	Infantile Spasms: 4 weeks. MS: 3 weeks. All other FDA-approved uses: 3 months.
<b>Other Criteria</b>	IS: Dosing for IS (West Syndrome) is in accordance with the United States Food and Drug Administration (FDA) approved labeling: not to exceed 150U/m <sup>2</sup> daily. MS: Dosing for MS is in accordance with the United States FDA approved labeling: not to exceed 120 units once daily. Other FDA-Approved Indications: Dosing is in accordance with the United States FDA approved labeling: not to exceed 80 units per day.

## HAEGARDA (S)

---

### Products Affected

- Haegarda

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prophylaxis of hereditary angioedema (HAE) attacks: Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
<b>Age Restrictions</b>	HAE (prophylaxis): Patient is 6 years of age or older
<b>Prescriber Restrictions</b>	HAE (prophylaxis): Prescribed by or in consultation with an immunologist or an allergist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## HARVONI (S)

### Products Affected

- Harvoni PACK
- Harvoni TABS 90MG; 400MG
- Ledipasvir/sofosbuvir

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guideline. All (including patients with genotype 5 or 6 infection AND decompensated cirrhosis): A) Diagnosis of chronic hepatitis C, B) Patient is not receiving ledipasvir/sofosbuvir in combination with another HCV direct acting antiviral agent [eg, Sovaldi (sofosbuvir)]. ONE of the following: Trial and failure, intolerance, or contraindication (eg, safety concerns, not indicated for patient's age/weight) to a) Mavyret (except patients with decompensated cirrhosis, and b) sofosbuvir/velpatasvir, OR for continuation of prior ledipasvir/sofosbuvir therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
<b>Coverage Duration</b>	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
<b>Other Criteria</b>	N/A



# HETLIOZ (S)

## Products Affected

- Tasimelteon

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-24-Hour Sleep-Wake Disorder (Non-24) (initial): Both of the following: 1) Diagnosis of non-24-hour sleep-wake disorder (also known as free-running disorder, free-running or non-entrained type circadian rhythm sleep disorder, or hypernycthemeral syndrome), AND 2) patient is totally blind (has no light perception). Smith-Magenis Syndrome (SMS) (initial): Diagnosis of Smith-Magenis Syndrome (SMS). Patient is experiencing nighttime sleep disturbances (i.e., difficulty falling asleep, frequent nighttime waking and early waking).
<b>Age Restrictions</b>	SMS (initial): 16 years of age or older
<b>Prescriber Restrictions</b>	Non-24 (initial): Prescribed by or in consultation with a specialist in sleep disorders or neurologist. SMS (initial): Prescribed by or in consultation with a specialist in sleep disorders or neurologist.
<b>Coverage Duration</b>	Non-24, SMS (initial): 6 mo. (reauth): 12 mo
<b>Other Criteria</b>	Non-24 (reauth): Patient demonstrates positive clinical response to therapy. SMS (reauth): Patient demonstrates positive clinical response to therapy (i.e., improvement in nighttime total sleep time, improvement in nighttime sleep quality)

## HORIZANT (S)

---

### Products Affected

- Horizant

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Restless Legs Syndrome (RLS): Diagnosis of moderate to severe primary RLS. Trial and failure, contraindication, or intolerance to ropinirole or pramipexole. Post-Herpetic Neuralgia (PHN): Diagnosis of PHN. One of the following: 1) Patient has tried and had an inadequate response to a dose of at least 1,800 mg of generic gabapentin, OR 2) History of intolerance to generic gabapentin.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	RLS (reauth): Patient experienced an improvement in disease symptoms (e.g., decrease in symptom onset or severity, improved sleep, or decrease in symptom intensity). PHN (reauth): Patient experienced an improvement in disease symptoms (e.g., decrease in pain severity).

## HRM - MEGESTROL SUSPENSION

---

### Products Affected

- Megestrol Acetate SUSP 40MG/ML, 625MG/5ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	PA applies to patients 65 years or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

# HRM - MEGESTROL TABLET

---

## Products Affected

- Megestrol Acetate TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	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.
<b>Age Restrictions</b>	PA applies to patients 65 years or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Applies to New Starts only.

## HRM - PAIN MEDICATIONS

---

### Products Affected

- Demerol INJ 25MG/ML, 50MG/ML
- Meperidine Hcl INJ 100MG/ML, 25MG/ML, 50MG/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
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	N/A
Coverage Duration	12 months
Other Criteria	N/A

# HUMIRA (S)

## Products Affected

- Humira INJ 10MG/0.1ML, 20MG/0.2ML, 40MG/0.4ML, 40MG/0.8ML
- Humira Pediatric Crohns Disease Starter Pack INJ 0, 80MG/0.8ML
- Humira Pen
- Humira Pen-cd/uc/hs Starter INJ 80MG/0.8ML
- Humira Pen-pediatric Uc Starter Pack
- Humira Pen-ps/uv Starter

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. PsO (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.
Age Restrictions	N/A

<b>Prescriber Restrictions</b>	RA, AS, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque Psoriasis, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
<b>Coverage Duration</b>	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.

---

**Other Criteria**

Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine]. Hidradenitis suppurativa (Initial): Diagnosis of moderate to severe hidradenitis suppurativa (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Hidradenitis suppurativa (HS), Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Patient demonstrates clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

---



## HYFTOR (S)

---

### Products Affected

- Hyftor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of facial angiofibroma associated with tuberous sclerosis complex.
<b>Age Restrictions</b>	Initial: Patient is 6 years of age or older.
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a dermatologist, neurologist, or geneticist.
<b>Coverage Duration</b>	Initial: 4 months, Reauth: 12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy (e.g., improvement in size or redness of facial angiofibroma).

## IBRANCE (S)

---

### Products Affected

- Ibrance

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of breast cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# ICLUSIG (S)

---

## Products Affected

- Iclusig

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic myelogenous leukemia: Diagnosis of chronic myelogenous leukemia. Acute Lymphoblastic Leukemia: Diagnosis of Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	All uses: 12 months
<b>Other Criteria</b>	All uses: Approve for continuation of prior therapy.

## IDHIFA (S)

---

### Products Affected

- Idhifa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acute Myeloid Leukemia (AML): Diagnosis of AML. Disease is relapsed or refractory. Patient has an isocitrate dehydrogenase-2 (IDH2) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH2 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ILUMYA (S)

### Products Affected

- Ilumya

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Plaque Psoriasis (initial): Diagnosis of moderate-to-severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. One of the following: a) Trial and failure, contraindication, or intolerance to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Otezla (apremilast), Skyrizi (risankizumab), Sotyktu (deucravacitinib), Stelara (ustekinumab), OR b) for continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist
<b>Coverage Duration</b>	Plaque Psoriasis (initial): 6 months. Plaque Psoriasis (reauth): 12 months.
<b>Other Criteria</b>	Plaque Psoriasis (Reauth): Patient demonstrates positive clinical response to therapy.

# IMBRUVICA (S)

## Products Affected

- Imbruvica CAPS
- Imbruvica SUSP
- Imbruvica TABS 140MG, 280MG, 420MG

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Waldenstrom's macroglobulinemia: Diagnosis of Waldenstrom's macroglobulinemia/lymphoplasmacytic lymphoma. Small lymphocytic lymphoma (SLL): Diagnosis of SLL. Chronic graft versus host disease (cGVHD): Diagnosis of cGVHD AND trial and failure of one or more lines of systemic therapy (e.g., corticosteroids like prednisone or methylprednisolone, mycophenolate).
<b>Age Restrictions</b>	(cGVHD): Patient is 1 year of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	All Uses: 12 months
<b>Other Criteria</b>	All Uses: Approve for continuation of prior therapy.

## IMVEXXY (S)

---

### Products Affected

- Imvexxy Maintenance Pack
- Imvexxy Starter Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Dyspareunia (initial): Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial, reauth: 12 months
<b>Other Criteria</b>	Dyspareunia (reauth): Patient demonstrates positive clinical response to therapy.

## INBRIJA (S)

---

### Products Affected

- Inbrija

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Parkinson's disease (PD) (initial): Diagnosis of PD. Patient is experiencing intermittent OFF episodes. Patient is currently being treated with carbidopa/levodopa. Trial and failure, contraindication or intolerance to two of the following: MAO-B inhibitor (e.g., rasagiline, selegiline), dopamine agonist (e.g., pramipexole, ropinirole), or COMT Inhibitor (e.g., entacapone).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PD (initial): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	PD (initial, reauth): 12 months
<b>Other Criteria</b>	PD (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with carbidopa/levodopa.



## INCRELEX (S)

---

### Products Affected

- Increlex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Insulin-like Growth Factor-1 (IGF-1) deficiency (initial): Diagnosis of severe primary IGF-1 deficiency. Height standard deviation score of -3.0 or less. Basal IGF-1 standard deviation score of -3.0 or less. Normal or elevated growth hormone (GH). GH gene deletion (initial): Diagnosis of GH gene deletion in patients who have developed neutralizing antibodies to GH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	Initial, reauth: 12 months
<b>Other Criteria</b>	(Reauth): Patient demonstrates positive clinical response to therapy.

## INGREZZA (S)

### Products Affected

- Ingrezza CAPS

- Ingrezza CPPK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Tardive Dyskinesia (initial): Diagnosis of moderate to severe tardive dyskinesia. One of the following: a) patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR b) patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Chorea associated with Huntington's disease (initial): Diagnosis of chorea in patients with Huntington's disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Tardive Dyskinesia (initial): Prescribed by or in consultation with a neurologist or psychiatrist. Chorea associated with Huntington's disease (initial): Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	All Uses (initial): 3 months. All Uses (reauth): 12 months
<b>Other Criteria</b>	All Uses (reauth): Patient demonstrates positive clinical response to therapy.

## INJECTABLE TESTOSTERONE, NON-PREFERRED (S)

### Products Affected

- Xyosted

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
<b>Age Restrictions</b>	HG (init): Patient is 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.

<b>Other Criteria</b>	HG (Initial), GD: Trial and failure or intolerance to both of the following generics: testosterone enanthate and testosterone cypionate. HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
-----------------------	---

## INLYTA (S)

---

### Products Affected

- Inlyta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renal cell carcinoma (RCC): Diagnosis of RCC. One of the following: (1) used as first-line treatment in combination with avelumab or pembrolizumab or (2) used after failure of one prior systemic therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## INQOVI (S)

---

### Products Affected

- Inqovi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Myelodysplastic syndrome (MDS): Diagnosis of myelodysplastic syndrome. Patient is intermediate-1, intermediate-2, or high-risk per the International Prognostic Scoring System (IPSS).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## INREBIC (S)

---

### Products Affected

- Inrebic

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Myelofibrosis: Diagnosis of one of the following: primary myelofibrosis, post-polycythemia vera myelofibrosis, or post-essential thrombocythemia myelofibrosis.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## INSULIN GLARGINE (S)

### Products Affected

- Insulin Glargine
- Insulin Glargine Solostar INJ 100UNIT/ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	At least 3 months use of the Brand product within the previous 365 days (document drug, duration, dose and date of use). Both of the following: 1) Documentation provided stating the Brand product has not been effective and 2) Justification provided for why the target drug is expected to provide benefit when the Brand product has not been shown to be effective.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A



## INTRAROSA (S)

---

### Products Affected

- Intrarosa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Dyspareunia (initial): Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause. Trial and failure, contraindication, or intolerance to one of the following: Estrace (estradiol) vaginal cream or Premarin (conjugated estrogens) vaginal cream.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial, reauth: 12 months
<b>Other Criteria</b>	Dyspareunia (reauth): Patient demonstrates positive clinical response to therapy.

## IRESSA (S)

---

### Products Affected

- Gefitinib
- Iressa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ISTURISA (S)

---

### Products Affected

- Isturisa TABS 1MG, 5MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cushing's disease (initial): Diagnosis of Cushing's disease. One of the following: a) Patient is not a candidate for pituitary surgery, OR b) Pituitary surgery has not been curative for the patient.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Cushing's disease (initial): Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	Cushing's disease (initial, reauth): 12 months
<b>Other Criteria</b>	Cushing's disease (reauth): Patient demonstrates positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease).

# ITRACONAZOLE CAPSULE (S)

## Products Affected

- Itraconazole CAPS
- Sporanox CAPS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Systemic Fungal Infection (SFI): Diagnosis of a systemic fungal infection (e.g., aspergillosis, histoplasmosis, blastomycosis). Fingernail Onychomycosis: Diagnosis of fingernail onychomycosis as confirmed by one of the following: i) positive potassium hydroxide (KOH) preparation, ii) fungal culture, OR iii) nail biopsy. Trial and failure (of a minimum 6-week supply), contraindication, or intolerance to oral terbinafine. Toenail Onychomycosis: Diagnosis of toenail onychomycosis as confirmed by one of the following: i) positive potassium hydroxide (KOH) preparation, ii) fungal culture, OR iii) nail biopsy. Trial and failure (of a minimum 12-week supply), contraindication, or intolerance to oral terbinafine.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	SFI:6mo.Fingernail Onychomycosis:5wks.Toenail Onychomycosis:3mo.
Other Criteria	N/A

# ITRACONAZOLE SOLUTION (S)

---

## Products Affected

- Itraconazole SOLN
- SporanoX SOLN

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Candidiasis: Diagnosis of esophageal or oropharyngeal candidiasis. One of the following: i) Trial and failure, contraindication, or intolerance to fluconazole OR ii) Susceptibility results demonstrate resistance to fluconazole.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Candidiasis: 1 month
<b>Other Criteria</b>	N/A

# IVERMECTIN (S)

---

## Products Affected

- Ivermectin TABS

- Stromectol TABS 3MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Strongyloidiasis: Diagnosis of intestinal (i.e., nondisseminated) strongyloidiasis due to the nematode parasite <i>Strongyloides stercoralis</i> . Onchocerciasis: Diagnosis of onchocerciasis due to the nematode parasite <i>Onchocerca volvulus</i> .
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Strongyloidiasis: 3 weeks. Onchocerciasis: 6 months.
<b>Other Criteria</b>	N/A

## IVIG (S)

### Products Affected

- Bivigam INJ 5GM/50ML
- Gammagard Liquid INJ 2.5GM/25ML
- Gammagard S/d Iga Less Than 1mcg/ml
- Gammaked INJ 1GM/10ML
- Gammaplex INJ 10GM/100ML, 10GM/200ML, 20GM/200ML, 5GM/50ML
- Gamunex-c INJ 1GM/10ML
- Octagam INJ 1GM/20ML, 2GM/20ML
- Panzyga
- Privigen INJ 20GM/200ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Initial: Immune globulin (Ig) will be administered at the minimum effective dose and appropriate frequency for the prescribed diagnosis. For IVIG – Ig is being used intravenously (IV) AND One of the following diagnoses: [A] Primary Immunodeficiency 1) Common variable immunodeficiency. 2) Congenital agammaglobulinemia (X-linked or autosomal recessive). 3) Severe combined immunodeficiencies. 4) Wiskott-Aldrich syndrome. OR 5) Other PI with an immunologic evaluation including IgG levels below the normal laboratory value for the patient’s age at the time of diagnosis and the patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine). [B] Secondary Acquired Antibody Deficiency 1) B-cell chronic lymphocytic leukemia with an Ig level less than 500 mg/dL OR history of recurrent bacterial infections. 2) HIV infection with an Ig level less than 400 mg/dL OR Patient has active bleeding or a platelet count less than 10 x 10<sup>9</sup>/L. 3) Multiple myeloma in plateau phase and patient has hypogammaglobulinemia. [C] Hematological Autoimmune Disorders 1) Acquired (pure) red cell aplasia (PRCA) that is immunologic and patient had a trial and failure, contraindication, or intolerance (TF/C/I) to a corticosteroid and an immunosuppressant (i.e., cyclophosphamide, cyclosporine) OR patient has viral PRCA caused by parvovirus B19. 2) Fetal alloimmune thrombocytopenia. 3) Hemolytic disease of the newborn and the patient has established hyperbilirubinemia. 4) Idiopathic thrombocytopenic purpura and patient had a TF/C/I to a corticosteroid OR a platelet count less than 30,000 cells/mm<sup>3</sup>. Continued in Other Criteria Section.</p>

<b>Age Restrictions</b>	HIV (initial): patient is less than or equal to 12 years of age.
<b>Prescriber Restrictions</b>	All uses (initial, reauth): Prescribed by or in consultation with a physician who has specialized expertise in managing patients on immune globulin therapy (e.g., immunologist, hematologist, neurologist).
<b>Coverage Duration</b>	4 months: Solid organ transplant. 12 months: all other diagnoses.
<b>Other Criteria</b>	<p>[D] Neuromuscular Autoimmune Disorders 1) Chronic inflammatory demyelinating polyneuropathy. 2) Guillain-Barré syndrome. 3) Inflammatory myopathies (dermatomyositis or polymyositis) AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., azathioprine, methotrexate, cyclosporine A, cyclophosphamide, or tacrolimus). 4) Lambert-Eaton myasthenic syndrome AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (e.g., azathioprine). 5) Multifocal motor neuropathy. 6) Myasthenia gravis with severe exacerbations or myasthenic crises AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., azathioprine, cyclosporine, cyclophosphamide, or mycophenolate mofetil). 7) Stiff person syndrome AND Patient had a TF/C/I to at least 2 standard therapies (i.e., benzodiazepines, muscle relaxants, or anti-convulsants).</p> <p>[E] Other Disorders 1) Autoimmune blistering disease AND Patient had a TF/C/I to a corticosteroid AND an immunosuppressant (i.e., cyclophosphamide, dapsone, methotrexate, azathioprine, or mycophenolate mofetil). 2) Kawasaki syndrome. 3) Solid organ transplant and IVIG is being used for CMV prophylaxis, or patient is a kidney transplant recipient and has donor specific antibodies, or patient has steroid-resistant rejection and had a TF/C/I to standard therapies. For SCIG (Gamunex-C, Gammagard Liquid, Gammaked only)- Immune globulin is being used subcutaneously AND One of the following PI diagnoses: 1) Common variable immunodeficiency. 2) Congenital agammaglobulinemia (X-linked or autosomal recessive). 3) Severe combined immunodeficiencies. 4) Wiskott-Aldrich syndrome. OR 5) Other PI with an immunologic evaluation including IgG levels below the normal laboratory value for the patient's age at the time of diagnosis and patient lacks an adequate response to protein and polysaccharide antigens (i.e., tetanus toxoid or diphtheria toxoid and pneumovax or HiB vaccine). All products: Subject to Part B vs. Part D review. Patient does not meet criteria for Part B or patient is in a long-term care facility. For non-oncology renewal, the patient has experienced an objective improvement on immune globulin therapy and the immune globulin will be administered at the minimum effective dose (by decreasing the dose, increasing the frequency, or implementing both strategies) for maintenance therapy.</p>



## IWILFIN (S)

---

### Products Affected

- Iwilfin

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of high-risk neuroblastoma (HRNB). Patient has shown at least a partial response to prior multiagent, multimodality therapy. Prior therapy included anti-GD2 immunotherapy (e.g., Danyelza [naxitamab-gqgk], Unituxin [dinutuximab]).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## JAKAFI (S)

### Products Affected

- Jakafi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Myelofibrosis: Diagnosis of primary myelofibrosis, OR post-polycythemia vera myelofibrosis, OR post-essential thrombocythemia myelofibrosis. Polycythemia vera: Diagnosis of polycythemia vera, AND trial and failure, contraindication, or intolerance to hydroxyurea. Acute graft versus host disease (aGVHD): Diagnosis of aGVHD. Disease is steroid-refractory. Chronic graft versus host disease (cGVHD): Diagnosis of cGVHD. Trial and failure of at least one or more lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months.
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# JATENZO (S)

## Products Affected

- Jatenzo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence.
<b>Age Restrictions</b>	HG (init): Patient is 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.

<b>Other Criteria</b>	HG (init): Trial and failure or intolerance to both of the following: Androderm (testosterone patch) and generic testosterone gel. HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
-----------------------	---

## JAVYGTOR (S)

---

### Products Affected

- Javygtor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient will have blood Phe levels measured after 1 week of therapy (new starts to therapy only) and periodically for up to 2 months of therapy to determine response. Trial and failure or intolerance to generic sapropterin.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	PKU (Init): 2 months. PKU (Reauth): 12 months
<b>Other Criteria</b>	PKU (reauth): Patient demonstrates a positive clinical response to therapy. Patient will continue to have blood Phe levels measured periodically during therapy.

## JAYPIRCA (S)

### Products Affected

- Jaypirca

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Mantle Cell Lymphoma (MCL): Diagnosis of MCL. Disease is one of the following: a) relapsed, or b) refractory. Patient has received at least two prior therapies for MCL, one of which is a Bruton Tyrosine Kinase (BTK) inhibitor therapy [e.g., Calquence (acalabrutinib), Brukinsa (zanubrutinib)]. Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL): Diagnosis of one of the following: a) CLL, or b) SLL. Patient has received treatment for CLL/SLL with both of the following therapies: a) BTK inhibitor therapy [e.g., Calquence (acalabrutinib), Brukinsa (zanubrutinib)], and b) B-cell lymphoma 2 (BCL-2) inhibitor therapy [e.g., Venclexta (venetoclax)].
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## JOENJA (S)

### Products Affected

- Joenja

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of activated phosphoinositide 3-kinase delta syndrome (APDS). Molecular genetic testing confirms mutations in the PIK3CD or PIK3R1 gene. Patient weighs greater than or equal to 45kg. Both of the following: a) Presence of nodal and/or extranodal proliferation (e.g., lymphadenopathy, splenomegaly, hepatomegaly) and b) Presence of other clinical findings and manifestations consistent with APDS (e.g., recurrent sino-pulmonary infections, bronchiectasis, enteropathy). Trial and failure, contraindication, or intolerance to at least one standard of care treatment for APDS (e.g., Immunoglobulin replacement therapy).
<b>Age Restrictions</b>	Initial: Patient is 12 years of age or older.
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with one of the following: geneticist, hematologist, or immunologist.
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

# JUXTAPID (S)

## Products Affected

- Juxtapid CAPS 10MG, 20MG, 30MG, 5MG

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Homozygous familial hypercholesterolemia (HoFH) (initial): Submission of medical records (eg, chart notes, laboratory values) documenting diagnosis of HoFH as confirmed by one of the following: a) genetic confirmation of 2 mutations in the LDL receptor, ApoB, PCSK9, or LDL receptor adaptor protein 1 (ie, LDLRAP1 or ARH), or b) both of the following: 1) either untreated/pre-treatment LDL-C greater than 500 mg/dL or treated LDL-C greater than 300 mg/dL AND 2) either xanthoma before 10 years of age or evidence of heterozygous FH in both parents. One of the following: a) patient is receiving other lipid-lowering therapy, or b) patient has an inability to take other lipid-lowering therapy. Trial and failure, contraindication, or intolerance to Repatha therapy. Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	HoFH (initial, reauth): Prescribed by or in consultation with a cardiologist, endocrinologist, or lipid specialist.
<b>Coverage Duration</b>	HoFH (initial): 6 months. (reauth): 12 months
<b>Other Criteria</b>	HoFH (reauthorization): One of the following: a) patient continues to receive other lipid-lowering therapy, or b) patient has an inability to take other lipid-lowering therapy. Submission of medical records (eg, chart notes, laboratory values) documenting LDL-C reduction from baseline while on therapy. Not used in combination with a proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor.



## JYNARQUE (S)

### Products Affected

- Jynarque TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Autosomal dominant polycystic kidney disease (ADPKD) (initial): Diagnosis of rapidly progressing ADPKD. One of the following: 1) Both of the following: Patient is new to therapy or has received Jynarque for less than or equal to 18 months AND Alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin will be measured prior to initiation, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months of therapy OR 2) Both of the following: Patient has received Jynarque for longer than 18 months AND ALT, AST, and bilirubin will be measured at least every 3 months. Patient does not have a history of significant liver impairment or injury, not including uncomplicated polycystic liver disease.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	ADPKD (reauth): Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient does not have signs or symptoms consistent with hepatic injury or 2) Patient has uncomplicated polycystic liver disease. One of the following: 1) Both of the following: Patient has received Jynarque for less than or equal to 18 months AND Alanine transaminase (ALT), aspartate transaminase (AST), and bilirubin will be measured prior to initiation, at 2 weeks and 4 weeks after initiation, then monthly for the first 18 months of therapy OR 2) Both of the following: Patient has received Jynarque for longer than 18 months AND ALT, AST, and bilirubin will be measured at least every 3 months.

## KALYDECO (S)

### Products Affected

- Kalydeco

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cystic Fibrosis (CF) (Initial): Diagnosis of cystic fibrosis. Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
<b>Age Restrictions</b>	CF (initial): Patient is 1 month of age or older.
<b>Prescriber Restrictions</b>	CF (initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
<b>Coverage Duration</b>	CF (initial, reauth): 12 months
<b>Other Criteria</b>	CF (Reauth): Patient demonstrates positive clinical response (i.e. improvement in lung function [percent predicted forced expiratory volume in one second (PPFEV1)], decreased number of pulmonary exacerbations) while on therapy.

## KERENDIA (S)

### Products Affected

- Kerendia

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of chronic kidney disease (CKD) associated with type 2 diabetes (T2D). Urine albumin-to-creatinine ratio (UACR) greater than or equal to 30 mg/g. Estimated glomerular filtration rate (eGFR) greater than or equal to 25 mL/min/1.73 m <sup>2</sup> . Serum potassium level less than or equal to 5.0 mEq/L prior to initiating treatment. One of the following: 1) Minimum 30-day supply trial of a maximally tolerated dose and will continue therapy with one of the following: a) generic angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril), or b) generic angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan), OR 2) Patient has a contraindication or intolerance to ACE inhibitors and ARBs.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial, Reauth: 12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient continues to be on a maximally tolerated dose of ACE inhibitor or ARB, OR 2) Patient has a contraindication or intolerance to ACE inhibitors and ARBs.

## KERYDIN (S)

---

### Products Affected

- Tavaborole

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Onychomycosis: Patient does not have dermatophytomas or lunula (matrix) involvement. Patient has a diagnosis of onychomycosis of the toenails. Diagnosis of onychomycosis has been confirmed by one of the following: a) positive potassium hydroxide (KOH) preparation, b) culture, or c) histology. Patient has mild to moderate disease in at least 1 target toenail. Both of the following: a) trial and failure (of a minimum 12-week supply), contraindication, or intolerance to oral terbinafine and b) trial and failure (of a minimum 48-week supply), contraindication, or intolerance to Jublia (efinaconazole).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	48 weeks.
<b>Other Criteria</b>	N/A

## KESIMPTA (S)

### Products Affected

- Kesimpta

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Multiple Sclerosis (MS) (Initial): Diagnosis of a relapsing form of multiple sclerosis (MS) (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to one disease-modifying therapy for MS [e.g., Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Gilenya fingolimod)], OR 2) For continuation of prior therapy. Not used in combination with another disease-modifying therapy for MS. Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ocrelizumab [Ocrevus]).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (Initial, Reauth): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	MS (Initial, Reauth): 12 months
<b>Other Criteria</b>	MS (Reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapse, or disease progression). Not used in combination with another disease-modifying therapy for MS. Not used in combination with another B-cell targeted therapy (e.g., rituximab [Rituxan], belimumab [Benlysta], ocrelizumab [Ocrevus]).

# KEVEYIS (S)

## Products Affected

- Keveyis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Periodic paralysis (Initial): Diagnosis of one of the following: Primary hyperkalemic periodic paralysis, Primary hypokalemic periodic paralysis, Paramyotonia Congenita with periodic paralysis, or Andersen-Tawil syndrome. One of the following: a) Patient has positive genetic panel for periodic paralysis, or b) One of the following tests demonstrated positive results for periodic paralysis: EMG/nerve conduction studies, long exercise test, muscle biopsy, or muscle MRI. Patient has distinct, regular episodes of weakness at least once a week. Provider attests that other known causes of potassium fluctuations have been excluded (e.g., thyrotoxic periodic paralysis, drugs that cause potassium abnormalities, etc.). One of the following: a) If new to therapy, dose will be initiated at 50mg twice daily, or b) Medication is being prescribed as continuation of therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses (initial): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	All uses (Initial): 3 months. (Reauth): 12 months
<b>Other Criteria</b>	All uses (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by a decrease in weekly attack frequency from baseline.

## KEVZARA (S)

### Products Affected

- Kevzara

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Rheumatoid Arthritis (RA) (initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Polymyalgia Rheumatica (PMR) (initial): Diagnosis of PMR. One of the following: a) Patient has had an inadequate response to corticosteroids (e.g., prednisone), OR b) Patient cannot tolerate tapering of corticosteroids (e.g., prednisone).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA, PMR (initial): Prescribed by or in consultation with a rheumatologist
<b>Coverage Duration</b>	RA, PMR (initial): 6 months, (reauth): 12 months
<b>Other Criteria</b>	RA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PMR (reauth): Patient demonstrates positive clinical response to therapy.

# KINERET (S)

## Products Affected

- Kineret

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Neonatal-Onset Multisystem Inflammatory Disease (NOMID) (initial): Diagnosis of NOMID AND dx of NOMID has been confirmed by one of the following: 1) NLRP-3 (nucleotide-binding domain, leucine rich family (NLR), pyrin domain containing 3) gene (also known as Cold-Induced Auto-inflammatory Syndrome-1 [CIAS1]) mutation OR 2) Both of the following: a) two of the following clinical symptoms: urticaria-like rash, cold/stress triggered episodes, sensorineural hearing loss, musculoskeletal symptoms (e.g., arthralgia, arthritis, myalgia), chronic aseptic meningitis, or skeletal abnormalities (e.g., epiphyseal overgrowth, frontal bossing) AND b) elevated acute phase reactants (eg, erythrocyte sedimentation rate [ESR], C-reactive protein [CRP], serum amyloid A [SAA]). Deficiency of Interleukin-1 Receptor Antagonist (DIRA): Diagnosis of DIRA.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA (initial): Prescribed by or in consultation with a rheumatologist. NOMID (initial): Prescribed by or in consultation with allergist/immunologist or rheumatologist or pediatrician.
<b>Coverage Duration</b>	RA, NOMID (initial): 6 months, (reauth): 12 months. DIRA: 12 months.



<b>Other Criteria</b>	RA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. NOMID (reauth): Patient demonstrates positive clinical response to therapy.
-----------------------	---

## KISQALI (S)

---

### Products Affected

- Kisqali

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Breast cancer: Diagnosis of breast cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy

## KISQALI-FEMARA PACK (S)

---

### Products Affected

- Kisqali Femara 200 Dose
- Kisqali Femara 400 Dose
- Kisqali Femara 600 Dose

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Breast cancer: Diagnosis of breast cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# KORLYM (S)

## Products Affected

- Korlym

- Mifepristone TABS 300MG

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cushing's syndrome (Initial): Diagnosis of endogenous Cushing's syndrome (i.e., hypercortisolism is not a result of chronic administration of high dose glucocorticoids). Diagnosis of either type 2 diabetes mellitus or diagnosis of glucose intolerance. Patient has either failed surgery or patient is not a candidate for surgery. Patient is not pregnant.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	Initial, reauth: 6 months
<b>Other Criteria</b>	Reauth: Patient demonstrates one of the following: patient has improved glucose tolerance while on therapy or patient has stable glucose tolerance while on therapy.

## KOSELUGO (S)

---

### Products Affected

- Koselugo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Neurofibromatosis Type 1 (NF1): Diagnosis of NF1. Patient has plexiform neurofibromas that are both of the following: inoperable and causing significant morbidity (e.g., disfigurement, motor dysfunction, pain, airway dysfunction, visual impairment). Patient is able to swallow a capsule whole.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## KRAZATI (S)

---

### Products Affected

- Krazati

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-Small Cell Lung Cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: locally advanced or metastatic. Disease is KRAS G12C-mutated as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received at least one prior systemic therapy (e.g., chemotherapy, immunotherapy).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## KUVAN (S)

### Products Affected

- Sapropterin Dihydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient will have blood Phe levels measured after 1 week of therapy (new starts to therapy only) and periodically for up to 2 months of therapy to determine response.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	PKU (Init): 2 months (Reauth): 12 months
<b>Other Criteria</b>	PKU (reauth): Patient demonstrates positive clinical response to therapy. Patient will continue to have blood Phe levels measured periodically during therapy.

# LENVIMA (S)

## Products Affected

- Lenvima 10 Mg Daily Dose
- Lenvima 12mg Daily Dose
- Lenvima 14 Mg Daily Dose
- Lenvima 18 Mg Daily Dose
- Lenvima 20 Mg Daily Dose
- Lenvima 24 Mg Daily Dose
- Lenvima 4 Mg Daily Dose
- Lenvima 8 Mg Daily Dose

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Differentiated thyroid cancer (DTC): Diagnosis of DTC. Renal Cell Carcinoma (RCC): Diagnosis of RCC. One of the following: 1) Both of the following: a) Used as first-line treatment and b) Used in combination with Keytruda (pembrolizumab), or 2) Both of the following: a) Treatment follows one prior anti-angiogenic therapy and b) Used in combination with everolimus. Hepatocellular Carcinoma (HCC): Diagnosis of HCC. Endometrial Carcinoma (EC): Diagnosis of advanced endometrial carcinoma that is not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR). Patient has disease progression following systemic therapy. Used in combination with Keytruda (pembrolizumab) therapy. Patient is not a candidate for curative surgery or radiation.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.



## LETAIRIS (S)

---

### Products Affected

- Ambrisentan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH (Initial): 6 months. PAH (Reauth): 12 months
<b>Other Criteria</b>	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

# LEUKINE (S)

## Products Affected

- Leukine INJ 250MCG

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Bone marrow/stem cell transplant (BMSCT): One of the following: 1) patient has non-myeloid malignancies undergoing myeloablative chemotherapy followed by autologous or allogeneic BMT, OR 2) used for mobilization of hematopoietic progenitor cells into the peripheral blood for collection by leukapheresis, OR 3) patient has had a peripheral stem cell transplant (PSCT) and has received myeloablative chemotherapy.</p> <p>Acute myeloid leukemia (AML): Diagnosis of AML. Patient has completed induction or consolidation chemotherapy. Age greater than or equal to 55 years.</p> <p>Febrile Neutropenia (FN) Prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute’s Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with a greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis).</p> <p>Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS). Treatment of High-Risk FN: Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia.</p> <p>Diagnosis of FN. Patient is at high risk for infection-associated complications.</p> <p>HIV-related neutropenia (HIVN): Patient is infected with HIV, and absolute neutrophil count (ANC) less than or equal to 1000 (cells/mm<sup>3</sup>).</p>
<b>Age Restrictions</b>	BMSCT: Patient is 2 years of age or older.

<b>Prescriber Restrictions</b>	HIVN: Prescribed by or in consultation with a hematologist/oncologist or infectious disease specialist. All other uses: Prescribed by or in consultation with a hematologist/oncologist.
<b>Coverage Duration</b>	BMSCT, AML, FN (prophylaxis, treatment): 3mo or duration of tx. HIVN: 6mo. ARS: 1 mo.
<b>Other Criteria</b>	N/A

## LEUPROLIDE BRAND (S)

---

### Products Affected

- Leuprolide Acetate INJ 22.5MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Trial and failure, contraindication, or intolerance to any brand Lupron formulation.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# LIDOCAINE TOPICAL (S)

---

## Products Affected

- Lidocaine Hydrochloride EXTERNAL SOLN

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

# LIDODERM (S)

---

## Products Affected

- Lidocaine PTCH 5%

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## LIDODERM BRAND (S)

---

### Products Affected

- Lidocan

- Lidoderm

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia. Trial and failure or intolerance to generic lidocaine patch 5%.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## LITFULO (S)

---

### Products Affected

- Litfulo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of alopecia areata. Patient has at least 50% scalp hair loss. Other causes of hair loss have been ruled out (eg, other types of alopecia, scalp disease, active systemic disease). Initial, Reauth: Not used in combination with other JAK inhibitors, biologic immunomodulators, cyclosporine or other potent immunosuppressants.
<b>Age Restrictions</b>	Initial: Patient is 12 years of age or older.
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	Initial, Reauth: 12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.



# LIVMARLI (S)

## Products Affected

- Livmarli

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Alagille syndrome (ALGS) (initial): Both of the following: a) Diagnosis of ALGS, and b) Molecular genetic testing confirms mutations in the JAG1 or NOTCH2 gene. Patient is experiencing moderate to severe cholestatic pruritus. Patient has had an inadequate response to at least two of the following treatments used for the relief of pruritus: a) Ursodeoxycholic acid (e.g., Ursodiol), b) Antihistamines (e.g., diphenhydramine, hydroxyzine), c) Rifampin, or d) Bile acid sequestrants (e.g., Questran, Colestid, Welchol). Progressive Familial Intrahepatic Cholestasis (PFIC) (init): Both of the following: a) Diagnosis of PFIC, and b) Molecular genetic testing confirms mutations in the ATP8B1, ABCB11, ABCB4, TJP2, NR1H4, or MYO5B gene. Patient is experiencing moderate to severe cholestatic pruritus. Patient has had an inadequate response to at least two of the following treatments used for the relief of pruritus: a) Ursodeoxycholic acid (e.g., Ursodiol), b) Antihistamines (e.g., diphenhydramine, hydroxyzine), c) Rifampin, or d) Bile acid sequestrants (e.g., Questran, Colestid, Welchol).</p>
<b>Age Restrictions</b>	ALGS (initial): Patient is 3 months of age or older. PFIC (init): Patient is 5 years of age or older.
<b>Prescriber Restrictions</b>	All indications (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist.
<b>Coverage Duration</b>	ALGS (initial, reauth): 12 months. PFIC (init): 6 months, (reauth): 12 months.
<b>Other Criteria</b>	All indications (reauth): Patient demonstrates positive clinical response to therapy (e.g., reduced bile acids, reduced pruritus severity score).

## LODOCO (S)

---

### Products Affected

- Lodoco

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of atherosclerotic disease. Used for the secondary prevention of cardiovascular (CV) disease events (e.g., very high-risk patients). Patient is on maximally tolerated therapy with at least two agents for coronary disease [e.g., antiplatelet (aspirin), lipid-lowering agent (statin [atorvastatin], ezetimibe, PCSK9 inhibitors [evolocumab]), beta-blocker (atenolol) or renin-angiotensin-aldosterone system blockers (lisinopril)].
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial, Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

## LONSURF (S)

### Products Affected

- Lonsurf

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Colorectal Cancer: Diagnosis of metastatic colorectal cancer AND One of the following: Used as a single agent or Used in combination with bevacizumab AND trial and failure, contraindication, or intolerance to fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy (e.g., FOLFOX, FOLFIRI, FOLFOXIRI) AND trial and failure, contraindication, or intolerance to at least one anti-VEGF therapy (e.g., bevacizumab)) AND One of the following: A) patient has RAS wild-type tumors and trial and failure, contraindication, or intolerance to at least one anti-EGFR therapy (e.g., Vectibix, Erbitux) OR Patient has RAS mutant tumors. Gastric/Gastroesophageal Junction Adenocarcinoma: Diagnosis of metastatic gastric cancer or diagnosis of metastatic gastroesophageal junction adenocarcinoma. Trial and failure, contraindication or intolerance to at least two of the following: fluoropyrimidine-based chemotherapy (e.g. fluorouracil), Platinum-based chemotherapy (e.g., carboplatin, cisplatin, oxaliplatin), Taxane (e.g., docetaxel, paclitaxel) or irinotecan-based chemotherapy, HER2/neu-targeted therapy (e.g., trastuzumab) (if HER2 overexpression).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## LORBRENA (S)

---

### Products Affected

- Lorbrena

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic NSCLC.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## LOTRONEX (S)

### Products Affected

- Alosetron Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Severe Diarrhea-Predominant Irritable Bowel Syndrome (IBS) in Women (initial): All of the following: 1) diagnosis of severe diarrhea-predominant IBS, 2) symptoms for at least 6 months, 3) female patient, AND 4) trial and failure, contraindication, or intolerance to an antidiarrheal agent [eg, loperamide].
<b>Age Restrictions</b>	Initial: 18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	IBS (initial): 12 weeks. IBS (reauth): 6 mo.
<b>Other Criteria</b>	IBS (reauth): Symptoms of IBS continue to persist. Patient demonstrates positive clinical response to therapy (e.g., relief of IBS abdominal pain and discomfort, improvement in stool consistency and frequency, improvement as measured by the Global Improvement Scale).

# LUMAKRAS (S)

---

## Products Affected

- Lumakras

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is one of the following: a) locally advanced or b) metastatic. Tumor is KRAS G12C-mutated as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has received at least one prior systemic therapy (e.g., chemotherapy, immunotherapy).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# LUMRYZ (S)

## Products Affected

- Lumryz

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND trial and failure, contraindication, or intolerance to one of the following: 1) amphetamine-based stimulant (eg, amphetamine, dextroamphetamine), OR 2) methylphenidate-based stimulant.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
<b>Coverage Duration</b>	All uses (initial): 6 months. All uses (reauth): 12 months
<b>Other Criteria</b>	All uses (reauth): Patient demonstrates positive clinical response to therapy.

## LUPKYNIS (S)

---

### Products Affected

- Lupkynis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Lupus Nephritis (initial): Diagnosis of active lupus nephritis. Used in combination with immunosuppressive therapy (e.g., mycophenolate mofetil, methylprednisolone).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Lupus Nephritis (initial): Prescribed by or in consultation with a nephrologist or rheumatologist
<b>Coverage Duration</b>	Lupus Nephritis (initial, reauth): 12 months
<b>Other Criteria</b>	Lupus Nephritis (reauth): Patient demonstrates positive clinical response to therapy.



# LUPRON (S)

---

## Products Affected

- Leuprolide Acetate INJ 1MG/0.2ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Prostate CA: 12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## LUPRON DEPOT (S)

### Products Affected

- Lupron Depot (1-month)
- Lupron Depot (3-month)
- Lupron Depot (4-month)
- Lupron Depot (6-month)

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prostate Cancer (7.5 mg, 22.5 mg, 30 mg, 45 mg): Diagnosis of advanced or metastatic prostate cancer. Endometriosis (3.75 mg, 11.25 mg): Diagnosis of endometriosis. One of the following: Patient has had surgical ablation to prevent recurrence, or trial and failure, contraindication, or intolerance to one NSAID (e.g., diclofenac, ibuprofen, meloxicam, naproxen) and one oral contraceptive (e.g., norethindrone-ethinyl estradiol, estradiol and norethindrone). Uterine Leiomyomata (UL) (3.75 mg, 11.25 mg): a) For use prior to surgery to reduce size of fibroids to facilitate a surgical procedure (eg, myomectomy, hysterectomy) OR b) all of the following: treatment of anemia, anemia is caused by uterine leiomyomata (fibroids), and for use prior to surgery.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Prostate CA: 12 mo. Endomet:6mo. UL (anemia):3 mo (fibroids):4 mo
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## LUPRON DEPOT PED (S)

### Products Affected

- Lupron Depot-ped (1-month) INJ  
7.5MG
- Lupron Depot-ped (3-month) INJ  
11.25MG
- Lupron Depot-ped (6-month)

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Central Precocious Puberty (CPP) (initial): Diagnosis of CPP (idiopathic or neurogenic). Early onset of secondary sexual characteristics in females less than age 8 or males less than age 9. Advanced bone age of at least one year compared with chronologic age. One of the following: a) patient has undergone gonadotropin-releasing hormone agonist (GnRHa) testing AND Peak luteinizing hormone (LH) level above pre-pubertal range, or b) patient has a random LH level in the pubertal range.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	CPP (initial, reauth): Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	CPP (initial, reauth): 12 months
<b>Other Criteria</b>	CPP (reauth): Patient demonstrates positive clinical response to therapy.

# LYNPARZA TABLET (S)

## Products Affected

- Lynparza TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of one of the following: epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Breast cancer: Diagnosis of breast cancer.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Pancreatic adenocarcinoma: Diagnosis of pancreatic adenocarcinoma. Prostate cancer: Diagnosis of castration-resistant prostate cancer. BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC): Diagnosis of metastatic castration-resistant prostate cancer (mCRPC). Presence of a deleterious or suspected deleterious BRCA-mutation as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with abiraterone and one of the following: a) prednisone or b) prednisolone. All indications: Approve for continuation of prior therapy.

## LYTGOBI (S)

---

### Products Affected

- Lytgobi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of intrahepatic cholangiocarcinoma. Disease is one of the following: a) unresectable, b) locally advanced, or c) metastatic. Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangements. Patient has been previously treated (e.g., chemotherapy).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a hepatologist, gastroenterologist, or oncologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## MARINOL (S)

### Products Affected

- Dronabinol

- Marinol

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. Trial and failure, contraindication, or intolerance to one 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). Trial and failure, contraindication, or intolerance to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine). AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CINV: 6 months. AIDS anorexia: 3 months.
<b>Other Criteria</b>	Subject to Part B vs. Part D review. CINV: Approve for continuation of therapy for treatment covered under Part B when patient is receiving cancer chemotherapy.

# MAVENCLAD (S)

## Products Affected

- Mavenclad

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Multiple Sclerosis (MS): Diagnosis of a relapsing form of MS (e.g., relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Patient has not been previously treated with cladribine AND Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two disease-modifying therapies for MS [e.g., Avonex (interferon beta-1a), Betaseron (interferon beta-1b), Gilenya fingolimod)], OR 2) Patient has previously received treatment with cladribine AND Patient has not already received the FDA-recommended lifetime limit of 2 treatment courses (or 4 treatment cycles total) of cladribine. Not used in combination with another disease-modifying therapy for MS.
Age Restrictions	N/A
Prescriber Restrictions	MS: Prescribed by or in consultation with a neurologist
Coverage Duration	MS: 2 months
Other Criteria	N/A

# MAVYRET (S)

---

## Products Affected

- Mavyret

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: Diagnosis of chronic hepatitis C, patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
<b>Coverage Duration</b>	8 to 16 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
<b>Other Criteria</b>	N/A



## MAYZENT (S)

---

### Products Affected

- Mayzent

- Mayzent Starter Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
<b>Required Medical Information</b>	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	MS (initial, reauth): 12 months
<b>Other Criteria</b>	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).

# MEKINIST (S)

## Products Affected

- Mekinist

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Melanoma: Diagnosis of unresectable or metastatic melanoma AND cancer is BRAF V600E or V600K mutant type as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Involvement of lymph nodes following complete resection. Used as adjunctive therapy. Medication is used in combination with Tafenlar (dabrafenib). Non-small Cell Lung Cancer (NSCLC): All of the following: diagnosis of metastatic non-small cell lung cancer AND cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND medication is used in combination with Tafenlar (dabrafenib). Anaplastic Thyroid Cancer (ATC): Diagnosis of locally advanced or metastatic ATC. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Cancer may not be treated with standard locoregional treatment options. Medication is used in combination with Tafenlar (dabrafenib).</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months

<b>Other Criteria</b>	<p>Approve for continuation of prior therapy. Solid tumors: Diagnosis of solid tumors. Disease is unresectable or metastatic. Patient has progressed on or following prior treatment and have no satisfactory alternative treatment options. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Tafenlar (dabrafenib). Low-grade glioma: Diagnosis of low-grade glioma. Patient requires systemic therapy. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Tafenlar (dabrafenib).</p>
-----------------------	--

## MEKTOVI (S)

---

### Products Affected

- Mektovi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAF V600E or V600K mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Braftovi (encorafenib). Non-Small Cell Lung Cancer (NSCLC): Diagnosis of metastatic NSCLC. Cancer is BRAF V600E mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with Braftovi (encorafenib).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy

# METFORMIN IR (S)

## Products Affected

- Metformin Hydrochloride TABS  
625MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: One of the following: a) History of greater than or equal to 12 week trial of another metformin immediate-release strength (e.g., 500mg, 850mg, 1000mg) AND documented history of an inadequate response to another metformin immediate-release as evidenced by hemoglobin A1c level above patient's goal OR b) Documented history of intolerance to another metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Reauth: Patient has experienced an objective response to therapy demonstrated by an improvement in HbA1c from baseline.

# METHOTREXATE INJECTION (S)

## Products Affected

- Rasuvo INJ 10MG/0.2ML, 12.5MG/0.25ML, 15MG/0.3ML, 17.5MG/0.35ML, 20MG/0.4ML, 22.5MG/0.45ML, 25MG/0.5ML, 30MG/0.6ML, 7.5MG/0.15ML

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Rheumatoid Arthritis (RA) (initial): Diagnosis of severe, active RA. Polyarticular juvenile idiopathic arthritis (PJIA) (initial): Diagnosis of active PJIA. Psoriasis (initial): Diagnosis of severe psoriasis. All Indications (initial): Trial and failure or intolerance to oral methotrexate.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA, PJIA (initial): Prescribed by or in consultation with a rheumatologist. Psoriasis (initial): Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	All Indications (Initial, reauth): 12 months
<b>Other Criteria</b>	All Indications (reauth): Patient demonstrates positive clinical response to therapy.

## METHOTREXATE INJECTION, NON-PREFERRED (S)

### Products Affected

- Otrexup INJ 10MG/0.4ML, 12.5MG/0.4ML, 15MG/0.4ML, 17.5MG/0.4ML, 20MG/0.4ML, 22.5MG/0.4ML, 25MG/0.4ML

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Rheumatoid Arthritis (RA) (initial): Diagnosis of severe, active RA. Polyarticular juvenile idiopathic arthritis (PJIA) (initial): Diagnosis of active PJIA. Psoriasis (initial): Diagnosis of severe psoriasis. All Indications (initial): Trial and failure or intolerance to oral methotrexate and Rasuvo.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA, PJIA (initial): Prescribed by or in consultation with a rheumatologist. Psoriasis (initial): Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	All Indications (Initial, reauth): 12 months
<b>Other Criteria</b>	All Indications (reauth): Patient demonstrates positive clinical response to therapy.

# METHYLTESTOSTERONE (S)

## Products Affected

- Methitest

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Delayed puberty (DP): Dx of DP AND male patient at birth. Breast cancer (BC): Dx of inoperable BC AND used for palliative treatment AND female patient at birth.
<b>Age Restrictions</b>	HG (init): Patient is 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	HG(init): (New to T tx:6 mo. Cont T tx:12 mo), (reauth): 12 mo. BC: 12 mo. DP: 6 mo.



<b>Other Criteria</b>	HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
-----------------------	--

## MIEBO (S)

---

### Products Affected

- Miebo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of dry eye disease confirmed by ONE of the following diagnostic tests: a) Schirmer test, b) Ocular surface dye staining (e.g., rose bengal, fluorescein, lissamine green), c) Tear function index/fluorescein clearance test, d) Tear break up time, e) Tear film osmolarity, f) Slit lamp lid evaluation, or g) Lacrimal gland function. Trial and failure, contraindication, or intolerance to Restasis (cyclosporine 0.05%).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with an ophthalmologist or optometrist.
<b>Coverage Duration</b>	Initial: 3 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

## MIGRANAL (S)

---

### Products Affected

- Dihydroergotamine Mesylate NASAL SOLN
- Migranal

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of migraine headaches with or without aura. Will be used for the acute treatment of migraine. One of the following: Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or contraindication to all triptans.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
<b>Coverage Duration</b>	Initial: 3 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea).

# MIRVASO (S)

---

## Products Affected

- Brimonidine Tartrate GEL
- Mirvaso

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Rosacea (init): Diagnosis of rosacea. Patient has moderate to severe persistent (nontransient) facial erythema.
<b>Age Restrictions</b>	Rosacea (init): Patient is 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Rosacea (init, reauth): 12 months
<b>Other Criteria</b>	Rosacea (reauth): Patient demonstrates positive clinical response to therapy.

## MS INTERFERONS (NON-PREFERRED) (S)

### Products Affected

- Rebif
- Rebif Rebidose
- Rebif Rebidose Titration Pack
- Rebif Titration Pack

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
<b>Required Medical Information</b>	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: 1) Trial and failure, contraindication, or intolerance (TF/C/I) to one of the following: Avonex (interferon beta-1a) or Betaseron (interferon beta-1b), or 2) for continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	MS (initial, reauth): 12 months
<b>Other Criteria</b>	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).

## MS INTERFERONS (PREFERRED) (S)

---

### Products Affected

- Avonex INJ 30MCG/0.5ML
- Avonex Pen
- Betaseron
- Plegridy

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
<b>Required Medical Information</b>	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	MS (initial, reauth): 12 months
<b>Other Criteria</b>	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).

## MULPLETA (S)

---

### Products Affected

- Mulpleta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Thrombocytopenia Prior to Planned Procedure (TPPP): Diagnosis (dx) of thrombocytopenia. Baseline platelet count is less than 50,000/mcL. Patient has chronic liver disease and is scheduled to undergo a procedure.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	1 month
<b>Other Criteria</b>	N/A

## MYALEPT (S)

---

### Products Affected

- Myalept

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Lipodystrophy (initial): Diagnosis of congenital or acquired generalized lipodystrophy AND one of the following: 1) Diabetes mellitus or insulin resistance despite insulin therapy at maximum tolerated doses OR 2) Hypertriglyceridemia.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with an endocrinologist
<b>Coverage Duration</b>	Initial, reauth: 12 months
<b>Other Criteria</b>	Lipodystrophy (reauth): Patient has experienced an objective response to therapy, such as A) Sustained reduction in hemoglobin A1c (HbA1c) level from baseline OR B) Sustained reduction in triglyceride (TG) levels from baseline.



## MYCAPSSA (S)

---

### Products Affected

- Mycapssa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acromegaly (initial): Diagnosis of acromegaly. One of the following: 1) Inadequate response to surgical resection and/or pituitary irradiation, or 2) Patient is not a candidate for surgical resection or pituitary irradiation. Patient has responded to and tolerated treatment with octreotide or lanreotide.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Acromegaly (initial, reauth): 12 months
<b>Other Criteria</b>	Acromegaly (reauth): Patient demonstrates positive clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size)

## MYFEMBREE (S)

### Products Affected

- Myfembree

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Uterine Leiomyomas (Fibroids) (initial): Diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids). Patient is premenopausal. One of the following: 1) History of inadequate control of bleeding following a trial of 30 days, or history of intolerance or contraindication to one of the following: combination (estrogen/progestin) contraceptive, progestins, or tranexamic acid or 2) Patient has had a previous interventional therapy to reduce bleeding. Treatment duration of therapy has not exceeded a total of 24 months. Pain Associated with Endometriosis (initial): Diagnosis of moderate to severe pain associated with endometriosis. Patient is premenopausal. One of the following: 1) History of inadequate pain control response following a trial of 30 days, or history of intolerance or contraindication to one of the following: danazol, combination (estrogen/progestin) contraceptive, or progestins or 2) Patient has had surgical ablation to prevent recurrence. Treatment duration of Myfembree has not exceeded a total of 24 months.</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	All Indications (initial, reauth): 12 months.
<b>Other Criteria</b>	<p>Uterine Leiomyomas (Fibroids) (reauth): Patient has improvement in bleeding associated with uterine leiomyomas (fibroids) (e.g., significant/sustained reduction in menstrual blood loss per cycle, improved quality of life, etc.). Treatment duration of therapy has not exceeded a total of 24 months. Pain Associated with Endometriosis (reauth): Patient has improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and nonmenstrual pelvic pain). Treatment duration of Myfembree has not exceeded a total of 24 months.</p>



## NERLYNX (S)

---

### Products Affected

- Nerlynx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Early Stage Breast cancer: Diagnosis (dx) of early stage breast cancer. Advanced or Metastatic Breast Cancer: Dx of advanced or metastatic breast cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## NEULASTA (S)

### Products Affected

- Neulasta

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute’s Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS). Treatment of FN: Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications.</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses: Prescribed by or in consultation with a hematologist/oncologist
<b>Coverage Duration</b>	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
<b>Other Criteria</b>	N/A

## NEXAVAR (S)

### Products Affected

- Nexavar

- Sorafenib Tosylate TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renal cell carcinoma (RCC): Diagnosis of RCC. Hepatocellular carcinoma (HCC): Diagnosis of HCC. Differentiated thyroid carcinoma (DTC): Diagnosis of DTC (ie, follicular carcinoma, Hurthle cell carcinoma, or papillary carcinoma). One of the following: locally recurrent disease, metastatic disease, or unresectable disease. One of the following: patient has symptomatic disease or patient has progressive disease. Disease is refractory to radioactive iodine (RAI) treatment. Medullary thyroid carcinoma (MTC): Diagnosis of MTC. One of the following: 1) Disease is progressive or 2) Disease is symptomatic with distant metastases. Trial and failure, contraindication, or intolerance to Caprelsa (vandetanib) or Cometriq (cabozantinib).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# NEXLETOL (S)

## Products Affected

- Nexletol

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Heterozygous familial hypercholesterolemia (HeFH) or primary hyperlipidemia (Initial): One of the following diagnoses: A) HeFH OR B) Primary hyperlipidemia. One of the following LDL-C values within the last 120 days: (1) LDL-C greater than or equal to 55 mg/dL with ASCVD or (2) LDL-C greater than or equal to 100 mg/dL without ASCVD. One of the following: 1) Used as adjunct to statin therapy OR 2) Pt is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR 3) Pt has a contraindication to all statins. Pt has been receiving at least 12 weeks of generic ezetimibe tx or pt has a history of contraindication or intolerance to ezetimibe.</p> <p>Established cardiovascular disease (CVD) or high risk for a CVD event but without established CVD (Initial): One of the following diagnoses: A) Established CVD (e.g., coronary artery disease, symptomatic peripheral arterial disease, cerebrovascular atherosclerotic disease), OR B) a high risk for a CVD event but without established CVD [e.g., diabetes mellitus (type 1 or type 2) in females over 65 years of age or males over 60 years of age]. One of the following: 1) Pt is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase) OR 2) Pt has a contraindication to all statins. One of the following LDL-C values within the last 120 days: (1) LDL-C greater than or equal to 55 mg/dL with ASCVD or (2) LDL-C greater than or equal to 100 mg/dL without ASCVD. Pt has been receiving at least 12 weeks of generic ezetimibe tx or pt has a history of contraindication, or intolerance to ezetimibe.</p>
<b>Age Restrictions</b>	N/A

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months
<b>Other Criteria</b>	HeFH or primary hyperlipidemia (Reauth): Patient demonstrates positive clinical response to therapy (eg reduction in LDL-C levels). Pt continues to receive other lipid-lowering tx (eg statins, ezetimibe) or pt has a documented inability to take other lipid-lowering therapy (eg statins, ezetimibe). Established CVD or high risk for a CVD event but without established CVD (Reauth):Pt demonstrates positive clinical response to therapy.



# NEXLIZET (S)

## Products Affected

- Nexlizet

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Heterozygous familial hypercholesterolemia (HeFH) or primary hyperlipidemia (Initial): One of the following diagnoses: A) HeFH OR B) Primary hyperlipidemia. One of the following LDL-C values within the last 120 days: (1) LDL-C greater than or equal to 55 mg/dL with ASCVD or (2) LDL-C greater than or equal to 100 mg/dL without ASCVD. One of the following: 1) Used as adjunct to statin therapy OR 2) Pt is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR 3) Pt has a contraindication to all statins. Pt has been receiving at least 12 weeks of generic ezetimibe tx or pt has a history of contraindication or intolerance to ezetimibe.</p> <p>Established cardiovascular disease (CVD) or high risk for a CVD event but without established CVD (Initial): One of the following diagnoses: A) Established CVD (e.g., coronary artery disease, symptomatic peripheral arterial disease, cerebrovascular atherosclerotic disease), OR B) a high risk for a CVD event but without established CVD [e.g., diabetes mellitus (type 1 or type 2) in females over 65 years of age or males over 60 years of age]. One of the following: 1) Pt is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase) OR 2) Pt has a contraindication to all statins. One of the following LDL-C values within the last 120 days: (1) LDL-C greater than or equal to 55 mg/dL with ASCVD or (2) LDL-C greater than or equal to 100 mg/dL without ASCVD. Pt has been receiving at least 12 weeks of generic ezetimibe tx.</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A

<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months
<b>Other Criteria</b>	HeFH or primary hyperlipidemia (Reauth): Patient demonstrates positive clinical response to therapy (eg reduction in LDL-C levels). Pt continues to receive other lipid-lowering tx (eg statins, ezetimibe) or pt has a documented inability to take other lipid-lowering therapy (eg statins, ezetimibe). Established CVD or high risk for a CVD event but without established CVD (Reauth):Pt demonstrates positive clinical response to therapy.

## NGENLA (S)

### Products Affected

- Ngenla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pediatric Growth Hormone Deficiency (PGHD) (initial): Both of the following: 1) Diagnosis of PGHD as confirmed by one of the following: a) Height is documented by one of the following (utilizing age and gender growth charts related to height): i) height is greater than 2.0 standard deviations (SD) below midparental height, or ii) height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender), b) Growth velocity is greater than 2 SD below mean for age and gender, or c) Delayed skeletal maturation of greater than 2 SD below mean for age and gender (eg, delayed greater than 2 years compared with chronological age), AND 2) Documentation of one of the following: a) Patient is male with bone age less than 16 years, or b) Patient is female with bone age less than 14 years. Trial and failure or intolerance to Genotropin.
<b>Age Restrictions</b>	PGHD (initial): Patient is 3 years of age or older.
<b>Prescriber Restrictions</b>	PGHD (initial, reauth): Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	PGHD (initial, reauth): 12 months.
<b>Other Criteria</b>	PGHD (reauth): Both of the following: A) Expected adult height not attained, AND B) Documentation of expected adult height goal.

## NINLARO (S)

---

### Products Affected

- Ninlaro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Multiple myeloma: Diagnosis of multiple myeloma.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## NON-PREFERRED TIRF (S)

### Products Affected

- Fentanyl Citrate TABS
- Fentora TABS 100MCG, 200MCG, 400MCG, 600MCG, 800MCG

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	For the management of breakthrough cancer pain. Patient is currently taking a long-acting opioid around the clock for cancer pain. Patient must have at least a one week history of ONE of the following medications to demonstrate tolerance to opioids: Morphine sulfate at doses of greater than or equal to 60 mg/day, Fentanyl transdermal patch at doses greater than or equal to 25 µg/hr, Oxycodone at a dose of greater than or equal to 30 mg/day, Oral hydromorphone at a dose of greater than or equal to 8 mg/day, Oral oxymorphone at a dose of greater than or equal to 25 mg/day, or an alternative opioid at an equianalgesic dose (e.g., oral methadone greater than or equal to 20 mg/day). Trial and failure or intolerance to generic fentanyl lozenge.
Age Restrictions	N/A
Prescriber Restrictions	Prescribed by or in consultation with one of the following: Pain specialist, Oncologist, Hematologist, Hospice care specialist, or Palliative care specialist.
Coverage Duration	12 months
Other Criteria	N/A

## NORTHERA (S)

### Products Affected

- Droxidopa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Neurogenic orthostatic hypotension (NOH) (init): Diagnosis of symptomatic NOH. NOH is caused by one of the following conditions: primary autonomic failure (eg, Parkinson's disease, multiple system atrophy, pure autonomic failure), dopamine beta-hydroxylase deficiency, non-diabetic autonomic neuropathy. Trial and failure, contraindication, or intolerance to one of the following agents: fludrocortisone acetate, midodrine.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	NOH (init): Prescribed by or in consultation with a cardiologist, neurologist, or nephrologist
<b>Coverage Duration</b>	NOH (init): 1 month (reauth): 12 months
<b>Other Criteria</b>	NOH (reauth): Patient demonstrates positive clinical response to therapy.

## NOURIANZ (S)

### Products Affected

- Nourianz

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Parkinson's disease (PD) (initial): Diagnosis of PD. Patient is experiencing "off" episodes. Medication will be used in combination with carbidopa/levodopa. Trial and failure, contraindication or intolerance to two of the following: MAO-B Inhibitor (e.g., rasagiline, selegiline), Dopamine Agonist (e.g., pramipexole, ropinirole), or COMT Inhibitor (e.g., entacapone).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PD (initial): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	PD (initial, reauth): 12 months
<b>Other Criteria</b>	PD (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with carbidopa/levodopa.

## NOXAFIL SUSPENSION (S)

### Products Affected

- Noxafil PACK
- Noxafil SUSP
- Posaconazole SUSP

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of systemic fungal infections (SFI): Used as prophylaxis of invasive fungal infections caused by Aspergillus or Candida for one of the following conditions: 1) Patient is at high risk of infections due to severe immunosuppression from hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD) or hematologic malignancies with prolonged neutropenia from chemotherapy OR 2) patient has a prior fungal infection requiring secondary prophylaxis. Oropharyngeal Candidiasis (OPC): Diagnosis of OPC. One of the following: 1) Trial and failure, contraindication, or intolerance to fluconazole OR 2) Susceptibility results demonstrate resistance to fluconazole.
Age Restrictions	Prophylaxis of SFI, OPC: Patient is 13 years or older.
Prescriber Restrictions	N/A
Coverage Duration	Prophylaxis of SFI: 6 months. OPC: 1 month.
Other Criteria	N/A



## NUBEQA (S)

---

### Products Affected

- Nubeqa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Castration-resistant or castration-recurrent prostate cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) or castration-recurrent prostate cancer. Hormone-sensitive prostate cancer (HSPC): Diagnosis of HSPC.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CRPC, HSPC: 12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# NUCALA (S)

## Products Affected

- Nucala

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Asthma (init): Diagnosis of severe asthma. Asthma is an eosinophilic phenotype as defined by one of the following: baseline (pre-tx) peripheral blood eosinophil level is greater than or equal to 150 cells/ml or peripheral blood eosinophil levels were greater than or equal to 300 cells/ml within the past 12 mo. Patient has had two or more asthma exacerbations requiring systemic corticosteroids (eg, prednisone) within the past 12 mo or Patient has had a prior asthma-related hospitalization within the past 12 mo. One of the following: 1) Both of the following: a) Patient is 6 years of age or older but less than 12 years of age b) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Medium-dose inhaled corticosteroid [ICS] (eg, greater than 100 – 200 mcg fluticasone propionate equivalent/day) and Additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]) or ii) One medium dosed combination ICS/LABA product (eg, Advair Diskus [fluticasone propionate 100mcg/ salmeterol 50mcg], Symbicort [budesonide 80mcg/ formoterol 4.5mcg] Breo Ellipta [fluticasone furoate 50 mcg/ vilanterol 25 mcg]) OR Patient is 12 years of age or older and Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: a) Both of the following: i) High-dose ICS (eg, greater than 500 mcg fluticasone propionate equivalent/day) and ii) additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]), OR b) One maximally-dosed combination ICS/LABA product [eg, Advair (fluticasone propionate/salmeterol), Breo Ellipta (fluticasone/vilanterol)].</p>
Age Restrictions	N/A

<b>Prescriber Restrictions</b>	Asthma (init, reauth): Prescribed by or in consultation with a pulmonologist or allergist/immunologist. CRSwNP (init, reauth): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist. EGPA (init): Prescribed by or in consultation with a pulmonologist, rheumatologist or allergist/immunologist. HES (init): Prescribed by or in consultation with an allergist/immunologist or hematologist.
<b>Coverage Duration</b>	Asthma (init): 6 mo, Asthma (reauth): 12 months. CRSwNP, EGPA, HES (init, reauth): 12 months
<b>Other Criteria</b>	<p>Hypereosinophilic Syndrome (HES) (init): Diagnosis of HES. Patient has been diagnosed for at least 6 months. Verification that other non-hematologic secondary causes have been ruled out (e.g., drug hypersensitivity, parasitic helminth infection, HIV infection, non-hematologic malignancy). Patient is FIP1L1-PDGFR<math>\alpha</math>-negative. Patient has uncontrolled HES defined as both of the following: a) History of 2 or more flares within the past 12 months AND b) Pre-treatment blood eosinophil count greater than or equal to 1000 cells/microliter. Trial and failure, contraindication, or intolerance to corticosteroid therapy (e.g., prednisone) or cytotoxic/immunosuppressive therapy (e.g., hydroxyurea, cyclosporine, imatinib). Asthma (reauth): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with an inhaled corticosteroid (ICS) (e.g., fluticasone, budesonide) with or without additional asthma controller medication (e.g., leukotriene receptor [LTRA] [e.g., montelukast], long-acting beta-2 agonist [LABA] [e.g., salmeterol], long-acting muscarinic antagonist [LAMA] [e.g., tiotropium]) unless there is a contraindication or intolerance to these medications. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP) (init): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to 2 months of treatment with an intranasal corticosteroid (e.g., fluticasone, mometasone). Used in combination with another agent for CRSwNP. Eosinophilic Granulomatosis with Polyangiitis (EGPA) (init): Diagnosis of EGPA. Patient's disease has relapsed or is refractory to standard of care therapy (i.e., corticosteroid treatment with or without immunosuppressive therapy). Patient is currently receiving corticosteroid therapy (e.g., prednisolone, prednisone). CRSwNP (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with another agent for CRSwNP. EGPA, HES (reauth): Patient demonstrates positive clinical response to therapy.</p>

# NUEDEXTA (S)

## Products Affected

- Nuedexta

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pseudobulbar affect (PBA) (initial): Diagnosis of PBA. Patient does not have any of the following contraindications: a) Concomitant use with other drugs containing quinidine, quinine, or mefloquine, b) History of Nuedexta, quinine, mefloquine or quinidine-induced thrombocytopenia, hepatitis, bone marrow depression, or lupus-like syndrome, c) Known hypersensitivity to dextromethorphan (e.g., rash, hives), d) Taking monoamine oxidase inhibitors (MAOIs) (e.g., phenelzine, selegiline, tranylcypromine) or have taken MAOIs within the preceding 14 days, e) Has prolonged QT interval, congenital long QT syndrome or a history suggestive of torsades de pointes, or has heart failure, f) Receiving drugs that both prolong QT interval and are metabolized by CYP2D6 (e.g., thioridazine, pimozide), g) Has complete atrioventricular (AV) block without implanted pacemakers, or at high risk of complete AV block.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PBA (initial): Prescribed by or in consultation with one of the following specialists: neurologist, psychiatrist.
<b>Coverage Duration</b>	PBA (initial/reauth): 12 months
<b>Other Criteria</b>	PBA (reauth): Patient demonstrates clinical benefit from ongoing therapy as demonstrated by a decrease in inappropriate laughing or crying episodes.

## NUPLAZID (S)

---

### Products Affected

- Nuplazid CAPS
- Nuplazid TABS 10MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Parkinson's disease psychosis: Diagnosis of Parkinson's disease. Patient has at least one of the following: hallucinations or delusions.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## NURTEC (S)

---

### Products Affected

- Nurtec

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acute Treatment of Migraine (initial): Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Medication will not be used in combination with another oral CGRP inhibitor for the acute treatment of migraines.
<b>Age Restrictions</b>	All Indications (initial): 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Acute Treatment (init): 3mo. Preventive Treatment (init): 6mo. All Indications (reauth): 12mo.

---

**Other Criteria**

Preventive Treatment of Episodic Migraine (EM) (initial): Both of the following: 1) Diagnosis of EM and 2) Patient has greater than or equal to 4 migraine days per month. History of failure (after at least a two month trial), contraindication, or intolerance to two of the following preventive treatments for migraine from different classes: a) An antidepressant (i.e., Elavil [amitriptyline] or Effexor [venlafaxine]), b) An anticonvulsant (i.e., Depakote/Depakote ER [divalproex sodium] or Topamax [topiramate]), c) A beta blocker (i.e., atenolol, propranolol, nadolol, timolol, or metoprolol), d) Atacand (candesartan), e) Generic lisinopril. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. Acute Treatment of Migraine (reauth): Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea). Medication will not be used in combination with another oral CGRP inhibitor for the acute treatment of migraines. Preventive Treatment of EM (reauth): Patient has experienced a positive response to therapy (e.g., a reduction in headache frequency and/or intensity, a reduction in the number of workdays missed due to migraines). Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.

---

# NUVIGIL (S)

## Products Affected

- Armodafinil

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Obstructive sleep apnea (OSA) (Initial): Diagnosis (dx) of OSA defined by one of the following: a) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or b) both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), AND 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work disorder (SWD) (Initial):Dx of SWD confirmed by one of the following: 1) symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, OR 2) A sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia. Narcolepsy (initial): Dx of narcolepsy as confirmed by sleep study (unless prescriber provides justification confirming that a sleep study is not feasible).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	OSA, SWD: Initial, Reauth: 6 mo. Narcolepsy: Initial, Reauth: 12 mo
<b>Other Criteria</b>	OSA, Narcolepsy (Reauth): Patient demonstrates positive clinical response to armodafinil therapy. SWD (Reauth): Patient demonstrates positive clinical response to armodafinil therapy.





## NYVEPRIA (S)

### Products Affected

- Nyvepria

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute’s Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. Acute radiation syndrome (ARS) (off-label): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses: Prescribed by or in consultation with a hematologist/oncologist
<b>Coverage Duration</b>	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
<b>Other Criteria</b>	All Indications (except for ARS): Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca/Udenyca Onbody. ARS: Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca.



## Ocaliva (S)

### Products Affected

- Ocaliva

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Primary Biliary Cholangitis (PBC) (initial): Diagnosis of PBC (aka primary biliary cirrhosis). One of the following: a) patient has failed to achieve an alkaline phosphatase (ALP) level of less than 1.67 times the upper limit of normal (ULN) after treatment with ursodeoxycholic acid (UDCA) (e.g., Urso, Urso Forte, ursodiol) AND used in combination with UDCA, OR b) contraindication or intolerance to UDCA. Patient does not have evidence of advanced cirrhosis (i.e., cirrhosis with current or prior evidence of hepatic decompensation including encephalopathy or coagulopathy). Patient does not have evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PBC (initial): Prescribed by or in consultation with a hepatologist or gastroenterologist.
<b>Coverage Duration</b>	PBC (initial): 6 months, (reauth): 12 months
<b>Other Criteria</b>	PBC (reauthorization): Submission of medical records (eg, laboratory values) documenting a reduction in ALP level from pre-treatment baseline (ie, prior obeticholic acid therapy) while on therapy. Patient does not have evidence of advanced cirrhosis (i.e., cirrhosis with current or prior evidence of hepatic decompensation including encephalopathy or coagulopathy). Patient does not have evidence of portal hypertension (e.g., ascites, gastroesophageal varices, persistent thrombocytopenia).

## ODACTRA (S)

### Products Affected

- Odactra

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Allergic rhinitis (AR) (Initial): Diagnosis of house dust mite (HDM)-induced allergic rhinitis. One of the following: 1) positive in vitro testing for IgE antibodies to Dermatophagoides farinae or Dermatophagoides pteronyssinus house dust mites, OR 2) skin testing to licensed house dust mite allergen extracts. Trial and failure, contraindication, or intolerance to an intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, flunisolide nasal spray) AND an antihistamine (e.g., cetirizine, loratadine, azelastine nasal spray, olapatadine nasal spray).
<b>Age Restrictions</b>	AR (Initial): Patient is 12 to 65 years of age
<b>Prescriber Restrictions</b>	AR (Initial): Prescribed by or in consultation with an allergist or immunologist
<b>Coverage Duration</b>	AR (initial, reauth): 12 months
<b>Other Criteria</b>	AR (Reauth): One of the following: A) Patient has experienced improvement in the symptoms of their allergic rhinitis, OR B) patient has experienced a decrease in the number of medications needed to control allergy symptoms.

## ODOMZO (S)

---

### Products Affected

- Odomzo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Basal cell carcinoma: Diagnosis of locally advanced basal cell carcinoma AND One of the following: 1) Cancer has recurred following surgery or radiation therapy or 2) Patient is not a candidate for surgery or radiation therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## OFEV (S)

### Products Affected

- Ofev

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Idiopathic pulmonary fibrosis (IPF) (initial): Diagnosis of IPF as documented by all of the following: a) exclusion of other known causes of interstitial lung disease (ILD) (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity) AND b) one of the following: i) in patients not subjected to surgical lung biopsy, the presence of a usual interstitial pneumonia (UIP) pattern on high-resolution computed tomography (HRCT) revealing IPF or probable IPF, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing IPF or probable IPF. Systemic sclerosis-associated interstitial lung disease (SSc-ILD) (initial): Diagnosis of SSc-ILD as documented by all of the following: a) exclusion of other known causes of ILD (eg, domestic and occupational environmental exposures, connective tissue disease, drug toxicity) AND b) One of the following: i) In patients not subjected to surgical lung biopsy, the presence of idiopathic interstitial pneumonia (eg, fibrotic nonspecific interstitial pneumonia [NSIP], usual interstitial pneumonia [UIP] and centrilobular fibrosis) pattern on HRCT revealing SSc-ILD or probable SSc-ILD, OR ii) in patients subjected to a lung biopsy, both HRCT and surgical lung biopsy pattern revealing SSc-ILD or probable SSc-ILD. Chronic Fibrosing Interstitial Lung Diseases (ILDs) with a Progressive Phenotype (initial): 1) diagnosis of chronic fibrosing interstitial lung disease, AND 2) patient has a high-resolution computed tomography (HRCT) showing at least 10% of lung volume with fibrotic features, AND 3) disease has a progressive phenotype as observed by one of the following: decline of forced vital capacity (FVC), worsening of respiratory symptoms, or increased extent of fibrosis seen on imaging.</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	IPF, SSc-ILD, Chronic Fibrosing ILDs with a Progressive Phenotype (initial): Prescribed by or in consultation with a pulmonologist

<b>Coverage Duration</b>	Initial, reauth: 12 months
<b>Other Criteria</b>	IPF, SSc-ILD, Chronic Fibrosing ILDs with a Progressive Phenotype (reauth): Patient demonstrates positive clinical response to therapy.



## OGSIVEO (S)

---

### Products Affected

- Ogsiveo TABS 50MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of desmoid tumor. Patient requires systemic treatment. Disease is progressive.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## OJJAARA (S)

---

### Products Affected

- Ojjaara

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of ONE of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, OR c) Post-essential thrombocythemia myelofibrosis. Disease is intermediate or high risk. Patient has anemia.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## OLPRUVA (S)

---

### Products Affected

- Olpruva

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Both of the following: 1) Diagnosis of urea cycle disorders (UCDs), and 2) One of the following deficiencies: a) carbamylphosphate synthetase (CPS), b) ornithine transcarbamylase (OTC), or c) argininosuccinic acid synthetase (AS). Molecular genetic testing confirms mutations in the CPS1, OTC, or ASS1 gene. Inadequate response to one of the following: a) Dietary protein restriction, or b) Amino acid supplementation.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders.
<b>Coverage Duration</b>	Initial, Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

# OLUMIANT (S)

## Products Affected

- Olumiant

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Excluded if used for the treatment of Coronavirus Disease 2019 (COVID-19) in hospitalized adults.
<b>Required Medical Information</b>	Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Not used in combination with other Janus kinase (JAK) inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (e.g., azathioprine, cyclosporine). Alopecia areata (AA) (Initial): Diagnosis of AA. Patient has at least 50% scalp hair loss. Other causes of hair loss have been ruled out (eg, androgenetic alopecia, trichotillomania, tinea capitis, psoriasis). Not used in combination with other JAK inhibitors, biologic immunomodulators, cyclosporine, or potent immunosuppressants (e.g., azathioprine).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA Initial: Prescribed by or in consultation with a rheumatologist. AA (Initial): Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	RA Initial: 6 months, Reauth: 12 months. AA (Initial, Reauth): 12 months.
<b>Other Criteria</b>	RA Reauth: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (e.g., azathioprine, cyclosporine). AA (Reauth): Patient demonstrates positive clinical response to therapy. Not used in combination with other JAK inhibitors, biologic immunomodulators, cyclosporine, or potent immunosuppressants (e.g., azathioprine).



## OMVOH (S)

---

### Products Affected

- Omvoh INJ 100MG/ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Ulcerative Colitis (UC) (initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction doses.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	UC (initial): Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	UC (initial): 6 months, (reauth): 12 months.
<b>Other Criteria</b>	UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.

## ONUREG (S)

---

### Products Affected

- Onureg

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acute Myeloid Leukemia (AML): Diagnosis of acute myeloid leukemia (AML). Patient has received previous treatment with an intensive induction chemotherapy regimen (e.g., cytarabine + daunorubicin, cytarabine + idarubicin, etc.). Patient has achieved one of the following: a) first complete remission (CR) or b) complete remission with incomplete blood count recovery (CRi). Patient is not able to complete intensive curative therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## OPSUMIT (S)

---

### Products Affected

- Opsumit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH: Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	PAH (Reauth): Patient demonstrates positive clinical response to therapy.



# OPZELURA (S)

## Products Affected

- Opzelura

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Atopic Dermatitis (AD) Initial: Diagnosis of mild to moderate atopic dermatitis. One of the following: a) Greater than or equal to 3% body surface area (BSA) involvement, or b) Involvement of sensitive body areas (e.g., face, hands, feet, scalp, groin). Trial and failure of a minimum 30-day supply (14-day supply for topical corticosteroids), contraindication, or intolerance to at least two of the following: a) Medium or higher potency topical corticosteroid, b) Elidel (pimecrolimus) cream, c) Tacrolimus ointment, or d) Eucrisa (crisaborole) ointment. Patient is not receiving Opzelura in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine). Opzelura will only be used for short-term and/or non-continuous chronic treatment. Nonsegmental Vitiligo (NV) Initial: Diagnosis of NV. Trial and failure, contraindication, or intolerance to at least one of the following: medium or higher potency topical corticosteroid or tacrolimus ointment. Not used in combination with therapeutic biologics, other Janus kinase (JAK) inhibitors, or potent immunosuppressants (eg, azathioprine or cyclosporine).
<b>Age Restrictions</b>	AD, NV Initial: Patient is 12 years of age or older.
<b>Prescriber Restrictions</b>	AD Initial: Prescribed by or in consultation with a dermatologist or allergist/immunologist. NV Initial: Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	AD Initial: 12 weeks. AD Reauth: 6 months. NV Initial: 6 months. NV Reauth: 12 months.

<b>Other Criteria</b>	AD Reauth: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, b) Reduction in pruritus severity from baseline, or c) Improvement in quality of life from baseline. Patient is not receiving Opzelura in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine). Opzelura will only be used for short-term and/or non-continuous chronic treatment. NV Reauth: Patient demonstrates positive clinical response to therapy. Not used in combination with therapeutic biologics, other JAK inhibitors, or potent immunosuppressants (eg, azathioprine or cyclosporine).
-----------------------	--

## ORALAIR (S)

### Products Affected

- Oralair

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Allergic Rhinitis (AR) (initial): Diagnosis of grass pollen-induced allergic rhinitis. Treatment will be initiated 4 months before the expected onset of the grass pollen season. Patient has a positive skin test or in vitro test for one the listed pollen-specific IgE antibodies: any of the five grass species including sweet vernal, orchard, perennial rye, timothy or kentucky blue grass mixed pollens. Trial and failure, contraindication or intolerance to an intranasal corticosteroid (e.g., fluticasone nasal spray, mometasone nasal spray, flunisolide nasal spray), AND an antihistamine (e.g., cetirizine, loratadine, azelastine nasal spray, olapatadine nasal spray).
<b>Age Restrictions</b>	AR (Initial): 5 to 65 years of age
<b>Prescriber Restrictions</b>	AR (Initial): Prescribed by or in consultation with an allergist or immunologist
<b>Coverage Duration</b>	AR (initial, reauth): 12 months
<b>Other Criteria</b>	AR (Reauth): One of the following: A) patient has experienced improvement in the symptoms of their allergic rhinitis, OR B) patient has experienced a decrease in the number of medications needed to control allergy symptoms.

## ORENCIA SC (S)

### Products Affected

- Orencia INJ 125MG/ML, 50MG/0.4ML, 87.5MG/0.7ML

- Orencia Clickject

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week trial and failure, contraindication, or intolerance to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
<b>Coverage Duration</b>	All uses (initial): 6 months, (reauth): 12 months
<b>Other Criteria</b>	RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.



# ORENITRAM (S)

## Products Affected

- Orenitram
- Orenitram Titration Kit Month 1
- Orenitram Titration Kit Month 2
- Orenitram Titration Kit Month 3

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH: Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

## ORGOVYX (S)

---

### Products Affected

- Orgovyx

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ORIAHNN (S)

---

### Products Affected

- Oriahnn

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids). Patient is premenopausal. One of the following: 1) History of inadequate control of bleeding following a trial of 30 days, or history of intolerance or contraindication to one of the following: combination (estrogen/progestin) contraceptive, progestins, or tranexamic acid or 2) Patient has had a previous interventional therapy to reduce bleeding. Treatment duration of therapy has not exceeded a total of 24 months.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Reauth: Patient has improvement in bleeding associated with uterine leiomyomas (fibroids) (e.g., significant/sustained reduction in menstrual blood loss per cycle, improved quality of life, etc.). Treatment duration of therapy has not exceeded a total of 24 months.



# ORILISSA (S)

## Products Affected

- Orilissa

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Endometriosis (EM) (initial - 150 mg): Diagnosis of moderate to severe pain associated with EM. One of the following: 1) History of inadequate pain control response following a trial of at least 3 months, or history of intolerance or contraindication to one of the following: danazol, combination (estrogen/progesterone) oral contraceptive, or progestins, or 2) Patient has had surgical ablation to prevent recurrence. EM (200 mg): Diagnosis of moderate to severe pain associated with EM. One of the following: 1) History of inadequate pain control response following a trial of at least 3 months, or history of intolerance or contraindication to one of the following: danazol, combination (estrogen/progesterone) oral contraceptive, or progestins, or 2) Patient has had surgical ablation to prevent recurrence.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	EM (init, reauth-150mg): 6 mo. EM (200mg): 6 mo.
<b>Other Criteria</b>	EM (reauthorization - 150 mg): Patient has improvement in pain associated with endometriosis (e.g., improvement in dysmenorrhea and nonmenstrual pelvic pain). Treatment duration has not exceeded a total of 24 months.

## ORKAMBI (S)

---

### Products Affected

- Orkambi TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
<b>Age Restrictions</b>	CF (Initial): Patient is 6 years of age or older
<b>Prescriber Restrictions</b>	CF (initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
<b>Coverage Duration</b>	CF (initial, reauth): 12 months
<b>Other Criteria</b>	CF (Reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).

## ORKAMBI GRANULES (S)

### Products Affected

- Orkambi PACK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cystic Fibrosis (CF) (Initial): Diagnosis of CF. Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). One of the following: A) Patient is 1 through 5 years of age, OR B) Both of the following: Patient is 6 years of age or greater AND Patient is unable to swallow oral tablets.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	CF (Initial): Prescribed by or in consultation with a specialist affiliated with a CF care center or pulmonologist
<b>Coverage Duration</b>	CF (initial, reauth): 12 months
<b>Other Criteria</b>	CF (Reauth): Patient is benefiting from treatment (i.e., improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations). One of the following: A) Patient is 1 through 5 years of age, OR B) Both of the following: Patient is 6 years of age or greater AND Patient is unable to swallow oral tablets.

## ORLADEYO (S)

---

### Products Affected

- Orladeyo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prophylaxis of hereditary angioedema (HAE) attacks: Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
<b>Age Restrictions</b>	HAE (prophylaxis): Patient is 12 years of age or older
<b>Prescriber Restrictions</b>	HAE (prophylaxis): Prescribed by or in consultation with an immunologist or an allergist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## ORSERDU (S)

---

### Products Affected

- Orserdu

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of breast cancer. Disease is advanced or metastatic. Disease is estrogen receptor (ER)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Presence of estrogen receptor (ESR1) mutation(s) as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease has progressed following at least one line of endocrine therapy [e.g., Faslodex (fulvestrant), Arimidex (anastrozole), Femara (letrozole), Aromasin (exemestane)].
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## OSMOLEX ER (S)

### Products Affected

- Osmolex Er TB24 129MG, 193MG

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Parkinson's Disease (PD) (initial): Diagnosis of Parkinson's disease. Trial and failure or intolerance to both of the following: A) amantadine immediate release AND B) one of the following: carbidopa-levodopa, MAO-B inhibitor (e.g., rasagiline, selegiline), or dopamine agonist (e.g., pramipexole, ropinirole). Drug-Induced Extrapyrasidal Reactions (EPS) (initial): Patient is experiencing drug-induced extrapyramidal reactions. One of the following: A) Patient has persistent extrapyramidal symptoms despite a trial of dose reduction, tapering, or discontinuation of the offending medication OR B) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Trial and failure or intolerance to amantadine immediate release.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PD (initial): Prescribed by or in consultation with a neurologist. EPS (initial): Prescribed by or in consultation with a neurologist or psychiatrist.
<b>Coverage Duration</b>	PD, EPS (initial, reauth): 12 months
<b>Other Criteria</b>	PD, EPS (Reauth): Patient demonstrates positive clinical response to therapy

## OSPHENA (S)

---

### Products Affected

- OspheNa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Dyspareunia (initial): Diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause. Vaginal dryness (initial): Diagnosis of moderate to severe vaginal dryness due to vulvar and vaginal atrophy associated with menopause.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	All uses (Initial, reauth): 12 months
<b>Other Criteria</b>	Dyspareunia, Vaginal dryness (reauth): Patient demonstrates positive clinical response to therapy.

## OTEZLA (S)

### Products Affected

- Otezla

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Psoriatic arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque psoriasis (initial): Diagnosis of plaque psoriasis. Oral ulcers associated with Behcet's Disease (Initial): Diagnosis of Behcet's Disease. Patient has active oral ulcers.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. Plaque psoriasis (init): Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	All uses (initial): 6 months. All uses (reauth): 12 months.
<b>Other Criteria</b>	PsA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy. Oral ulcers associated with Behcet's Disease (reauth): Patient demonstrates positive clinical response to therapy (eg, reduction in pain from oral ulcers or reduction in number of oral ulcers).



# OXBRYTA (S)

## Products Affected

- Oxbryta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of Sickle Cell Disease. Patient demonstrates hemoglobin level that does not exceed 10.5 g/dL prior to therapy initiation. Trial and failure or inadequate response, contraindication, or intolerance to hydroxyurea.
<b>Age Restrictions</b>	Initial: Patient is 4 years of age or older.
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with one of the following: 1) Hematologist/Oncologist or 2) Specialist w/ expertise in the diagnosis and management of sickle cell disease.
<b>Coverage Duration</b>	Initial, Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

# OXERVATE (S)

## Products Affected

- Oxervate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Neurotrophic keratitis (NK) (initial): Diagnosis of NK.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	NK (initial): Prescribed by or in consultation with an ophthalmologist.
<b>Coverage Duration</b>	NK (initial): 8 weeks, (reauth): One 8-Week Approval
<b>Other Criteria</b>	NK (reauth): One of the following: 1) Both of the following: a) Provider attests patient is being treated for disease recurrence (e.g., new corneal damage following prior corneal healing), and b) Provider attests patient has not experienced treatment failure (e.g., patient has not experienced corneal healing after a previous course of Oxervate), OR 2) Provider attests treatment is for an eye that has not previously been treated with Oxervate.

## PALYNZIQ (S)

---

### Products Affected

- Palynziq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Phenylketonuria (PKU) (initial): Diagnosis of PKU. Patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on existing management (e.g., Kuvan [sapropterin]). One of the following: Patient has had a trial and failure or intolerance to Kuvan (sapropterin) or patient is not a candidate for Kuvan (sapropterin) therapy due to the presence of two null mutations in trans. Patient will have phenylalanine blood levels measured every 4 weeks until a maintenance dose is established and periodically thereafter.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	PKU (initial, reauth): 12 months
<b>Other Criteria</b>	PKU (reauth): Patient demonstrates positive clinical response to therapy. Patient will continue to have phenylalanine blood levels measured periodically during therapy.

## PEGASYS (S)

---

### Products Affected

- Pegasys

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic hepatitis B: Diagnosis of chronic hepatitis B infection, and patient is without decompensated liver disease. Chronic Hepatitis C: Criteria will be applied consistent with current AASLD-IDSA guidance.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Chronic Hepatitis C: Prescribed by or in consultation with one of the following: hepatologist, gastroenterologist, infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine
<b>Coverage Duration</b>	HepB: 48 wks. HepC: Initial: 28 wks. Reauth: 20 wks.
<b>Other Criteria</b>	N/A

## PEMAZYRE (S)

---

### Products Affected

- Pemazyre

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cholangiocarcinoma: Diagnosis of cholangiocarcinoma. Disease is one of the following: unresectable locally advanced or metastatic. Disease has presence of a fibroblast growth factor receptor 2 (FGFR2) fusion or other rearrangement as detected by an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Patient has been previously treated. Myeloid/lymphoid neoplasms: Diagnosis of myeloid/lymphoid neoplasms (MLNs). Disease is relapsed or refractory. Disease has presence of a fibroblast growth factor receptor 1 (FGFR1) rearrangement.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## PENNSAID (S)

### Products Affected

- Diclofenac Sodium EXTERNAL SOLN 1.5%, 2%

- Pennsaid SOLN 2%

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Osteoarthritis of the knees (initial): Diagnosis of osteoarthritis of the knees. Patient meets one of the following: 1) Treatment failure with at least two prescription strength topical or oral non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., diclofenac, ibuprofen, meloxicam, naproxen) OR 2) History of peptic ulcer disease/gastrointestinal bleed OR 3) Patient is older than 65 years of age with one additional risk factor for gastrointestinal adverse events (e.g. use of anticoagulants, chronic corticosteroids).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial, reauth: 12 months
<b>Other Criteria</b>	Osteoarthritis of the knees (reauth): Patient demonstrates positive clinical response to therapy (e.g., improvement in pain symptoms of osteoarthritis).

## PIQRAY (S)

---

### Products Affected

- Piqray 200mg Daily Dose
- Piqray 250mg Daily Dose
- Piqray 300mg Daily Dose

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Breast Cancer (BC): Diagnosis of advanced or metastatic BC. Disease is hormone receptor (HR)-positive, and human epidermal growth factor receptor 2 (HER2)-negative. Cancer is PIK3CA-mutated as detected by an FDA-approved test (therascreen PIK3CA RGQ PCR Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Used in combination with fulvestrant. Disease has progressed on or after an endocrine-based regimen.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# POMALYST (S)

---

## Products Affected

- Pomalyst

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Multiple Myeloma (MM): Diagnosis of MM. Kaposi sarcoma (KS): One of the following: 1) Diagnosis of AIDS-related KS, OR 2) Both of the following: a) Diagnosis of KS and b) Patient is HIV-negative.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.



## PONVORY (S)

### Products Affected

- Ponvory

- Ponvory 14-day Starter Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
<b>Required Medical Information</b>	MS (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	MS (initial, reauth): 12 months
<b>Other Criteria</b>	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).

# POSACONAZOLE TABLET (S)

## Products Affected

- Noxafil TBEC

- Posaconazole Dr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Prophylaxis of systemic fungal infections (SFI): Used as prophylaxis of invasive fungal infections caused by Aspergillus or Candida for one of the following conditions: 1) Patient is at high risk of infections due to severe immunosuppression from hematopoietic stem cell transplant (HSCT) with graft-versus-host disease (GVHD) or hematologic malignancies with prolonged neutropenia from chemotherapy OR 2) patient has a prior fungal infection requiring secondary prophylaxis. Treatment (Tx) of SFI: Used as treatment of systemic fungal infections caused by Aspergillus.
Age Restrictions	Prophylaxis of SFI: Patient is 2 years of age or older. Tx of SFI: Patient is 13 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Prophylaxis of SFI: 6 months. Tx of SFI: 3 months.
Other Criteria	N/A

# PRALUENT (S)

## Products Affected

- Praluent

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>HeFH/ASCVD/Primary HLD (init): One of the following dx: A)HeFH, B)ASCVD, OR C)Primary hyperlipidemia (HLD). One of the following: 1)Pt has been receiving highest tolerable dose of statin therapy, OR (2) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR (3) Pt has an FDA labeled contraindication to all statins. ONE of the following: a) One of the following: LDL values while on max tolerated lipid lowering regimen w/in the last 120 days: (1) LDL greater than or equal to 55 mg/dL w/ ASCVD. (2) LDL greater than or equal to 100 mg/dL w/o ASCVD. OR b) Both of the following: (1) Patient has been receiving PCSK9 therapy as adjunct to maximally tolerated lipid lowering therapy (e.g., statins, ezetimibe) and (2) LDL-C values drawn within the past 12 months while on maximally tolerated lipid lowering therapy is within normal limits. ONE of the following: Pt has been receiving ezetimibe (Zetia) tx as adjunct to max tolerated statin tx OR Pt has a hx of contraindication or intolerance to ezetimibe. HoFH (init): Dx of HoFH as confirmed by one of the following: 1)Gen confirmation of 2 mutations in LDL receptor, ApoB, PCSK9, or LDLRAP1 or ARH, or 2)either untreated LDL greater than 500 or treated LDL greater than 300, AND either xanthoma before 10 yo or evidence of HeFH in both parents. One of the following: 1)Pt is receiving other lipid-lowering tx (eg statin, ezetimibe) or 2)Pt has a documented inability to take other lipid-lowering tx (eg statin, ezetimibe).</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A

<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months
<b>Other Criteria</b>	HeFH/ASCVD/Primary HLD (reauth): Pt continues to receive other lipid-lowering tx (eg statins, ezetimibe) at max tolerated dose (unless pt has documented inability to take these medications). HoFH (reauth): One of the following: 1)Pt continues to receive other lipid-lowering tx (eg statin, ezetimibe) or 2)Pt has a documented inability to take other lipid-lowering tx (eg statin, ezetimibe). HeFH/ASCVD/Primary HLD/HoFH (reauth): Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline.

# PROMACTA (S)

## Products Affected

- Promacta

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Immune (idiopathic) thrombocytopenic purpura (ITP) (initial): Diagnosis of one of the following: relapsed/refractory ITP, persistent ITP, or chronic ITP. Baseline platelet count is less than 30,000/mcL. Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding. Trial and failure, intolerance, contraindication to corticosteroids (e.g., prednisone, methylprednisolone), immunoglobulins [e.g., Gammagard, immune globulin (human)], or splenectomy. Chronic hepatitis C (initial): Diagnosis of chronic hepatitis C-associated thrombocytopenia. One of the following: 1) Planning to initiate and maintain interferon-based treatment, or 2) currently receiving interferon-based treatment. First-line for severe aplastic anemia (SAA): Diagnosis of SAA. Used for first-line treatment (i.e., patient has not received prior immunosuppressive therapy). Used in combination with standard immunosuppressive therapy (e.g., horse antithymocyte globulin, cyclosporine). Patient meets at least two of the following: 1) absolute neutrophil count less than 500/mcL, 2) platelet count less than 20,000/mcL, 3) absolute reticulocyte count less than 60,000/mcL. Refractory SAA (initial): Diagnosis of refractory severe aplastic anemia. Patient has a platelet count less than 30,000/mcL. Insufficient response to immunosuppressive therapy (e.g., horse antithymocyte globulin, cyclosporine).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	ITP and SAA: Prescribed by or in consultation with a hematologist/oncologist. Chronic hepatitis C associated thrombocytopenia: Prescribed by or in consultation with a hematologist/oncologist, gastroenterologist, hepatologist, infectious disease specialist, or HIV specialist certified through the American Academy of HIV Medicine.
<b>Coverage Duration</b>	ITP(init, reauth): 12mo. HepC: 3mo(init), 12mo(reauth). 1stline SAA: 6mo. RefractSAA: 16wk-init, 12mo-reauth

<b>Other Criteria</b>	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding. Hepatitis C (reauth): One of the following: 1) For patients that started treatment with eltrombopag prior to initiation of treatment with interferon, eltrombopag will be approved when both of the following are met: a) Currently on antiviral interferon therapy for treatment of chronic hepatitis C and b) Documentation that the patient reached a threshold platelet count that allows initiation of antiviral interferon therapy with eltrombopag treatment by week 9, OR 2) For patients that started treatment with eltrombopag while on concomitant treatment with interferon, eltrombopag will be approved based on the following: Currently on antiviral interferon therapy for treatment of chronic hepatitis C. Refractory SAA (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count.
-----------------------	--

# PROVIGIL (S)

## Products Affected

- Modafinil TABS

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Obstructive sleep apnea (OSA) (Initial): Diagnosis (dx) of OSA defined by one of the following: 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), or both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible), and 1 of the following symptoms: unintentional sleep episodes during wakefulness, daytime sleepiness, unrefreshing sleep, fatigue, insomnia, waking up breath holding/gasping/choking, loud snoring, or breathing interruptions during sleep. Shift-work disorder (SWD) (Initial):Dx of SWD confirmed by one of the following: 1) Symptoms of excessive sleepiness or insomnia for at least 3 months, which is associated with a work period (usually night work) that occurs during the normal sleep period, OR 2) A sleep study demonstrating loss of a normal sleep-wake pattern (ie, disturbed chronobiologic rhythmicity). Confirmation that no other medical conditions or medications are causing the symptoms of excessive sleepiness or insomnia. Narcolepsy (initial): Dx of narcolepsy as confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible). MS Fatigue (initial): Dx of multiple sclerosis (MS). Patient is experiencing fatigue. Depression (initial): Treatment-resistant depression defined as diagnosis of major depressive disorder (MDD) or bipolar depression, AND trial and failure, contraindication, or intolerance to at least two antidepressants from different classes (eg, SSRIs, SNRIs, bupropion). Used as adjunctive therapy. Idiopathic Hypersomnia (Initial): Diagnosis of idiopathic hypersomnia as confirmed by a sleep study (unless prescriber provides justification confirming that a sleep study is not feasible).</p>
Age Restrictions	N/A

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Narcolepsy: Init, Reauth: 12 mo. All other indications: Init, Reauth: 6 mo.
<b>Other Criteria</b>	OSA, Narcolepsy, Idiopathic Hypersomnia (Reauth): Patient demonstrates positive clinical response to modafinil therapy. SWD (Reauth): Patient demonstrates positive clinical response to modafinil therapy. MS Fatigue (reauth): Patient is experiencing relief of fatigue with modafinil therapy. Depression (reauth): Patient demonstrates positive clinical response to modafinil therapy. Used as adjunctive therapy.



# PULMOZYME (S)

## Products Affected

- Pulmozyme SOLN 2.5MG/2.5ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cystic Fibrosis (CF) (Initial, Reauth): Diagnosis of CF.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CF (initial, reauth): 12 months
<b>Other Criteria</b>	Part B vs D determination applies. CF (reauth): Patient is benefiting from treatment (i.e. improvement in lung function [forced expiratory volume in one second (FEV1)], decreased number of pulmonary exacerbations).

## PYRUKYND (S)

### Products Affected

- Pyrukynd

- Pyrukynd Taper Pack

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of hemolytic anemia confirmed by the presence of chronic hemolysis (e.g., increased indirect bilirubin, elevated lactated dehydrogenase [LDH], decreased haptoglobin, increased reticulocyte count). Diagnosis of pyruvate kinase deficiency confirmed by molecular testing of ALL the following mutations on the PKLR gene: a) Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, of which at least 1 was a missense variant AND b) Patients is not homozygous for the c.1436G to A (p.R479H) variant AND c) Patient does not have 2 non-missense variants (without the presence of another missense variant) in the PKLR gene. Hemoglobin is less than or equal to 10g/dL. Patient has symptomatic anemia or is transfusion dependent. Exclusion of other causes of hemolytic anemias (e. g., infections, toxins, drugs).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a hematologist.
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

## QINLOCK (S)

---

### Products Affected

- Qinlock

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Gastrointestinal Stromal Tumor (GIST): Diagnosis of gastrointestinal stromal tumor (GIST). Disease is advanced. Patient has received prior treatment with three or more kinase inhibitors (e.g., sunitinib, regorafenib), one of which must include imatinib.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## QUALAQUIN (S)

---

### Products Affected

- Qualaquin

- Quinine Sulfate CAPS 324MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Excluded if used solely for the treatment or prevention of nocturnal leg cramps.
<b>Required Medical Information</b>	Malaria: Diagnosis of uncomplicated malaria. One of the following: 1) Treatment in areas of chloroquine-sensitive malaria, and trial and failure, contraindication, or intolerance to chloroquine or hydroxychloroquine, OR 2) Treatment in areas of chloroquine-resistant malaria.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	7 days
<b>Other Criteria</b>	N/A

## QULIPTA (S)

### Products Affected

- Qulipta

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Episodic Migraine (EM) (initial): Both of the following: 1) Diagnosis of EM and 2) Patient has greater than or equal to 4 migraine days per month. Chronic Migraines (CM) (initial): Diagnosis of CM. Medication overuse headache has been considered and potentially offending medication(s) have been discontinued. Patient has greater than or equal to 8 migraine days per month. All Indications (initial): History of failure (after at least a two month trial), contraindication, or intolerance to two of the following preventive treatments for migraine from different classes: a) An antidepressant [i.e., Elavil (amitriptyline) or Effexor (venlafaxine)], OR b) An anticonvulsant [i.e., Depakote/Depakote ER (divalproex sodium) or Topamax (topiramate)], OR c) A beta blocker [i.e., atenolol, propranolol, nadolol, timolol, or metoprolol], OR d) Atacand (candesartan), OR e) Generic lisinopril. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines.</p>
<b>Age Restrictions</b>	EM, CM (initial): 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	EM, CM (init): 6mo. EM, CM (reauth): 12mo.
<b>Other Criteria</b>	<p>EM, CM (reauth): Patient has experienced a positive response to therapy (e.g., a reduction in headache frequency and/or intensity, a reduction in the number of workdays missed due to migraines). Use of acute migraine medications [e.g., nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g., ibuprofen, naproxen), triptans (e.g., eletriptan, rizatriptan, sumatriptan)] has decreased since the start of CGRP therapy. Medication will not be used in combination with another CGRP inhibitor for the preventive treatment of migraines. CM (reauth): Patient continues to be monitored for medication overuse headache.</p>



## QUVIVIQ (S)

---

### Products Affected

- Quviviq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of insomnia characterized by difficulties with sleep onset and/or sleep maintenance. Trial and failure, contraindication, or intolerance to Belsonra. One of the following: 1) Patient is 65 years of age or older, OR 2) Both of the following: a) Patient is less than 65 years of age and b) Trial and failure, contraindication, or intolerance to one of the following: eszopiclone, temazepam, zaleplon, zolpidem, or zolpidem ER.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy (e.g., improvement in sleep onset, sleep maintenance, or total sleep time from baseline).

## RADICAVA ORS (S)

---

### Products Affected

- Radicava Ors Starter Kit

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Amyotrophic lateral sclerosis (ALS) (initial): Submission of medical records (e.g., chart notes, previous medical history, diagnostic testing including: imaging, nerve conduction studies, laboratory values) to support a diagnosis of “definite” or “probable” ALS per the revised El Escorial diagnostic criteria. Patient has scores of greater than or equal to 2 in all items of the ALS Functional Rating Scale-Revised (ALSFRS-R) criteria at the start of treatment. Patient has a percent forced vital capacity (%FVC) of greater than or equal to 80% at the start of treatment.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	ALS (initial): Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial, reauth: 6 months
<b>Other Criteria</b>	ALS (reauthorization): Patient demonstrates positive response to therapy.



## RAVICTI (S)

---

### Products Affected

- Ravicti

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Urea cycle disorders (UCDs) (Initial): Both of the following: 1) Diagnosis of UCD AND 2) One of the following deficiencies: a) carbamylphosphate synthetase (CPS), b) ornithine transcarbamylase (OTC), or c) argininosuccinic acid synthetase (AS). Molecular genetic testing confirms mutations in the CPS1, OTC, or ASS1 gene. Inadequate response to one of the following: 1) Dietary protein restriction or 2) Amino acid supplementation.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	UCDs (initial): Prescribed by or in consultation with a specialist focused on the treatment of metabolic disorders.
<b>Coverage Duration</b>	UCDs (Initial, reauth): 12 months
<b>Other Criteria</b>	UCDs (reauth): Patient demonstrates positive clinical response to therapy (e.g., plasma ammonia or amino acid levels within normal limits).

## REGRANEX (S)

---

### Products Affected

- Regranex

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diabetic neuropathic ulcers: Patient has a lower extremity diabetic neuropathic ulcer. Treatment will be given in combination with ulcer wound care (eg, debridement, infection control, and/or pressure relief).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	5 months
<b>Other Criteria</b>	N/A

## REPATHA (S)

### Products Affected

- Repatha
- Repatha Pushtronex System
- Repatha Sureclick

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>HeFH/ASCVD/Primary HLD (init): One of the following dx: A)HeFH, B)ASCVD, OR C)Primary hyperlipidemia (HLD). One of the following: a) Pt has been receiving the highest tolerable dose of statin therapy, OR b) Patient is statin intolerant as evidenced by an inability to tolerate at least two statins, with at least one started at the lowest starting daily dose, due to intolerable symptoms or clinically significant biomarker changes of liver function or muscle function (e.g., creatine kinase), OR c) Pt has an FDA labeled contraindication to all statins. ONE of the following: 1) One of the following LDL values while on max tolerated lipid lowering tx w/in the last 120 days: a) LDL greater than or equal to 55 mg/dL w/ ASCVD or b) LDL greater than or equal to 100 mg/dL w/o ASCVD. OR 2) Both of the following: a) Patient has been receiving PCSK9 therapy as adjunct to maximally tolerated lipid lowering therapy (e.g., statins, ezetimibe) and b) LDL-C values drawn within the past 12 months while on maximally tolerated lipid lowering therapy is within normal limits. ONE of the following: Pt has been receiving at least 12 weeks of ezetimibe (Zetia) tx as adjunct to max tolerated statin tx OR Pt has a hx of contraindication or intolerance to ezetimibe. HoFH (init): Dx of HoFH as confirmed by one of the following: 1)Gen confirmation of 2 mutations in LDL receptor, ApoB, PCSK9, or LDLRAP1 or ARH, or 2)either untreated LDL greater than 500 or treated LDL greater than 300, AND either xanthoma before 10 yo or evidence of HeFH in both parents. One of the following: 1)Pt is receiving other lipid-lowering tx (eg statin, ezetimibe) or 2)Pt has a documented inability to take other lipid-lowering tx (eg statin, ezetimibe).</p>
Age Restrictions	(Initial) HeFH/HoFH: 10 years or older.
Prescriber Restrictions	N/A

<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months
<b>Other Criteria</b>	HeFH/ASCVD/Primary HLD (reauth): Pt continues to receive other lipid-lowering tx (eg statins, ezetimibe) at max tolerated dose (unless pt has documented inability to take these medications). HoFH (reauth): One of the following: 1)Pt continues to receive other lipid-lowering tx (eg statin, ezetimibe) or 2)Pt has a documented inability to take other lipid-lowering tx (eg statin, ezetimibe). HeFH/ASCVD/Primary HLD/HoFH (reauth): Patient demonstrates positive clinical response to therapy as evidenced by a reduction in LDL-C levels from baseline.

# RETACRIT (S)

## Products Affected

- Retacrit

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Anemia with Chronic Kidney Disease (CKD) (Initial): Diagnosis (Dx) of CKD. Anemia by lab values (Hct less than 30% or Hgb less than 10 g/dL) collected within 30 days of request. One of the following: a) both of the following: Patient is on dialysis, patient is without ESRD OR b) all of the following: patient is not on dialysis, the rate of hemoglobin decline indicates the likelihood of requiring a red blood cell (RBC) transfusion, and reducing the risk of alloimmunization and/or other RBC transfusion-related risks is a goal. Anemia with chemo (Initial): Other causes of anemia have been ruled out. Anemia by lab values (Hct less than 30%, Hgb less than 10 g/dL) collected within the prior 2 weeks of request. Cancer is a non-myeloid malignancy. Patient is receiving chemo.</p> <p>Preoperative for reduction of allogeneic blood transfusion: Patient is scheduled to undergo elective, non-cardiac, non-vascular surgery. Hgb is greater than 10 to less than or equal to 13 g/dL. Patient is at high risk for perioperative transfusions. Patient is unwilling or unable to donate autologous blood pre-operatively. Anemia in hepatitis C virus (HCV)-infected pts due to ribavirin in combination with interferon/peg-interferon (Initial): Dx of HCV infection. Anemia by labs (Hct less than 36% or Hgb less than 12 g/dL) collected within 30 days of request. Patient is receiving ribavirin and one of the following: interferon alfa or peginterferon alfa.</p> <p>Anemia with HIV (Initial): Anemia by lab values (Hgb less than 12 g/dL or Hct less than 36%) collected within 30 days of request. Serum erythropoietin level less than or equal to 500 mU/mL. Receiving zidovudine therapy or dx of HIV. Anemia in Myelodysplastic Syndrome (MDS) (Initial): Dx of MDS. Serum erythropoietin level is 500 mU/mL or less, or dx of transfusion-dependent MDS.</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A

<b>Coverage Duration</b>	CKD,HIV(Init):6mo. CKD,HIV(reauth):12mo. Chemo,HCV(all):3mo. MDS:(init) 3mo,(reauth)12mo. Preop:1mo.
<b>Other Criteria</b>	<p>Subject to ESRD review. CKD (Reauth): Dx of CKD. One of the following: 1) Most recent or average (avg) Hct over 3 months is 33% or less (Hgb is 11 g/dL or less) for patients on dialysis, without ESRD, 2) Most recent or avg Hct over 3 mo is 30% or less (Hgb 10 g/dL or less) for patients not on dialysis, OR 3) Most recent or avg Hct over 3 mo is 36% or less (Hgb 12 g/dL or less) for pediatric patients. Patient demonstrates positive clinical response to therapy from pre-treatment level. HIV (Reauth): Most recent or avg Hct over 3 months is below 36% or most recent or avg Hgb over 3 months is below 12 g/dl. Patient demonstrates positive clinical response to therapy from pre-treatment level. Chemo (Reauth): Anemia by lab values (Hgb less than 10 g/dl or Hct less than 30%) collected within the prior 2 weeks of request. Patient demonstrates positive clinical response to therapy from pre-treatment level. Patient is receiving chemo. HCV (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates positive clinical response to therapy from pre-treatment level. If patient has demonstrated response to therapy, authorization will be issued for the full course of ribavirin therapy. MDS (Reauth): Most recent or avg Hct over 3 months is 36% or less, OR most recent or avg Hgb over 3 months is 12 g/dl or less. Patient demonstrates positive clinical response to therapy from pre-treatment level. Other Off-label uses (except MDS, HCV): Will not be approved if patient has Hgb greater than 10 g/dL or Hct greater than 30%. CKD (init, reauth), HIV (init), Chemo (init), Preop, MDS (init), HCV (init): Verify iron evaluation for adequate iron stores.</p>

## RETEVMO (S)

### Products Affected

- Retevmo

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Non-Small Cell Lung Cancer: Diagnosis of non-small cell lung cancer (NSCLC). Disease is locally advanced or metastatic. Disease has presence of RET gene fusion-positive tumor(s) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).</p> <p>Medullary Thyroid Cancer (MTC): Diagnosis of medullary thyroid cancer (MTC). Disease is advanced or metastatic. Disease has presence of RET gene mutation tumor(s) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease requires treatment with systemic therapy.</p> <p>Thyroid Cancer: Diagnosis of thyroid cancer. Disease is advanced or metastatic. Disease has presence of RET gene fusion-positive tumor(s) as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Disease requires treatment with systemic therapy. Patient is radioactive iodine-refractory or radioactive iodine therapy is not appropriate.</p> <p>Solid Tumors: Diagnosis of solid tumors. Disease is locally advanced or metastatic. Disease has presence of RET gene fusion-positive tumor(s). ONE of the following: a) Disease has progressed on or following prior systemic treatment (e.g., chemotherapy), OR b) There are no satisfactory alternative treatment options.</p>
<b>Age Restrictions</b>	MTC, Thyroid Cancer: Patient is 12 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Non-Small Cell Lung Cancer, MTC, Thyroid Cancer, Solid Tumors: 12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.





## REVATIO (S)

### Products Affected

- Sildenafil Citrate TABS 20MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH: Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

## REVATIO SUSPENSION (S)

### Products Affected

- Liqrev
- Sildenafil Citrate SUSR

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. One of the following: A) Intolerance to generic Revatio tablets, OR B) Patient is unable to ingest a solid dosage form (e.g., an oral tablet or capsule) due to one of the following: age, oral-motor difficulties, or dysphagia.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH: Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

## REVCOVI (S)

---

### Products Affected

- Revcovi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of adenosine deaminase deficiency (ADA) with severe combined immunodeficiency (SCID).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## REVLIMID (S)

---

### Products Affected

- Lenalidomide

- Revlimid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Multiple myeloma (MM): Diagnosis of MM. Myelodysplastic syndromes (MDS): Diagnosis of transfusion-dependent anemia due to low- or intermediate-1-risk MDS associated with a deletion 5q. Mantle cell lymphoma (MCL): Diagnosis of MCL. Follicular Lymphoma (FL): Diagnosis of FL. Marginal Zone Lymphoma (MZL): Diagnosis of MZL.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## REYVOW (S)

---

### Products Affected

- Reyvow

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Patient has less than 15 headache days per month. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 8 hours after taking each dose of Reyvow.
<b>Age Restrictions</b>	Initial: 18 years of age or older.
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
<b>Coverage Duration</b>	Initial: 3 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea). Will not be used for preventive treatment of migraine.

## REZLIDHIA (S)

---

### Products Affected

- Rezlidhia

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Presence of a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH1 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## REZUROCK (S)

---

### Products Affected

- Rezurock

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic graft versus host disease (cGVHD) (initial): Diagnosis of cGVHD. Trial and failure of two or more lines of systemic therapy (e.g., corticosteroids, mycophenolate, etc.).
<b>Age Restrictions</b>	Initial: Patient is 12 years of age or older.
<b>Prescriber Restrictions</b>	cGVHD (initial): Prescribed by or in consultation with one of the following: hematologist, oncologist, or physician experienced in the management of transplant patients.
<b>Coverage Duration</b>	cGVHD (initial, reauth): 12 months
<b>Other Criteria</b>	cGVHD (reauth): Patient does not show evidence of progressive disease while on therapy.

# RINVOQ (S)

## Products Affected

- Rinvoq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Rheumatoid arthritis (RA) (init): Diagnosis (Dx) of moderately to severely active RA. Minimum (min) duration of a 3-mo trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Psoriatic arthritis (PsA) (init): Dx of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing spondylitis (AS) (init): Dx of active AS. Non-radiographic axial spondyloarthritis (NRAS, init): Dx of active NRAS. Pt has signs of inflammation. Pt has had an inadequate response or intolerance to one or more TNF inhibitors (eg, certolizumab pegol). AS, NRAS (init): Min duration of a 1-mo TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PsA, AS (init): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). RA, PsA, AS, NRAS (init, reauth): Not used in combo with other JAK inhibitors (JAK-I), biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine). Atopic dermatitis (AD) (init): Dx of moderate to severe AD. One of the following: Involvement of at least 10% body surface area (BSA), or SCORing Atopic Dermatitis (SCORAD) index value of at least 25. TF of a min 30-day supply (14-day supply for topical corticosteroids), C/I to at least one of the following: Medium or higher potency topical corticosteroid, Pimecrolimus cream, Tacrolimus oint, or Eucrisa oint. One of the following: 1) TF of a min 12-week supply of at least one systemic drug product for the treatment of AD (examples include, but are not limited to, Adbry, Dupixent, etc.), OR 2) Pt has a C/I, or treatment is inadvisable with both of the following FDA-approved AD therapies: Adbry and Dupixent. Not used in combo with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine).</p>
Age Restrictions	AD (initial): Patient is 12 years of age or older



<b>Prescriber Restrictions</b>	RA, AS, NRAS (init): Prescribed by or in consultation with a rheumatologist. PsA (init): Prescribed by or in consultation with a dermatologist or rheumatologist. AD (init): Prescribed by or in consultation with a dermatologist or allergist/immunologist. CD, UC (init): Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	RA, PsA, AS, NRAS, CD, UC, AD (init): 6 months, (reauth): 12 months.

<p><b>Other Criteria</b></p>	<p>Crohn's disease (CD) (init): Dx of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate. Ulcerative colitis (UC) (init): Dx of moderately to severely active UC. One of the following: greater than 6 stools/day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate (eg, mesalamine, olsalazine, sulfasalazine), azathioprine, or corticosteroids (eg, prednisone). CD, UC (init): Pt has had an inadequate response or intolerance to one or more TNF inhibitors (eg, Humira). Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, azathioprine, cyclosporine). RA (reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, NRAS (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. AD (reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: a) Reduction in BSA involvement from baseline, or b) Reduction in SCORAD index value from baseline. Not used in combination with other JAK-I, biologic immunomodulators, or other immunosuppressants (eg, azathioprine, cyclosporine). CD/UC (Reauth): Pt demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, ESR, CRP]) from baseline OR reversal of high fecal output state. Not used in combination with other JAK-I, biological therapies for CD/UC, or potent immunosuppressants (eg, azathioprine, cyclosporine).</p>
------------------------------	---

## RIVFLOZA (S)

### Products Affected

- Rivfloza

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of primary hyperoxaluria type 1 (PH1). Disease has been confirmed by both of the following: a) One of the following: i) Elevated urinary oxalate excretion, ii) Elevated plasma oxalate concentration, or iii) Spot urinary oxalate to creatinine molar ratio greater than normal for age, and b) One of the following: i) Genetic testing demonstrating a mutation in the alanine:glyoxylate aminotransferase (AGXT) gene, or ii) Liver biopsy demonstrating absence or reduced alanine:glyoxylate aminotransferase (AGT) activity. Patient has preserved kidney function (e.g., eGFR greater than or equal to 30mL/min/1.73m <sup>2</sup> ).
<b>Age Restrictions</b>	Initial: Patient is 9 years of age or older.
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with one of the following: hepatologist, nephrologist, urologist, geneticist, or specialist with expertise in the treatment of PH1.
<b>Coverage Duration</b>	Initial, Reauth: 12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

## ROZLYTREK (S)

### Products Affected

- Rozlytrek

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Non-small cell lung cancer (NSCLC): Diagnosis of metastatic non-small cell lung cancer (NSCLC). Patient has ROS1 rearrangement positive tumor(s). Solid Tumors: Patient has solid tumors with a neurotrophic tyrosine receptor kinase (NTRK) gene fusion (e.g., ETV6-NTRK3, TPM3-NTRK1, TPR-NTRK1, etc.). Disease is without a known acquired resistance mutation (e.g., TRKA G595R, TRKA G667C or TRKC G623R substitutions). Disease is one of the following: metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: disease has progressed following previous treatment (e.g., surgery, radiation therapy, or systemic therapy) or disease has no satisfactory alternative treatments.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

## RUBRACA (S)

---

### Products Affected

- Rubraca

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Ovarian cancer: Diagnosis of epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer. Prostate cancer: Diagnosis of castration-resistant prostate cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy

## RUCONEST (S)

---

### Products Affected

- Ruconest

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Treatment of hereditary angioedema (HAE) attacks: Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For the treatment of acute HAE attacks. Not used in combination with other approved treatments for acute HAE attacks.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	HAE: Prescribed by or in consultation with an immunologist or an allergist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

# RYDAPT (S)

## Products Affected

- Rydapt

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acute Myeloid Leukemia (AML): Newly diagnosed acute myeloid leukemia (AML), FMS-like tyrosine kinase 3 (FLT3) mutation-positive as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), used in combination with standard cytarabine and daunorubicin induction and cytarabine consolidation. Aggressive Systemic Mastocytosis (ASM), Systemic Mastocytosis with Associated Hematological Neoplasm (SM-AHN), Mast Cell Leukemia (MCL): Diagnosis of one of the following: aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN), or mast cell leukemia (MCL).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## SABRIL (S)

---

### Products Affected

- Vigabatrin
- Vigadrone
- Vigpoder

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Complex Partial Seizures (CPS): For use as adjunctive therapy. Failure, contraindication, or intolerance to two formulary anticonvulsants [eg, Lamictal (lamotrigine), Depakene (valproic acid), Dilantin (phenytoin)]. Infantile Spasms (IS): Diagnosis of infantile spasms.
<b>Age Restrictions</b>	IS: 1 month to 2 years of age. CPS: 2 years or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.



## SAMSCA (S)

---

### Products Affected

- Samsca
- Tolvaptan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of significant hyponatremia (euvolemic or hypervolemic). Treatment has been initiated or re-initiated in a hospital setting prior to discharge within the past 30 days.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	30 days
<b>Other Criteria</b>	N/A

## SANDOSTATIN (S)

### Products Affected

- Octreotide Acetate INJ 1000MCG/ML, 100MCG/ML, 200MCG/ML, 500MCG/ML, 50MCG/ML

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acromegaly (initial): Diagnosis of acromegaly. One of the following: A) Inadequate response to surgical resection and/or pituitary irradiation OR B) Patient is not a candidate for surgical resection or pituitary irradiation. Trial and failure, contraindication or intolerance to a dopamine agonist (e.g., bromocriptine or cabergoline) at maximally tolerated doses. Carcinoid tumor (initial): Diagnosis of metastatic carcinoid tumor requiring symptomatic treatment of severe diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (initial): Diagnosis of vasoactive intestinal peptide tumor requiring treatment of profuse watery diarrhea.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	All uses (initial, reauth): 12 months
<b>Other Criteria</b>	Acromegaly (reauth): Patient demonstrates positive clinical response to therapy (e.g., reduction or normalization of IGF-1/GH level for same age and sex, reduction in tumor size). Carcinoid tumor (reauth): Patient has improvement in number of diarrhea or flushing episodes. Vasoactive intestinal peptide tumor (reauth): Patient has improvement in number of diarrhea episodes.

## SCSEMBLIX (S)

---

### Products Affected

- Scemblix

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of chronic myelogenous/myeloid leukemia (CML). Disease is Philadelphia chromosome-positive (Ph+). Disease is in chronic phase. One of the following: 1) Patient has been previously treated with two or more alternative tyrosine kinase inhibitors (TKI) [e.g., Bosulif (bosutinib), imatinib, Sprycel (dasatinib), Tassigna (nilotinib), Iclusig (ponatinib)], OR 2) Disease is T315I mutation positive.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## SEROSTIM (S)

### Products Affected

- Serostim INJ 4MG, 5MG, 6MG

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	HIV wasting (Initial): Diagnosis of HIV-associated wasting syndrome or cachexia, and one of the following: unintentional weight loss greater than 10% over the last 12 months, or unintentional weight loss greater than 7.5% over the last 6 months, or loss of 5% body cell mass (BCM) within 6 months, or body mass index (BMI) less than 20 kg/m <sup>2</sup> , or patient is male and has BCM less than 35% of total body weight (TBW) and BMI less than 27 kg/m <sup>2</sup> , or patient is female and has BCM less than 23% of TBW and BMI less than 27 kg/m <sup>2</sup> . Nutritional evaluation since onset of wasting first occurred. Anti-retroviral tx has been optimized to decrease the viral load. Patient has not had weight loss as a result of other underlying treatable conditions (eg, depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes). Patient has tried and had an inadequate response or intolerance to dronabinol or megestrol acetate.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial/Reauth: Prescribed by or in consultation with an infectious disease specialist.
<b>Coverage Duration</b>	Initial: 3 months. Reauth: 6 months
<b>Other Criteria</b>	HIV wasting (reauth): Evidence of positive response to therapy. One of the following targets or goals has not been achieved: weight, BCM, BMI. Patient is currently receiving treatment with antiretrovirals.

## SIGNIFOR (S)

---

### Products Affected

- Signifor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cushing's disease (initial): Diagnosis of Cushing's disease. One of the following: a) Pituitary surgery has not been curative for the patient or b) Patient is not a candidate for pituitary surgery.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Cushing's disease (initial): Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	Cushing's disease (initial, reauth): 12 months
<b>Other Criteria</b>	Cushing's disease (reauth): Patient demonstrates positive clinical response to therapy (e.g., a clinically meaningful reduction in 24-hour urinary free cortisol levels, improvement in signs or symptoms of the disease).

## SILIQ (S)

### Products Affected

- Siliq

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Plaque psoriasis (initial): Diagnosis of moderate-to-severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. One of the following: a) Trial and failure, contraindication, or intolerance to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Otezla (apremilast), Skyrizi (risankizumab), Sotyktu (deucravacitinib), Stelara (ustekinumab), OR b) for continuation of prior therapy.
Age Restrictions	N/A
Prescriber Restrictions	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist.
Coverage Duration	Plaque psoriasis (initial): 6 months. Plaque psoriasis (reauth): 12 months.
Other Criteria	Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy.

# SIMPONI (S)

## Products Affected

- Simponi

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. One of the following: a) Either a trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Rinvoq (upadacitinib), Xeljanz/Xeljanz XR (tofacitinib), or attestation demonstrating a trial may be inappropriate, OR b) For continuation of prior therapy. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. One of the following: a) Trial and failure, contraindication (e.g., safety concerns, not indicated for patient's age/weight), or intolerance to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Otezla (apremilast), Skyrizi (risankizumab-rzaa), Stelara (ustekinumab), Rinvoq (upadacitinib), Xeljanz/XR (tofacitinib/ER), OR b) for continuation of prior therapy. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. One of the following: TF/C/I to two of the following: Cosentyx, Enbrel, one formulary adalimumab product, Rinvoq, or Xeljanz/Xeljanz XR, OR for continuation of prior therapy. Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: a) Either TF/C/I to two of the following: one formulary adalimumab product, Stelara, Rinvoq, Xeljanz/Xeljanz XR, OR b) for continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	RA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a rheumatologist or dermatologist. UC (initial): Prescribed by or in consultation with a gastroenterologist.

<b>Coverage Duration</b>	UC (Initial): 12 weeks, (Reauth): 12 months. RA, AS, PsA (Initial): 6 months, (Reauth): 12 months
<b>Other Criteria</b>	<p>RA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.</p>



## SKYCLARYS (S)

### Products Affected

- Skyclarys

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of Friedreich's ataxia confirmed via genetic testing demonstrating mutation in the FXN gene. Patient has a Modified Friedreich's Ataxia Rating Scale (mFARS) score of greater than or equal to 20 and less than or equal to 80. Patient has a B-type natriuretic peptide value less than or equal to 200 pg/mL.
<b>Age Restrictions</b>	Initial: Patient is 16 years of age or older.
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with one of the following: Neurologist, Neurogeneticist, or Psychiatrist (Physical Medicine and Rehabilitation Specialist).
<b>Coverage Duration</b>	Initial, Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

# SKYRIZI (S)

## Products Affected

- Skyrizi INJ 150MG/ML, 180MG/1.2ML, 360MG/2.4ML

- Skyrizi Pen

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active CD. Will be used as a maintenance dose following the intravenous induction doses.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD (Initial): Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	All uses (initial): 6 months, (reauth): 12 months

<b>Other Criteria</b>	Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
-----------------------	--

## SKYTROFA (S)

### Products Affected

- Skytrofa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pediatric Growth Hormone Deficiency (PGHD) (initial): One of the following: A) History of neonatal hypoglycemia associated with pituitary disease, B) Diagnosis of panhypopituitarism, OR C) Both of the following: 1) Diagnosis of PGHD as confirmed by one of the following: a) Height is documented by one of the following (utilizing age and gender growth charts related to height): i) height is greater than 2.0 standard deviations (SD) below midparental height OR ii) height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender), b) Growth velocity is greater than 2 SD below mean for age and gender, or c) Delayed skeletal maturation of greater than 2 SD below mean for age and gender (eg, delayed greater than 2 years compared with chronological age), AND 2) Patient demonstrates one of the following: a) Patient is male with bone age less than 16 years, OR b) Patient is female with bone age less than 14 years. Patient weight is 11.5 kg or greater. Trial and failure or intolerance to Genotropin.
<b>Age Restrictions</b>	PGHD (initial): 1 year of age or older.
<b>Prescriber Restrictions</b>	PGHD (initial, reauth): Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	PGHD (initial, reauth): 12 months.
<b>Other Criteria</b>	PGHD (reauth): Both of the following: 1) Expected adult height not attained AND 2) Documentation of expected adult height goal.

## SOGROYA (S)

### Products Affected

- Sogroya

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Pediatric Growth Hormone Deficiency (PGHD) (initial): Both of the following: 1) Diagnosis of PGHD as confirmed by one of the following: a) Height is documented by one of the following (utilizing age and gender growth charts related to height): i) height is greater than 2.0 standard deviations (SD) below midparental height, or ii) height is greater than 2.25 SD below population mean (below the 1.2 percentile for age and gender), b) Growth velocity is greater than 2 SD below mean for age and gender, or c) Delayed skeletal maturation of greater than 2 SD below mean for age and gender (e.g., delayed greater than 2 years compared with chronological age), AND 2) Documentation of one of the following: a) Patient is male with bone age less than 16 years, or b) Patient is female with bone age less than 14 years. Isolated Growth Hormone Deficiency in Adults (IGHDA) (initial): Documentation of GHD as demonstrated by both of the following: A) Patient has undergone two of the following GH stim tests: 1) insulin tolerance test [ITT], 2) glucagon, or 3) macimorelin, AND B) Two of the corresponding peak GH values: 1) ITT less than or equal to 5 mcg/L, 2) glucagon less than or equal to 3mcg/L, 3) macimorelin less than 2.8 ng/mL 30, 45, 60, 90 mins after administration.</p>
<b>Age Restrictions</b>	PGHD (initial): Patient is 2.5 years of age or older.
<b>Prescriber Restrictions</b>	PGHD, AGHD, IGHDA (initial, reauth): Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	PGHD, AGHD, IGHDA (initial, reauth): 12 months.

---

**Other Criteria**

PGHD (reauth): Both of the following: A) Expected adult height not attained, AND B) Documentation of expected adult height goal. Adult Growth Hormone Deficiency (AGHD) (initial): Diagnosis of AGHD as a result of one of the following: A) Clinical records supporting diagnosis of childhood-onset GHD, or B) Adult-onset GHD with clinical records documenting hormone deficiency is a result of hypothalamic-pituitary disease from organic or known causes (eg, damage from surgery, cranial irradiation, head trauma, subarachnoid hemorrhage). One of the following: A) Both of the following: 1) Patient has undergone one of the following GH stim tests to confirm AGHD: a) ITT, b) glucagon, or c) macimorelin, AND 2) One of the following peak GH values: a) ITT less than or equal to 5mcg/L, b) glucagon less than or equal to 3 mcg/L, c) macimorelin less than 2.8 ng/mL 30, 45, 60 and 90 mins after administration, OR B) Both of the following: 1) Documented deficiency of 3 anterior pituitary hormones: a) prolactin, b) adrenocorticotrophic hormone (ACTH), c) thyroid stimulating hormone (TSH), d) follicle-stimulating hormone/luteinizing hormone (FSH/LH), AND 2) IGF-1/somatomedin-C below age and gender adjusted normal range as provided by the physician's lab. All indications (initial): Trial and failure or intolerance to Genotropin. AGHD, IGHDA (reauth): Evidence of ongoing monitoring as demonstrated by documentation within the past 12 months of an IGF-1/somatomedin-C level.

---

## SOHONOS (S)

---

### Products Affected

- Sohonos

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of fibrodysplasia ossificans progressiva (FOP). Molecular genetic testing confirms mutation in the ACVR1 gene. One of the following: A) Both of the following: 1) Patient is female, and 2) Patient is 8 years of age or older, OR B) Both of the following: 1) Patient is male, and 2) Patient is 10 years of age or older.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a geneticist, orthopedic physician, rheumatologist, or endocrinologist.
<b>Coverage Duration</b>	Initial: 3 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

# SOMAVERT (S)

## Products Affected

- Somavert

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acromegaly (initial): Diagnosis of acromegaly. One of the following: 1) failure to one of the following: surgery, radiation therapy, or other medical therapies (such as dopamine agonists [e.g., bromocriptine, cabergoline]) or 2) not a candidate for one of the following: surgery, radiation therapy, or dopamine agonist (e.g., bromocriptine, cabergoline) therapy. One of the following: 1) inadequate response, contraindication, or intolerance to a somatostatin analog (e.g., octreotide, lanreotide) or 2) clinical rationale provided for preferred treatment with pegvisomant (e.g., comorbid diabetes mellitus is present with acromegaly).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Acromegaly (initial): Prescribed by or in consultation with an endocrinologist.
<b>Coverage Duration</b>	Initial and reauth: 12 months
<b>Other Criteria</b>	Acromegaly (reauth): Patient has experienced a positive clinical response to therapy (biochemical control, decrease or normalization of IGF-1 levels).



## SOTYKTU (S)

---

### Products Affected

- Sotyktu

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Plaque psoriasis (initial): Diagnosis of moderate-to-severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Not used in combination with other potent immunosuppressants (eg, azathioprine, cyclosporine).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	Plaque psoriasis (initial): 6 months. Plaque psoriasis (reauth): 12 months.
<b>Other Criteria</b>	Plaque psoriasis (reauth): Patient demonstrates positive clinical response to therapy. Not used in combination with other potent immunosuppressants (eg, azathioprine, cyclosporine, biologic DMARDs).

## SOVALDI (S)

### Products Affected

- Sovaldi

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guideline. Diagnosis of chronic hepatitis C. All GT1 and GT4: 1) trial and failure, intolerance or contraindication (TF/I/C) (eg, safety concerns, not indicated for patient's age/weight) to both of the following: a) sofosbuvir/velpatasvir and b) Mavyret OR 2) For continuation of prior therapy. For GT2 or GT3 patients using sofosbuvir plus ribavirin: TF/I/C (eg, safety concerns, not indicated for patient's age/weight) to a) sofosbuvir/velpatasvir AND Mavyret OR b) for continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
<b>Coverage Duration</b>	12 to 48 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
<b>Other Criteria</b>	N/A

## SPEVIGO (S)

### Products Affected

- Spevigo INJ 150MG/ML

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of generalized pustular psoriasis (GPP). Patient has a moderate to severe GPP flare based on one of the following: a) presence of fresh pustules (new appearance or worsening of pustules), b) at least 5% of body surface area (BSA) covered with erythema and the presence of pustules, c) a Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score of at least 3 (moderate), or d) GPPPGA pustulation sub score of at least 2 (mild). Patient has not already received two infusions of Spevigo for a single flare.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	N/A

## SPRYCEL (S)

---

### Products Affected

- Sprycel

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Philadelphia chromosome positive (Ph+)/BCR ABL chronic myelogenous leukemia (CML): Diagnosis of Ph+/BCR ABL CML. Ph+/BCR ABL acute lymphoblastic leukemia (ALL): Diagnosis of Ph+/BCR ABL ALL.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	All Uses: 12 months
<b>Other Criteria</b>	All Uses: Approve for continuation of prior therapy.

## STELARA (S)

### Products Affected

- Stelara INJ 45MG/0.5ML, 90MG/ML

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Plaque psoriasis (Initial - 45mg/0.5mL): Diagnosis of moderate to severe plaque psoriasis. Plaque psoriasis (Initial - 90mg/1mL): Diagnosis of moderate to severe plaque psoriasis. Patient's weight is greater than 100 kg (220 lbs). Plaque psoriasis (Initial): One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Psoriatic arthritis (PsA) (Initial - 45mg/0.5mL): Diagnosis of active PsA. PsA (Initial - 90mg/1mL): Diagnosis of active PsA. Patient's weight is greater than 100 kg (220 lbs). Diagnosis of co-existent moderate to severe psoriasis. PsA (Initial): One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Crohn's disease (CD) (Initial): Diagnosis of moderately to severely active Crohn's disease. Will be used as a maintenance dose following the intravenous induction dose.
<b>Age Restrictions</b>	Plaque psoriasis, PsA: Patient is 6 years of age or older.
<b>Prescriber Restrictions</b>	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. CD and UC (initial): Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	All uses (Initial): 6 months. All uses (reauth): 12 months

<b>Other Criteria</b>	Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. Will be used as a maintenance dose following the intravenous induction dose. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy. CD (Reauth), UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.
-----------------------	--

# STIMUFEND (S)

## Products Affected

- Stimufend

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute’s Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. Acute radiation syndrome (ARS) (off-label): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses: Prescribed by or in consultation with a hematologist/oncologist
<b>Coverage Duration</b>	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
<b>Other Criteria</b>	All Indications (except for ARS): Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca/Udenyca Onbody. ARS: Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca.





## STIVARGA (S)

---

### Products Affected

- Stivarga

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Metastatic colorectal cancer (mCRC): Diagnosis of mCRC. Gastrointestinal stromal tumor (GIST): Diagnosis of locally advanced, unresectable or metastatic GIST. Hepatocellular Carcinoma (HCC): Diagnosis of HCC.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# SUNOSI (S)

## Products Affected

- Sunosi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Narcolepsy (initial): Diagnosis (Dx) of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible). Obstructive Sleep Apnea (OSA) (initial): Dx of OSA defined by one of the following: a) 15 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), or b) both of the following: 5 or more obstructive respiratory events per hour of sleep confirmed by a sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND one of the following signs/symptoms are present: daytime sleepiness, nonrestorative sleep, fatigue, insomnia, waking up with breath holding/gasping/choking, habitual snoring noted by a bed partner or other observer, or observed apnea. All uses (initial): Trial and failure, contraindication or intolerance to both generic modafinil and generic armodafinil.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Narcolepsy (initial): 6 mo, (reauth): 12 mo. OSA (initial, reauth): 6 mo.
<b>Other Criteria</b>	Narcolepsy (reauth): Patient demonstrates positive clinical response to therapy. OSA (reauth): Patient demonstrates positive clinical response to therapy.

## SUTENT (S)

---

### Products Affected

- Sunitinib Malate

- Sutent

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renal cell carcinoma: Diagnosis of advanced or metastatic renal cell carcinoma. Gastrointestinal stromal tumor (GIST): Diagnosis of GIST after disease progression on, or contraindication or intolerance to Gleevec (imatinib). Pancreatic neuroendocrine tumors: Diagnosis of progressive, well-differentiated pancreatic neuroendocrine tumor that is unresectable locally advanced or metastatic disease. Adjuvant treatment of renal cell carcinoma: Diagnosis of renal cell carcinoma (RCC). Used as adjuvant therapy. Patient is at high risk of recurrent RCC following nephrectomy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	All uses: 12 months
<b>Other Criteria</b>	All Indications: Approve for continuation of prior therapy.

## SYMDEKO (S)

### Products Affected

- Symdeko

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of cystic fibrosis. One of the following: 1) Patient is homozygous for the F508del mutation in the CF transmembrane conductance regulator (CFTR) gene as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR 2) Patient has at least one mutation in the CFTR gene that is responsive to tezacaftor/ivacaftor based on in vitro data and/or clinical evidence as detected by a U.S. Food and Drug Administration (FDA)-cleared cystic fibrosis mutation test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
<b>Age Restrictions</b>	Initial: Patient is 6 years of age or older
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy (e.g., improvement in lung function or decreased number of pulmonary exacerbations).

## SYMLIN (S)

---

### Products Affected

- Symlinpen 120
- Symlinpen 60

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: One of the following diagnoses: A) Type 1 diabetes OR B) Type 2 diabetes. Patient has failed to achieve desired glucose control despite optimal insulin therapy. Patient is taking concurrent mealtime insulin therapy (e.g., Humulin, Humalog, Novolin, Novolog).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Reauth: Patient has experienced an objective response to therapy demonstrated by an improvement in HbA1c from baseline. Patient is receiving concurrent mealtime insulin therapy (e.g., Humulin, Humalog, Novolin, Novolog).

## SYNDROS (S)

### Products Affected

- Syndros

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Nausea and Vomiting Associated with Cancer Chemotherapy (CINV): Patient is receiving cancer chemotherapy. Trial and failure, contraindication, or intolerance (TF/C/I) to a 5HT-3 receptor antagonist (eg, Anzemet [dolasetron], Kytril [granisetron], or Zofran [ondansetron]). TF/C/I to one of the following: Compazine (prochlorperazine), Decadron (dexamethasone), Haldol (haloperidol), Zyprexa (olanzapine). AIDS anorexia: Diagnosis of anorexia with weight loss in patients with AIDS. Patient is on antiretroviral therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CINV: 6 months. AIDS anorexia: 3 months.
<b>Other Criteria</b>	Subject to Part B vs. Part D review. CINV: Approve for continuation of therapy for treatment covered under Part B when patient is receiving chemotherapy.

## SYPRINE (S)

---

### Products Affected

- Trientine Hydrochloride

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of Wilson's disease (i.e., hepatolenticular degeneration). Trial and failure, contraindication, or intolerance to a penicillamine product (e.g., Depen, Cuprimine)
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy

## TABRECTA (S)

---

### Products Affected

- Tabrecta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of non-small cell lung cancer (NSCLC). Disease is metastatic. Presence of mesenchymal-epithelial transition (MET) exon 14 skipping positive tumors as detected with an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.



## TADLIQ (S)

---

### Products Affected

- Tadliq

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH: Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

# TAFAMIDIS (S)

## Products Affected

- Vyndamax

- Vyndaqel

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM) (initial): Diagnosis of transthyretin-mediated amyloidosis with cardiomyopathy (ATTR-CM). One of the following: 1) Patient has a transthyretin (TTR) mutation (e.g., V122I), 2) Cardiac or noncardiac tissue biopsy demonstrating histologic confirmation of TTR amyloid deposits, OR 3) All of the following: i) echocardiogram or cardiac magnetic resonance imaging suggestive of amyloidosis, ii) scintigraphy scan suggestive of cardiac TTR amyloidosis, and iii) absence of light-chain amyloidosis. One of the following: 1) History of heart failure (HF), with at least one prior hospitalization for HF, OR 2) Presence of clinical signs and symptoms of HF (e.g., dyspnea, edema). Patient has New York Heart Association (NYHA) Functional Class I, II, or III heart failure.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	ATTR-CM (initial, reauth): Prescribed by or in consultation with a cardiologist
<b>Coverage Duration</b>	ATTR-CM (initial, reauth): 12 months
<b>Other Criteria</b>	ATTR-CM (reauth): Patient demonstrates positive clinical response to therapy. Patient continues to have New York Heart Association (NYHA) Functional Class I, II, or III heart failure.

# TAFINLAR (S)

## Products Affected

- Tafinlar

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Melanoma: Diagnosis of unresectable or metastatic melanoma AND cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) OR both of the following: cancer is BRAF V600E or V600K mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) and medication is used in combination with Mekinist (trametinib). Adjuvant Treatment for Melanoma: Diagnosis of melanoma. Cancer is BRAF V600E or V600K mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Involvement of lymph nodes following complete resection. Used as adjunctive therapy. Medication is used in combination with Mekinist (trametinib). Non-small Cell Lung Cancer (NSCLC): Diagnosis of metastatic non-small cell lung cancer AND cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) AND medication is used in combination with Mekinist (trametinib). Anaplastic Thyroid Cancer (ATC): Diagnosis of locally advanced or metastatic anaplastic thyroid cancer. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Cancer may not be treated with standard locoregional treatment options. Medication is used in combination with Mekinist (trametinib) .</p>
Age Restrictions	N/A
Prescriber Restrictions	N/A

<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	<p>Approve for continuation of prior therapy. Solid tumors: Diagnosis of solid tumors. Disease is unresectable or metastatic. Patient has progressed on or following prior treatment and have no satisfactory alternative treatment options. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Mekinist (trametinib). Low-grade Glioma: Diagnosis of low-grade glioma. Patient requires systemic therapy. Cancer is BRAF V600E mutant type as detected by an FDA-approved test (THxID-BRAF Kit) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Medication is used in combination with Mekinist (trametinib).</p>

# TAGRISO (S)

## Products Affected

- Tagrisso

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Non-small cell lung cancer (NSCLC): One of the following: A) All of the following: Diagnosis of metastatic NSCLC. One of the following: 1) Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA), OR 2) Both of the following: a) Patient has known active EGFR T790M mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) and b) Patient has experienced disease progression on or after one of the following EGFR Tyrosine Kinase Inhibitors (TKIs): Gilotrif (afatinib), Iressa (gefitinib), Tarceva (erlotinib), or Vizimpro (dacomitinib). OR B) All of the following: Diagnosis of NSCLC. Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Both of the following: 1) Patient is receiving as adjuvant therapy, and 2) Patient has had a complete surgical resection of the primary NSCLC tumor. OR C) All of the following: Diagnosis of NSCLC. Disease is locally advanced. Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R mutations as detected by an U.S. FDA-approved test or a test performed at a facility approved by CLIA. Used in combination with both of the following: a) Pemetrexed, and b) Platinum-based chemotherapy (e.g., cisplatin, carboplatin).</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A

<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# TAKHZYRO (S)

## Products Affected

- Takhzyro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prophylaxis of hereditary angioedema (HAE) attacks: Diagnosis of HAE. Diagnosis has been confirmed by C1 inhibitor (C1-INh) deficiency or dysfunction (Type I or II HAE) as documented by one of the following: a) C1-INH antigenic level below the lower limit of normal OR b) C1-INH functional level below the lower limit of normal. For prophylaxis against HAE attacks. Not used in combination with other approved treatments for prophylaxis against HAE attacks.
<b>Age Restrictions</b>	HAE (prophylaxis): Patient is 2 years of age or older
<b>Prescriber Restrictions</b>	HAE (prophylaxis): Prescribed by or in consultation with an immunologist or an allergist
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

# TALTZ (S)

## Products Affected

- Taltz

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure, contraindication (eg, safety concerns, not indicated for patient's age/weight), or intolerance to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Otezla (apremilast), Skyrizi (risankizumab), Sotyktu (deucravacitinib), Stelara (ustekinumab), OR for continuation of prior therapy. Psoriatic Arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Cosentyx, Enbrel, one formulary adalimumab product, Orencia (abatacept), Otezla, Skyrizi, Stelara, Rinvoq (upadacitinib), or Xeljanz/XR (tofacitinib/ER), OR for continuation of prior therapy. Ankylosing spondylitis (AS) (initial): Diagnosis of active AS. One of the following: a) TF/C/I to two of the following: Cosentyx, Enbrel, one formulary adalimumab product, Rinvoq, or Xeljanz/XR, OR b) for continuation of prior therapy. Non-radiographic axial spondyloarthritis (nr-axSpA, initial): Dx of active nr-axSpA with objective signs of inflammation (eg, C-reactive protein [CRP] levels above the upper limit of normal and/or sacroiliitis on magnetic resonance imaging [MRI], indicative of inflammatory disease, but without definitive radiographic evidence of structural damage on sacroiliac joints.) One of the following: a) Trial and failure, contraindication, or intolerance to Cosentyx and Rinvoq, OR b) for continuation of prior therapy.</p>
<b>Age Restrictions</b>	N/A



<b>Prescriber Restrictions</b>	Plaque Psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. AS, nr-axSpA (initial): Prescribed by or in consultation with a rheumatologist.
<b>Coverage Duration</b>	Initial: 6 months, reauth: 12 months
<b>Other Criteria</b>	PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS, nr-axSpA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy.

## TALZENNA (S)

---

### Products Affected

- Talzenna

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Breast cancer: Diagnosis of breast cancer. Prostate cancer: Diagnosis of metastatic castration-resistant prostate cancer (mCRPC). Disease is homologous recombination repair (HRR) gene-mutated. Taken in combination with Xtandi (enzalutamide).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# TARCEVA (S)

## Products Affected

- Erlotinib Hydrochloride TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): Diagnosis of locally advanced or metastatic (Stage III or IV) NSCLC AND Patient has known active epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 (L858R) substitution mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Pancreatic Cancer: Diagnosis of locally advanced, unresectable, or metastatic pancreatic cancer AND erlotinib will be used in combination with gemcitabine.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	All uses: 12 months
<b>Other Criteria</b>	All Indications: Approve for continuation of prior therapy.

# TARGRETIN (S)

---

## Products Affected

- Bexarotene

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cutaneous T-Cell Lymphoma (CTCL): Diagnosis of CTCL. Trial and failure, contraindication, or intolerance to at least one prior therapy (including skin-directed therapies [eg, corticosteroids {ie, clobetasol, diflorasone, halobetasol, augmented betamethasone dipropionate}] or systemic therapies [eg, brentuximab vedotin, methotrexate]).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# TARPEYO (S)

## Products Affected

- Tarpeyo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of primary immunoglobulin A nephropathy (IgAN). Patient is at risk for disease progression. Used to reduce the loss of kidney function. Estimated glomerular filtration rate (eGFR) greater than or equal to 35 mL/min/1.73 m <sup>2</sup> . One of the following: 1) Patient has been on a minimum 90-day trial of a maximally tolerated dose and will continue to receive therapy with one of the following: a) an angiotensin-converting enzyme (ACE) inhibitor (e.g., benazepril, lisinopril), or b) an angiotensin II receptor blocker (ARB) (e.g., losartan, valsartan), OR 2) Patient has a contraindication or intolerance to both ACE inhibitors and ARBs. Trial and failure, contraindication, or intolerance to another glucocorticoid (e.g., methylprednisolone, prednisone).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a nephrologist.
<b>Coverage Duration</b>	9 months.
<b>Other Criteria</b>	N/A

# TASCENSO (S)

## Products Affected

- Tascenso Odt

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
<b>Required Medical Information</b>	MS (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Trial and failure (of a minimum 4-week supply), contraindication (e.g., safety concerns, not indicated for patient's age/weight), or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy.
<b>Age Restrictions</b>	MS (initial): Patient is 10 years of age or older.
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	MS (initial, reauth): 12 months
<b>Other Criteria</b>	MS (reauth): Documentation of positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).

# TASIGNA (S)

---

## Products Affected

- Tasigna

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic myelogenous leukemia (CML): Diagnosis of Ph+/BCR ABL CML
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# TAVALISSE (S)

## Products Affected

- Tavalisse

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic Idiopathic Thrombocytopenic Purpura (ITP) (initial): Diagnosis of chronic immune ITP or relapsed/refractory ITP. Baseline platelet count is less than 30,000/mcL. Trial and failure, contraindication, or intolerance to one of the following: corticosteroids (e.g., dexamethasone, prednisone), immune globulins (e.g., Gammaplex, Gammagard S/D), or splenectomy. Patient's degree of thrombocytopenia and clinical condition increase the risk of bleeding.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	ITP (initial): Prescribed by or in consultation with a hematologist/oncologist.
<b>Coverage Duration</b>	ITP (initial, reauth): 12 months
<b>Other Criteria</b>	ITP (reauth): Patient demonstrates positive clinical response to therapy as evidenced by an increase in platelet count to a level sufficient to avoid clinically important bleeding.



# TAVNEOS (S)

## Products Affected

- Tavneos

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of one of the following types of severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis: a) Granulomatosis with polyangiitis (GPA) OR b) Microscopic polyangiitis (MPA). Diagnosis is confirmed by one of the following: a) ANCA test positive for proteinase 3 (PR3) antigen, b) ANCA test positive for myeloperoxidase (MPO) antigen, OR c) Tissue biopsy. Patient is receiving concurrent immunosuppressant therapy with one of the following: a) cyclophosphamide OR b) rituximab. One of the following: a) Patient is concurrently on glucocorticoids (e.g., prednisone) OR b) History of contraindication or intolerance to glucocorticoids (e.g., prednisone).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a nephrologist, pulmonologist, or rheumatologist
<b>Coverage Duration</b>	Initial, Reauth: 12 months
<b>Other Criteria</b>	Reauth: Patient does not show evidence of progressive disease while on therapy. Patient is receiving concurrent immunosuppressant therapy (e.g., azathioprine, cyclophosphamide, methotrexate, rituximab).

## TAZVERIK (S)

---

### Products Affected

- Tazverik

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Epithelioid sarcoma: Diagnosis of epithelioid sarcoma. Disease is one of the following: metastatic or locally advanced. Patient is not eligible for complete resection. Follicular lymphoma: Diagnosis of follicular lymphoma. Disease is one of the following: relapsed or refractory.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## TECFIDERA (S)

### Products Affected

- Dimethyl Fumarate CPDR
- Dimethyl Fumarate Starterpack CDPK 0

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
<b>Required Medical Information</b>	MS (initial): Diagnosis of a relapsing form of MS (eg, clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	MS (initial, reauth): 12 months
<b>Other Criteria</b>	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).

# TEGSEDI (S)

## Products Affected

- Tegsedi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) (initial): Diagnosis of hATTR amyloidosis with polyneuropathy. Patient has a transthyretin (TTR) mutation (e.g., V30M). One of the following: 1) Patient has a baseline polyneuropathy disability (PND) score less than or equal to IIIb, 2) Patient has baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2, OR 3) Patient has a baseline neuropathy impairment score (NIS) between 10 and 130. Presence of clinical signs and symptoms of the disease (e.g., peripheral/autonomic neuropathy).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	hATTR amyloidosis (initial): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	hATTR amyloidosis (initial, reauth): 12 months
<b>Other Criteria</b>	hATTR amyloidosis (reauth): Patient demonstrates positive clinical response to therapy.

## TEPMETKO (S)

---

### Products Affected

- Tepmetko

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is metastatic. Presence of mesenchymal-epithelial transition (MET) exon 14 skipping alterations.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## TERIPARATIDE (S)

### Products Affected

- Forteo INJ 600MCG/2.4ML

- Teriparatide INJ 620MCG/2.48ML

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Postmenopausal osteoporosis or osteopenia or men with primary or hypogonadal osteoporosis or osteopenia (initial): Diagnosis of one of the following: a) postmenopausal osteoporosis or osteopenia or b) primary or hypogonadal osteoporosis or osteopenia. One of the following: Set I) Both of the following: A) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) trial and failure, contraindication, or intolerance (TF/C/I) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]), or Set II) Both of the following: A) BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) both of the following: i) TF/C/I to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) and ii) One of the following FRAX 10-year probabilities: a) Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions. Glucocorticoid-Induced Osteoporosis: See Other Criteria section.
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	All uses (initial): 24 months. All uses (reauth): 12 months.

---

**Other Criteria**

Glucocorticoid-Induced Osteoporosis (initial): Diagnosis of glucocorticoid-induced osteoporosis. History of prednisone or its equivalent at a dose greater than or equal to 5mg/day for greater than or equal to 3 months. One of the following: 1) BMD T-score less than or equal to -2.5 based on BMD measurements from lumbar spine, femoral neck, total hip, or radius (one-third radius site), or 2) One of the following FRAX 10-year probabilities: a) Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions, 3) History of one of the following fractures resulting from minimal trauma: vertebral compression fx, fx of the hip, fx of the distal radius, fx of the pelvis, or fx of the proximal humerus, or 4) One of the following: a) glucocorticoid dosing of at least 30 mg per day, or b) cumulative glucocorticoid dosing of at least 5 grams per year. TF/C/I to one bisphosphonate (e.g., alendronate). All uses (initial, reauth): One of the following: 1) Treatment duration of parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)] has not exceeded a total of 24 months during the patient's lifetime, or 2) Patient remains at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)].

---

# TESTOSTERONE (S)

## Products Affected

- Androgel Pump GEL 1.62%
- Depo-testosterone INJ 100MG/ML, 200MG/ML
- Testim
- Testosterone GEL 10MG/ACT, 20.25MG/1.25GM, 25MG/2.5GM, 40.5MG/2.5GM, 50MG/5GM
- Testosterone SOLN
- Testosterone Cypionate INJ 100MG/ML, 200MG/ML
- Testosterone Pump

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
Age Restrictions	Testosterone cypionate only: HG (init): 12 years of age or older. All other testosterone: HG (init): Patient is 18 years of age or older.
Prescriber Restrictions	N/A



<b>Coverage Duration</b>	HG(init): (New to T tx:6 mo. New to plan and cont T tx:12 mo), (reauth): 12 mo. GD: 12 mo.
<b>Other Criteria</b>	HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.

# TESTOSTERONE ENANTHATE (S)

## Products Affected

- Testosterone Enanthate INJ

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Hypogonadism (HG) (Initial): Diagnosis (dx) of HG AND male patient at birth AND one of the following: 1) Two pre-treatment serum total testosterone (T) levels less than 300 ng/dL (10.4 nmol/L) or less than the reference range for the lab, OR 2) Both of the following: a) Has a condition that may cause altered sex-hormone binding globulin (SHBG) (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and b) one pre-treatment calculated free or bioavailable T level less than 5 ng/dL (0.17 nmol/L) or less than reference range for the lab, OR 3) History of bilateral orchiectomy, panhypopituitarism, or a genetic disorder known to cause HG (eg, congenital anorchia, Klinefelter's syndrome), OR 4) Both of the following: a) Patient is continuing testosterone therapy, and b) One of the following: i) Follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is within or below the normal limits of the reporting lab, or ii) follow-up total serum T level or calculated free or bioavailable T level drawn within the past 12 months is outside of upper limits of normal for the reporting lab and the dose is adjusted. Delayed puberty (DP): Dx of DP AND male patient at birth. Breast cancer (BC): Dx of inoperable BC AND used for palliative treatment AND female patient at birth. Gender Dysphoria (GD)/Gender Incongruence (off-label): Dx of GD/Gender Incongruence. Using hormones to change characteristics to align with gender expression.
<b>Age Restrictions</b>	HG (init): Patient is 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	HG(init): (New to T tx:6 mo. Cont T tx:12 mo), (reauth): 12 mo. BC, GD: 12 mo. DP: 6 mo.

<b>Other Criteria</b>	HG (Reauth): 1) Follow-up total serum T level within or below the normal limits of the reporting lab, or 2) Follow-up total serum T level outside of upper limits of normal for the reporting lab and the dose is adjusted, OR 3) Has a condition that may cause altered SHBG (eg, thyroid disorder, HIV disease, liver disorder, diabetes, obesity), and one of the following: Follow-up calculated free or bioavailable T level within or below the normal limits of the reporting lab, or follow-up calculated free or bioavailable T level outside of upper limits of normal for the reporting lab and the dose is adjusted.
-----------------------	--

## THALOMID (S)

---

### Products Affected

- Thalomid

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Multiple myeloma (MM): Diagnosis of MM. Used in combination with dexamethasone, unless the patient has an intolerance to steroids. Erythema nodosum leprosum (ENL): Diagnosis of moderate to severe ENL with cutaneous manifestations. Thalomid is not used as monotherapy if moderate to severe neuritis is present.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# TIBSOVO (S)

## Products Affected

- Tibsovo

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Relapsed or refractory Acute Myeloid Leukemia (AML): Diagnosis of AML. Disease is relapsed or refractory. Newly-Diagnosed AML: Diagnosis of newly-diagnosed AML. One of the following: 1) patient is greater than or equal to 75 years old OR 2) patient has comorbidities that preclude use of intensive induction chemotherapy. Locally Advanced or Metastatic Cholangiocarcinoma: Diagnosis of cholangiocarcinoma. Disease is locally advanced or metastatic. Patient has been previously treated. Relapsed or Refractory Myelodysplastic Syndromes: Diagnosis of myelodysplastic syndromes (MDS). Disease is relapsed or refractory. All indications: Patient has an isocitrate dehydrogenase-1 (IDH1) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., Abbott RealTime IDH1 assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# TIGLUTIK (S)

---

## Products Affected

- Teglutik

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Amyotrophic Lateral Sclerosis (ALS): Diagnosis of ALS. Trial and failure or intolerance to generic riluzole tablets.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## TOPICAL RETINOID (S)

---

### Products Affected

- Atralin
- Retin-a CREA
- Retin-a GEL
- Retin-a Micro
- Retin-a Micro Pump GEL 0.08%
- Tretinoin CREA
- Tretinoin GEL
- Tretinoin Microsphere

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Acne vulgaris: Diagnosis of acne vulgaris (i.e., acne).
Age Restrictions	PA applies to members 26 years of age or older
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	N/A

## TRACLEER (S)

---

### Products Affected

- Bosentan

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH AND PAH is symptomatic AND One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH (Initial): 6 months. PAH (Reauth): 12 months
<b>Other Criteria</b>	PAH (Reauth): Patient demonstrates positive clinical response to therapy.



## TRELSTAR (S)

---

### Products Affected

- Trelstar Mixject

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prostate Cancer: Diagnosis of advanced or metastatic prostate cancer. Trial and failure, contraindication, or intolerance to any brand Lupron formulation.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# TREMFYA (S)

## Products Affected

- Tremfya

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Plaque psoriasis (Initial): Diagnosis of moderate to severe plaque psoriasis. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Trial and failure, contraindication, or intolerance (TF/C/I) to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Otezla (apremilast), Skyrizi (risankizumab), Sotyktu (deucravacitinib), Stelara (ustekinumab), OR for continuation of prior therapy. Psoriatic Arthritis (PsA) (initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Either TF/C/I to two of the following: Cosentyx (secukinumab), Enbrel (etanercept), one formulary adalimumab product, Orencia (abatacept), Otezla (apremilast), Skyrizi (risankizumab), Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz/XR (tofacitinib/ER), OR for continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Plaque psoriasis (initial): Prescribed by or in consultation with a dermatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist.
<b>Coverage Duration</b>	All Indications (Initial): 6 months, (reauth): 12 months
<b>Other Criteria</b>	Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline.

## TRIKAFTA (S)

### Products Affected

- Trikafta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cystic Fibrosis (CF) (initial): Diagnosis of CF. Patient has at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator (CFTR) gene as detected by an FDA-cleared cystic fibrosis mutation test or a test performed at a Clinical Laboratory Improvement Amendments (CLIA)-approved facility: F508del mutation OR a mutation in the CFTR gene that is responsive based on in vitro data.
<b>Age Restrictions</b>	CF (initial): For granule packets: patient is at least 2 to less than 6 years of age. For tablets: patient is 6 years of age or older.
<b>Prescriber Restrictions</b>	CF (initial): Prescribed by or in consultation with a pulmonologist or specialist affiliated with a CF care center.
<b>Coverage Duration</b>	CF (initial, reauth): 12 months
<b>Other Criteria</b>	CF (reauth): Patient demonstrates positive clinical response to therapy (e.g., improvement in lung function [percent predicted forced expiratory volume in one second {PPFEV1}] or decreased number of pulmonary exacerbations).

## TRUDHESA (S)

---

### Products Affected

- Trudhesa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of migraine headaches with or without aura. Will be used for the acute treatment of migraine. One of the following: Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or contraindication to all triptans.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a neurologist, headache specialist, or pain specialist.
<b>Coverage Duration</b>	Initial: 3 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea).

# TRUQAP (S)

## Products Affected

- Truqap

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of breast cancer. Disease is one of the following: locally advanced or metastatic. Will be taken in combination with fulvestrant. Disease is hormone receptor (HR)-positive. Disease is human epidermal growth factor receptor 2 (HER2)-negative. Patient has one or more PIK3CA/AKT1/PTEN-alterations as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). One of the following: A) Following progression on at least one endocrine-based regimen in the metastatic setting (e.g., anastrozole, letrozole, exemestane, tamoxifen, etc.) OR B) Recurrence on or within 12 months of completing adjuvant therapy (e.g., chemotherapy).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# TUKYSA (S)

---

## Products Affected

- Tukysa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Breast cancer: Diagnosis of breast cancer. Disease is one of the following: a) advanced unresectable or b) metastatic. Disease is human epidermal growth factor receptor 2 (HER2)-positive. Used in combination with trastuzumab and capecitabine. Patient has received one or more prior anti-HER2 based regimens (e.g., trastuzumab, pertuzumab, ado-trastuzumab emtansine).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## TURALIO (S)

---

### Products Affected

- Turalio CAPS 125MG

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Tenosynovial Giant Cell Tumor (TGCT): Diagnosis of TGCT. Patient is symptomatic. Patient is not a candidate for surgery due to worsening functional limitation or severe morbidity with surgical removal.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# TYKERB (S)

## Products Affected

- Lapatinib Ditosylate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Breast Cancer: Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive metastatic or recurrent breast cancer. Used in combination with one of the following: Trastuzumab, Xeloda (capecitabine), or aromatase inhibitors [eg, Aromasin (exemestane), Femara (letrozole), Arimidex (anastrozole)].
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.



# TYMLOS (S)

## Products Affected

- Tymlos

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>One of the following diagnoses: 1) postmenopausal osteoporosis or osteopenia, OR 2) primary or hypogonadal osteoporosis or osteopenia. One of the following: Set I) For diagnosis of osteoporosis, both of the following: A) Bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) trial and failure, contraindication, or intolerance (TF/C/I) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]), or Set II) For diagnosis of osteopenia, both of the following: A) BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) AND B) One of the following: 1) history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm, or 2) both of the following: i) TF/C/I to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab]) and ii) one of the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities: a) major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions, or b) hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions. Treatment duration of parathyroid hormones (e.g., teriparatide, Tymlos [abaloparatide]) has not exceeded a total of 24 months during the patient's lifetime.</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	24 months (max 24 months of therapy per lifetime)

<b>Other Criteria</b>	N/A
-----------------------	-----

# TYVASO DPI (S)

## Products Affected

- Tyvaso Dpi Maintenance Kit
- Tyvaso Dpi Titration Kit

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH. Pulmonary Hypertension associated with Interstitial Lung Disease (PH-ILD) (Initial): Diagnosis of PH-ILD. Diagnosis of PH-ILD was confirmed by diagnostic test(s) (e.g., right heart catheterization, doppler echocardiogram, computerized tomography imaging).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH, PH-ILD (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH, PH-ILD: Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	PAH, PH-ILD (Reauth): Patient demonstrates positive clinical response to therapy.

## UBRELVY (S)

---

### Products Affected

- Ubrelyvy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of migraine with or without aura. Will be used for the acute treatment of migraine. Trial and failure or intolerance to one triptan (e.g., eletriptan, rizatriptan, sumatriptan) or a contraindication to all triptans. Medication will not be used in combination with another oral CGRP inhibitor for the acute treatment of migraines.
<b>Age Restrictions</b>	Initial: 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial: 3 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient has experienced a positive response to therapy (e.g., reduction in pain, photophobia, phonophobia, nausea). Will not be used for preventive treatment of migraine. Medication will not be used in combination with another oral CGRP inhibitor for the acute treatment of migraines.

## UDENYCA (S)

### Products Affected

- Udenyca

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute’s Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Treatment of FN (off-label): Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications. Acute radiation syndrome (ARS) (off-label): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS).</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses: Prescribed by or in consultation with a hematologist/oncologist
<b>Coverage Duration</b>	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
<b>Other Criteria</b>	N/A

## UPTRAVI (S)

### Products Affected

- Uptravi TABS

- Uptravi Titration Pack

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization OR B) Patient is currently on any therapy for the diagnosis of PAH. One of the following: A) Trial and failure, contraindication, or intolerance to a PDE5 inhibitor [i.e., Adcirca (tadalafil), Revatio (sildenafil)] or Adempas (riociguat), and trial and failure, contraindication, or intolerance to an endothelin receptor antagonist [e.g., Letairis (ambrisentan), Opsumit (macitentan), or Tracleer (bosentan)] OR B) For continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months
<b>Other Criteria</b>	PAH (Reauth): Patient demonstrates positive clinical response to therapy.

## VALCHLOR (S)

---

### Products Affected

- Valchlor

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Mycosis fungoides-type cutaneous T-cell lymphoma (MF-CTCL) (initial): All of the following: 1) diagnosis of Stage IA MF-CTCL, OR diagnosis of Stage IB MF-CTCL, AND 2) patient has received at least one prior skin-directed therapy (e.g., topical corticosteroids [e.g., clobetasol, fluocinonide], bexarotene topical gel [Targretin topical gel], etc.).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## VANFLYTA (S)

---

### Products Affected

- Vanflyta

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acute Myeloid Leukemia (AML): Diagnosis of AML. Patient has a FMS-like tyrosine kinase 3 (FLT3) internal tandem duplication (FLT3-ITD) mutation as detected by a U.S. Food and Drug Administration (FDA)-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Both of the following: a) Used in combination with standard cytarabine and anthracycline (e.g., daunorubicin, idarubicin) induction and cytarabine consolidation, and b) Used as maintenance monotherapy following consolidation chemotherapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.



## VELSIPITY (S)

### Products Affected

- Velsipity

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Ulcerative Colitis (UC) (initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: a) Trial and failure, contraindication, or intolerance to two of the following: one formulary adalimumab product, Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz/Xeljanz XR (tofacitinib/ER), OR b) for continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	UC (initial): Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	UC (initial): 6 months, (reauth): 12 months.
<b>Other Criteria</b>	UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.

## VENCLEXTA (S)

---

### Products Affected

- Venclexta

- Venclexta Starting Pack

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic lymphocytic leukemia (CLL)/Small lymphocytic lymphoma (SLL): Diagnosis of CLL or SLL. Acute Myeloid Leukemia (AML): Diagnosis of newly diagnosed AML. Used in combination with azacitidine, or decitabine, or low-dose cytarabine. One of the following: 1) age 75 years or older OR 2) comorbidities that preclude use of intensive induction chemotherapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## VENTAVIS (S)

---

### Products Affected

- Ventavis

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Pulmonary arterial hypertension (PAH) (Initial): Diagnosis of PAH. PAH is symptomatic. One of the following: A) Diagnosis of PAH was confirmed by right heart catheterization or B) Patient is currently on any therapy for the diagnosis of PAH.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	PAH (initial): Prescribed by or in consultation with a pulmonologist or cardiologist.
<b>Coverage Duration</b>	PAH (Initial): 6 months. (Reauth): 12 months
<b>Other Criteria</b>	Subject to Part B vs D review. PAH (Reauth): Patient demonstrates positive clinical response to therapy.

## VEOZAH (S)

---

### Products Affected

- Veozah

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of moderate to severe vasomotor symptoms due to menopause.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial, Reauth: 6 months
<b>Other Criteria</b>	Reauth: Documentation of positive clinical response to therapy.

## VERKAZIA (S)

### Products Affected

- Verkazia

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of moderate to severe vernal keratoconjunctivitis confirmed by the presence of clinical signs and symptoms (e.g., itching, photophobia, giant papillae at the upper tarsal conjunctiva or at the limbus, thick mucus discharge, conjunctival hyperaemia). Trial and failure, contraindication, or intolerance to ONE of the following: a) Topical ophthalmic “dual-acting” mast cell stabilizer and antihistamine (e.g., olopatadine, azelastine), OR b) Topical ophthalmic mast cell stabilizers (e.g., cromolyn). Trial and failure, contraindication, or intolerance for short-term use (for up to 2 to 3 weeks) of topical ophthalmic corticosteroids (e.g., dexamethasone, prednisolone, fluoromethalone).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with an ophthalmologist or optometrist.
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy (e.g., improvement in clinical signs and symptoms of itching, photophobia, papillary hypertrophy, mucus discharge, conjunctival hyperaemia).

## VERQUVO (S)

### Products Affected

- Verquvo

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic Heart Failure (CHF) (initial): Diagnosis of CHF. Patient has an ejection fraction less than 45 percent. Patient has New York Heart Association (NYHA) Class II, III, or IV symptoms. One of the following: A) Patient was hospitalized for heart failure within the last 6 months, or B) Patient used outpatient intravenous diuretics (e.g., bumetanide, furosemide) for heart failure within the last 3 months. Trial and failure, contraindication, or intolerance to two of the following at a maximally tolerated dose: A) One of the following: 1) Angiotensin converting enzyme (ACE) inhibitor (e.g., captopril, enalapril), 2) Angiotensin II receptor blocker (ARB) (e.g., candesartan, valsartan), or 3) Angiotensin receptor-neprilysin inhibitor (ARNI) [e.g., Entresto (sacubitril and valsartan)], B) One of the following: 1) bisoprolol, 2) carvedilol, or 3) metoprolol succinate extended release, C) Sodium-glucose co-transporter 2 (SGLT2) inhibitor [e.g., Jardiance (empagliflozin), Farxiga (dapagliflozin), Xigduo XR (dapagliflozin and metformin)], or D) Mineralocorticoid receptor antagonist (MRA) [e.g., eplerenone, spironolactone].
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	CHF (initial): Prescribed by or in consultation with a cardiologist.
<b>Coverage Duration</b>	CHF (initial, reauth): 12 months
<b>Other Criteria</b>	CHF (reauth): Patient demonstrates positive clinical response to therapy.

## VERZENIO (S)

---

### Products Affected

- Verzenio

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Breast Cancer: Diagnosis of breast cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## VEVYE (S)

---

### Products Affected

- Vevye

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of dry eye disease. Trial and failure, contraindication, or intolerance to one of the following: a) Restasis (cyclosporine 0.05%), b) Xiidra (lifitegrast), or c) Tyrvaya (varenicline solution).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Initial, Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.



## VIBERZI (S)

---

### Products Affected

- Viberzi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Irritable bowel syndrome with diarrhea (IBS-D) (initial): Diagnosis of IBS-D. Trial and failure, contraindication, or intolerance to an antidiarrheal agent [eg, loperamide].
<b>Age Restrictions</b>	IBS-D (initial): 18 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	IBS-D (initial): 12 mo. IBS-D (reauth): 12 mo.
<b>Other Criteria</b>	IBS-D (reauth): Symptoms of IBS-D continue to persist. Patient demonstrates positive clinical response to therapy.

## VIJOICE (S)

### Products Affected

- Vijoice TBPK

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of PIK3CA-related overgrowth spectrum (PROS). Patient demonstrates mutation in the PIK3CA gene. Patient demonstrates severe clinical manifestations (e.g., congenital lipomatous overgrowth, vascular malformations, epidermal nevi, scoliosis/skeletal and spinal [CLOVES], facial infiltrating lipomatosis [FIL], klippel-trenaunay syndrome [KTS], megalencephaly-capillary malformation polymicrogyria [MCAP]).
<b>Age Restrictions</b>	Initial: Patient is 2 years of age or older.
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a physician who specializes in the treatment of PROS.
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

## VITRAKVI (S)

### Products Affected

- Vitrakvi

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Presence of solid tumors (e.g., salivary gland, soft tissue sarcoma, infantile fibrosarcoma, thyroid cancer, lung, melanoma, colon, etc.). Disease is positive for neurotrophic receptor tyrosine kinase (NTRK) gene fusion (e.g. ETV6-NTRK3, TPM3-NTRK1, LMNA-NTRK1, etc.). Disease is without a known acquired resistance mutation [e.g., TRKA G595R substitution, TRKA G667C substitution, or other recurrent kinase domain (solvent front and xDFG) mutations]. Disease is one of the following: metastatic or unresectable (including cases where surgical resection is likely to result in severe morbidity). One of the following: Disease has progressed on previous treatment (e.g., surgery, radiotherapy, or systemic therapy) OR Disease has no satisfactory alternative treatments.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## VIZIMPRO (S)

---

### Products Affected

- Vizimpro

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC. Disease is metastatic. Disease is positive for one of the following epidermal growth factor receptor (EGFR) mutations: exon 19 deletion or exon 21 L858R substitution.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## VONJO (S)

---

### Products Affected

- Vonjo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of ONE of the following: a) Primary myelofibrosis, b) Post-polycythemia vera myelofibrosis, OR c) Post-essential thrombocythemia myelofibrosis. Disease is intermediate or high risk. Pre-treatment platelet count below $50 \times 10^9/L$ .
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

# VOQUENZA (S)

## Products Affected

- Voquezna

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Helicobacter pylori (H. pylori) (Voquezna Dual Pak, Voquezna Triple Pak): Diagnosis of H. pylori infection. Trial and failure, contraindication, or intolerance to ONE of the following first line treatment regimens: a) Clarithromycin based therapy (e.g., clarithromycin based triple therapy, clarithromycin based concomitant therapy), or b) Bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI]). H. pylori (Voquezna): Diagnosis of H. pylori infection. One of the following: a) Used in combination with amoxicillin and clarithromycin for the treatment of H. pylori infection, or b) Used in combination with amoxicillin for the treatment of H. pylori infection. Trial and failure, contraindication, or intolerance to ONE of the following first line treatment regimens: a) Clarithromycin based therapy (e.g., clarithromycin based triple therapy, clarithromycin based concomitant therapy), or b) Bismuth quadruple therapy (e.g., bismuth and metronidazole and tetracycline and proton pump inhibitor [PPI]). Healing and Relief of Heartburn associated with Erosive Esophagitis (HRH) (Voquezna): Diagnosis of erosive esophagitis. Used for healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis. Trial and inadequate response, contraindication, or intolerance to TWO of the following generic PPIs: a) omeprazole, b) esomeprazole, c) pantoprazole, d) lansoprazole, e) rabeprazole, or f) dexlansoprazole. Maintenance of Healing and Relief of Heartburn associated with Erosive Esophagitis (MHRH) (Voquezna): Used to maintain healing and relief of heartburn associated with erosive esophagitis. Trial and inadequate response, contraindication, or intolerance to TWO of the following generic PPIs: a) omeprazole, b) esomeprazole, c) pantoprazole, d) lansoprazole, e) rabeprazole, or f) dexlansoprazole.</p>
Age Restrictions	N/A

<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	H. pylori (Voquezna, Dual Pak, Triple Pak): 1 mo. HRH (Voquezna): 8 wks. MHRH (Voquezna): 6 mos.
<b>Other Criteria</b>	N/A

# VORICONAZOLE INJECTION (S)

## Products Affected

- Vfend IV

- Voriconazole INJ

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	Invasive aspergillosis: Diagnosis of invasive aspergillosis (IA). Candidemia: Diagnosis of candidemia. One of the following: (1) patient is non-neutropenic or (2) infection is located in skin, abdomen, kidney, bladder wall, or wounds. Esophageal Candidiasis: Diagnosis of esophageal candidiasis. Mycosis: Diagnosis of fungal infection caused by <i>Scedosporium apiospermum</i> (asexual form of <i>Pseudallescheria boydii</i> ) or <i>Fusarium</i> spp. including <i>Fusarium solani</i> . For fusariosis: Patient is intolerant of, or refractory to, other therapy (e.g., liposomal amphotericin B, amphotericin B lipid complex).
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 weeks
Other Criteria	N/A



## VOSEVI (S)

---

### Products Affected

- Vosevi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: Diagnosis of chronic hepatitis C, patient is without decompensated liver disease (defined as Child-Pugh Class B or C), and not used in combination with another HCV direct acting antiviral agent [e.g., Harvoni, Zepatier].
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
<b>Coverage Duration</b>	12 to 24 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
<b>Other Criteria</b>	N/A

## VOTRIENT (S)

---

### Products Affected

- Pazopanib Hydrochloride
- Votrient

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Renal cell carcinoma (RCC): Diagnosis of advanced/metastatic RCC. Soft tissue sarcoma: Diagnosis of advanced soft tissue sarcoma.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## VOWST (S)

### Products Affected

- Vowst

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of recurrent clostridioides difficile infection (CDI) as defined by both of the following: 1) Presence of diarrhea defined as a passage of 3 or more loose bowel movements within a 24-hour period for two consecutive days, and 2) A positive stool test for C.difficile toxin or toxigenic C.difficile. Patient has a history of two or more recurrent episodes of CDI within 12 months. All of the following: 1) Patient has completed at least 10 consecutive days of one of the following antibiotic therapies 2-4 days prior to initiating Vowst: oral vancomycin or Difucid (fidaxomicin), 2) Patient has completed the recommended course of magnesium citrate the day before and at least 8 hours prior to initiating Vowst, and 3) Previous episode of CDI is under control (e.g., less than 3 unformed/loose [i.e., Bristol Stool Scale type 6-7] stools/day for 2 consecutive days).
<b>Age Restrictions</b>	Patient is 18 years of age or older.
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a gastroenterologist or infectious disease specialist.
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	N/A

# VOXZOGO (S)

## Products Affected

- Voxzogo

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Patient has open epiphyses. Diagnosis of achondroplasia as confirmed by one of the following: 1) Both of the following: a) Patient has clinical manifestations characteristic of achondroplasia (e.g., macrocephaly, frontal bossing, midface retrusion, disproportionate short stature with rhizomelic shortening of the arms and the legs, brachydactyly, trident configuration of the hands, thoracolumbar kyphosis, and accentuated lumbar lordosis) and b) Patient has radiographic findings characteristic of achondroplasia (e.g., large calvaria and narrowing of the foramen magnum region, undertubulated, shortened long bones with metaphyseal abnormalities, narrowing of the interpedicular distance of the caudal spine, square ilia and horizontal acetabula, small sacrosciatic notches, proximal scooping of the femoral metaphyses, and short and narrow chest), OR 2) Molecular genetic testing confirmed c.1138G to A or c.1138G to C variant (i.e., p.Gly380Arg mutation) in the fibroblast growth factor receptor-3 (FGFR3) gene. Patient did not have limb-lengthening surgery in the previous 18 months and does not plan on having limb-lengthening surgery while on Voxzogo therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with a clinical geneticist, endocrinologist, or a physician who has specialized expertise in the management of achondroplasia.
<b>Coverage Duration</b>	Initial, Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient continues to have open epiphyses. Patient demonstrates positive clinical response to therapy as evidenced by one of the following: 1) Improvement in annualized growth velocity (AGV) compared to baseline, OR 2) Improvement in height Z-score compared to baseline.



## VTAMA (S)

### Products Affected

- Vtama

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Plaque psoriasis (Initial): Diagnosis of plaque psoriasis. One of the following: a) Minimum duration of a 4-week trial and failure, contraindication, or intolerance (TF/C/I) to two of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, OR coal tar, or b) minimum duration of a 4-week TF/C/I to one of the following topical combination therapies: vitamin D analog/corticosteroid (eg, Enstilar, Taclonex) or Duobrii (halobetasol/tazarotene).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	Initial: 6 months, Reauth: 12 months
<b>Other Criteria</b>	Plaque psoriasis (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline.

## VUITY (S)

---

### Products Affected

- Vuity

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of presbyopia.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial, Reauth: Prescribed by or in consultation with an ophthalmologist or optometrist.
<b>Coverage Duration</b>	Initial: 3 months. Reauth: 6 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy (e.g., improvement in near vision in low light conditions without loss of distance vision).

## VUMERITY (S)

### Products Affected

- Vumerity

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	Multiple Sclerosis (MS) (initial, reauth): Not used in combination with another disease-modifying therapy for MS.
<b>Required Medical Information</b>	MS (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Trial and failure (of a minimum 4-week supply), contraindication, or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist
<b>Coverage Duration</b>	MS (initial, reauth): 12 months
<b>Other Criteria</b>	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression).



# VYVANSE (S)

## Products Affected

- Vyvanse
- Lisdexamfetamine Dimesylate

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	ADHD, ADD: one of the following: a) diagnosis of attention deficit hyperactivity disorder (ADHD), OR b) diagnosis of attention deficit disorder (ADD). Binge eating disorder (BED)(initial): diagnosis of moderate to severe BED as confirmed by all of the following: a) patient has had BED for 3 months or longer, AND b) Patient has between 4 and 13 binge-eating episodes per week, AND c) patient meets at least 3 of the following criteria: i) patient eats much more rapidly than normal, ii) patient eats until feeling uncomfortably full, iii) patient eats large amounts of food when not feeling physically hungry, iv) patient eats alone because of feeling embarrassed by how much he or she is eating, v) patient feels disgusted with himself or herself, depressed, or very guilty after binge eating.
<b>Age Restrictions</b>	PA applies to members 19 years of age or older
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	ADHD, ADD: 12 months, BED (initial): 3 months, (reauthorization): 12 months
<b>Other Criteria</b>	BED (reauth): Patient demonstrates positive clinical response (eg, meaningful reduction in the number of binge eating episodes or binge days per week from baseline, improvement in the signs and symptoms of binge eating disorder).

## WAINUA (S)

### Products Affected

- Wainua

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of hereditary transthyretin-mediated amyloidosis (hATTR amyloidosis) with polyneuropathy. Patient has a transthyretin (TTR) mutation (e.g., V30M). One of the following: 1) Patient has a baseline familial amyloidotic polyneuropathy (FAP) stage of 1 or 2, 2) Patient has a baseline neuropathy impairment score (NIS) greater than or equal to 10 and less than or equal to 130, or 3) Patient has a baseline Karnofsky Performance Status score greater than 50%. Presence of clinical signs and symptoms of the disease (e.g., neuropathy, quality of life).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial, Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy. One of the following: 1) Patient continues to have a familial amyloidotic polyneuropathy (FAP) stage of 1 or 2, 2) Patient continues to have a neuropathy impairment score (NIS) greater than or equal to 10 and less than or equal to 130, or 3) Patient continues to have a Karnofsky Performance Status score greater than 50%.

## WAKIX (S)

### Products Affected

- Wakix

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Narcolepsy with cataplexy (Narcolepsy Type 1) (initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible). Symptoms of cataplexy are present. Symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2) (initial): Diagnosis (Dx) of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible). Symptoms of cataplexy are absent. Symptoms of excessive daytime sleepiness (e.g., irrepressible need to sleep or daytime lapses into sleep) are present. Trial and failure, contraindication or intolerance to both generic modafinil and generic armodafinil.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
<b>Coverage Duration</b>	All uses (initial): 6 months. All uses (reauth): 12 months.
<b>Other Criteria</b>	Narcolepsy with cataplexy (Narcolepsy Type 1) (reauth): Documentation demonstrating a reduction in the frequency of cataplexy attacks associated with therapy, OR documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy. Narcolepsy without cataplexy (Narcolepsy Type 2) (reauth): Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy.

# WEGOVY (S)

## Products Affected

- Wegovy

PA Criteria	Criteria Details
Indications	All FDA-approved Indications.
Off-Label Uses	N/A
Exclusion Criteria	Excluded if used for weight loss only.
Required Medical Information	Initial: Treatment is being requested to reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke). Submission of medical records (e.g., chart notes) documenting that patient has established cardiovascular disease as evidenced by one of the following: A) prior myocardial infarction (MI), B) prior stroke (i.e., ischemic or hemorrhagic stroke), or C) peripheral arterial disease (i.e., intermittent claudication with ankle-brachial index less than 0.85, peripheral arterial revascularization procedure, or amputation due to atherosclerotic disease). Used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise). BMI greater than or equal to 27 kg/m <sup>2</sup> . Medication is not being co-administered with any of the following: A) GLP-1 receptor agonists (e.g., Victoza, Ozempic, Rybelsus, Trulicity) or B) Tirzepatide-containing products (e.g., Mounjaro).
Age Restrictions	Initial: Patient is 18 years of age or older.
Prescriber Restrictions	N/A
Coverage Duration	Initial, Reauth: 12 months.
Other Criteria	Reauth: Patient is currently on a maintenance dose of 1.7mg or 2.4mg once weekly. Used as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise). Medication is not being co-administered with any of the following: A) GLP-1 receptor agonists (e.g., Victoza, Ozempic, Rybelsus, Trulicity) or B) Tirzepatide-containing products (e.g., Mounjaro).

## WELIREG (S)

### Products Affected

- Welireg

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	von Hippel-Lindau (VHL) disease: Diagnosis of VHL disease. Patient requires therapy for one of the following: a) renal cell carcinoma (RCC), b) central nervous system (CNS) hemangioblastoma, or c) pancreatic neuroendocrine tumor (pNET). Patient does not require immediate surgery. Advanced Renal Cell Carcinoma: Diagnosis of advanced renal cell carcinoma. Disease has progressed after treatment with both of the following: a) One of the following: i) Programmed death receptor-1 (PD-1) inhibitor [e.g., Keytruda (pembrolizumab), Opdivo (nivolumab)], or ii) Programmed death-ligand 1 (PD-L1) inhibitor [e.g., Bavencio (avelumab), Imfinzi (durvalumab)], and b) Vascular endothelial growth factor tyrosine kinase inhibitor (VEGF-TKI) [e.g., Votrient (pazopanib), Inlyta (axitinib)].
Age Restrictions	N/A
Prescriber Restrictions	N/A
Coverage Duration	12 months
Other Criteria	Approve for continuation of prior therapy.

## WINLEVI (S)

---

### Products Affected

- Winlevi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Acne (initial): Diagnosis of acne vulgaris (i.e., acne). Trial and inadequate response (of a minimum 30-day supply) within the past 180 days, contraindication, or intolerance to two of the following: i) generic adapalene (cream, gel, lotion), ii) generic topical tretinoin or tretinoin microsphere, iii) generic tazarotene cream, iv) generic single-agent topical clindamycin product, or v) generic dapsone gel.
<b>Age Restrictions</b>	Acne (initial): Patient is 12 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Acne (initial): 6 months. Acne (reauth): 12 months.
<b>Other Criteria</b>	Acne (reauth): Patient demonstrates positive clinical response to therapy.

## XALKORI (S)

### Products Affected

- Xalkori

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): Diagnosis of advanced or metastatic NSCLC AND One of the following: A) Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA) or B) Patient has MET amplification- or ROS1 rearrangement-positive tumor as detected with an FDA-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Anaplastic Large Cell Lymphoma (ALCL): Diagnosis of systemic ALCL. Disease is relapsed or refractory. Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Inflammatory Myofibroblastic Tumor (IMT): Diagnosis of IMT. Disease is one of the following: a) unresectable, b) recurrent, or c) refractory. Patient has an anaplastic lymphoma kinase (ALK)-positive tumor as detected with a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
<b>Age Restrictions</b>	IMT, ALCL: Patient is 1 year of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## XCOPRI (S)

---

### Products Affected

- Xcopri

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of partial onset seizures.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.



## XELJANZ (S)

### Products Affected

- Xeljanz

- Xeljanz Xr

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Xeljanz tab/Xeljanz XR tab: Rheumatoid arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Psoriatic arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Ankylosing spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one nonsteroidal anti-inflammatory drug (NSAID) (eg, ibuprofen, naproxen) at maximally tolerated doses. RA, PsA, AS (Initial): Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). Ulcerative colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, aminosalicylate (e.g., mesalamine, olsalazine, sulfasalazine), azathioprine, or corticosteroids (eg, prednisone). Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab). Not used in combination with other Janus kinase (JAK) inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine).</p>
Age Restrictions	N/A
Prescriber Restrictions	RA, PJIA, AS (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. UC (initial): Prescribed by or in consultation with a gastroenterologist.

<b>Coverage Duration</b>	RA/PJIA/PsA/AS (initial): 6 mo, (reauth): 12 months. UC (init): 4 mo. UC (reauth): 12 mo.
<b>Other Criteria</b>	<p>Xeljanz: Polyarticular course juvenile idiopathic arthritis (PJIA) (Initial): Diagnosis of active polyarticular course juvenile idiopathic arthritis. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Patient has had an inadequate response or intolerance to one or more TNF inhibitors (eg, adalimumab, etanercept). RA, PsA, AS, PJIA (Initial): Not used in combination with other JAK inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), or potent immunosuppressants (eg, azathioprine, cyclosporine). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. RA, PsA, AS, PJIA (reauth): Not used in combination with other JAK inhibitors, biologic DMARDs, or potent immunosuppressants (eg, azathioprine, cyclosporine). UC (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state. Not used in combination with other JAK inhibitors, biological therapies for UC, or potent immunosuppressants (e.g., azathioprine, cyclosporine).</p>

## XENAZINE (S)

### Products Affected

- Tetrabenazine

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chorea associated with Huntington's Disease (HD) (Initial): Diagnosis of chorea in patients with Huntington's disease. Tardive dyskinesia (Initial): Diagnosis of tardive dyskinesia. One of the following: 1) Patient has persistent symptoms of tardive dyskinesia despite a trial of dose reduction, tapering, or discontinuation of the offending medication, OR 2) Patient is not a candidate for a trial of dose reduction, tapering, or discontinuation of the offending medication. Tourette's syndrome (Initial): Patient has tics associated with Tourette's syndrome. Trial and failure, contraindication, or intolerance to Haldol (haloperidol).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	HD (Initial): Prescribed by or in consultation with a neurologist. Tardive dyskinesia, Tourette's syndrome (Initial): Prescribed by or in consultation with neurologist or psychiatrist.
<b>Coverage Duration</b>	All uses: (initial) 3 months. (Reauth) 12 months.
<b>Other Criteria</b>	All indications (Reauth): Patient demonstrates positive clinical response to therapy.

## XERMELO (S)

---

### Products Affected

- Xermelo

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Carcinoid syndrome diarrhea (Initial): Diagnosis of carcinoid syndrome diarrhea AND diarrhea is inadequately controlled by a stable dose of somatostatin analog (SSA) therapy (e.g., octreotide [Sandostatin, Sandostatin LAR], lanreotide [Somatuline Depot]) for at least 3 months AND used in combination with SSA therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with an oncologist, endocrinologist, or gastroenterologist
<b>Coverage Duration</b>	Initial: 6 months. Reauth: 12 months
<b>Other Criteria</b>	Carcinoid syndrome diarrhea (Reauthorization): Patient demonstrates positive clinical response to therapy AND drug will continue to be used in combination with SSA therapy.

## XGEVA (S)

### Products Affected

- Xgeva

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Multiple Myeloma (MM)/Bone metastasis from solid tumors (BMST): One of the following: 1) Both of the following: a) Diagnosis of multiple myeloma and b) Trial and failure, contraindication (e.g., renal insufficiency), or intolerance to one bisphosphonate therapy, OR 2) Both of the following: a) Diagnosis of solid tumors (eg, breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer) and b) Documented evidence of one or more metastatic bone lesions. Giant cell tumor of bone (GCTB): Both of the following: 1) Diagnosis of giant cell tumor of bone AND 2) One of the following: a) tumor is unresectable, OR b) surgical resection is likely to result in severe morbidity. Hypercalcemia of malignancy (HCM): Both of the following: 1) Diagnosis of hypercalcemia of malignancy, AND 2) Trial and failure, contraindication, or intolerance to one bisphosphonate therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	MM/BMST, GCTB: 12 mo. HCM: 2 mo.
<b>Other Criteria</b>	GCTB: Approve for continuation of prior therapy.

# XIFAXAN (S)

## Products Affected

- Xifaxan

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Travelers' diarrhea (TD): Diagnosis of travelers' diarrhea. One of the following: a) Trial and failure, contraindication, or intolerance to one of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin) OR b) resistance to all of the following: Cipro (ciprofloxacin), Levaquin (levofloxacin), ofloxacin, Zithromax (azithromycin). Prophylaxis (ppx) of hepatic encephalopathy (HE) recurrence (initial): Used for the prophylaxis of hepatic encephalopathy recurrence, AND One of the following: 1) Trial and failure, contraindication or intolerance to lactulose or 2) Add-on treatment to lactulose. Treatment (tx) of HE: Used for the treatment of HE. One of the following: 1) Trial and failure, contraindication, or intolerance to lactulose or 2) Add-on treatment to lactulose. Irritable bowel syndrome with diarrhea (IBS-D) (initial): Diagnosis of IBS-D, AND trial and failure, contraindication or intolerance to an antidiarrheal agent [eg, loperamide].
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	TD: 14 days. HE (tx): 12 months. HE (ppx) (init, reauth): 12 months. IBS-D (init, reauth): 2 weeks.
<b>Other Criteria</b>	Prophylaxis of HE recurrence (reauth): Patient demonstrates positive clinical response to therapy. IBS-D (reauth): Symptoms of IBS continue to persist. Patient demonstrates positive clinical response to therapy.

# XOLAIR (S)

## Products Affected

- Xolair

PA Criteria	Criteria Details
Indications	All Medically-accepted Indications.
Off-Label Uses	N/A
Exclusion Criteria	N/A
Required Medical Information	<p>Asthma (init): Diagnosis of moderate to severe persistent allergic asthma. Positive skin test or in vitro reactivity to a perennial aeroallergen. One of the following: A) All of the following: a) Patient is 6 years of age or older but less than 12 years of age, b) Pretreatment serum immunoglobulin (Ig)E level between 30 to 1300 IU/mL, c) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Both of the following: 1) Medium-dose inhaled corticosteroid [ICS] (eg, greater than 100-200 mcg fluticasone propionate equivalent/day), and 2) Additional asthma controller medication (eg, leukotriene receptor antagonist [LTRA] [eg, montelukast], long-acting beta-2 agonist [LABA] [eg, salmeterol], long-acting muscarinic antagonist [LAMA] [eg, tiotropium]), OR ii) One medium dosed combination ICS/LABA product (eg, Advair Diskus [fluticasone propionate 100mcg/salmeterol 50mcg], Symbicort [budesonide 80mcg/formoterol 4.5mcg], Breo Ellipta [fluticasone furoate 50 mcg/vilanterol 25 mcg]), OR B) All of the following: a) Patient is 12 years of age or older, b) Treatment serum immunoglobulin (Ig)E level between 30 to 700 IU/mL, c) Patient is currently being treated with one of the following unless there is a contraindication or intolerance to these medications: i) Both of the following: 1) High-dose ICS [eg, greater than 500 mcg fluticasone propionate equivalent/day], and 2) Additional asthma controller medication (eg, LTRA [eg, montelukast], LABA [eg, salmeterol], LAMA [eg, tiotropium]), OR ii) One maximally-dosed combination ICS/LABA product [eg, Advair (fluticasone propionate/salmeterol), Breo Ellipta (fluticasone/vilanterol)].</p>
Age Restrictions	IgE-Mediated Food Allergy (init): Patient is 1 year of age or older.

<b>Prescriber Restrictions</b>	Asthma (init/reauth): Prescribed by or in consultation with an allergist/immunologist, or pulmonologist. CSU (init): Prescribed by or in consultation with an allergist/immunologist, or dermatologist. CRSwNP (init/reauth): Prescribed by or in consultation with an allergist/immunologist, otolaryngologist, or pulmonologist. IgE-Mediated Food Allergy (Init/Reauth): Prescribed by or in consultation with an allergist/immunologist.
<b>Coverage Duration</b>	Asthma,init:6mo,reauth:12mo. CSU,init:3mo,reauth:6mo. CRSwNP:12mo. Allergy,init:20wk,reauth:12mo



---

**Other Criteria**

Asthma (reauth): Patient demonstrates positive clinical response to therapy. Patient continues to be treated with ICS (eg, fluticasone, budesonide) with or without additional asthma controller medication (eg, LTRA [eg, montelukast], LABA [eg, salmeterol], LAMA [eg, tiotropium]) unless there is a contraindication or intolerance to these medications. Chronic Spontaneous Urticaria (CSU) (init): Diagnosis of CSU. Persistent symptoms (itching and hives) with a second generation H1 antihistamine (eg, cetirizine, fexofenadine), unless there is a contraindication or intolerance to H1 antihistamines. Patient has tried and had an inadequate response or intolerance or contraindication to at least one of the following additional therapies: H2 antagonist (eg, famotidine, cimetidine), leukotriene receptor antagonist (eg, montelukast), H1 antihistamine, hydroxyzine, doxepin. Used concurrently with an H1 antihistamine, unless there is a contraindication or intolerance to H1 antihistamines. CSU (reauth): Patient's disease status has been re-evaluated since the last authorization to confirm the patient's condition warrants continued treatment. Patient has experienced one or both of the following: Reduction in itching severity from baseline or Reduction in the number of hives from baseline. Chronic Rhinosinusitis with Nasal polyps (CRSwNP) (init): Diagnosis of CRSwNP. Unless contraindicated, the patient has had an inadequate response to an intranasal corticosteroid (eg, fluticasone, mometasone). Used in combination with another agent for chronic rhinosinusitis with nasal polyps. CRSwNP (reauth): Patient demonstrates positive clinical response to therapy. Used in combination with another agent for chronic rhinosinusitis with nasal polyps. IgE-Mediated Food Allergy (Initial): One of the following: A) Both of the following: 1) Diagnosis of IgE Mediated Food Allergy as evidenced by one of the following: a) Positive skin prick test (defined as greater than or equal to 4 mm wheal greater than saline control) to food, b) Positive food specific IgE (greater than or equal to 6 kUA/L), c) Positive oral food challenge, defined as experiencing dose-limiting symptoms at a single dose of less than or equal to 300 mg of food protein, AND 2) Clinical history of IgE Mediated Food Allergy, OR B) Provider attestation that patient has a history of severe allergic response, including anaphylaxis, following exposure to one or more foods. Used in conjunction with food allergen avoidance. Baseline (pre-Xolair tx) serum total IgE level is greater than or equal to 30 IU/mL and less than or equal to 1850 IU/mL. Dosing is according to serum total IgE levels and body weight. IgE-Mediated Food Allergy (Reauth): Patient demonstrates positive clinical response to therapy. Used in conjunction with food allergen avoidance. Dosing will continue to be based on body weight and pretreatment total IgE serum levels.

---

## XOSPATA (S)

---

### Products Affected

- Xospata

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of acute myeloid leukemia (AML). Disease is relapsed or refractory. Patient has a FMS-like tyrosine kinase (FLT3) mutation as determined by a U.S. Food and Drug Administration (FDA)-approved test (e.g., LeukoStrat CDx FLT3 Mutation Assay) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## XPOVIO (S)

---

### Products Affected

- Xpovio
- Xpovio 60 Mg Twice Weekly
- Xpovio 80 Mg Twice Weekly

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Multiple Myeloma (MM), Diffuse large B-cell lymphoma (DLBCL): Diagnosis of one of the following: 1) DLBCL OR 2) Multiple Myeloma.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## XTANDI (S)

### Products Affected

- Xtandi

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Castration-resistant or castration-recurrent prostate cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) or recurrent prostate cancer. Metastatic castration-sensitive prostate cancer (M-CSPC): Diagnosis of metastatic castration-sensitive prostate cancer. Non-metastatic castration-sensitive prostate cancer (nm-CSPC): Diagnosis of non-metastatic castration-sensitive prostate cancer (nmCSPC). Patient has high-risk biochemical recurrence (BCR) defined by a PSA doubling time less than or equal to 9 months and one of the following: A) PSA values greater than or equal to 1 ng/mL if the patient had prior prostatectomy (with or without radiotherapy) OR B) PSA values at least 2 ng/mL above the nadir if the patient had prior radiotherapy only.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## XURIDEN (S)

---

### Products Affected

- Xuriden

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Hereditary orotic aciduria (Initial): Diagnosis of hereditary orotic aciduria.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a medical geneticist or other specialist that treats inborn errors of metabolism
<b>Coverage Duration</b>	Initial, reauth: 12 months
<b>Other Criteria</b>	Hereditary orotic aciduria (reauth): Patient demonstrates positive clinical response to therapy.

## XYREM (S)

### Products Affected

- Sodium Oxybate

- Xyrem

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND trial and failure, contraindication, or intolerance to one of the following: 1) amphetamine-based stimulant (eg, amphetamine, dextroamphetamine), OR 2) methylphenidate-based stimulant.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
<b>Coverage Duration</b>	All uses (initial): 6 months. All uses (reauth): 12 months
<b>Other Criteria</b>	Narcolepsy Type 1 (reauth): Documentation demonstrating a reduction in the frequency of cataplexy attacks associated with therapy, OR documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy. Narcolepsy Type 2 (reauth): Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy.

## XYWAV (S)

### Products Affected

- Xywav

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Narcolepsy with cataplexy (Narcolepsy Type 1)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are present, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present. Narcolepsy without cataplexy (Narcolepsy Type 2)(initial): Diagnosis of narcolepsy as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of cataplexy are absent, AND symptoms of excessive daytime sleepiness (eg, irrepressible need to sleep or daytime lapses into sleep) are present, AND one of the following: 1) both of the following: A) patient is 18 years of age or older, and B) trial and failure, contraindication or intolerance to both of the following: i) generic modafinil, AND ii) generic armodafinil, OR 2) patient is 7 to 17 years of age. Idiopathic Hypersomnia (IH)(initial): Diagnosis of idiopathic hypersomnia as confirmed by sleep study (unless the prescriber provides justification confirming that a sleep study would not be feasible), AND symptoms of excessive daytime sleepiness (e.g., nap duration of longer than 60 minutes) are present.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses (initial): Prescribed by or in consultation with one of the following: neurologist, psychiatrist, or sleep medicine specialist.
<b>Coverage Duration</b>	All uses (initial): 6 months. All uses (reauth): 12 months

<b>Other Criteria</b>	Narcolepsy with cataplexy (Narcolepsy Type 1)(reauth): Documentation demonstrating a reduction in the frequency of cataplexy attacks associated with therapy, OR documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy. Narcolepsy without Cataplexy (Narcolepsy Type 2)(reauth): Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy. Idiopathic Hypersomnia (IH)(reauth): Documentation demonstrating a reduction in symptoms of excessive daytime sleepiness associated with therapy.
-----------------------	--



## YONSA (S)

---

### Products Affected

- Yonsa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Prostate Cancer: Diagnosis of castration-resistant (chemical or surgical) or recurrent prostate cancer. Trial and failure or intolerance to Xtandi (enzalutamide).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy

## YUFLYMA (S)

### Products Affected

- Yuflyma 1-pen Kit
- Yuflyma 2-syringe Kit
- Yuflyma Cd/uc/hs Starter

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Rheumatoid Arthritis (RA) (Initial): Diagnosis of moderately to severely active RA. Minimum duration of a 3-month trial and failure, contraindication, or intolerance (TF/C/I) to one of the following conventional therapies at maximally tolerated doses: methotrexate, leflunomide, sulfasalazine. Polyarticular Juvenile Idiopathic Arthritis (PJIA) (Initial): Diagnosis of moderately to severely active PJIA. Minimum duration of a 6-week TF/C/I to one of the following conventional therapies at maximally tolerated doses: leflunomide or methotrexate. Psoriatic Arthritis (PsA) (Initial): Diagnosis of active PsA. One of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, or active skin and/or nail involvement. Plaque Psoriasis (PsO) (Initial): Diagnosis of moderate to severe chronic PsO. One of the following: at least 3% body surface area (BSA) involvement, severe scalp psoriasis, OR palmoplantar (ie, palms, soles), facial, or genital involvement. Ankylosing Spondylitis (AS) (Initial): Diagnosis of active AS. Minimum duration of a one-month TF/C/I to one NSAID (eg, ibuprofen, naproxen) at maximally tolerated doses. Crohn's Disease (CD) (Initial): Diagnosis of moderately to severely active CD. One of the following: frequent diarrhea and abdominal pain, at least 10% weight loss, complications (eg, obstruction, fever, abdominal mass), abnormal lab values (eg, CRP), OR CD Activity Index (CDAI) greater than 220. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), methotrexate. Uveitis (initial): Diagnosis of non-infectious uveitis, classified as intermediate, posterior, or panuveitis.</p>
<b>Age Restrictions</b>	N/A

<b>Prescriber Restrictions</b>	RA, AS, JIA (initial): Prescribed by or in consultation with a rheumatologist. PsA (initial): Prescribed by or in consultation with a dermatologist or rheumatologist. PsO, HS (initial): Prescribed by or in consultation with a dermatologist. CD, UC (initial): Prescribed by or in consultation with a gastroenterologist. Uveitis (initial): Prescribed by or in consultation with an ophthalmologist or rheumatologist.
<b>Coverage Duration</b>	UC (Initial): 12 wks. UC (reauth): 12 mo. All other indications (initial): 6 mo, (reauth): 12 mo.

---

**Other Criteria**

Ulcerative Colitis (UC) (Initial): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. TF/C/I to one of the following conventional therapies: 6-mercaptopurine, azathioprine, corticosteroid (eg, prednisone), aminosalicylate [eg, mesalamine, olsalazine, sulfasalazine]. Hidradenitis suppurativa (HS) (Initial): Diagnosis of moderate to severe hidradenitis suppurativa (ie, Hurley Stage II or III). RA, PJIA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline OR improvement in symptoms (eg, pain, stiffness, inflammation) from baseline. PsA (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: reduction in the total active (swollen and tender) joint count from baseline, improvement in symptoms (eg, pain, stiffness, pruritus, inflammation) from baseline, OR reduction in the BSA involvement from baseline. HS, Uveitis (Reauth): Patient demonstrates positive clinical response to therapy. PsO (Reauth): Patient demonstrates positive clinical response to therapy. AS (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by improvement from baseline for at least one of the following: disease activity (eg, pain, fatigue, inflammation, stiffness), lab values (erythrocyte sedimentation rate, C-reactive protein level), function, axial status (eg, lumbar spine motion, chest expansion), OR total active (swollen and tender) joint count. CD (Reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state. UC (Reauth): For patients who initiated therapy within the past 12 weeks: Patient demonstrates clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy OR For patients who have been maintained on therapy for longer than 12 weeks: Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline, OR reversal of high fecal output state.

---

## ZAVESCA (S)

---

### Products Affected

- Miglustat

- Yargesa

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Gaucher disease: Diagnosis of mild to moderate type 1 Gaucher disease.
<b>Age Restrictions</b>	Gaucher disease: Patient is 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	Gaucher disease: 12 months
<b>Other Criteria</b>	N/A

## ZEJULA (S)

---

### Products Affected

- Zejula

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Epithelial ovarian, fallopian tube, or primary peritoneal cancer: Diagnosis of one of the following: epithelial ovarian cancer, fallopian tube cancer, or primary peritoneal cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ZELBORAF (S)

---

### Products Affected

- Zelboraf

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Melanoma: Diagnosis of unresectable melanoma or metastatic melanoma. Cancer is BRAFV600 mutant type (MT) as detected by a U.S. Food and Drug Administration (FDA)-approved test (eg, cobas 4600 BRAFV600 Mutation Test) or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA). Erdheim-Chester Disease: Diagnosis of Erdheim-Chester disease AND Disease is BRAFV600 mutant type (MT).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	All indications: Approve for continuation of therapy.

## ZEPATIER (S)

### Products Affected

- Zepatier

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Criteria will be applied consistent with current AASLD/IDSA guideline. All patients: Diagnosis of chronic hepatitis C, ONE of the following: 1) Patient has a trial and failure, contraindication or intolerance to a) sofosbuvir/velpatasvir AND b) Mavyret, OR 2) For continuation of prior therapy. Patient does not have moderate to severe hepatic impairment (eg, Child-Pugh Class B or C). For genotype 1a, patient has been tested for the presence of NS5A resistance-associated polymorphisms (ie, polymorphisms at amino acid positions 28, 30, 31, or 93). One of the following: patient is 12 years of age or older OR patient weight is at least 30 kg.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with one of the following: Hepatologist, Gastroenterologist, Infectious disease specialist, HIV specialist certified through the American Academy of HIV Medicine.
<b>Coverage Duration</b>	12 to 16 weeks. Criteria will be applied consistent with current AASLD/IDSA guideline.
<b>Other Criteria</b>	N/A



## ZEPOSIA (S)

### Products Affected

- Zeposia
- Zeposia 7-day Starter Pack
- Zeposia Starter Kit

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Multiple Sclerosis (MS) (initial): Diagnosis of a relapsing form of MS (e.g., clinically isolated syndrome, relapsing-remitting disease, secondary progressive disease, including active disease with new brain lesions). One of the following: a) Failure after a trial of at least 4 weeks, contraindication, or intolerance to two of the following disease-modifying therapies for MS: 1) Teriflunomide, 2) Gilenya (fingolimod), or 3) Brand Tecfidera/generic dimethyl fumarate, OR b) for continuation of prior therapy. Ulcerative Colitis (UC) (init): Diagnosis of moderately to severely active UC. One of the following: greater than 6 stools per day, frequent blood in the stools, frequent urgency, presence of ulcers, abnormal lab values (eg, hemoglobin, ESR, CRP), OR dependent on, or refractory to, corticosteroids. One of the following: a) Trial and failure, contraindication, or intolerance to two of the following: one formulary adalimumab product, Stelara (ustekinumab), Rinvoq (upadacitinib), or Xeljanz IR (tofacitinib IR)/Xeljanz XR (tofacitinib XR), OR b) for continuation of prior therapy.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	MS (initial, reauth): Prescribed by or in consultation with a neurologist. UC (init): Prescribed by or in consultation with a gastroenterologist.
<b>Coverage Duration</b>	MS (initial, reauth): 12 months. UC (init): 6 months, (reauth): 12 months.

<b>Other Criteria</b>	MS (reauth): Patient demonstrates positive clinical response to therapy (e.g., stability in radiologic disease activity, clinical relapses, disease progression). UC (reauth): Patient demonstrates positive clinical response to therapy as evidenced by at least one of the following: improvement in intestinal inflammation (eg, mucosal healing, improvement of lab values [platelet counts, erythrocyte sedimentation rate, C-reactive protein level]) from baseline OR reversal of high fecal output state.
-----------------------	--

# ZIEXTENZO (S)

## Products Affected

- Ziextenzo

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	<p>Febrile neutropenia (FN) prophylaxis: Patient will be receiving prophylaxis for FN due to one of the following: 1) Patient is receiving National Cancer Institute’s Breast Intergroup, INT C9741 dose dense chemotherapy protocol for primary breast cancer, 2) patient is receiving a dose-dense chemotherapy regimen for which the incidence of FN is unknown, 3) patient is receiving chemotherapy regimen(s) associated with greater than 20% incidence of FN, 4) both of the following: a) patient is receiving chemotherapy regimen(s) associated with 10-20% incidence of FN, AND b) patient has one or more risk factors associated with chemotherapy-induced infection, FN, or neutropenia, OR 5) Both of the following: a) patient is receiving myelosuppressive anticancer drugs associated with neutropenia, AND b) patient has a history of FN or dose-limiting event during a previous course of chemotherapy (secondary prophylaxis). Acute radiation syndrome (ARS): Patient was/will be acutely exposed to myelosuppressive doses of radiation (hematopoietic subsyndrome of ARS). Treatment of FN: Patient has received or is receiving myelosuppressive anticancer drugs associated with neutropenia. Diagnosis of FN. Patient is at high risk for infection-associated complications.</p>
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	All uses: Prescribed by or in consultation with a hematologist/oncologist
<b>Coverage Duration</b>	ARS: 1 mo. FN (prophylaxis, treatment): 3 mo or duration of tx.
<b>Other Criteria</b>	All Indications (except for ARS): Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca/Udenyca Onbody. ARS: Trial and failure or intolerance to both of the following: Neulasta/Neulasta Onpro AND Udenyca.



## ZILBRYSQ (S)

### Products Affected

- Zilbrysq

PA Criteria	Criteria Details
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of generalized myasthenia gravis (gMG). Patient is anti-acetylcholine receptor (AChR) antibody positive. One of the following: A) Trial and failure, contraindication, or intolerance (TF/C/I) to two immunosuppressive therapies (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), or B) Both of the following: 1) TF/C/I to one immunosuppressive therapy (e.g., glucocorticoids, azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus), and 2) TF/C/I to one of the following: a) chronic plasmapheresis or plasma exchange (PE), or b) intravenous immunoglobulin (IVIG).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	Initial, Reauth: 12 months
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy.

## ZOKINVY (S)

---

### Products Affected

- Zokinvy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	One of the following: 1) Diagnosis of Hutchinson-Gilford Progeria Syndrome, OR 2) For treatment of processing-deficient Progeroid Laminopathies with one of the following: i) Heterozygous LMNA mutation with progerin-like protein accumulation OR ii) Homozygous or compound heterozygous ZMPSTE24 mutations. Patient has a body surface area of 0.39 m <sup>2</sup> and above.
<b>Age Restrictions</b>	Patient is 12 months of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## ZOLINZA (S)

---

### Products Affected

- Zolinza

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Cutaneous T-cell lymphoma (CTCL): Diagnosis of CTCL. Progressive, persistent or recurrent disease on or contraindication or intolerance to two systemic therapies (e.g., bexarotene, romidepsin, etc.).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ZORYVE (S)

### Products Affected

- Zoryve CREA

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Initial: Diagnosis of plaque psoriasis. One of the following: a) Minimum duration of a 4 week trial and failure, contraindication, or intolerance (TF/C/I) to two of the following topical therapies: corticosteroids (eg, betamethasone, clobetasol), vitamin D analogs (eg, calcitriol, calcipotriene), tazarotene, calcineurin inhibitors (eg, tacrolimus, pimecrolimus), anthralin, or coal tar, OR b) minimum duration of a 4 week TF/C/I to one of the following topical combination therapies: vitamin D analog/corticosteroid (eg, Enstilar, Taclonex) or Duobrii (halobetasol/tazarotene).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	Initial: Prescribed by or in consultation with a dermatologist.
<b>Coverage Duration</b>	Initial: 6 months, Reauth: 12 months.
<b>Other Criteria</b>	Reauth: Patient demonstrates positive clinical response to therapy as evidenced by one of the following: reduction in the body surface area (BSA) involvement from baseline, OR improvement in symptoms (eg, pruritus, inflammation) from baseline.



## ZTALMY (S)

---

### Products Affected

- Ztalmy

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Diagnosis of cyclin-dependent kinase-like 5 (CDKL5) deficiency disorder (CDD). Patient has a mutation in the CDKL5 gene. Trial and failure, contraindication, or intolerance to two formulary anticonvulsants (e.g., valproic acid, levetiracetam, lamotrigine).
<b>Age Restrictions</b>	Patient is 2 years of age or older.
<b>Prescriber Restrictions</b>	Prescribed by or in consultation with a neurologist.
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ZTLIDO (S)

---

### Products Affected

- Ztlido

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Post-herpetic neuralgia: Diagnosis of post-herpetic neuralgia. Trial and failure or intolerance to generic lidocaine patch 5%.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	N/A

## ZURZUVAE (S)

---

### Products Affected

- Zurzuvae

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Postpartum Depression (PPD): One of the following: A) Diagnosis of severe PPD or B) Both of the following: a) Diagnosis of mild to moderate PPD, and b) Trial and failure, contraindication, or intolerance to at least one oral SSRI or SNRI (e.g., escitalopram, duloxetine). Onset of symptoms in the third trimester or within 4 weeks of delivery. Prescriber attests that the patient has been counseled and has agreed to adhere to the following: Will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence or the degree of driving impairment caused by Zurzuvae.
<b>Age Restrictions</b>	PPD: Patient is 18 years of age or older.
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	14 days
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ZYDELIG (S)

---

### Products Affected

- Zydelig

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Chronic lymphocytic leukemia (CLL): Diagnosis of CLL. Used in combination with Rituxan (rituximab). The patient has relapsed on at least one prior therapy (eg, purine analogues [fludarabine, pentostatin, cladribine], alkylating agents [chlorambucil, cyclophosphamide], or monoclonal antibodies [rituximab]). Patient is a candidate for Rituxan (rituximab) monotherapy due to presence of other comorbidities (eg, coronary artery disease, peripheral vascular disease, diabetes mellitus, pulmonary disease [COPD]).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ZYKADIA (S)

---

### Products Affected

- Zykadia TABS

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Non-small cell lung cancer (NSCLC): Diagnosis of NSCLC that is metastatic or recurrent. Tumor is anaplastic lymphoma kinase (ALK)-positive as detected by a U.S. Food and Drug Administration (FDA)-approved test or a test performed at a facility approved by Clinical Laboratory Improvement Amendments (CLIA).
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy.

## ZYTIGA (PREFERRED) (S)

---

### Products Affected

- Abiraterone Acetate

<b>PA Criteria</b>	<b>Criteria Details</b>
<b>Indications</b>	All Medically-accepted Indications.
<b>Off-Label Uses</b>	N/A
<b>Exclusion Criteria</b>	N/A
<b>Required Medical Information</b>	Castration-Resistant Prostate Cancer (CRPC): Diagnosis of castration-resistant (chemical or surgical) or recurrent prostate cancer. Castration-Sensitive Prostate Cancer (CSPC): Diagnosis of castration-sensitive prostate cancer.
<b>Age Restrictions</b>	N/A
<b>Prescriber Restrictions</b>	N/A
<b>Coverage Duration</b>	CRPC, CSPC: 12 months
<b>Other Criteria</b>	Approve for continuation of prior therapy

## PART B VERSUS PART D

---

### Products Affected

- Abelcet
- Acetylcysteine INHALATION SOLN
- Acyclovir Sodium INJ 50MG/ML
- Albuterol Sulfate NEBU 0.083%, 0.63MG/3ML, 1.25MG/3ML, 2.5MG/0.5ML
- Ambisome
- Amphotericin B INJ
- Amphotericin B Liposome
- Aprepitant CAPS
- Astagraf XL
- Azasan
- Azathioprine TABS
- Bethkis
- Budesonide SUSP
- Cellcept
- Clinimix 4.25%/dextrose 10%
- Clinimix 4.25%/dextrose 5%
- Clinimix 5%/dextrose 15%
- Clinimix 5%/dextrose 20%
- Clinimix E 2.75%/dextrose 5% INJ 570MG/100ML; 316MG/100ML; 33MG/100ML; 5GM/100ML; 515MG/100ML; 132MG/100ML; 165MG/100ML; 201MG/100ML; 159MG/100ML; 51MG/100ML; 110MG/100ML; 454MG/100ML; 154MG/100ML; 261MG/100ML; 187MG/100ML; 138MG/100ML; 217MG/100ML; 112MG/100ML; 116MG/100ML; 50MG/100ML; 11MG/100ML; 160MG/100ML
- Clinimix E 4.25%/dextrose 10%
- Clinimix E 4.25%/dextrose 5%
- Clinimix E 5%/dextrose 15%
- Clinimix E 5%/dextrose 20%
- Clinisol Sf 15%
- Cromolyn Sodium NEBU
- Cyclophosphamide CAPS
- Cyclophosphamide TABS
- Cyclosporine CAPS
- Cyclosporine Modified
- Emend CAPS 80MG
- Emend SUSR
- Emend Tripack
- Engerix-b
- Envarsus Xr
- Everolimus TABS 0.25MG, 0.5MG, 0.75MG, 1MG
- Formoterol Fumarate NEBU
- Gengraf CAPS 100MG, 25MG
- Gengraf SOLN
- Granisetron Hydrochloride TABS
- Heplisav-b
- Imovax Rabies (h.d.c.v.)
- Imuran TABS
- Intralipid INJ 20GM/100ML, 30GM/100ML
- Ipratropium Bromide INHALATION SOLN 0.02%
- Ipratropium Bromide/albuterol Sulfate
- Kitabis Pak
- Levalbuterol NEBU
- Levalbuterol Hcl NEBU 0.31MG/3ML, 1.25MG/3ML
- Levalbuterol Hydrochloride NEBU 0.63MG/3ML
- Mycophenolate Mofetil CAPS
- Mycophenolate Mofetil SUSR
- Mycophenolate Mofetil TABS
- Mycophenolic Acid Dr
- Myfortic
- Nebupent
- Neoral
- Nutrilipid
- Ondansetron Hcl SOLN
- Ondansetron Hydrochloride TABS
- Ondansetron Odt
- Pentamidine Isethionate INHALATION SOLR
- Perforomist

- Plenamine INJ 147.4MEQ/L; 2.17GM/100ML; 1.47GM/100ML; 434MG/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 749MG/100ML; 1.04GM/100ML; 1.18GM/100ML; 749MG/100ML; 1.04GM/100ML; 894MG/100ML; 592MG/100ML; 749MG/100ML; 250MG/100ML; 39MG/100ML; 960MG/100ML
- Prehevbrio
- Premasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Prograf CAPS
- Prograf PACK
- Prosol
- Rabavert
- Rapamune
- Recombivax Hb
- Sandimmune CAPS 100MG, 25MG
- Sandimmune ORAL SOLN
- Sirolimus SOLN
- Sirolimus TABS
- Tacrolimus CAPS
- Tobramycin NEBU
- Travasol INJ 52MEQ/L; 1760MG/100ML; 880MG/100ML; 34MEQ/L; 1760MG/100ML; 372MG/100ML; 406MG/100ML; 526MG/100ML; 492MG/100ML; 492MG/100ML; 526MG/100ML; 356MG/100ML; 500MG/100ML; 356MG/100ML; 390MG/100ML; 34MG/100ML; 152MG/100ML
- Trimethobenzamide Hydrochloride
- Trophamine INJ 0.54GM/100ML; 1.2GM/100ML; 0.32GM/100ML; 0; 0; 0.5GM/100ML; 0.36GM/100ML; 0.48GM/100ML; 0.82GM/100ML; 1.4GM/100ML; 1.2GM/100ML; 0.34GM/100ML; 0.48GM/100ML; 0.68GM/100ML; 0.38GM/100ML; 5MEQ/L; 0.025GM/100ML; 0.42GM/100ML; 0.2GM/100ML; 0.24GM/100ML; 0.78GM/100ML
- Varubi TBPK
- Yupelri
- Zortress

## Details

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



# INDEX

## A

Abelcet .....	519	Alosetron Hydrochloride .....	237
Abiraterone Acetate.....	518	Alpha-1 Proteinase Inhibitor, Non-preferred (s)..	18
Acetylcysteine .....	519	Alpha-1 Proteinase Inhibitor, Prolastin (s) .....	19
Actemra .....	1	Altreno .....	20
Actemra Actpen.....	1	Altreno (s) .....	20
Actemra Sc (s).....	1	Alunbrig .....	21
Acthar .....	165	Alunbrig (s).....	21
Actimmune .....	3	Alvaiz.....	22
Actimmune (s).....	3	Alvaiz (s).....	22
Acyclovir Sodium .....	519	Alyq.....	5
Adbry.....	4	Ambisome .....	519
Adbry (s) .....	4	Ambrisentan .....	225
Adcirca (s).....	5	Amphotericin B.....	519
Adempas.....	6	Amphotericin B Liposome.....	519
Adempas (s).....	6	Ampyra .....	24
Aemcolo .....	7	Ampyra (s) .....	24
Aemcolo (s).....	7	Androgel Pump .....	424
Afinitor .....	8	Apokyn.....	25
Afinitor (s).....	8	Apokyn (s) .....	25
Afinitor Disperz.....	9	Apomorphine Hydrochloride .....	25
Afinitor Disperz (s) .....	9	Aprepitant .....	519
Afrezza .....	10	Aralast Np .....	18
Afrezza (s).....	10	Aranesp (s) .....	26
Agamree .....	11	Aranesp Albumin Free .....	26
Agamree (s).....	11	Arcalyst.....	28
Aimovig.....	12	Arcalyst (s).....	28
Aimovig (s) .....	12	Arformoterol (s).....	30
Ajovy .....	14	Arformoterol Tartrate.....	30
Ajovy (s).....	14	Arikayce .....	31
Akeega.....	15	Arikayce (s).....	31
Akeega (s) .....	15	Armodafinil.....	288
Aklief.....	16	Astagraf XL .....	519
Aklief (s) .....	16	Atralin .....	431
Albuterol Sulfate .....	519	Aubagio.....	32
Alecensa .....	17	Aubagio (s).....	32
Alecensa (s).....	17	Augtyro .....	33
		Augtyro (s) .....	33
		Auryxia .....	34

Auryxia (s).....	34
Austedo.....	35
Austedo (s) .....	35
Avonex .....	262
Avonex Pen .....	262
Ayvakit .....	36
Ayvakit (s).....	36
Azasan .....	519
Azathioprine .....	519

## **B**

Bafiertam .....	37
Bafiertam (s).....	37
Balversa .....	38
Balversa (s).....	38
Benlysta.....	39
Benlysta (s).....	39
Berinert.....	40
Berinert (s).....	40
Besremi.....	41
Besremi (s) .....	41
Betaseron.....	262
Bethkis.....	519
Bexarotene.....	412
Bimzelx .....	42
Bimzelx (s) .....	42
Bivigam .....	199
Bosentan .....	432
Bosulif .....	43
Bosulif (s).....	43
Braftovi.....	44
Braftovi (s) .....	44
Brimonidine Tartrate.....	260
Briviact .....	45
Briviact (s).....	45
Bronchitol.....	46
Bronchitol (s).....	46
Brovana .....	47
Brovana (s) .....	47
Brukinsa .....	48
Brukinsa (s) .....	48
Budesonide.....	519
Bydureon Bcise .....	156
Byetta .....	156
Bylvay .....	49

Bylvay (pellets).....	49
Bylvay (s).....	49

## **C**

Cabliivi.....	51
Cabliivi (s).....	51
Cabometyx .....	52
Cabometyx (s).....	52
Calquence.....	53
Calquence (s) .....	53
Camzyos.....	54
Camzyos (s) .....	54
Caplyta .....	55
Caplyta (s).....	55
Caprelsa.....	56
Caprelsa (s) .....	56
Carisoprodol.....	57
Carisoprodol (s) .....	57
Cayston .....	58
Cayston (s) .....	58
Cellcept .....	519
Cequa .....	59
Cequa (s).....	59
Cerdelga .....	60
Cerdelga (s).....	60
Chenodal .....	61
Chenodal (s) .....	61
Cholbam.....	62
Cholbam (s).....	62
Cialis .....	63
Cialis (s).....	63
Cibinqo.....	64
Cibinqo (s) .....	64
Ciclopirox (s) .....	65
Ciclopirox Nail Lacquer .....	65
Cimzia.....	66
Cimzia (s).....	66
Cinryze.....	68
Cinryze (s).....	68
Clinimix 4.25%/dextrose 10% .....	519
Clinimix 4.25%/dextrose 5% .....	519
Clinimix 5%/dextrose 15% .....	519
Clinimix 5%/dextrose 20% .....	519
Clinimix E 2.75%/dextrose 5%.....	519
Clinimix E 4.25%/dextrose 10%.....	519

Clinimix E 4.25%/dextrose 5% .....	519
Clinimix E 5%/dextrose 15% .....	519
Clinimix E 5%/dextrose 20% .....	519
Clinisol Sf 15% .....	519
Cometriq.....	69
Cometriq (s).....	69
Copaxone.....	153
Copiktra.....	70
Copiktra (s).....	70
Corlanor.....	71
Corlanor (s) .....	71
Cortrophin .....	73
Cortrophin (s) .....	73
Cosentyx.....	75
Cosentyx (s).....	75
Cosentyx Sensoready Pen .....	75
Cosentyx Unoready .....	75
Cotellic .....	77
Cotellic (s).....	77
Cresemba.....	78
Cresemba Oral (s).....	78
Crinone.....	79
Crinone (s).....	79
Cromolyn Sodium.....	519
Cuprimine (s).....	80
Cuvposa (s).....	81
Cuvrior .....	82
Cuvrior (s) .....	82
Cyclophosphamide .....	519
Cyclosporine.....	519
Cyclosporine Modified.....	519
Cyltezo .....	83
Cyltezo (s) .....	83
Cyltezo Starter Package For Crohns Disease/uc/hs .....	83
Cyltezo Starter Package For Psoriasis.....	83

## **D**

Dalfampridine Er.....	24
Daliresp .....	86
Daliresp (s) .....	86
Daraprim.....	87
Daraprim (s) .....	87
Daurismo .....	88
Daurismo (s).....	88

Daybue .....	89
Daybue (s).....	89
Dayvigo.....	90
Dayvigo (s).....	90
Deferasirox.....	91
Deferasirox (s) .....	91
Deferiprone .....	131
Deflazacort.....	106
Demerol.....	173
Demser .....	92
Demser (s).....	92
Depo-testosterone .....	424
Desoxyn (s) .....	93
Diacomit.....	94
Diacomit (s) .....	94
Dibenzyliline .....	95
Dibenzyliline (s).....	95
Diclofenac Epolamine.....	138
Diclofenac Sodium.....	326
Dihydroergotamine Mesylate.....	259
Dimethyl Fumarate .....	419
Dimethyl Fumarate Starterpack .....	419
Doptelet.....	96
Doptelet (s).....	96
Doxepin Hydrochloride .....	97
Doxepin Topical (s) .....	97
Dronabinol .....	246
Droxidopa .....	278
Dulera.....	98
Dulera (s) .....	98
Duopa.....	99
Duopa (s).....	99
Dupixent.....	100
Dupixent (s) .....	100

## **E**

Egrifta (s) .....	103
Egrifta Sv .....	103
Eligard.....	104
Eligard (s).....	104
Elyxyb.....	105
Elyxyb (s).....	105
Emend .....	519
Emend Tripack.....	519
Emflaza (s) .....	106

Emgality .....	107	Fentanyl (s) .....	130
Emgality (s) .....	107	Fentanyl Citrate.....	277
Enbrel .....	109	Fentanyl Citrate Oral Transmucosal .....	130
Enbrel (s) .....	109	Fentora .....	277
Enbrel Mini .....	109	Ferriprox (s) .....	131
Enbrel Sureclick .....	109	Ferriprox Twice-a-day .....	131
Endari .....	111	Filspari .....	132
Endari (s) .....	111	Filspari (s) .....	132
Engerix-b.....	519	Filsuvez .....	133
Enspryng.....	112	Filsuvez (s).....	133
Enspryng (s) .....	112	Fingolimod Hydrochloride.....	151
Entyvio .....	113	Fintepla .....	134
Entyvio (s).....	113	Fintepla (s) .....	134
Envarsus Xr.....	519	Firazyr .....	135
Epclusa .....	114	Firazyr (s).....	135
Epclusa Non-preferred (s) .....	114	Firdapse.....	136
Epclusa Preferred (s) .....	115	Firdapse (s).....	136
Epidiolex .....	116	Firmagon .....	137
Epidiolex (s) .....	116	Firmagon (s).....	137
Epoetin Alfa (s) .....	117	Flector (s).....	138
Epogen.....	117	Fluticasone Furoate/vilanterol Ellipta.....	140
Erivedge .....	119	Fluticasone Hfa (s).....	139
Erivedge (s) .....	119	Fluticasone Propionate Hfa.....	139
Erleada.....	120	Fluticasone-vilanterol (s) .....	140
Erleada (s) .....	120	Formoterol Fumarate .....	519
Erlotinib Hydrochloride .....	411	Forteo .....	422
Esbriet.....	121	Fotivda .....	141
Esbriet (s) .....	121	Fotivda (s) .....	141
Eucrisa.....	122	Fruzaqla.....	142
Eucrisa (s).....	122	Fruzaqla (s) .....	142
Evenity .....	123	Fulphila .....	143
Evenity (s) .....	123	Fulphila (s) .....	143
Everolimus .....	8, 9, 519	Furoscix.....	145
Evrysdi .....	124	Furoscix (s) .....	145
Evrysdi (s) .....	124	Fylnetra .....	146
Exjade.....	91	Fylnetra (s) .....	146
Eysuvis .....	126	<b>G</b>	
Eysuvis (s).....	126	Galafold.....	148
<b>F</b>		Galafold (s) .....	148
Fabhalta .....	127	Gammagard Liquid .....	199
Fabhalta (s).....	127	Gammagard S/d Iga Less Than 1mcg/ml.....	199
Fasenra .....	128	Gammaked .....	199
Fasenra (s) .....	128	Gammaplex .....	199
Fasenra Pen .....	128	Gamunex-c .....	199

Gattex .....	149
Gattex (s).....	149
Gavreto.....	150
Gavreto (s).....	150
Gefitinib .....	194
Gengraf.....	519
Genotropin.....	163
Genotropin Miniquick.....	163
Gilenya .....	151
Gilenya (s).....	151
Gilotrif.....	152
Gilotrif (s).....	152
Glassia .....	18
Glatiramer Acetate .....	153
Glatiramer Acetate (s).....	153
Glatopa .....	153
Gleevec (s).....	154
Glp (non-preferred) (s).....	155
Glp1 (preferred) (s).....	156
Glumetza (s).....	157
Glycopyrrolate.....	81, 158
Glycopyrrolate Tablet (s) .....	158
Gocovri.....	159
Gocovri (s).....	159
Granisetron Hydrochloride.....	519
Grastek .....	160
Grastek (s).....	160
Growth Hormone, Non-preferred (s) .....	161
Growth Hormone, Preferred (s) .....	163

## **H**

H.p. Acthar Gel (s).....	165
Haegarda.....	167
Haegarda (s) .....	167
Harvoni.....	168
Harvoni (s).....	168
Heplisav-b .....	519
Hetlioz (s).....	169
Horizant.....	170
Horizant (s).....	170
Hrm - Megestrol Suspension.....	171
Hrm - Megestrol Tablet.....	172
Hrm - Pain Medications .....	173
Humatrope.....	161
Humira.....	174

Humira (s).....	174
Humira Pediatric Crohns Disease Starter Pack..	174
Humira Pen .....	174
Humira Pen-cd/uc/hs Starter.....	174
Humira Pen-pediatric Uc Starter Pack.....	174
Humira Pen-ps/uv Starter.....	174
Hyftor.....	177
Hyftor (s).....	177

## **I**

Ibrance.....	178
Ibrance (s) .....	178
Icatibant Acetate .....	135
Iclusig.....	179
Iclusig (s) .....	179
Idhifa.....	180
Idhifa (s).....	180
Ilumya .....	181
Ilumya (s).....	181
Imatinib Mesylate .....	154
Imbruvica .....	182
Imbruvica (s).....	182
Imovax Rabies (h.d.c.v.).....	519
Imuran .....	519
Invexxy (s).....	183
Invexxy Maintenance Pack.....	183
Invexxy Starter Pack .....	183
Inbrija.....	184
Inbrija (s).....	184
Increlex .....	185
Increlex (s) .....	185
Ingrezza.....	186
Ingrezza (s).....	186
Injectable Testosterone, Non-preferred (s) .....	187
Inlyta .....	189
Inlyta (s).....	189
Inqovi .....	190
Inqovi (s).....	190
Inrebic .....	191
Inrebic (s).....	191
Insulin Glargine .....	192
Insulin Glargine (s) .....	192
Insulin Glargine Solostar .....	192
Intralipid.....	519
Intrarosa .....	193

Intrarosa (s) .....	193
Ipratropium Bromide.....	519
Ipratropium Bromide/albuterol Sulfate .....	519
Iressa.....	194
Iressa (s) .....	194
Isturisa .....	195
Isturisa (s).....	195
Itraconazole .....	196, 197
Itraconazole Capsule (s) .....	196
Itraconazole Solution (s) .....	197
Ivermectin.....	198
Ivermectin (s) .....	198
Ivig (s) .....	199
Iwilfin .....	201
Iwilfin (s).....	201

**J**

Jadenu Sprinkle .....	91
Jakafi .....	202
Jakafi (s) .....	202
Jatenzo.....	203
Jatenzo (s).....	203
Javygtor .....	205
Javygtor (s).....	205
Jaypirca.....	206
Jaypirca (s) .....	206
Joenja.....	207
Joenja (s) .....	207
Juxtapid .....	208
Juxtapid (s) .....	208
Jynarque .....	209
Jynarque (s) .....	209

**K**

Kalydeco.....	210
Kalydeco (s) .....	210
Kerendia .....	211
Kerendia (s).....	211
Kerydin (s).....	212
Kesimpta.....	213
Kesimpta (s) .....	213
Keveyis.....	214
Keveyis (s).....	214
Kevzara.....	215
Kevzara (s) .....	215

Kineret.....	216
Kineret (s) .....	216
Kisqali.....	218
Kisqali (s).....	218
Kisqali Femara 200 Dose.....	219
Kisqali Femara 400 Dose.....	219
Kisqali Femara 600 Dose.....	219
Kisqali-femara Pack (s).....	219
Kitabis Pak .....	519
Korlym .....	220
Korlym (s).....	220
Koselugo .....	221
Koselugo (s) .....	221
Krazati.....	222
Krazati (s).....	222
Kuvan (s).....	223

**L**

Lapatinib Ditosylate.....	440
Ledipasvir/sofosbuvir .....	168
Lenalidomide .....	356
Lenvima (s).....	224
Lenvima 10 Mg Daily Dose.....	224
Lenvima 12mg Daily Dose .....	224
Lenvima 14 Mg Daily Dose.....	224
Lenvima 18 Mg Daily Dose.....	224
Lenvima 20 Mg Daily Dose.....	224
Lenvima 24 Mg Daily Dose.....	224
Lenvima 4 Mg Daily Dose.....	224
Lenvima 8 Mg Daily Dose.....	224
Letairis (s) .....	225
Leukine .....	226
Leukine (s) .....	226
Leuprolide Acetate.....	228, 241
Leuprolide Brand (s).....	228
Levalbuterol .....	519
Levalbuterol Hcl .....	519
Levalbuterol Hydrochloride.....	519
Lidocaine.....	230
Lidocaine Hydrochloride .....	229
Lidocaine Topical (s) .....	229
Lidocan .....	231
Lidoderm.....	231
Lidoderm (s).....	230
Lidoderm Brand (s).....	231

Liqrev .....	354	Mekinist .....	250
Lisdexamfetamine Dimesylate .....	473	Mekinist (s) .....	250
Litfulo .....	232	Mektovi .....	252
Litfulo (s) .....	232	Mektovi (s) .....	252
Livmarli .....	233	Meperidine Hcl .....	173
Livmarli (s) .....	233	Metformin Hydrochloride .....	253
Lodoco .....	234	Metformin Hydrochloride Er .....	157
Lodoco (s) .....	234	Metformin Ir (s) .....	253
Lonsurf .....	235	Methamphetamine Hcl .....	93
Lonsurf (s) .....	235	Methitest .....	256
Lorbrena .....	236	Methotrexate Injection (s) .....	254
Lorbrena (s) .....	236	Methotrexate Injection, Non-preferred (s) .....	255
Lotronex (s) .....	237	Methyltestosterone (s) .....	256
Lumakras .....	238	Metyrosine .....	92
Lumakras (s) .....	238	Miebo .....	258
Lumryz .....	239	Miebo (s) .....	258
Lumryz (s) .....	239	Mifepristone .....	220
Lupkynis .....	240	Miglustat .....	501
Lupkynis (s) .....	240	Migranal .....	259
Lupron (s) .....	241	Migranal (s) .....	259
Lupron Depot (1-month) .....	242	Mirvaso .....	260
Lupron Depot (3-month) .....	242	Mirvaso (s) .....	260
Lupron Depot (4-month) .....	242	Modafinil .....	335
Lupron Depot (6-month) .....	242	Mounjaro .....	156
Lupron Depot (s) .....	242	Ms Interferons (non-preferred) (s) .....	261
Lupron Depot Ped (s) .....	243	Ms Interferons (preferred) (s) .....	262
Lupron Depot-ped (1-month) .....	243	Mulpleta .....	263
Lupron Depot-ped (3-month) .....	243	Mulpleta (s) .....	263
Lupron Depot-ped (6-month) .....	243	Myalept .....	264
Lynparza .....	244	Myalept (s) .....	264
Lynparza Tablet (s) .....	244	Mycapssa .....	265
Lytgobi .....	245	Mycapssa (s) .....	265
Lytgobi (s) .....	245	Mycophenolate Mofetil .....	519
<b>M</b>		Mycophenolic Acid Dr .....	519
Marinol .....	246	Myfembree .....	266
Marinol (s) .....	246	Myfembree (s) .....	266
Mavenclad .....	247	Myfortic .....	519
Mavenclad (s) .....	247	<b>N</b>	
Mavyret .....	248	Nebupent .....	519
Mavyret (s) .....	248	Neoral .....	519
Mayzent .....	249	Nerlynx .....	268
Mayzent (s) .....	249	Nerlynx (s) .....	268
Mayzent Starter Pack .....	249	Neulasta .....	269
Megestrol Acetate .....	171, 172	Neulasta (s) .....	269

Nexavar .....	270	Ofev (s) .....	295
Nexavar (s) .....	270	Ogsiveo .....	297
Nexletol .....	271	Ogsiveo (s) .....	297
Nexletol (s) .....	271	Ojjaara .....	298
Nexlizet .....	273	Ojjaara (s) .....	298
Nexlizet (s) .....	273	Olpruva .....	299
Ngenla .....	275	Olpruva (s) .....	299
Ngenla (s) .....	275	Olumiant .....	300
Ninlaro .....	276	Olumiant (s) .....	300
Ninlaro (s) .....	276	Omnitrope .....	161
Non-preferred Tirf (s) .....	277	OmvoH .....	302
Norditropin Flexpro .....	161	OmvoH (s) .....	302
Northera (s) .....	278	Ondansetron Hcl .....	519
Nourianz .....	279	Ondansetron Hydrochloride .....	519
Nourianz (s) .....	279	Ondansetron Odt .....	519
Noxafil .....	280, 330	Onureg .....	303
Noxafil Suspension (s) .....	280	Onureg (s) .....	303
Nubeqa .....	281	Opsumit .....	304
Nubeqa (s) .....	281	Opsumit (s) .....	304
Nucala .....	282	Opzelura .....	305
Nucala (s) .....	282	Opzelura (s) .....	305
Nuedexta .....	284	Oralair .....	307
Nuedexta (s) .....	284	Oralair (s) .....	307
Nuplazid .....	285	Orencia .....	308
Nuplazid (s) .....	285	Orencia Clickject .....	308
Nurtec .....	286	Orencia Sc (s) .....	308
Nurtec (s) .....	286	Orenitram .....	310
Nutrilipid .....	519	Orenitram (s) .....	310
Nutropin Aq Nuspin 10 .....	163	Orenitram Titration Kit Month 1 .....	310
Nutropin Aq Nuspin 20 .....	163	Orenitram Titration Kit Month 2 .....	310
Nutropin Aq Nuspin 5 .....	163	Orenitram Titration Kit Month 3 .....	310
Nuvigil (s) .....	288	Orgovyx .....	311
Nyvepria .....	290	Orgovyx (s) .....	311
Nyvepria (s) .....	290	Oriahnn .....	312
<b>O</b>		Oriahnn (s) .....	312
Ocaliva .....	292	Orilissa .....	313
Ocaliva (s) .....	292	Orilissa (s) .....	313
Octagam .....	199	Orkambi .....	314, 315
Octreotide Acetate .....	370	Orkambi (s) .....	314
Odactra .....	293	Orkambi Granules (s) .....	315
Odactra (s) .....	293	Orladeyo .....	316
Odomzo .....	294	Orladeyo (s) .....	316
Odomzo (s) .....	294	Orserdu .....	317
Ofev .....	295	Orserdu (s) .....	317



Osmolex Er.....	318
Osmolex Er (s) .....	318
Osphena.....	319
Osphena (s).....	319
Otezla .....	320
Otezla (s) .....	320
Otrexup.....	255
Oxbryta.....	321
Oxbryta (s).....	321
Oxervate .....	322
Oxervate (s).....	322
Ozempic .....	156

**P**

Palynziq.....	323
Palynziq (s).....	323
Panzyga .....	199
Part B Versus Part D .....	519
Pazopanib Hydrochloride .....	466
Pegasys.....	324
Pegasys (s).....	324
Pemazyre .....	325
Pemazyre (s).....	325
Penicillamine.....	80
Pennsaid .....	326
Pennsaid (s) .....	326
Pentamidine Isethionate .....	519
Perforomist.....	519
Phenoxybenzamine Hydrochloride .....	95
Piqray (s).....	327
Piqray 200mg Daily Dose .....	327
Piqray 250mg Daily Dose .....	327
Piqray 300mg Daily Dose .....	327
Pirfenidone .....	121
Plegridy .....	262
Plenaminate .....	520
Pomalyst.....	328
Pomalyst (s).....	328
Ponvory .....	329
Ponvory (s) .....	329
Ponvory 14-day Starter Pack.....	329
Posaconazole .....	280
Posaconazole Dr.....	330
Posaconazole Tablet (s).....	330
Praluent.....	331

Praluent (s).....	331
Prehevbrio.....	520
Premasol.....	520
Privigen.....	199
Procrit.....	117
Prograf.....	520
Prolastin-c .....	19
Promacta .....	333
Promacta (s) .....	333
Prosol .....	520
Provigil (s) .....	335
Pulmozyme .....	337
Pulmozyme (s) .....	337
Pyrimethamine .....	87
Pyrukynd.....	338
Pyrukynd (s).....	338
Pyrukynd Taper Pack.....	338

**Q**

Qinlock.....	339
Qinlock (s) .....	339
Qalaaquin.....	340
Qalaaquin (s).....	340
Quinine Sulfate .....	340
Qulipta.....	341
Qulipta (s) .....	341
Quviviq .....	343
Quviviq (s) .....	343

**R**

Rabavert .....	520
Radicava Ors (s).....	344
Radicava Ors Starter Kit .....	344
Rapamune .....	520
Rasuvo.....	254
Ravicti.....	345
Ravicti (s).....	345
Rebif.....	261
Rebif Rebidose.....	261
Rebif Rebidose Titration Pack .....	261
Rebif Titration Pack .....	261
Recombivax Hb .....	520
Regranex .....	346
Regranex (s).....	346
Repatha .....	347

Repatha (s).....	347	Scemblix .....	371
Repatha Pushtrex System .....	347	Scemblix (s) .....	371
Repatha Sureclick.....	347	Serostim .....	372
Retacrit .....	349	Serostim (s).....	372
Retacrit (s).....	349	Signifor .....	373
Retevmo .....	351	Signifor (s) .....	373
Retevmo (s) .....	351	Sildenafil Citrate .....	353, 354
Retin-a .....	431	Siliq.....	374
Retin-a Micro .....	431	Siliq (s).....	374
Retin-a Micro Pump .....	431	Simponi .....	375
Revatio (s) .....	353	Simponi (s).....	375
Revatio Suspension (s).....	354	Sirolimus .....	520
Revcovi.....	355	Skyclarys.....	377
Revcovi (s) .....	355	Skyclarys (s).....	377
Revlimid.....	356	Skyrizi .....	378
Revlimid (s).....	356	Skyrizi (s).....	378
Reyvow.....	357	Skyrizi Pen .....	378
Reyvow (s) .....	357	Skytrofa.....	380
Rezlidhia.....	358	Skytrofa (s).....	380
Rezlidhia (s) .....	358	Sodium Oxybate.....	494
Rezurock.....	359	Sofosbuvir/velpatasvir .....	115
Rezurock (s) .....	359	Sogroya .....	381
Rinvoq .....	360	Sogroya (s).....	381
Rinvoq (s).....	360	Sohonos.....	383
Rivfloza .....	363	Sohonos (s).....	383
Rivfloza (s).....	363	Somavert .....	384
Roflumilast.....	86	Somavert (s) .....	384
Rozlytrek .....	364	Sorafenib Tosylate .....	270
Rozlytrek (s).....	364	Sotyktu .....	385
Rubraca.....	365	Sotyktu (s).....	385
Rubraca (s) .....	365	Sovaldi .....	386
Ruconest.....	366	Sovaldi (s).....	386
Ruconest (s).....	366	Spevigo .....	387
Rybelsus .....	156	Spevigo (s) .....	387
Rydapt .....	367	Sporanox .....	196, 197
Rydapt (s) .....	367	Sprycel .....	388
<b>S</b>			
Sabril (s) .....	368	Sprycel (s).....	388
Sajazir.....	135	Stelara .....	389
Samsca.....	369	Stelara (s) .....	389
Samsca (s) .....	369	Stimufend.....	391
Sandimmune.....	520	Stimufend (s).....	391
Sandostatin (s).....	370	Stivarga .....	393
Sapropterin Dihydrochloride.....	223	Stivarga (s).....	393
		Stromectol.....	198

Sunitinib Malate .....	395
Sunosi .....	394
Sunosi (s).....	394
Sutent.....	395
Sutent (s) .....	395
Symdeko.....	396
Symdeko (s).....	396
Symlyn (s) .....	397
Symlynpen 120.....	397
Symlynpen 60.....	397
Syndros.....	398
Syndros (s).....	398
Syprine (s) .....	399

## **T**

Tabrecta.....	400
Tabrecta (s).....	400
Tacrolimus.....	520
Tadalafil .....	5, 63
Tadliq .....	401
Tadliq (s) .....	401
Tafamidis (s) .....	402
Tafinlar .....	403
Tafinlar (s).....	403
Tagrisso .....	405
Tagrisso (s).....	405
Takhzyro.....	407
Takhzyro (s) .....	407
Taltz.....	408
Taltz (s) .....	408
Talzenna .....	410
Talzenna (s).....	410
Tarceva (s).....	411
Targretin (s).....	412
Tarpeyo.....	413
Tarpeyo (s) .....	413
Tascenso (s).....	414
Tascenso Odt.....	414
Tasigna .....	415
Tasigna (s).....	415
Tasimelteon .....	169
Tavaborole.....	212
Tavalisse.....	416
Tavalisse (s).....	416
Tavneos .....	417

Tavneos (s).....	417
Tazverik .....	418
Tazverik (s).....	418
Tecfidera (s).....	419
Teglutik.....	430
Tegsedi.....	420
Tegsedi (s).....	420
Tepmetko .....	421
Tepmetko (s) .....	421
Teriflunomide .....	32
Teriparatide .....	422
Teriparatide (s).....	422
Testim .....	424
Testosterone .....	424
Testosterone (s).....	424
Testosterone Cypionate.....	424
Testosterone Enanthate .....	426
Testosterone Enanthate (s).....	426
Testosterone Pump.....	424
Tetrabenazine.....	483
Thalomid.....	428
Thalomid (s).....	428
Tibsovo .....	429
Tibsovo (s) .....	429
Tiglutik (s) .....	430
Tobramycin.....	520
Tolvaptan .....	369
Topical Retinoid (s) .....	431
Tracleer (s).....	432
Travasol.....	520
Trelstar (s).....	433
Trelstar Mixject.....	433
Tremfya.....	434
Tremfya (s).....	434
Tretinoin.....	431
Tretinoin Microsphere .....	431
Trientine Hydrochloride.....	399
Trikafta.....	435
Trikafta (s) .....	435
Trimethobenzamide Hydrochloride .....	520
Trophamine .....	520
Trudhesa.....	436
Trudhesa (s) .....	436
Trulicity.....	156

Truqap .....	437	Vfend IV .....	464
Truqap (s) .....	437	Viberzi.....	457
Tukysa .....	438	Viberzi (s) .....	457
Tukysa (s).....	438	Victoza .....	155
Turalio .....	439	Vigabatrin .....	368
Turalio (s).....	439	Vigadrone.....	368
Tykerb (s) .....	440	Vigpoder .....	368
Tymlos.....	441	Vijoice.....	458
Tymlos (s) .....	441	Vijoice (s).....	458
Tyvaso Dpi (s).....	443	Vitrakvi .....	459
Tyvaso Dpi Maintenance Kit .....	443	Vitrakvi (s).....	459
Tyvaso Dpi Titration Kit.....	443	Vizimpro .....	460
<b>U</b>		Vizimpro (s) .....	460
Ubrelvy.....	444	Vonjo.....	461
Ubrelvy (s).....	444	Vonjo (s) .....	461
Udenyca.....	445	Voquenza (s) .....	462
Udenyca (s) .....	445	Voquezna .....	462
Uptravi.....	446	Voriconazole .....	464
Uptravi (s) .....	446	Voriconazole Injection (s).....	464
Uptravi Titration Pack.....	446	Vosevi .....	465
<b>V</b>		Vosevi (s) .....	465
Valchlor.....	447	Votrient .....	466
Valchlor (s).....	447	Votrient (s).....	466
Vanflyta.....	448	Vowst .....	467
Vanflyta (s).....	448	Vowst (s).....	467
Varubi.....	520	Voxzogo .....	468
Velsipity .....	449	Voxzogo (s).....	468
Velsipity (s).....	449	Vtama .....	470
Venclexta.....	450	Vtama (s).....	470
Venclexta (s) .....	450	Vuity .....	471
Venclexta Starting Pack .....	450	Vuity (s) .....	471
Ventavis.....	451	Vumerity .....	472
Ventavis (s) .....	451	Vumerity (s) .....	472
Veozah.....	452	Vyndamax.....	402
Veozah (s) .....	452	Vyndaqel.....	402
Verkazia .....	453	Vyvanse.....	473
Verkazia (s) .....	453	Vyvanse (s) .....	473
Verquvo.....	454	<b>W</b>	
Verquvo (s).....	454	Wainua .....	474
Verzenio .....	455	Wainua (s).....	474
Verzenio (s).....	455	Wakix .....	475
Veveye .....	456	Wakix (s).....	475
Veveye (s) .....	456	Wegovy .....	476
		Wegovy (s).....	476
			532

Welireg .....	477
Welireg (s) .....	477
Winlevi .....	478
Winlevi (s) .....	478

## X

Xalkori .....	479
Xalkori (s) .....	479
Xcopri .....	480
Xcopri (s) .....	480
Xeljanz .....	481
Xeljanz (s) .....	481
Xeljanz Xr .....	481
Xenazine (s) .....	483
Xermelo .....	484
Xermelo (s) .....	484
Xgeva .....	485
Xgeva (s) .....	485
Xifaxan .....	486
Xifaxan (s) .....	486
Xolair .....	487
Xolair (s) .....	487
Xospata .....	490
Xospata (s) .....	490
Xpovio .....	491
Xpovio (s) .....	491
Xpovio 60 Mg Twice Weekly .....	491
Xpovio 80 Mg Twice Weekly .....	491
Xtandi .....	492
Xtandi (s) .....	492
Xuriden .....	493
Xuriden (s) .....	493
Xyosted .....	187
Xyrem .....	494
Xyrem (s) .....	494
Xywav .....	495
Xywav (s) .....	495

## Y

Yargesa .....	501
Yonsa .....	497
Yonsa (s) .....	497

Yuflyma (s) .....	498
Yuflyma 1-pen Kit .....	498
Yuflyma 2-syringe Kit .....	498
Yuflyma Cd/uc/hs Starter .....	498
Yupelri .....	520

## Z

Zavesca (s) .....	501
Zejula .....	502
Zejula (s) .....	502
Zelboraf .....	503
Zelboraf (s) .....	503
Zemaira .....	18
Zepatier .....	504
Zepatier (s) .....	504
Zeposia .....	505
Zeposia (s) .....	505
Zeposia 7-day Starter Pack .....	505
Zeposia Starter Kit .....	505
Ziextenzo .....	507
Ziextenzo (s) .....	507
Zilbrysq .....	509
Zilbrysq (s) .....	509
Zokinvy .....	510
Zokinvy (s) .....	510
Zolinza .....	511
Zolinza (s) .....	511
Zomacton .....	161
Zortress .....	520
Zoryve .....	512
Zoryve (s) .....	512
Ztalmy .....	513
Ztalmy (s) .....	513
Ztlido .....	514
Ztlido (s) .....	514
Zurzuvae .....	515
Zurzuvae (s) .....	515
Zydelig .....	516
Zydelig (s) .....	516
Zykadia .....	517
Zykadia (s) .....	517
Zytiga (preferred) (s) .....	518